TESTIMONYSB857.pdf

Uploaded by: Barber, Claudia

Position: FAV

TESTIMONY BEFORE THE SENATE FINANCE COMMITTEE

SENATE BILL 857

Hearing: Tuesday, March 11, 2021 at 1:00 pm

Presented by Claudia Barber, First Vice President of Anne Arundel County Branch of NAACP

Good afternoon Chair Delores Kelly and Vice Chair Brian Feldman.

My name is Claudia Barber, and I am the first vice president of the Anne Arundel County NAACP.

The Anne Arundel County NAACP wholeheartedly supports Senate Bill 857. The bill creates and establishes within the Governor's Office of Crime Prevention, Youth and Victim Services, a Maryland Community Health and Public Safety Center of Excellence. We applaud this and ask that you **issue a favorable report on this bill**.

The Center is to provide technical assistance to local governments for the purposes of sharing best practices across jurisdictions, applying for grants to support work related behavioral health and justice and facilitating the distribution of resources, technical assistance and training in best practices related to programs along all intercepts of the community health and public safety system. The Anne Arundel County NAACP is behind this bill because it is all inclusive, and will assist the African American community greatly as a valuable resource to people of all colors. We understand its legislative intent is to divert adults with serious mental illness from a criminal justice system to community mental health and addiction services. For that, we say thank you. It is long overdue.

The bill also includes facilitating subsequent local and regional sequential intercept model summits to establish a regional approach to community health and public safety, which includes facilitating multi-jurisdictional applications for federal behavioral health and criminal justice grants.

We also applaud the bill's mention of recommendations for investment in preventive services systems, including assertive community treatment, expanded housing options for justice involved persons and an increase in access to transportation.

Finally, we strongly endorse the five priorities set forth in Section 13-4206 on the last page of the bill. They are (1) behavioral health crisis grants; (2) training for 911 operators; (3) peer support services; (4) behavioral health screenings; and (5) scholarships for students who attend a Maryland HBCU to study criminal justice related issues.

Please vote YES for Senate Bill 857. Thank you.

HFAM Testimony SB 857 Final.pdf

Uploaded by: DeMattos, Joseph

Position: FAV

TESTIMONY BEFORE THE
SENATE FINANCE COMMITTEE
March 11, 2021
Senate Bill 857: Health - Maryland Community Health and Public Safety Center of Excellence - Establishment
Written Testimony Only

POSITION: SUPPORT

On behalf of the members of the Health Facilities Association of Maryland (HFAM), we appreciate the opportunity to express our support for Senate Bill 857. HFAM represents over 170 skilled nursing centers and assisted living communities in Maryland, as well as nearly 80 associate businesses that offer products and services to healthcare providers. Our members provide services and employ individuals in nearly every jurisdiction in the state.

HFAM members provide the majority of post-acute and long-term care to Marylanders in need: 6 million days of care across all payer sources annually, including more than 4 million Medicaid days of care and one million Medicare days of care. Thousands of Marylanders across the state depend on the high-quality services that our skilled nursing and rehabilitation centers offer every day.

Senate Bill 857 would establish the Maryland Community Health and Public Safety Center and would authorize the Center to enter into contracts with the University of Maryland System or other entities to carry out its mission. The Center would develop a plan to enhance community health and safety, working with state and local governments to provide technical assistance, as well as working with other entities, to facilitate sequential impact models. This type of model is a systems-level framework for criminal justice, mental health, and addictions stakeholders to divert adults with serious mental illness from the criminal justice system to the community health and addictions services. This legislation outlines the activities and requirements of the Center, as well as responsibilities of local jurisdictions.

The highest honor of my work is visiting with residents, patients, and staff in Maryland skilled nursing and rehabilitation centers and on assisted living campuses. Before it became unsafe to visit due to the COVID-19 pandemic I was made these visits, on average, every two weeks.

I bring up these visits relative to our support for SB 857 because the majority of Marylanders providing and receiving quality care in our setting come from diverse backgrounds. They have sadly experienced and suffered from healthcare inequity, social determinants of health, and tragic outcomes of racism.

As I have often shared, the pandemic has highlighted the disparities that exist in healthcare, among both those providing and receiving care, and especially in communities of color and among those who are economically disadvantaged. Healthcare disparity and social determinants of health are a national embarrassment. Together, we must do better in ensuring that resources are not only available, but efficiently coordinated and facilitated across jurisdictions and among stakeholders.

(more)

In order to do better, we must have a framework in place that is able to provide assistance in tangible, measurable ways that are data-driven and documented. SB 857 is critical to ensuring we fully understand and can better advocate to improve public health and safety, and find solutions to inequities in public policy at the intersections of mental health, addiction and substance abuse, community development, and criminal justice.

While none of us caused COVID-19, we all have ownership in public policies associated with and our individual actions on healthcare, transportation, local access to key businesses, access to care, and homelessness that are in part to blame for people and communities of color being disproportionately attacked by COVID-19.

I admired the late Kaiser Permanente CEO Bernard Tyson, who said about the intersection of healthcare disparity and public policy, “Such a small part of healthcare actually happens in the doctor’s office.” He was right.

For these reasons we request a favorable report from the Committee on Senate Bill 857.

Submitted by:

Joseph DeMattos, Jr.
President and CEO
(410) 290-5132

SB857.CASAinSupport.pdf
Uploaded by: Etey-Benissan, Ida
Position: FAV

Testimony in Support of SB 857

March 9, 2021

SB 857 – Maryland Community Health and Public Safety Center of Excellence

Ida Etey-Benissan

CASA, Lead Contact Tracer, Health and Human Services Department

Honorable Chair, Vice Chair and Members of the Finance Committee :

My name is Ida Etey Benissan, I am the Lead Contact Tracer within our Health and Human Services Department at CASA, the mid-Atlantic region's largest immigrant serving and advocacy organization with over 90,000 members statewide. CASA offers a wide array of services including health, legal, employment and education services while engaging members to work collectively to advocate for solutions that address structural inequities present in these very same fields. As such, on behalf of my organization and our members, I urge you to vote in favor of Senate Bill 857, which would help significantly advance efforts to create effective diversion programs aimed at reducing the number of the incarcerated in our state with behavior health needs.

The appalling number of individuals in our prison system with behavioral health needs is a shameful reminder of how we have chosen to deploy our law enforcement to address situations that do not require such measures, and rather call for much more strategic interventions involving our behavioral health and social service infrastructure. This bill seeks to assist those jurisdictions interested in using data and best practices to help create effective diversion programs that can address this issue. The Center of Excellence proposed here would act as a central repository of resources for the purposes of improving our behavioral health and justice systems. Additionally, the legislation as proposed would generate more opportunities for data sharing between departments and community providers that would allow for greater data driven programmatic evaluation and implementation.

As an organization working daily to address racial and ethnic disparities, we believe it is vital these efforts encompass a racial impact analysis as proposed in the legislation. Understanding the data behind how communities of color are disproportionally impacted by current standards of practice is vital to creating an effective diversion system that is inclusive. Such an evaluation must also include criteria that evaluate standards and practices in culturally competent care. Culturally competent behavioral care for the Latino community is essential to the success of any diversion program targeted for that population. There has long

existed gaps in the availability of that type of care for the immigrant community, as such we hope this legislation will help define standards of practice that will increase accessibility for those most vulnerable.

For the reasons outlined above, we ask for a favorable report for SB 857

Thank you

Ida Etey-Benissan

CASA – Health and Human Service Department

SB 857 Maryland Center of Excellence and Public Sa
Uploaded by: frazier, derrell
Position: FAV

mhamd
MENTAL HEALTH ASSOCIATION OF MARYLAND

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Senate Bill 857- Health - Maryland Community Health and Public Safety Center of Excellence - Establishment
Finance Committee
March 11, 2021
Position: Favorable

The Mental Health Association of Maryland is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates, and concerned citizens for unified action in all aspects of mental health, mental illness, and substance use. We appreciate this opportunity to present testimony in support of Senate Bill 857 as amended by the sponsor.

SB 857 establishes the Maryland Community Health and Public Safety Center of Excellence. This bill charges the Center with furthering a sequential intercept model (SIM) framework to divert individuals with serious mental health and substance use disorders away from the criminal justice system. We thank the sponsor for introducing this bill, and for adopting amendments to ensure the Center is performing its duties with an eye toward equity.

According to the Bureau of Justice Statistics, two million adult arrests, or roughly 16.9 percent, in the United States each year involve people with serious mental Illnesses. It's estimated that roughly 70 percent of youth in the juvenile justice system have mental health conditions.[1] Social, economic, and environmental conditions – where individuals live, work and play- significantly impact an individual's health and healthcare, including access to mental and substance use disorder treatment services. Public health professionals refer to these conditions as the social determents of health.

The problem is even worse for certain populations of society. Racial and ethnic minorities have less access to behavioral health services than white people. They are less likely to receive needed care. They are more likely to receive poor-quality care when they are treated. Troublingly, although this results in disparate minority criminalization, incarcerated people of color are less likely to be identified as having a behavioral health disorder and are less likely to receive treatment.

The SIM is a systems-planning framework to improve outcomes for people with mental health and substance use needs who become involved with the criminal justice system. However, the model has never been implemented with an eye toward ensuring the resulting strategies and policies are equitable across populations, particularly those minority populations who will be most impacted.

For these reasons, we support Senate Bill 857 with the sponsor amendments.

[1] https://www.beckershospitalreview.com/care-coordination/mental-illness-a-condition-not-a-crime.html

For more information, please contact Derrell Frazier at (443) 854-1413

Testimony SB857.pdf
Uploaded by: Gibson, Marianne
Position: FAV

STATE OF MARYLAND
OFFICE OF THE GOVERNOR
OPIOID OPERATIONAL COMMAND CENTER

STEVEN R. SCHUH
EXECUTIVE DIRECTOR

100 COMMUNITY PLACE
CROWNSVILLE, MARYLAND 21032

March 9, 2021

Delores G. Kelley
Chair, Finance Committee
Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

Brian J. Feldman
Vice Chair, Finance Committee
James Senate Office Building
Room 104
11 Bladen Street
Annapolis, MD 21401

Dear Chair Kelley, Vice Chair Feldman, and Members of the Finance Committee:

I am Steve Schuh, Executive Director of the Opioid Operational Command Center, and I am pleased to provide written testimony in support of Senate Bill 857: Behavioral Health and Public Safety Center of Excellence.

For those who are unfamiliar, the Opioid Operational Command Center was established by Governor Hogan in 2017 to respond to the acceleration in overdose-related fatalities. Our office is charged with coordinating the state's response to the opioid crisis through partnering with all relevant state departments and with the local Opioid Intervention Teams that are located in Maryland's 23 counties and Baltimore City. Through this coordination, we ensure that the state is implementing strategies that align with Governor Hogan's policy priorities for responding to the opioid crisis: *Prevention & Education*, *Enforcement & Public Safety* and *Treatment & Recovery*.

The Opioid Operational Command Center recognizes fully the link between substance use disorder and involvement in the criminal justice system. The National Institute on Drug Abuse indicates that an estimated 65% of the United States prison population has an active substance use disorder. Another 20% of people in prison – who do not technically meet the criteria for having an active substance use disorder – were under the influence of drugs or alcohol at the time of their arrest. These are staggering statistics, and they underscore the need to identify innovative approaches for meeting the needs of this population. Accordingly, I am strongly supporting the creation of the Center of Excellence, which we believe will help achieve this goal.

Senator Hester and I both have the honor of serving on the Commission to Study Mental and Behavioral Health, which is chaired by Lt. Governor Boyd Rutherford. Senator Hester and Dr. Linda Boneskie co-chair the Public Safety and Judicial Subcommittee, and I chair the Crisis Services subcommittee. Understanding that there is an overrepresentation of individuals with substance use disorder involved in the criminal justice system, we believe that there needs to be better coordination

and partnership between the behavioral health and public safety worlds. Therefore, I was excited to learn about Senator Hester's work with the Public Safety and Judicial Subcommittee to bring to bear a Sequential Intercept Model (SIM) Summit last fall. The Sequential Intercept Model is a framework for identifying points at which someone with a mental health or substance use disorder encounters the criminal justice system. After some initial planning discussions with the Senator, she and I quickly decided to join forces and began pursuing this Summit as a joint venture between each of our respective subcommittees.

The purpose of hosting the SIM Summit was to convene subject-matter experts from around the state to complete a landscape analysis of resources, gaps and opportunities related to the various intercepts outlined in the SIM Framework. The product was a report that identified recommendations on how the state can better meet the needs of people with behavioral health disorders and help prevent interactions with the criminal justice system, avoid penetration through the correctional system, and provide support to justice-involved individuals as they reenter the community.

Pursuing the recommendations outlined in the SIM Summit Report will take a coordinated effort from multiple stakeholders with subject-matter expertise in behavioral health and public safety. We are glad that SB857 will establish a Center of Excellence to oversee the implementation of the recommendations of the SIM Summit Report and will facilitate a more-targeted focus on bridging the behavioral health and public safety worlds.

Ensuring that people with behavioral health care needs who are involved in the criminal-justice system, or who are at risk of involvement, are connected to resources is of critical importance to our office. We know that the criminal-justice system is not the right place for individuals with behavioral health needs, which is why we as a state need to do more to ensure that actions are taken to provide resources and support for individuals at whatever point they encounter the criminal justice system. The establishment of the Center of Excellence will help achieve this, which is why we urge a favorable report on SB857.

Sincerely,

Steve Schuh
Executive Director
Opioid Operational Command Center

SB0857_Cntr_of_Excellence_MLC_FAV.pdf
Uploaded by: Plante, Cecilia
Position: FAV

TESTIMONY FOR SB0857
HEALTH - MARYLAND COMMUNITY HEALTH AND PUBLIC SAFETY CENTER OF EXCELLENCE – ESTABLISHMENT

Bill Sponsor: Senator Hester
Committee: Finance
Organization Submitting: Maryland Legislative Coalition
Person Submitting: Cecilia Plante, co-chair
Position: FAVORABLE

I am submitting this testimony in favor of SB0857 on behalf of the Maryland Legislative Coalition. The Maryland Legislative Coalition is an association of activists - individuals and grassroots groups in every district in the state. We are unpaid citizen lobbyists, and our Coalition supports well over 30,000 members.

The establishment of this Community Health and Public Safety Center of Excellence is an important addition that will establish policy for diverting adults with serious mental illness from the criminal justice system and get them into community mental health and addictions services. We have seen that the criminal justice system is no place for those with mental illness and it is past time that we develop policy for ensuring that the correct services are available for those people.

This Center of Excellence will be part of the Governor's Office of Crime Prevention, Youth and Victims Services. The Center of Excellence will be tasked with coming up with a multi-year strategic plan that includes –

- A statewide pre-crisis-to-recovery service delivery model and infrastructure
- A plan for formal and coordinated screening processes at jail booking; recommendations for investment in preventative services including –
    - Assertive community treatment
    - Expanded housing options for justice-involved persons
    - An increase in access to transportation
- Expansion of the use of technology across all intercepts of community health and public safety

Our members feel that we have a critical need for this type of strategy and policy. The Maryland Legislative Coalition supports this bill and we recommend a **FAVORABLE** report in Committee.

SB857 Lt. Governor Letter - March 2.2021.pdf

Uploaded by: Whitaker, Jake
Position: FAV

STATE OF MARYLAND
OFFICE OF THE LIEUTENANT GOVERNOR

BOYD K. RUTHERFORD
Lt. GOVERNOR

March 2, 2021

Chair Kelley
Vice Chair Feldman
Members of the Senate Finance Committee:

Thank you for your consideration of Senate Bill 857, establishing the Maryland Community Health and Public Safety Center of Excellence. As chair of the Commission to Study Mental and Behavioral Health in Maryland, I can attest to the hard work our subcommittees have done to study our behavioral health system and provide recommendations to better deliver service to the people of Maryland. I also know that centralizing and organizing information on our wide array of behavioral health programs in a Center of Excellence, with a particular focus on those programs intersecting with our justice system, will enable us to fully implement the recommendations of the commission and take advantage of the opportunities for improvement identified during our Sequential Intercept Model Summit at the end of last year.

The Maryland Community Health and Public Safety Center of Excellence will track program development, centralize resources, provide technical assistance to local jurisdictions, and help formalize local planning bodies to implement mental and behavioral health treatment best practices.

At a time when criminal justice and behavioral health are at the forefront of the national conversation, the statewide implementation of comprehensive mental and behavioral health services to support our communities is essential. However, it requires that we are intentional in terms of planning and evaluating our programs, assisting our local jurisdictions, and coordinating efforts across agencies. The establishment of this Center of Excellence will support Marylanders across the State as we work to improve mental and behavioral health services and create a system that takes care of some of our most vulnerable community members.

I respectfully request a favorable report for Senate Bill 857.

Sincerely,

Boyd K. Rutherford
Lt. Governor of Maryland

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TTY USERS CALL VIA MD RELAY

RMC SB857 FWA.pdf
Uploaded by: Davis, Charlotte
Position: FWA

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Website: www.rural.maryland.gov

John Hartline, Chairman *Charlotte Davis, Executive Director*

Testimony in Support of
Senate Bill 857 - Health – Maryland Community Health and Public Safety Center of Excellence – Establishment
Finance Committee
March 11, 2021

The Rural Maryland Council **Supports with Amendments** SB-857 - Health – Maryland Community Health and Public Safety Center of Excellence – Establishment. The Bill would establish the Maryland Community Health and Public Safety Center of Excellence within the Governor's Office of Crime Prevention, Youth, and Victim Services. The Center would provide strategic planning, technical assistance, and assist in the coordination between state and local governments to carry out specified purposes.

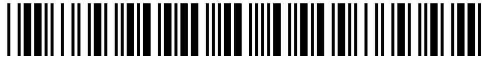
The intent of the bill is to prevent those with mental health issues from being arrested or returning to incarceration after being released. By providing these individuals with proper behavioral health treatment, it will help reduce arrests against those with mental health disorders and reduce the rate of recidivism for those who have been released. The Treatment Advocacy Center reports 20% of jail inmates and 15% of inmates in state prisons suffer from serious mental illness. The total population of inmates that have a serious mental illness is 356,000. How many of these incarcerated individuals could have avoided being arrested and becoming incarcerated if they were directed earlier to get the proper help that they needed. This issue is targeted through many aspects of the bill, including the sequential intercept model which focuses on diverting those with mental health illnesses away from the criminal justice system and to community mental health and addiction services.

The Rural Maryland Council agrees with the Sponsors amendments, including the addition of funding behavioral health in rural areas, and respectfully suggests the additional amendments as well. First, The Council suggests the Center does a strategic plan, including a local assessment of capacity. There are very few public mental health facilities in rural parts of Maryland, specifically in western Maryland and on the shore. Second, In the Collaboration section of the bill, add local health improvement coalitions. These local stakeholders would have information on what is happening on the ground in their areas.

We believe the creation of a Center will help connect the sparse services that do exist in rural areas with local expertise. The Rural Maryland Council respectfully asks for a **favorable with amendments** report on SB-857.

The Rural Maryland Council (RMC) is an independent state agency governed by a nonpartisan, 40-member board that consists of inclusive representation from the federal, state, regional, county and municipal governments, as well as the for-profit and nonprofit sectors. We bring together federal, state, county and municipal government officials as well as representatives of the for-profit and nonprofit sectors to identify challenges unique to rural communities and to craft public policy, programmatic or regulatory solutions.

SB 857 Sponsor Amendments
Uploaded by: Fry Hester, Katie
Position: FWA



SB0857/193329/1

AMENDMENTS
PREPARED
BY THE
DEPT. OF LEGISLATIVE
SERVICES

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BY: Senator Hester
(To be offered in the Finance Committee)

AMENDMENTS TO SENATE BILL 857
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 2, strike "**Community**" and substitute "**Behavioral**"; in lines 4 and 24, in each instance, strike "Community" and substitute "Behavioral"; in line 6, after "Center;" insert "requiring the Center to monitor and analyze its models, plans, policies, strategies, programs, technical assistance, and training in a certain manner and for certain purposes; requiring the Office to appoint certain individuals to jointly oversee the Center; providing that certain individuals may be associated with a certain entity; authorizing the Center to designate certain points of contact for a certain purpose; authorizing the Center to coordinate with the Justice Reinvestment Oversight Board and other State entities;"; in line 7, after "purposes;" insert "providing that the operation of the Center is subject to the limitations of the State budget;"; in line 8, strike "and"; in line 9, after "coordination" insert ", and facilitation"; in line 10, after "purposes;" insert "requiring the Center to develop certain models, recommendations, and procedures;"; in lines 10 and 11, strike "at certain intervals" and substitute "each year"; in line 11, after "purposes;" insert "stating the intent of the General Assembly;"; in line 14, after "plan;" insert "requiring the Center to consider certain factors when developing the plan;"; in line 16, strike "authorizing" and substitute "encouraging"; and strike beginning with "requiring" in line 18 down through "purposes;" in line 19.

AMENDMENT NO. 2

On page 2, in lines 2, 7, and 22, in each instance, strike "**COMMUNITY**" and substitute "**BEHAVIORAL**"; in line 16, strike "**(D)**" and substitute "**(F)**"; after line 15, insert:

"**(D) "RACIAL IMPACT ANALYSIS" MEANS A SYSTEMATIC EXAMINATION OF HOW RACIAL MINORITIES ARE OR WILL BE IMPACTED BY EXISTING OR PROPOSED**

(Over)

MODELS, PLANS, POLICIES, STRATEGIES, PROGRAMS, PROCESSES, OR RECOMMENDATIONS.

(E) "RACIAL MINORITY" MEANS:

(1) BLACK OR AFRICAN AMERICAN;

(2) HISPANIC OR LATINO;

(3) INDIGENOUS, AMERICAN INDIAN, OR ALASKA NATIVE;

(4) ASIAN; OR

(5) NATIVE HAWAIIAN OR PACIFIC ISLANDER.";

in line 16, strike "**INTERCEPT MODEL**" and substitute "**INTERCEPT MODEL**"; strike beginning with "**, MENTAL**" in line 17 down through "**SERVICES**" in line 20 and substitute "**AND BEHAVIORAL HEALTH STAKEHOLDERS TO PREVENT ENTRANCE INTO THE CRIMINAL JUSTICE SYSTEM, MINIMIZE PENETRATION INTO THE CRIMINAL JUSTICE SYSTEM, AND ENGAGE INDIVIDUALS WITH BEHAVIORAL HEALTH SERVICES AND RECOVERY SUPPORTS AS THEY TRANSITION INTO THE COMMUNITY FROM THE CRIMINAL JUSTICE SYSTEM**"; after line 25, insert:

"**(1) ACT AS THE STATEWIDE INFORMATION REPOSITORY FOR BEHAVIORAL HEALTH TREATMENT AND DIVERSION PROGRAMS RELATED TO THE CRIMINAL JUSTICE SYSTEM;**";

and strike beginning with "**ENHANCE**" in line 26 down through "**SAFETY**" in line 27 and substitute "**INCREASE TREATMENT AND REDUCE THE DETENTION OF INDIVIDUALS**

WITH BEHAVIORAL HEALTH DISORDERS INVOLVED IN THE CRIMINAL JUSTICE SYSTEM".

On page 2 in line 26, and on page 3 in lines 1, 4, 6, and 10, strike "**(1)**", "**(2)**", "**(3)**", "**(4)**", and "**(5)**", respectively, and substitute "**(2)**", "**(3)**", "**(4)**", "**(5)**", and "**(6)**", respectively.

On page 3, strike beginning with "**AND**" in line 2 down through "**CARE**" in line 3 and substitute "**SYSTEMS OF CARE THAT PREVENT AND MINIMIZE INVOLVEMENT WITH THE CRIMINAL JUSTICE SYSTEM FOR INDIVIDUALS WITH BEHAVIORAL HEALTH DISORDERS**"; strike beginning with "**THE**" in line 4 down through "**MODELS**" in line 5 and substitute "**LOCAL OR REGIONAL PLANNING WORKSHOPS USING THE SEQUENTIAL INTERCEPT MODEL**"; in line 8, strike "**AND COMMUNITY HEALTH**"; in line 9, after "**STATE**" insert "**RELATING TO INDIVIDUALS INVOLVED IN THE CRIMINAL JUSTICE SYSTEM**"; in line 10, strike "**SEEK AND DISBURSE**" and substitute "**IDENTIFY AND INFORM ANY RELEVANT STAKEHOLDERS OF**"; in line 14, strike "**COMMUNITY HEALTH AND**" and substitute "**BEHAVIORAL HEALTH,**"; in the same line, after "**SAFETY**" insert "**, AND CRIMINAL JUSTICE**"; after line 14, insert:

"**(C) IN CARRYING OUT ITS DUTIES, THE CENTER SHALL CONTINUOUSLY MONITOR AND ANALYZE ITS MODELS, PLANS, POLICIES, STRATEGIES, PROGRAMS, TECHNICAL ASSISTANCE, AND TRAINING FOR OPPORTUNITIES TO REDUCE AND ELIMINATE DISPARITIES IN THE CRIMINALIZATION OF RACIAL MINORITIES WITH BEHAVIORAL HEALTH DISORDERS AND INCREASE ACCESS TO CULTURALLY COMPETENT CARE.**

(D) (1) THE GOVERNOR'S OFFICE OF CRIME PREVENTION, YOUTH, AND VICTIM SERVICES SHALL APPOINT THE FOLLOWING INDIVIDUALS TO JOINTLY OVERSEE THE CENTER:

(I) A CRISIS INTERVENTION LAW ENFORCEMENT COORDINATOR;

(II) A MENTAL HEALTH COORDINATOR; AND

(III) ANY OTHER INDIVIDUALS DETERMINED NECESSARY BY THE OFFICE.

(2) THE INDIVIDUALS APPOINTED UNDER PARAGRAPH (1) OF THIS SUBSECTION MAY BE ASSOCIATED WITH THE CRISIS INTERVENTION TEAM CENTER OF EXCELLENCE WITHIN THE GOVERNOR'S OFFICE OF CRIME PREVENTION, YOUTH, AND VICTIM SERVICES.

(E) THE CENTER MAY DESIGNATE POINTS OF CONTACT THROUGHOUT THE STATE WHO SPECIALIZE IN BEHAVIORAL HEALTH TREATMENT WITHIN THE CRIMINAL JUSTICE SYSTEM TO BRIEF THE CENTER ON THE PROGRESS OF STATEWIDE IMPLEMENTATION OF DIVERSION PROGRAMS.

(F) THE CENTER MAY COORDINATE WITH THE JUSTICE REINVESTMENT OVERSIGHT BOARD AND OTHER STATE ENTITIES WORKING TO REDUCE STATE AND LOCAL DETENTION FACILITY POPULATIONS AND RECIDIVISM.";

in line 15, strike "**(C)**" and substitute "**(G)**"; in line 16, after "**SYSTEM**" insert "**, MARYLAND HBCUS,**"; after line 17, insert:

"**(H) THE OPERATION OF THE CENTER IS SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET.**";

in line 21, strike "**AND**"; in line 22, after "**COORDINATION**" insert "**; AND**

(4) FACILITATING THE PROVISION OF TRAIN–THE–TRAINER COURSES FOR THE SEQUENTIAL INTERCEPT MODEL FOR COMPLETION IN 2021 IN PARTNERSHIP WITH THE FEDERAL SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, WITH THE GOAL OF TRAINING 50 INDIVIDUALS IN THE STATE AS FACILITATORS";

in line 27, after "**HEALTH**" insert "**, PUBLIC SAFETY, OR CRIMINAL**"; in the same line, strike "**AND**"; and strike beginning with "**PROGRAMS**" in line 29 down through "**SYSTEM;**" in line 30 and substitute "**BEHAVIORAL HEALTH, PUBLIC SAFETY, OR CRIMINAL JUSTICE; AND**".

On page 4, strike in their entirety lines 1 through 5, inclusive; in line 6, strike "**(5)**" and substitute "**(4)**"; in the same line, strike "**SUBSEQUENT**"; in lines 6 and 7, strike "**SEQUENTIAL INTERCEPT MODEL SUMMITS**" and substitute "SEQUENTIAL INTERCEPT MODEL SUMMITS"; after line 7, insert:

"**(C)** THE CENTER SHALL DEVELOP THE FOLLOWING:

(1) A STATEWIDE MODEL FOR LAW ENFORCEMENT–ASSISTED DIVERSION;

(2) RECOMMENDATIONS FOR PRETRIAL SERVICES;

(3) PROCEDURES FOR SHARING DEFLECTION AND DIVERSION STATISTICS BETWEEN RELEVANT STATE AGENCIES;

(4) RECOMMENDATIONS FOR STATEWIDE IMPLEMENTATION OF LAW ENFORCEMENT–ASSISTED DIVERSION PROGRAMS; AND

(5) A STATEWIDE MODEL FOR COMMUNITY CRISIS INTERVENTION SERVICES OTHER THAN LAW ENFORCEMENT.";

in lines 8, 12, and 15, strike "**(C)**", "**(D)**", and "**(E)**", respectively, and substitute "**(D)**", "**(E)**", and "**(F)**", respectively; in line 8, before "**THE**" insert "**(1)**"; in lines 8 and 9, strike "**SEQUENTIAL INTERCEPT MODEL SUMMIT EVERY 2 YEARS**" and substitute "SEQUENTIAL INTERCEPT MODEL SUMMIT EACH YEAR"; after line 11, insert:

"**(2)** IT IS THE INTENT OF THE GENERAL ASSEMBLY THAT THE CENTER APPLY TO THE FEDERAL SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION FOR GRANT FUNDING TO HOLD SUBSEQUENT STATE SEQUENTIAL INTERCEPT MODEL SUMMITS ANNUALLY.";

in lines 12 and 13, strike "**SEQUENTIAL INTERCEPT MODEL**" and substitute "SEQUENTIAL INTERCEPT MODEL"; in line 23, strike "**COMMUNITY HEALTH AND PUBLIC SAFETY**" and substitute "BEHAVIORAL HEALTH, PUBLIC SAFETY, AND CRIMINAL JUSTICE"; in line 25, strike "**2021**" and substitute "**2022**"; strike beginning with "**NOVEMBER**" in line 27 down through "**JUSTICE**" in line 28 and substitute "ANNUAL STATE SEQUENTIAL INTERCEPT MODEL SUMMIT"; and strike in their entirety lines 30 and 31.

On page 5, in line 1, strike "**(2)**" and substitute "**(1)**"; in the same line, after "**FORMAL**" insert ", CONSISTENT,"; in the same line, after "**COORDINATED**" insert "BEHAVIORAL HEALTH"; in line 2, after "**BOOKING**" insert ", INCLUDING EXPANDED BEHAVIORAL HEALTH SCREENING FOR VETERANS"; after line 2, insert:

"**(2)** RECOMMENDATIONS FOR THE COORDINATION OF BEHAVIORAL HEALTH AND CRIMINAL JUSTICE INITIATIVES WITH RELATED STATE HEALTH INITIATIVES;";

strike in their entirety lines 6 through 8, inclusive, and substitute:

"**(II) CRISIS RESPONSE SERVICES;**

(III) HARM REDUCTION STRATEGIES; AND

(IV) OTHER PREVENTIVE SERVICES FOR INDIVIDUALS WITH BEHAVIORAL HEALTH DISORDERS;";

in line 9, after "**TECHNOLOGY**" insert "**AND DATA ANALYSIS**"; strike beginning with "**ALL**" in line 9 down through "**SYSTEM.**" in line 10 and substitute "**THE BEHAVIORAL HEALTH, PUBLIC SAFETY, AND CRIMINAL JUSTICE SYSTEMS IN ACCORDANCE WITH THE PURPOSES OF THE CENTER;**"; after line 10, insert:

"**(5) A PLAN FOR EXPANDING THE USE OF PEER SUPPORT SERVICES ACROSS INTERCEPTS; AND**

(6) A RACIAL IMPACT ANALYSIS.

(C) IN DEVELOPING THE STRATEGIC PLAN, THE CENTER SHALL CONSIDER:

(1) OPPORTUNITIES FOR THE PROVISION OF PRE-CRISIS-TO-RECOVERY SERVICES TO INDIVIDUALS WITH BEHAVIORAL HEALTH DISORDERS WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM;

(2) THE AVAILABILITY OF HOUSING OPTIONS FOR INDIVIDUALS WITH BEHAVIORAL HEALTH DISORDERS WHO ARE INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM; AND

(3) **THE AVAILABILITY OF TRANSPORTATION FOR INDIVIDUALS WITH BEHAVIORAL HEALTH DISORDERS WHO ARE INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM.**";

in line 18, strike "**AND**"; after line 18, insert:

"**(5)** **THE LOCAL HEALTH IMPROVEMENT COUNCIL;**

(6) **COMMUNITY–BASED BEHAVIORAL HEALTH PROVIDERS;**

(7) **A REPRESENTATIVE OF THE NAACP;**

(8) **A REPRESENTATIVE OF PUBLIC DEFENDERS; AND**";

in line 19, strike "**(5)**" and substitute "**(9)**"; strike in their entirety lines 21 and 22 and substitute:

"**(1)** **AN ASSESSMENT OF THE CAPACITY OF THE LOCAL BEHAVIORAL SYSTEM;**

(2) **RECOMMENDATIONS FOR THE ENHANCEMENT OF THE LOCAL CRISIS RESPONSE SYSTEM;**

(3) **RECOMMENDATIONS FOR THE ENHANCEMENT OF THE LOCAL BEHAVIORAL HEALTH CARE SYSTEM, INCLUDING CULTURALLY COMPETENT CARE;**";

in line 23, strike "**(3)**" and substitute "**(4)**"; and in line 24, after "**JURISDICTION**" insert "**; AND**

(5) A RACIAL IMPACT ANALYSIS".

On page 6, in line 1, strike "**MAY**" and substitute "**IS ENCOURAGED TO**"; strike in their entirety lines 5 and 6 and substitute:

"**IT IS THE INTENT OF THE GENERAL ASSEMBLY THAT THE CENTER, TO THE EXTENT PRACTICABLE, IDENTIFY OPPORTUNITIES TO FUND:**";

in line 10, strike "**AND**"; in line 12, after "**STUDY**" insert "**BEHAVIORAL HEALTH–, PUBLIC SAFETY–, OR**"; in the same line, after "**ISSUES**" insert "**; AND**

(6) BEHAVIORAL HEALTH INITIATIVES IN RURAL COMMUNITIES";

and in line 13, strike "June" and substitute "July".

Maryland SIM Summit Report (1).pdf
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Position: FWA

Maryland Lieutenant Governor's Commission to Study Mental and Behavioral Health: State Summit on Behavioral Health and the Justice System

Using the Sequential Intercept Mapping Initiative to Inform Efforts in Maryland

Prepared by: SAMHSA's GAINS Center

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SAMHSA's GAINS Center

November 17-18, 2020

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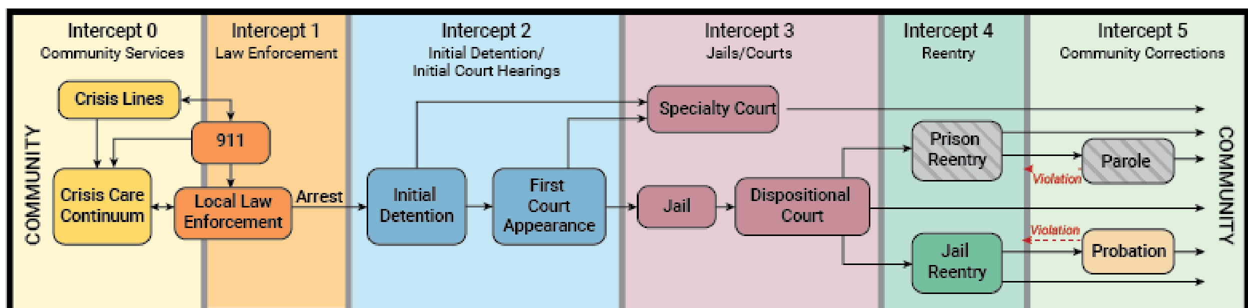
ACKNOWLEDGEMENT

The Substance Abuse and Mental Health Services (SAMHSA) GAINS Center wishes to thank Lieutenant Governor Boyd Rutherford and Maryland State Senator Katie Fry Hester, for their guidance and assistance with the coordination of this event. We also acknowledge Senate Judicial Proceedings Chairman Will Smith, Judge John P. Morrissey, Judge George Lipman, Department of Public Safety and Correctional Services Secretary Robert Green, Director Martha Danner, Dr. Lynda Bonieskie, Richard Abbot, Kimberlee Watts, Lieutenant Colonel Roland Butler, Steve Schuh, Marianne Gibson, Jen Solan, and Nithin Venkatraman for their involvement in the planning of and participation in this event. In addition, we would like to thank Regina Huerter for her assistance facilitating the Intercept 0-1 Breakout Session.

BACKGROUND

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

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



Maryland's 2020 State Summit on Behavioral Health and the Justice System consisted of a presentation of the SIM and best and evolving practices to

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

- 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.

Dan Abreu, senior project associate with the Substance Abuse and Mental Health Services Administration's (SAMHSA) GAINS Center, and Dr. Debra Pinals, SAMHSA's GAINS Center consultant and national expert in forensic psychiatry, co-facilitated the Summit. On Day One, the Summit was open to a broad group of stakeholders, and there were 224 individuals in attendance. Dr. Pinals and Mr. Abreu provided an overview of the SIM, which was followed by a series of intercept-specific panels that highlighted a sample of Maryland's Best Practice Programs. On day two, a smaller group of cross-system stakeholders representing all regions of the state participated in one of three breakout workgroups: Intercept 0-1, Crisis Response and Pre-booking Diversion; Intercept 2-3, Court Diversion and Jail Services; or Intercept 4-5, Reentry and Community Corrections. Each of the groups had a facilitator who led a discussion that identified resources for their specific area, identified gaps in programs or planning for their specific workgroup, and prioritized the identified gaps through a voting process.

The work from these breakout workgroups informed recommendations listed later in this report.

INTRODUCTION

The Commission to Study Mental and Behavioral Health in Maryland, led by Lieutenant Governor Rutherford, requested that SAMHSA's GAINS Center provide a state-level strategic planning workshop to inform the work of the Public Safety and Justice System and Crisis Services subcommittees and to guide targeted legislative appropriations for crisis services and jail diversion. The Maryland Lieutenant Governor's Commission to Study Mental and Behavioral Health: State Summit on Behavioral Health and the Justice System was held virtually on November 17-18, 2020.

Senator Katie Fry Hester and her co-chair, Dr. Lynda Bonieskie, led the coordination of this Summit as a key deliverable of the Public Safety and Justice System subcommittee's work in collaboration with the subcommittee on Crisis Services chaired by Steve Schuh. Senator Hester opened the Summit by providing national statistics related to the interaction of individuals with mental illnesses and the criminal justice system and acknowledged that these statistics are compounded by racial disparities within the criminal justice and healthcare systems. In her opening remarks to all attendees, Senator Hester encouraged optimism, collaboration, and learning.

Persons with mental illness and co-occurring disorders are overrepresented in the criminal justice system. Steadman et al. (2009) found that the prevalence of people with serious mental illness in the criminal justice system is three times higher than among the general population. Teplin et al. (1991) found that 72 percent of people held in jail have a co-occurring disorder.

Other research on justice-involved individuals with mental illness indicates the following.

- They are less likely to make bail (Fader-Towe & Osher, 2015).
- They are more likely to have longer pretrial incarceration (Fader-Towe & Osher, 2015).
- They are more likely to have serious disciplinary issues in jail or prison (Fader-Towe & Osher, 2015).
- They have higher rates of homelessness, unemployment, and substance use (James & Glaze, 2006).
- They are more likely to face technical probation violations (Dauphinot, 1996).
- Lifetime prevalence rates of trauma for jail diversion participants are over 90 percent (unpublished TAPA data).
- Over 70% of jail diversion participants experienced a traumatic event in the year prior to their participation. (unpublished TAPA data).

Across the criminal justice system, persons with mental illness fare worse than those without. In addition, incarcerated populations have higher rates of medical conditions:

- the prevalence of tuberculosis is 4 times higher,
- the prevalence of hepatitis C is 9-10 times higher, and
- the prevalence of HIV is 8-9 times higher among people who are incarcerated than that among the general population (National Commission on Correctional Health Care, 2004).

It is not surprising then, that a study of Washington State prison releases found that, within 90 days of release, the mortality rate for the cohort was 3 times higher than that of the general population, and within 2 weeks of release, the mortality rate was 12 times higher than that of the general population (Binswanger, et al., 2007). A more recent study showed that the opioid overdose death rate within 2 weeks of release for previously incarcerated people in North Carolina was 40 times higher than that of the general population (Ranapurwala, et al., 2018).

Summit Goals

- To identify opportunities for coordination and collaboration among state and local stakeholders;
- To inform state and local stakeholders about best practices in the behavioral health and correctional fields;
- To consider the impact of healthcare reform and state behavioral health and criminal justice initiatives on justice-involved populations;
- To introduce the SIM as a planning tool to strategically inform legislation, policy, planning, and funding.

Summit participants represented multiple stakeholder systems, including mental health, substance treatment, health care, human services, corrections, advocates, law enforcement, health care (emergency department and inpatient acute psychiatric care), academia, and the courts. Two hundred and twenty-four people were recorded present at the Maryland Summit.

Summit Day One

Welcome and Opening Remarks: Lieutenant Governor Rutherford opened the State Summit on Behavioral Health and the Justice System by welcoming participants and asking for their participation in efforts to reduce harmful interactions between those with mental disorders and law enforcement. Since 2018, Lieutenant Governor Rutherford has led the Commission to Study Mental and Behavioral Health in Maryland, for which Senator Katie Fry Hester has served as co-chair of the Public Safety and Justice System subcommittee. He noted the state has already taken great strides, specifically through the implementation and expansion of the Law

Enforcement Assisted Diversion (LEAD) Program, which works directly with police departments to provide diversion options for low-level offenses among those who may have a mental illness or substance use disorder. The model has resulted in a 58 percent decrease in recidivism in participating counties thus far and will continue to expand throughout Maryland in 2021.

John Morrissey, chief judge of the District Court of Maryland, provided remarks next and advocated for a holistic approach that matches individuals' needs for mental health and recovery services, housing, employment, transportation, and health care. He highlighted Maryland's 7 mental health courts, 33 drug courts, 2 reentry courts, 8 truancy reduction courts, 7 Veterans' courts, and 1 "Back on Track" program. In 2020, 3,499 people participated in problem-solving courts statewide. These courts equip judges with resources and treatment options that provide needs-based analyses and service coordination in lieu of detention.

Nicole E. Taylor, associate judge of Baltimore City's Drug Treatment Court, greeted Summit participants next and discussed the challenges that she has faced in establishing a drug treatment court in Baltimore to address a gap identified by a Sequential Intercept Mapping. Baltimore City's Drug Treatment Court was Maryland's first problem-solving court, initially implemented in 1994. In 2019 the court was restructured to incorporate developments in the treatment community and to better fit the needs that have arisen with the opioid epidemic. Judge Taylor emphasized the importance of communication, collaboration, and data collection and sharing across the SIM.

Following these welcoming remarks and an explanation of the SIM by Mr. Abreu and Dr. Pinals, Senator Hester invited attendees to pose their questions about the process. Concerns were expressed about the importance of recognizing and addressing the impact of race and equity in health care, the juvenile justice system, and especially the criminal justice system. After it was affirmed that these disparities would be considered throughout the Summit, panel presentations highlighting existing resources in Maryland across the intercepts commenced.

Intercept 0/1 Panel Presentation: The Intercept 0/1 panel comprised Maryland State Senator William Smith, Lawanda Williams, Lucy Bill, Steve Thomas, and Jenn Corbin. Senator Smith, chair of the Senate Judicial Proceedings Committee, started off the conversation by recognizing that the current national dialogue is heavily influenced by the political climate. He indicated that now is the time to discuss injustice and implement meaningful changes. Lawanda Williams, chief behavioral health officer at Health Care for the Homeless, spoke next and provided information about the work they do and the people they serve. Health Care for the Homeless has a large and inclusive community composed of 230 staff members and 28 members on their board of directors. They serve individuals characterized by the U.S. Department of Health and Human Services' definition of "homelessness." The size of this population in Maryland is large, rising, and worsened by COVID-19.

Health Care for the Homeless provides comprehensive health care and support services to people experiencing homelessness. This includes but is not limited to primary care, mental health care, and assistance procuring Supplemental Security Income (SSI) and Social Security

Disability Insurance (SSDI) benefits; procurement support is provided by social workers and representatives trained in the SSI/SSDI Outreach, Access, and Recovery (SOAR) methodology. In 2018, Health Care for the Homeless led 330 programs that served more than 1 million patients. Through their work with justice-involved clients and patients, they've found that these individuals tend to have poor health or compounded conditions, high risk of overdose, no health insurance, no benefits, no documents or identification, no medications, no employment, no housing, no stability, few constructive support systems, no community support, and an acute need for complex care across many systems and providers. Additional challenges that Health Care for the Homeless has confronted in their work are the need for holistic multi-provider care, housing placement issues due to prior incarceration history, lack of cross-system data sharing between correctional facilities and community resources, conflicts between release terms and harm-reduction care models, and integration struggles upon reentry into the community. Expectedly, these challenges have been further complicated by COVID-19, which has also led to a rise in overdoses.

After identifying various challenges and gaps in the work that Health Care for the Homeless does, Ms. Williams posited the following ideas for addressing some of them.

- State requirements should mandate that prisons and jails provide comprehensive treatment during incarceration.
- Medicaid should auto-enroll individuals prior to their release from incarceration; streamlining the application process would help to alleviate some of the barriers to enrollment and eligibility.
- There needs to be a variety of programs capable of handling clients with mental health challenges and that operate with a harm-reduction focus.
- Further, employment opportunities and housing need to be more accessible for justice-involved individuals.
- Lastly, the workforce that provides services to this population needs training, resources, and additional providers in order to reduce caseloads and improve the quality of care.

Lucy Bill, Mobile Crisis and LEAD manager, spoke next and discussed the LEAD program that Lieutenant Governor Rutherford previously referred to. First designed and implemented in Seattle in 2011, there are now 40 jurisdictions across the country using this diversion model, which is intended to target Intercepts 0 and 1. The Maryland Governor's Office of Crime Prevention, Youth, and Victim Services and the Maryland Department of Health have also collaborated in a harm-reduction effort to reduce overdoses. This work led to the expansion of the LEAD program, modeled after Maryland's Washington County Model, which is dedicated to coordinating existing entities to provide more appropriate and effective support to clients and to streamline access to resources. Through technical assistance, training, targeting low-level offenses for diversion, making individualized referrals, and following up with case management and other recovery resources, they are hoping to reduce opioid-related deaths.

Lieutenant Steven Thomas of the Anne Arundel County Police Department and Jenn Corbin, Crisis Response Director, provided the final presentation for the Intercept 0/1 panel. They spoke about the integration of crisis response into policing in Anne Arundel County. Their crisis

response program began in 1999 and now has several mobile crisis teams that pair police officers and health clinicians together and facilitate communication and collaboration. The program was expanded in 2014 after finding that 30% percent of calls required partnership with a clinician. In 2019, mobile crisis teams responded to 21,000 calls.

Anne Arundel County attributes their success to a series of changes made to the culture of their policing. By facilitating a culture of helping and expecting officers to assist the community individuals with mental health challenges—and training officers in mental health first aid and Critical Incident Stress Management, providing Crisis Intervention Team (CIT) training, and making CIT unit referrals for people and families connected to traumatic events, recidivism rates have been effectively reduced.

Intercept 2/3 Panel Presentation: The Intercept 2/3 panel was moderated by Robert Green, Maryland's secretary of public safety and correctional services, and featured presentations from Judge George Lipman and Alisha Saulsbury. Judge Lipman, associate judge of the District Court of Maryland, opened by stating that courts must focus on people who have repeatedly appeared on charges and made frequent use of the hospital. Noting that problem-solving courts are only as effective as the resources that they can provide and connect defendants to, he highlighted the following as necessary for a successful problem-solving court: treatment (of all kinds, not just limited to mental health, addiction, and trauma) and wrap-around services, assistance with housing and employment, behavioral health case management, clear responsibility for individualized treatment plan development and modification, prompt hospitalization when needed, and criminal justice monitoring with sufficient knowledge of clients and programs. Courts also need specialized team members, including state attorneys and defense coordinators, and prompt deadlines for evaluation, placement into community programs or treatment facilities, and setting court appearance dates. Additionally, there are key aspects of Maryland's existing competency statute that may favorably inform the best practices for Intercepts 2 and 3. These are the requirement for prompt evaluations, prompt admissions to hospitals, and prompt returns to court for defendants when competency has been restored. He asserted that a much more proactive and comprehensive pretrial release system was needed in most areas of the state, and that individualized considerations for bail reviews, re-reviews, and pretrial release supervision were critically needed.

Secretary Green also spoke about pretrial services and agreed that the focus should be on local services and remaining nimble. He maintained that strengthened pretrial release planning is necessary for effective community supervision and that pre-release assessment is crucial for making recommendations. Factors that must be examined during consideration of pretrial release are formal and informal supervision, personal accountability, and prior record, as pretrial tends to serve as a guiding process for defendants.

The final presenter for this panel was trauma specialist Alisha Saulsbury. In 1998, she conducted research that looked at gender-specific programs and found that 90 percent of women interviewed did not trust substance use programs; this attitude was found to be influenced by lifetime experiences and trauma. She suggested that unaddressed trauma may lead to chemical

dependencies and subsequent illegal activity and that the most effective solution to these issues would be proactive community planning and resource development. Programs must be sustainable, connected to the community, and staffed with licensed clinicians; have open enrollment; provide continuity of treatment; and reflect increased awareness of trauma. She found that monthly meetings between community providers and stakeholders would be useful in adapting services to address these needs.

Intercept 4/5 Panel Presentation: The last panel, for Intercepts 4 and 5, was moderated by Martha Danner, director of the Division of Parole and Probation at the Maryland Department of Public Safety and Correctional Services, and featured presentations from Mary Ann Thompson, Scott Sheldon, and Patricia Towns.

Ms. Thompson, support services manager and deputy warden at St. Mary's County Detention and Rehabilitation Center and vice president of the Maryland Correctional Administrators Association, spoke to the prevalence of serious mental illnesses (SMI) among incarcerated individuals. She shared that nationally, more of those held in jail met the threshold for having an SMI than those in prison, and persons with an SMI tend to have higher recidivism rates. Though work has been done to work to reduce recidivism rates in St. Mary's County, such as the implementation of medication-assisted treatment (MAT) in jails as of 2019 and improved community supervision at reentry, there are still several challenges to offender reentry and community corrections. Housing, lack of funding, lack of buy-in from the formerly incarcerated individual, lack of employment opportunities, and occupancy restrictions in provider offices and classrooms all complicate efforts to improve the reentry process for people released from incarceration. In order to facilitate a successful reentry, Ms. Thompson advocated for positive working relationships between criminal justice and mental and behavioral health partners and agencies, stating that open lines of communication and collaboration are essential to bridging the gaps at reentry.

Mr. Scott Sheldon, a peer recovery specialist from Howard County, spoke next and defined his title "peer recovery specialist" as "a person with 'lived experience' who has been trained to support individuals with substance use problems." Mr. Sheldon shared that he has been incarcerated 15 times, and that meeting with peers while incarcerated was what changed his life. He emphasized the need for pre-screening processes to determine an individual's history with substance use disorders and prioritize treatment for those who are in need. Howard County's detention centers utilize MAT and see faster recoveries and higher success rates. Clients can also take Narcan, an emergency narcotic overdose treatment, upon their release, and their families are informed of its use as well.

For Howard County, the role of peer recovery specialists has increased steadily, and there are specialists now working in hospitals, on public peer phone lines, and in harm reduction centers. Mr. Sheldon emphasized the importance of finding new ways to keep the community informed of and connected with resources, especially those with a substance use disorder. In 2019, nearly 600 people entering the detention center pre-screened for possible substance use disorders,

and with almost half of them, opioids were considered the primary concern. Almost every person who met with a peer support specialist entered some form of treatment that year.

The final presentation of the third panel was given by Ms. Towns, of the Maryland Division of Parole and Probation. She concurred that assessment is necessary as it determines if an individual has a substance use disorder that may potentially endanger the community. These assessments, conducted by certified assessors and addiction counselors, would be used for referrals. Currently, any person being supervised by Baltimore City or Baltimore County can be assessed, which includes drug testing, outpatient services, and intensive outpatient services if needed. The department currently partners with 57 treatment providers and regularly distributes Narcan kits to offenders.

Summit Day One Closing Remarks: Steve Schuh, director of the Opioid Operational Command Center, provided closing remarks for day one of the Summit, by highlighting the biggest takeaway of the day—17 percent of Maryland's jail population has a serious mental illness. Key concepts that were consistent across all the intercepts were the need for healthcare reform, information sharing, trauma-informed approaches, housing, employment, and access to MAT.

SUMMIT DAY TWO

On day two of the Summit, Mr. Schuh, Senator Hester, and Mr. Abreu of SAMHSA's GAINS Center greeted participants and highlighted some of the invaluable information that was shared during the presentations from day one. Following the welcoming remarks, attendees were divided into breakout sessions based their respective intercepts.

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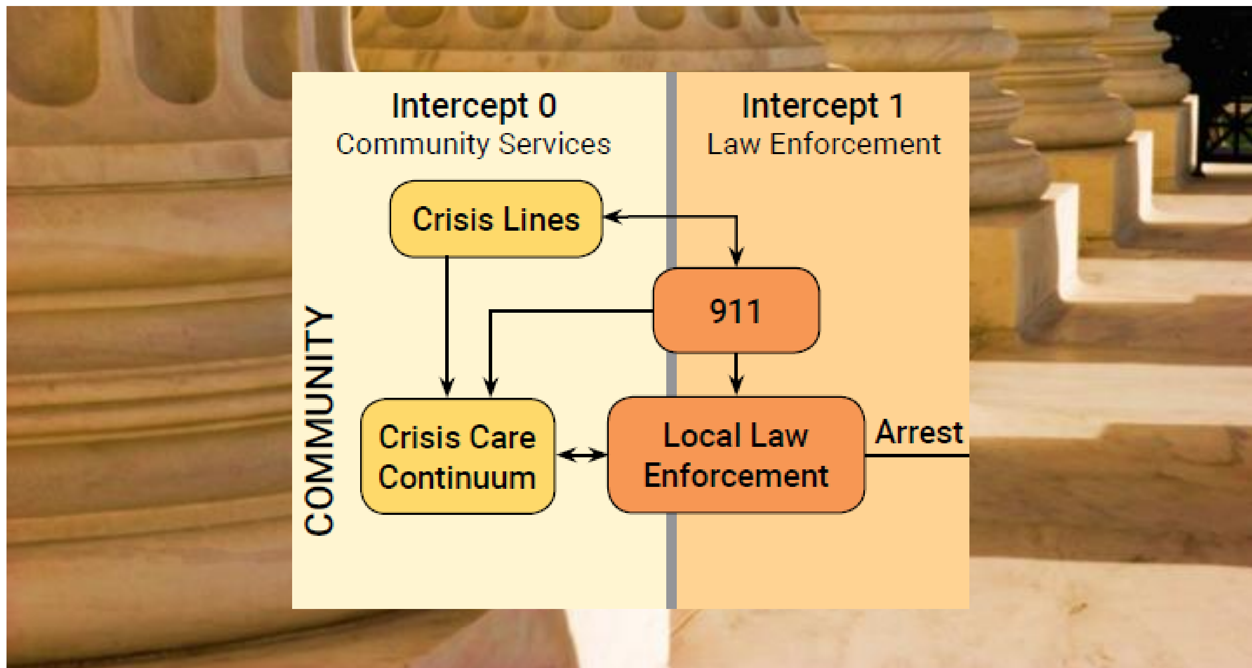
Intercepts 0 and 1



Resources

- Health Care for the Homeless provides comprehensive health care and support services to people experiencing homelessness.
- Law Enforcement Assisted Diversion (LEAD)
  - Provides law enforcement with referral options that include case management and peer recovery support options
  - Operational workgroups to foster collaborative case management across providers
- Mobile Crisis Teams
- 211 Call Centers
- People who are repeatedly charged with offenses are tracked

Gaps

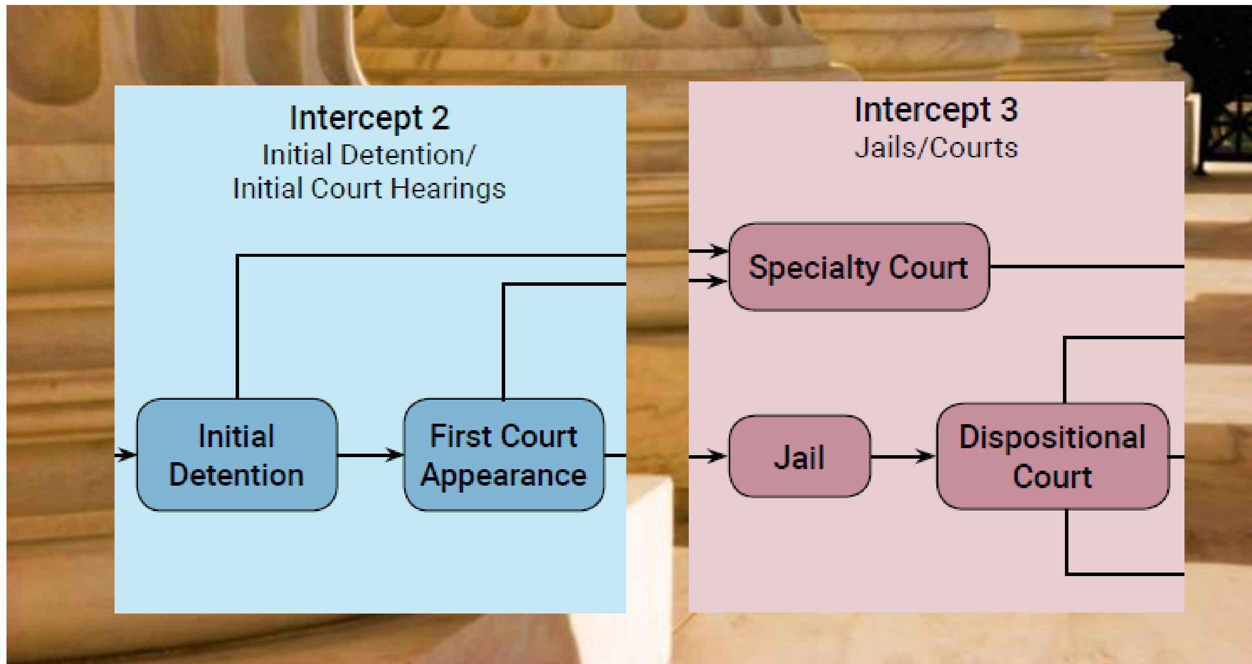
- Integrating screening tools for traumatic brain injury (TBI) across the state
- Harm-reduction processes could be expanded statewide
- Staffing and integration for 211 Maryland
- High-needs and complex-need populations, especially those who present behavioral management challenges, could use better management for a warm handoff
- Hospital air traffic control system model for people in crisis could be enhanced across the state
- Integrating services to enhance communication and linkage between agencies across the state and eliminate silos
- Explore options for a licensed mental health clinician in the call center
- Could use more trauma-informed care before Intercept 0
- Explore option of telehealth services for law enforcement and division of parole and probation
- Limited psychiatric hospitals for children
- Integrating peer services/support across the system
- Explore options with a statewide database using data link
- The follow-up mechanisms at each intercept could be enhanced
- 911 call centers need some form of CIT and mental health training
- Explore options with laws and policies for people experiencing substance use and mental disorders
- Integrating alcohol-related detox centers across the state
- There is a need for replication and integration of crisis response and treatment services across the state
- Division of Parole and Probation needs a specialized caseload
- Division of Parole and Probation agents need additional training
- Coordination entry tool for housing could be enhanced
- Available housing is a challenge

- Psychiatric services for children should be enhanced
- There are no adolescent residential treatment beds in Maryland for substance use disorder
- Creating core competencies for the workforce
- Enhanced training and expertise in responding to people with autism
- Need services for specialized populations (people with sex-offense records)
- Workforce credential license and barriers for persons of color
- Training on trauma-informed principles across the board; this includes adding the Adverse Childhood Experiences (ACE) survey to each service
- Services for the population of people with sex-offense records
- Reimbursement issues across the system
- Behavioral health/substance use disorder clients need better management

Intercept 0-1 Priorities

1.	Expanding availability of and access to various levels and types of housing	8 Votes
2.	Developing “prevention” and “intervention” resources – trauma, use of ACE survey, community and inpatient treatment resources for children and youth (substance use disorder, mental health)	7 Votes
3.	Statewide integration of crisis services and supports (replication, expansion, and interconnection of crisis intervention services), including workforce and timely payment for services	6 Votes
4.	Peers integrated across system	5 Votes
5.	Trauma-informed care	4 Votes

Intercepts 2 and 3



Resources

- Diversion Linkages Program – public defender's office to request diversion at bond-review hearing
- Justice and Mental Health Collaboration Program grant
- Correctional facilities using outpatient treatment programs
- Maryland House Bill 116 - correctional facilities must assess the mental health and substance use status of each inmate using evidence-based screenings and assessments
- Competence to stand trial system – no competency restoration done in the jails
- Data link initiative – jails and local behavioral health authorities to ensure coordination of services
- Task forces – opioid command center
- Robust women's health program in Baltimore City
- Day reporting center in the jail

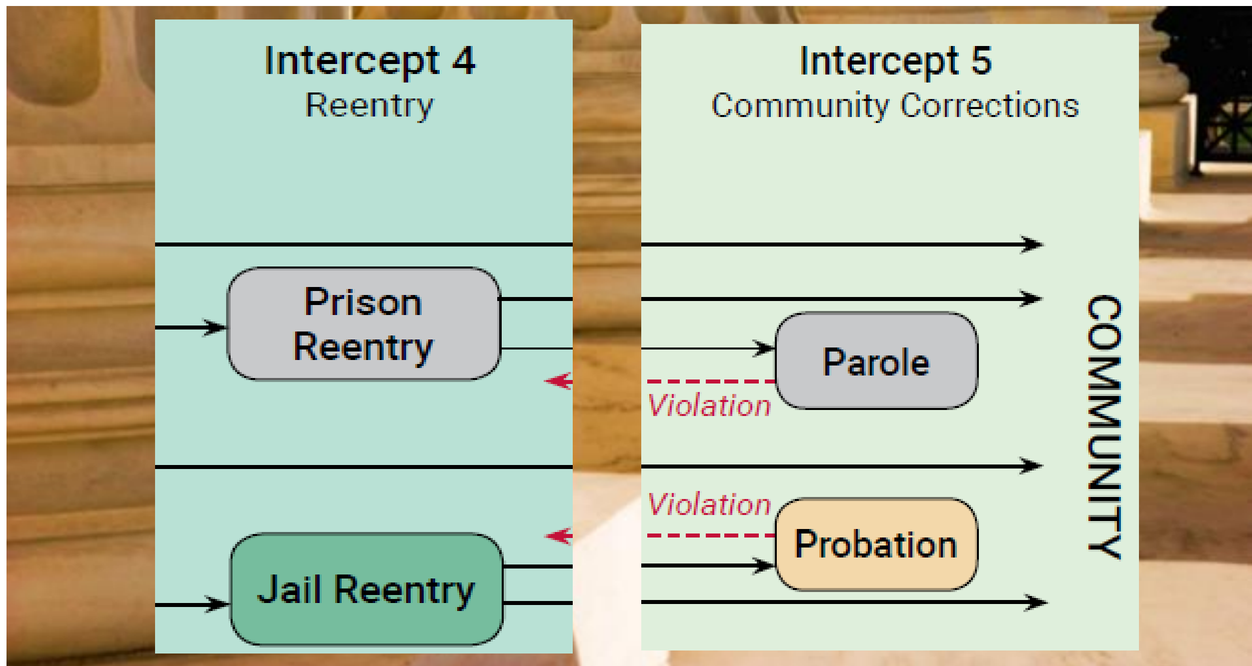
Gaps

- Need to increase pretrial planning and linkage – need pretrial services to develop plan to give to judges at pretrial release with screening and sufficient funding
- Need additional support such as case management and day reporting center for people released and sentenced individuals
- Lack of housing – resources need to be in place to support programs; can't allow for conditional release if nowhere to go
- Not always able to maintain medications for people in the jail coming back from the state hospital because they cannot force medication and people are able to refuse
- Need more hospital beds for individuals found incompetent
- DataLink initiative is not hooked up with pretrial release, so the info coming back and forth from provider in jail is just going to in-jail treatment and not informing conditions of release
- Cross-system coordination needs and communication
- No-contact lists allow providers to refuse services to certain people – need no refusal policies
- Rural area challenges – transportation, step-down housing, etc.
- Space limitations in jails for programming – if new jails are being built, population needs and therapeutic space needs to be considered when creating facility design
- Lack of technology being used in the jail
- Lack of uniform screening for Veteran status – Veterans should be identified at booking based on some clear indicator
- Need to implement trauma-informed care across all of the intercepts
- Lack of peer support – many positions are grant-funded, so they exist for a couple of years but might go away when funding runs out
- Need to routinely track data on racial and ethnic disparities (written for infractions, referred for work release, etc.)
- Midnight releases from jail

Intercept 2-3 Priorities

1.	Need to increase pretrial planning and linkage – need pretrial services to develop plan to give to judges at pretrial release with screening and sufficient funding	10 Votes
2.	Lack of housing – resources need to be in place to support programs; can't allow for conditional release if nowhere to go	10 Votes
3.	Rural area challenges – transportation, step-down housing, etc.	6 Votes
4.	Lack of technology being used in the jail	3 Votes
5.	Need to routinely track data on racial and ethnic disparities (written for infractions, referred for work release, etc.)	3 Votes

Intercepts 4 and 5



Resources

- State social workers connect and oversee anyone identified as "special needs"
- Currently, social workers are utilizing telehealth to connect with clients
- Individuals with special needs are identified at least a year before release and are connected with housing, transportation, and treatment resources
- Re-entry specialists assist the general population with acquiring services and resources
- Supplemental Security Income (SSI) applications can be submitted up to 120 days before release
- Chronic care clients meet with nurse discharge planners and are connected with aftercare for after release through Corizon Correctional Healthcare and Centurion Correctional Healthcare
- There are a few housing and employment programs like Vehicles for Change and Christopher's Place which provide housing, job training, and assist with saving money

- Howard County received a Second Chance Grant that led to the development of transitional housing that connects Re-entry coordinators and caseworkers with individuals and follows them up to 4 years after incarceration
- Howard County also has a Strengthening Families Program and offers mediation to assist with reconnecting formerly incarcerated people with their children, families, and other support

Gaps

- Housing
- Consistent data collection, sharing, and recording
- Transportation
- One-stop centralized resources
- Inter-agency collaboration
- Statewide harm reduction
- Funding across initiatives (gap funding and additional staffing)
- Crisis intervention (mental health and substance use; Narcan training)
- Active engagement and utilization of peers and families
- Increased opportunities with employers
- Identification and important personal documents
- Workforce development (job training and certification while still incarcerated)
- Trauma-informed care (within prisons as well as across probation services)
- Dual-diagnosis treatment providers
- Restricted coverage with private insurance
- Not all counties have specialty courts

Intercept 4-5 Priorities

1.	Housing	16 Votes
2.	One-stop centralized resources	8 Votes
3.	Inter-agency collaboration	6 Votes

4.	Transportation	5 Votes
5.	Funding across initiatives (gap funding and additional staffing	5 Votes

Priorities Across the Intercepts

Intercept 0-1		Intercept 2-3		Intercept 4-5		Total Votes	
Housing	8	Housing	10	Housing	16	Housing	34
	0	Transportation/rural challenges	6	Transportation	5	Transportation	11
	0	Pretrial expansion and utilization	10		0	Pretrial expansion and utilization	10
	0		0	Community one-stop resource centers	8	Community one-stop resource centers	8
Trauma	7	Listed as a gap	0	Listed as a gap	0	Trauma	7
Crisis care expansion	6		0		0	Crisis care expansion	6
Listed as a gap		Listed as a gap		Interagency collaboration	6	Interagency collaboration	6
Peers	5	Listed as a gap	0	Listed as a gap	0	Peers	5
Listed as a gap.	0	Listed as a gap	0	Funding including gap funding	5	Funding including gap funding (funding services during transition from incarceration to the community)	5
Listed as a gap	0	Technology	3		0	Technology/rural challenges	3
	0	Data on racial disparities	3		0	Data on racial disparities	3

Recommendations

In many ways, the Summit confirmed needs identified by the Commission and other planning groups. In addition, many of the issues raised have been addressed through legislation and other state funding initiatives at varying stages of implementation. The recommendations below are primarily derived from the priorities identified in the breakout groups, document review, national initiatives, SAMHSA's GAINS Center's experience consulting with other states and localities, and Dr. Pinal's experience as a national expert.

There are two issues that should be addressed within all the recommendations below and across the six Intercepts. Both issues were addressed in introductory remarks, during the Intercept specific panels and across the Intercept breakout groups.

The first is racial equity and disparity. While the focus of the Summit, is on individuals with behavioral health disorders, disparities in health care access and criminal justice involvement must also be addressed to ensure comprehensive system change. At this time, The *Racial Disparities in Overdose Task Force* is being convened as an extension of Lt. Governor Boyd K. Rutherford's Inter-Agency Opioid Coordinating Council. The *Racial Disparities in Overdose Task Force* will promote more equitable outcomes by investigating contributing factors and proposing recommended solutions to eliminate racial disparities related to overdose fatalities.

The second is trauma. Justice involved individuals have lifetime prevalence rates of 90%. As Ms. Saulsbury indicated in her panel presentation, it is critical that both the healthcare and criminal justice systems be trauma-informed and that there be trauma screening and trauma specific treatment available. A trauma-informed approach incorporates three key elements:

(1) realizing the prevalence of trauma

(2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce

(3) responding by putting this knowledge into practice

Trauma-Informed Care in Behavioral Health Services (SAMHSA, 2014)

1. ***Formalize a statewide planning body to address the needs of justice-involved persons with mental or substance use disorders.***

The Maryland Commission to Study Mental and Behavioral Health has made an excellent start on convening stakeholders and investigating system improvement and enhancement. The work of the Commission must be formalized to ensure long-term planning, implementation, and funding to address issues raised during the Summit.

A review of the work of the Maryland Behavioral Health Advisory Council (BHAC) and its membership and subcommittees suggest that the BHAC could be the appropriate lead entity to address recommendations within this report and those of the Commission. Many of the issues raised at the Summit have been or are being addressed by the Council.

Generally, state strategies for criminal justice/behavioral health collaboration include executive orders, enabling legislation, or administrative orders from the state chief justice. Some examples include the following:

- Michigan Mental Health Diversion Order: https://www.michigan.gov/documents/snyder/EO_2013-7_411969_7.pdf
- Ohio Attorney General's Task Force on Criminal Justice and Mental Illness:
- Virginia Commonwealth Consortium for Mental Health/Criminal Justice Transformation (PDF)
- Virginia Center for Behavioral Health and Justice: https://dbhds.virginia.gov/library/forensics/cbhj%20one%20pager%20info/cbhj%20one%20pager%20info.pdf

2. Develop a mental health-criminal justice "Center of Excellence" or expanded evaluation system to track program development, centralize resources, and provide technical assistance.

As the Summit panels demonstrated, specifically in the work of the intercept-specific breakout groups and as identified through an environmental scan, Maryland has an impressive array of legislation, programs, and exemplary practices at both the state and county level that address the needs of justice-involved individuals with mental or substance use disorders. Maryland lacks a central entity charged with collecting and disseminating evaluation data and information to promote expansion of programs and guide state priorities. Development of a Center of Excellence or a university partnership that could serve as an evaluation and technical assistance hub would provide a resource center where information regarding criminal justice/mental health resources, events, and initiatives can be

centralized to facilitate broader access to relevant material and help facilitate program development and expansion across the state. A plan for a center or expanded evaluation hub would serve to accomplish the following:

- Disseminate information
- Track diversion activity
- Publish performance outcome measures
- Inform the Maryland Department of Behavioral Health and inform future planning
- Provide published resources
- Provide technical assistance and training
- Promote local planning and initiatives
- Assist with further grant applications
- Link Maryland to national programs and research development

Such a center or information and evaluation hub or academic center can be modeled after Centers of Excellence/academic entities in the following states:

- Ohio Criminal Justice Coordinating Center of Excellence
- University of South Florida, Criminal Justice, Mental Health, & Substance Abuse Technical Assistance Center
- Virginia Center for Behavioral Health and Justice
- Oregon Center on Behavioral Health and Justice Integration
- Center for Behavioral Health and Justice of Wayne State University

3. ***Broaden and formalize county-level criminal justice/behavioral health planning committees.***

Improving interagency cooperation was the 3rd ranked priority in the Intercept 4 and 5 breakout group and it was identified as a gap in the Intercept 0-1 and Intercept 4-5 breakout groups. The Summit breakout groups and an environmental scan highlighted the importance of local collaborative efforts. In counties where they exist (e.g., Howard County, Prince George's County, Baltimore County [see below]), program development is robust, and there are mechanisms to address unexpected events, prioritize use of resources, and even enhance funding by blending funds and seeking grants. Other counties participating in the Summit expressed a need for additional collaboration. Strategies to enhance local collaboration include the following.

- Encourage participation in the Stepping Up Initiative, which provides a number of resources for and models of how counties across the country have ensured appropriate leadership and representation from local justice and health partners. Five Maryland counties currently participate: Anne Arundel, Calvert, Harford, Montgomery, and Prince George's Counties. Perhaps convene the Stepping Up counties to share best practices and disseminate those practices to other Maryland localities.
- Criminal Justice Coordinating Councils might add membership to include behavioral health partners to address cross-system issues. Charleston County, South Carolina, (PDF) is an example. Police CIT Advisory Committees or Mental Health Court Advisory Committees have morphed to take on broader cross-system planning roles by changing mission and membership.

At the Summit, it was evident that the Maryland judiciary has also championed criminal justice and behavioral health collaboration across the state. Judges are in a unique position to convene local behavioral health and criminal justice partners. Judge Lippman's March 2020 summary (Appendix 1) of his visit to the Los Angeles Office of Diversion and Reentry Program (ODR) touches upon many issues that were raised by Summit participants, including the need for centralized state and local leadership, expansion of housing and wrap-around resources, and leveraging Medicaid and other funding resources.

Local leadership may come from many areas, whether sheriffs, judges, county commissioners, or others. Local leaders should be provided information about Stepping Up and other free resources that can help them develop and effectively manage such efforts.

There are so many changes in the crisis care and criminal justice system due to the pandemic, police reform, and renewed focus on racial equity that the earlier collaborative mechanisms are developed, the better communities will be prepared to respond to these changes and to take full advantage of new opportunities.

4. ***Integrate Maryland's behavioral health and criminal justice initiatives with related state health initiatives.***

The pandemic has highlighted how interdependent the community healthcare system and jail and prison healthcare systems are. Yet, there remain significant gaps in information sharing, promoting continuity of care, access to services upon release, and insufficient planning for the transition health needs of this population.

- We recommend that the BHAC include jail healthcare providers in membership and that the state encourage local health authorities to include their jail healthcare providers in their planning and healthcare initiatives to improve planning and healthcare integration and access across systems.

It is noted that the Maryland Commission to Study Mental and Behavioral Health 2019 Report (p. 11) recommends continuing with coordination with the Behavioral Health System of Care Workgroup and many of the issues raised in this Summit can inform that work.
Maryland has a number of mental health and criminal justice initiatives that can either directly support the work of the Maryland Department of Health, Behavioral Health Administration or that can be integrated with its work. Some of these initiatives already involve criminal justice partners. It will be critical for state leadership to consider not only how to promote healthcare integration in ongoing planning efforts, but also how it will influence healthcare integration in planning and implementation of future efforts.

Existing efforts include but are not limited to the following:

- Built for Zero (Baltimore City, Baltimore County, Montgomery County)
    - Determine justice partner participation and access for justice-involved individuals.
    - Use sites as learning sites for other state housing initiatives
    - Include law enforcement in program development.
- First Episode Psychosis (FEP) Center of Excellence Clinics (Baltimore, Catonsville, Gaithersburg)
    - Train law enforcement and consider jail for FES screening sites
- Medicaid Suspension Implementation
    - Maryland is one of 17 states that have Medicaid Suspension (upon incarceration) legislation; Summit participants noted that implementation is uneven
    - Survey county implementation issues and provide technical assistance
- Maryland's Certified Community Behavioral Health Clinics (CCBHC)
    - Leverage experience of CCBHCs, including Mosaic CCBHC, Baltimore City; Cornerstone Montgomery CCBHC, Montgomery County; and Volunteers of America CCBHC, Prince George's County. CCBHCs have been proven to improve both health care and criminal justice outcomes through flexible funding that can be tailored to community needs, expanded crisis care and follow-up services, improved access to MAT, and on-demand access strategies. It is noted that the

Maryland Commission to Study Mental and Behavioral Health's 2019 Report (p.11) references CCBHC's as an area for further assessment. For more on CCBHCs, see *Hope for the Future: CCBHCs Expanding Mental Health and Addiction Treatment: An Impact Report* (PDF)

- Maryland's Health Equity Zone (HEZ) Initiatives
- Federally Qualified Health Centers (FQHCs)
    - Improve access to FQHCs for justice-involved individuals
    - FQHCs provide easy access and low-barrier service models that are especially suited for justice-involved individuals.

5. ***Continue to expand the Crisis Care Continuum and expand strategies to reduce law enforcement's need to respond to crisis events and provide adequate clinical support when law enforcement does respond.***

Expansion and enhancement of crisis services was the 3rd ranked priority in the Intercept 0-1 breakout group. As highlighted in the SIM presentation, Maryland joins a growing number of states that are financing the expansion of crisis care services. Much of this work was directed by the BHA's Legislative Committee on Crisis Services' *Strategic Plan: 24/7 Crisis Walk-in and Mobile Crisis Team Services*. The plan details Maryland's decade-long enhancements of and focus on crisis services development. More recently, House Bill 1092 enacted the Behavioral Health Crisis Response Grant Program, which provided funding for communities to implement and enhance crisis services. As noted in the Maryland Commission to Study Mental and Behavioral Health's 2019 Report and as reported by Summit participants, implementation across the state is uneven, and there remain gaps, including integration of 211 and 911 crisis calls and initiatives targeted at reducing over-reliance on law enforcement to respond to crisis calls. The following work is suggested to further this effort.

- Build on the Eastern Shore regional approach to improve continuity of services and gap identification.
- Deploy a "pay for success" and reinvestment model to incentivize better outcomes and improve service delivery, especially for those living with complex needs and those who are hard to serve or engage.
- Explore strategies to integrate 211 and 911 call centers to facilitate reduced involvement of law enforcement in crisis calls.
- Develop key performance indicators and an information sharing and data tracking system that supports transactions and analytics.

Note: Note: Since the completion of the Summit, The Health Services Cost Review Commission, an independent state agency that establishes hospital rates and supports overall improvements in Maryland's healthcare delivery system, granted 3 communities in Maryland Behavioral Health Crisis Services grants through its Regional Partnership Catalyst Grant Program. These communities will use the funding to expand and enhance the crisis care continuum.

Other resources to address this priority include the following:

- Crisis Now - Transforming Services Is Within Our Reach.
- Guidebook to Reimagining America's Crisis Response Systems https://www.abtassociates.com/files/Projects/PDFs/2020/reimagining-crisis-response_20200911-final.pdf
- Consider use of video-conferencing to expand access to mental health consultation in rural communities. See *Skyping During a Crisis? Telehealth Is a 24/7 Crisis Connection* (Appendix 2), or the work of Behavioral Health Response, which provides Virtual Crisis Support to the St. Louis, Missouri, police department.
- Also see CIT International's *Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises* (PDF)

6. Develop more formal and coordinated diversion strategies for arraignment diversion (Intercept 2) and pretrial diversion (Intercept 3).

Increasing pre-trial services and linkages was the 1st ranked priority of the Intercept 2-3 breakout group. Summit participants reported challenges in diverting individuals with behavioral health needs at the bond hearings and Lawanda Williams in her panel discussion highlighted the need to expand and enhance pre-trial services. Among challenges discussed are:

- Housing
- Adequate screening
- Inadequate clinical support to reduce failure to appear (FTA)
- Lack of peer support at early appearance
- Lack of sharing of DataLink information with pretrial professionals

Many states are undertaking bail reform initiatives, expanding the use of pretrial services, and relying on risk-assessment instruments to guide release decisions. These initiatives require

careful thought regarding persons with mental illness, who may not be identified due to inadequate mental health screening who may have higher risk scores due to higher rates of homelessness and community supports. Dr. Sheryl Kubiak, evaluating Michigan jail diversion programs, showed that persons with SMI had more risk factors than persons without mental illness. Addressing responsivity needs is critical to participation in pre-release programs.

Essential elements of Intercept 2 diversion can be found in monographs written both for SAMHSA (*Municipal Courts: An Effective Tool for Diverting People with Mental and Substance Use Disorders in the Criminal Justice System*) and BJA (*Improving Responses to People with Mental Illnesses at the Pretrial Stage: Essential Elements*). Improving screening, clinical assessment, and behavioral health disorders who are released without referral or follow-up. The CASES Transitional Case Management Program is an example.

Training for judges, attorneys, and court staff is critical to the success of these programs. Increasing understanding of mental illness and how various tools measure pretrial risk (as opposed to risk of violence)[2] facilitates informed decision-making by court-based professionals. [3]

7. Develop a formal and coordinated screening process at jail booking or as early as possible upon entry into jail to identify mental illness and behavioral health needs.

House Bill 116—which requires enhanced screening and assessment of opioid disorders and funds opioid treatment services and increased utilization of peers—is another example of Maryland's robust effort to address the needs of justice-involved individuals with substance use and mental disorders. However, summit participants reported insufficient mental health screening at some jails and lack of DataLink implementation as barriers to supporting this priority. To further efforts in this area, expand jail services for uniform screening for mental and substance use disorders and introduce or increase access to jail-based MAT.

In addition, while DataLink is a good start toward improving mental health screening, data from Douglas County, Kansas—a Data-Driven Justice Initiative county—indicates that utilizing the Brief Jail Mental Health Screen increased identification of individuals with mental health needs by 30 percent over their data matching procedure.

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[2] See, e.g., *On the Over-Valuation of Risk for People with Mental Illnesses*, available online at https://csgjusticecenter.org/publications/on-the-over-valuation-of-risk-for-people-with-mental-illnesses/

[3] For example, the Judges' and Psychiatrists' Leadership Initiative has developed a bench card to help judges recognize and respond appropriately to individuals with mental illnesses who appear in court. See https://csgjusticecenter.org/projects/judges-and-psychiatrists-leadership-initiative/

Brief alcohol and drug screens include the following:

- Texas Christian University Drug Screen V
- Simple Screening Instrument for Substance Abuse
- Alcohol, Smoking and Substance Involvement Screening Test

Utilize the Baltimore Jail, Prince George's County Jail, Howard Montgomery County Jails, and other sites to develop peer learning opportunities for jails across Maryland.

8. ***Develop a more formal approach at the local and state level to expanding housing options for justice-involved persons.***

Housing was the 1st ranked priority across all three intercept breakout groups. Housing is also a major priority identified in Judge Lippman's ODR visit summary and in the Commission's Report.

There are currently three Maryland communities involved in the Built for Zero initiative, which is a national change effort working to help communities end Veteran and chronic homelessness. Coordinated by Community Solutions, the national effort supports participants in developing real-time data on homelessness, optimizing local housing resources, tracking progress against monthly goals, and accelerating the spread of proven strategies. Baltimore City, Baltimore County, and Montgomery County participate in the Built for Zero initiative. These communities may serve as learning sites for other communities to address homelessness. Community Solutions reports that Montgomery County has achieved the milestone of ending Veteran homelessness, defined by reaching "functional zero." Surveying these sites to determine if the justice-involved population is addressed in Built for Zero and if the sites have justice systems partners would further inform Maryland's effort to address housing for the justice-involved population.

Maryland has been successfully involved with SAMHSA's SOAR program for many years. Developing strategies to enhance SOAR partnerships with jails and probation is likely to improve access to housing for justice-involved persons.

Other resources include the following:

- *Moving Toward Evidence-based Housing Program for Person with Mental Illness in Contact with the Justice System* (PDF)

- National Law Center on Homelessness and Poverty monograph, *Housing, Not Handcuffs* (PDF)
- Milwaukee Housing First

9. Expand screening for Veterans across intercepts. Allow early diversion and misdemeanor alternatives for Veterans.

Summit participants are familiar with Veteran's Justice Outreach (VJO) coordinators. Still, participants reported that in some jails and at various points in the criminal justice system there is not sufficient screening for military service. The United States Department of Veterans Affairs (VA) has developed a Veterans Reentry Search Service (VRSS), which allows jails and prisons to upload census data for comparison with a United States Department of Defense database to increase identification of Veterans. VA reports that utilization of the VRSS has significantly increased identification of Veterans.

To ensure access to diversion opportunities for Veterans, VJOs should be kept apprised of new initiatives and included in planning. Veteran status should also be captured in program evaluation efforts to measure access to diversion opportunities and inform the development and expansion of Veteran-specific programs.

10. Increase access to transportation

Access to transportation was the 2nd ranked priority across all breakout groups (Intercept 2-3: 6 votes; Intercept 4-5: 5 votes). A common and under-addressed gap nationally is access to transportation, especially for justice-involved individuals. This not only impacts access to health care but also impacts criminal justice outcomes. During the Summit, Howard County reported on local collaborations that have eased transportation barriers. Other communities around the country have worked with faith-based groups, foundations, and public/private partnerships to improve transportation access. The Non-Emergency Medical Transportation (NEMT) program is another resource.

- Survey localities to identify current use of NEMT for correctional populations, identify best practices, and assess under-utilization of this important resource.

11. Expand use of technology across the intercepts.

Expanding use of technology was the 4th ranked priority in the Intercept 2-3 workgroup and listed as a gap in the Intercept 0-1 workgroup. Developing capacity to implement or expand use of technology across the justice system could help address many healthcare access gaps and improve criminal justice outcomes, especially with respect to Failure to Appear.

The pandemic has altered how individuals access behavioral health services and even how courts and community supervision programs operate. Use of videoconferencing and teleconferencing has allowed individuals to initiate or maintain access to services and to courts and community supervision agencies. These changes may be worth sustaining. Access to technology will function similarly to access to transportation, and states and communities will need to develop strategies to provide use of mobile devices and training for end users.

Jails and prisons, in particular, have varying degrees of technology infrastructure and are not always receptive to utilization of technology. The following are examples of utilization of technology across the Intercepts.

- Intercept 0-1 applications include using video-conferencing to provide crisis-worker consultation to field law-enforcement response in rural areas and to interview persons in crisis.
- Intercept 2-3 applications include using video-conferencing for follow-up court hearings to avoid taking time off from work or disrupting treatment programs or to address transportation barriers; telepsychiatry to provide consultation and treatment in hard-to-recruit locations; and telephone consultation by local crisis centers to jails with limited mental health services.
- Intercept 4 applications include video-conferencing detained individuals with prospective service and housing providers.
- Intercept 5 applications include probation substituting video-conferencing for in-person reporting to avoid probationers taking time off from work or disrupting treatment or to address transportation barriers.

12. Expand data driven strategies across the intercepts.

Improving cross-system data collection and integration is key to identifying high-utilizer populations, justifying expansion of programs, and measuring program outcomes and success. For example, some 911 dispatchers spend an inordinate amount of time on comfort and support calls. Collecting information on the number of calls, identifying the callers, and working to link the callers to services has been a successful strategy in other communities to reduce repeated calls. In addition, establishing protocols to develop a "warm handoff," or direct transfers to crisis lines, can also direct calls to the most appropriate agency and result in improved service engagement.

Data dashboard indicators can be developed on the prevalence, justice equity, and case characteristics of adults with mental and substance use disorders who are being arrested, passing through the courts, booked into the jail, sentenced to prison, placed on probation, etc.

A mental health dashboard can also be developed to monitor wait times in hospitals for people in mental health crises and transfer times from the emergency department to inpatient units or other services to determine whether procedures can be implemented to improve such responses. These dashboard indicators can be employed by a county planning and monitoring council to better identify opportunities for programming and to determine where existing initiatives require adjustments.

The Laura and John Arnold Foundation and the National Association of Counties lead the Data Driven Justice Initiative. The publication *Data-Driven Justice Playbook: How to Develop a System of Diversion* provides guidance on development of data-driven strategies and use of data to develop programs and improve outcomes. Prince George's County was highlighted in a National Association of Counties brief, *Building Data-Driven Justice: Prince George's County, Maryland*. The brief describes the county's partnership with law enforcement and the county jail to ensure inclusion of the justice-involved population in broader health initiatives.

The SAMSHA publication *Data Collection Across the Sequential Intercept Model (SIM): Essential Measures* is an additional resource.

See also the *Data Analysis and Matching* publications in the Resources section.

13. Expand the utilization of peer support across intercepts.

Summit participants expressed a need to expand peer support across the intercepts and to improve reimbursement for their services. Peer support has been found to be particularly helpful in easing the trauma of the corrections process and encouraging consumers to engage in treatment services. Mr. Sheldon in his panel presentation on Peer Recovery Support Specialist, spoke of the variety of settings that have successfully involved peers include crisis evaluation centers, emergency departments, jails, treatment courts, and reentry services. Please see the below resources on *Peers* for more information.

APPENDIX INDEX

Appendix 1 LA ODR impressions-Lipman

Appendix 2 Skyping During a Crisis

Appendix 1

My Impressions of Key Elements of Los Angeles' Office of Diversion and Reentry Program (ODR) as they may Inform Maryland and Baltimore's Efforts to Coordinate Supportive Housing and Wrap Around Services for Persons in Contact with Maryland Criminal Justice System (George Lipman, March 2020)

In February 2020, I visited two courts within the Los Angeles Superior Court system: the Competency Court and the ODR Housing Court.[1] Both of these courts rely upon the Office of Diversion and Reentry (ODR) of the Health Services of Los Angeles County to provide supportive housing and extensive wrap-around services to the mentally ill defendants that these courts conditionally place in the community as an alternative to detention in the mammoth Los Angeles County Detention Center.[2]

I visited Los Angeles as a member of small group of judges from across the country chosen by the National Center for State Courts in conjunction with its effort to develop guidance as to the best practices for the adjudication of competency cases. I may had been chosen, in part, because Maryland is complying with workable statutory requirements mandating that defendants found incompetent and dangerous promptly be placed in fully accredited non-jail psychiatric hospital units. Further, Maryland mandates the prompt return to the trial court, not to jail, of defendants who have regained competency or who would not be dangerous if conditionally released. Maryland's Behavioral Health Administration, state hospitals and courts have complied with these prompt placement and prompt return to court requirements while many other states have failed to restore defendants to competency in a hospital setting when clinically appropriate. The rapid expansion of Los Angeles ODR supportive housing program is attributable, in part, to that jurisdiction's desire to create and "off -ramp" for incompetent defendants inappropriately housed in-jail.

It is essential that Maryland continues to maintain compliance with prompt admission and prompt return mandates. However, in Los Angeles I did witness, in ODR, an extensive and successful wrap-around services and supportive housing program operating with considerable success in a very large jurisdiction.

A wholesale importation of the Los Angeles ODR program to Maryland will never work. But ODR may be instructive as Baltimore and Maryland seeks to improve the availability and coordination of

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[1] Judge James Bianco hosted our visit and presides over the Competency Court. We also visited the courtroom of Judge Karla Kerlin, who presides over the ODR Housing Court.

[2] See the attached appendix which contains at pp. 1-2, a web description of the ODR programs, at pp 3-4 an article regarding the ODR Housing Court, at pp 5-9, Rand Research Report on participants housing stability and new felony convictions, at pp 10-23 , September 9, 2019 Progress Report to the Los Angeles County Board of Supervisors on scaling up diversion and reentry efforts, p. 24, slide describing wraparound services for the Competency Court, and at p. 25, slide describing the ODR Housing.

interim and permanent supportive housing accompanied by robust services. Could we not apply variations of some of the successful elements of the Los Angeles Program across our Baltimore and Maryland "sequential intercepts" from jail and prison reentry , through probation and pretrial release, to crisis intervention, emergency evaluation discharge and other pre- arrest "pure diversions"?

The longstanding Maryland priority for developing and coordinating housing and wrap around services; a priority that has not been met.

For decades, committees, task forces and other groups studying Maryland mental health issues have highlighted the need for supportive housing as a key element of the wrap-around services critical to the successful diversion from arrest and to the community reentry of severely mentally ill persons; as a necessary option for many mentally ill persons diverted from the criminal justice system along the "sequential intercepts": reentry form prison, conditional release from a forensic mental health facility, on probation (whether from a mental health or other specialty court or "regular probation"), reentry from detention on pre-trial release or "purely diverted" through crisis response, an emergency evaluation or another pre-arrest mechanism.

Baltimore City and other Maryland jurisdiction are not without good supportive housing programs and evidence-based wrap-around services. There are quality ACT teams with some expedited access to housing. Social Workers from the City Mental Health Courts have pursued supportive housing aggressively for probationers from those courts. Likewise, state hospital social workers preparing discharge plans have dug deeply for supportive housing options. One of BHA's welcomed responses during the time of the state hospital admission delay crisis was an increase in step-down services and housing for those being released from court ordered inpatient competency hospitalization.

Yet, the creation of well-serviced supportive housing has been incomplete, delayed and siloed. There have been repeated calls for: (1) more supportive housing, (2) more comprehensive quality wrap-around services associated with that housing and, of great importance, (3) clear delineation of the responsibility for the needed development of (1)and (2). A recent study, The Gap Analysis commissioned in response to the Federal Court's consent decree regarding Baltimore Police Practices notes[3]:

[3] https://www.baltimorepolice.org/baltimore-public-health-system-gap-analysis

> Housing was nearly unanimously endorsed by stakeholders as one of the largest gaps within the system. All types of affordable housing were identified as being in need, but access to evidence-based housing models pairing permanent housing with supportive services was a dire need.[4]
>
> There was broad consensus that there needs to be an increase in the number of crisis respite beds available in the city[5].
>
> While housing with supportive services was identified as a strong need for individuals throughout the behavioral health system, there were a number of populations singled out as having particular difficulty accessing housing. The populations identified as in need of extra consideration when addressing housing included people with only a mental health or substance use disorder (that is, not co-occurring), people in recovery from SUD (especially for women with children), people transitioning out of jail or criminal justice settings, people with criminal backgrounds (especially some sort of sex offense), people with HIV, survivors of domestic violence, members of the LGBTQIA community, senior citizens, and transition aged-youth [6]
>
> The lack of regulation and oversight of housing programs was also identified as a major gap impacting accessibility to quality housing services.[7]
>
> In addition, we recommend that BHSB endeavor be at the table for every housing development initiative that is underway in the city to advocate for people with behavioral health disabilities to be considered as a priority population. BHSB should assess it's need for PSH and other housing models for people with MI/SUD and develop strategies with housing partners to address this need.[8]

Unquestionably a leadership gap clearly has been identified: what entity is responsible for the maintenance and expansion of these wrap around services with supportive housing at its core?

Los Angeles' Counties' size and strength

Los Angeles is huge as is its criminal justice system. Nearly 10 million people live in Los Angeles County. There are over 1,000 assistant District Attorneys and multiple trial court locations, with 68 criminal parts in the Downtown Criminal Courts Building alone. The Los Angeles Detention Center continues as the world's largest jail with an average daily population of 16,000 inmates with a large percentage of this population (estimated at 20%) suffering from serious and persistent mental illness. Los Angeles County is a wealth jurisdiction. Los Angeles Counties homicide rate approximates 10% of

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[4] Id at p.46
[5] Id at p.60
[6] Id at p.46
[7] Id at p.47
[8] Id at p.110

that in Baltimore City. Yet, homelessness is a visible issue with an estimated 60,000 persons living on the streets of Los Angeles.

More than 70 interim houses with 15 to 20 residents each are now available to the ODR program or will soon come online. There are approximately $100 million designated local taxpayer funds supporting ODR's staff, programs and wrap around services in addition to Medi-Cal (Medicaid), private insurance, State health grant funding, State justice reinvestment- like funding and other federal funding. This diversion effort has been well capitalized by a city with a very substantial tax base. There appears to be a capability to quickly and effectively fill gaps or otherwise modify the clinically appropriate wrap around services in any given defendants individualized treatment plan.

Mental Health treatment, supportive services and particularly housing is a significant concern of the citizenry Los Angeles. Super Tuesday TV ads by candidates for local office regularly included mental health and housing discussions and focused on the complexity of criminal justice mental health issues. Jackie Lacey, The District Attorney, with whom our contingency of judges met, has made mental health diversion a major issue: in prior elections, in her current reelection bid, in reshaping much of her professional staff and notably in pushing a supportive Board of Supervisor to fund expansion of the ODR program.

The Office of Diversion and Reentry ODR Programs: supportive housing and robust services

ODR describes its basic programmatic intent as follows:

> ODRs jail and community-based diversion programs serve to reduce the number of inmates in the LA County jail who suffer from mental illness and/or substance use disorder by removing them from jail though various court interventions or through pre arrest or pre booking diversion and providing them with care and housing.

ODR's basic premise is succinctly stated by its current director who is a retired supervising judge of the criminal courts: "What we know about this population is that if they are left untreated and unhoused, they have a higher recidivism rate… They come in and come out of the County Jail at an alarmingly high rate.[9]"

A recent slide presentation by the Office of Diversion and Reentry listed some of the categories of services available in the Competency Off Ramp program:

1. linkage to physical health, mental health and substance use treatment,

[9] App. p.3 Former Superior Court Administrative Judge Peter Espinoza is now the Director of ODR.

2. stabilization needs (food, shelter, documentation, benefits),

3. employment and education services

4. housing support services and

5. cognitive behavioral intentions. [10]

In a complimentary slide services for the ODR Housing program were noted." The program provides intensive case management services, linkage to mental health and substance use treatment interim housing, and permanent supportive housing". [11]

Given the size of Los Angeles County, the specialization of its trial courts and California State's various legislative initiatives, ODR has created multiple programs which share common practices: a range of supportive housing coupled with robust clinical and other supportive services. ODR's literature descriptively lists the most relevant programs:[12]

(1) ODR Housing: permanent supportive housing, intensive care management, formal probation,

(2) MIST-CBR Misdemeanor Incompetent to Stand Trial Community Based Restoration.

(3) FIST-CBR and the Off Ramp: Felony Incompetent to Stand Trial Community-Based Restoration and the Off Ramp, which is a program effectuating competency findings and services for persons under 1370 (a)(1)(g), and

(4) Department of State Hospital Diversion: Specialized use of PC 1001.36.

The Office of Diversion and Reentry also coordinates a LEAD program, runs a sobering center, supervises a diversion program for pregnant women in custody and contracts with a UCLA Medical Center for a dedicated 18 bed acute in-patient psychiatric unit.

However, the four listed programs share a focus on wrap around services guided by a clinically appropriate individualized treatment plan. The necessity of the housing component is evident from excerpts contained in the brief blurbs that follow the above listings of each of the four most relevant programs:

> "… the intervention consists of three components: pre-release jail in-reach services with enhanced treatment efforts (additional clinical assessments and immediate initiation of

[10] App. p. 23.

[11] App. p. 24

[12] App p 1 and 2 contain brief but informative excerpts from the Los Angeles County Department of Health Services- Office of Diversion and Reentry-Jail and Community Based Diversion Innovative Programs website. The September report to the Los Angeles Board of Supervisors for scaling up diversion efforts references some of the local California initiatives, App. pp. 10-23.

> medications as indicated), *and immediate interim housing upon release from jail in anticipation permanent supportive housing..."* [ODR Housing]
>
> *"…* the community-based settings are tailored to meet the needs and clinical acuity of the clients; placements range from acute inpatient to open residential settings…" [MIST-CBR]
>
> "…The Off Ramp is a program… which allows those on the wait list who have become competent be adjudicated and diverted to housing and care in the community…" [FIST-CBR]
>
> "… DHS Diversion is funded by the State Hospitals to support the diversion of clients with serious mental illness have the potential to be found incompetent to stand trial on felony charges. ODR provides supportive housing, intensive case management and client services to participants and the Probation Department provides pre-trial supervision…" [Department of State Hospitals]

A recent Rand Research Report highlighted the housing component. It is entitled "*Los Angeles County Office of Diversion and Reentry's Supportive Housing Program: A Study of Participants Housing Stability and New Felony Convictions."* [13]The interim reports initial focus on housing and the way it stated its conclusions speaks loudly as to the primacy of housing coupled with wrap around services.

> This report presents early interim findings about ODR's supportive housing program. We found six-month and 12- month housing stability rates of 91 percent and 74 percent, respectively. Of the cohort that had been placed, 14 percent had new felony convictions. Our next analysis will examine county service use and associated costs for this population prior to and after placement to better understand how the program influence changes to service access and use of different publicly funded resources.[14]

The Competency and ODR Housing Courts.

Our contingent of judges visited the downtown ODR Probation Housing Court and spent nearly two days at the Hollywood Competency Court. The ODR Housing Court is a probation court, not unlike many mental health courts built on the probation model. However, its clients uniformly begin by residing in ODR housing after full assessments as to the appropriateness of that residential model. There are frequent review hearings to monitor a defendant's progress in line with his or her individualized treatment plan. This court's caseload is expanding rapidly.

The Competency Court is one of at least 5 Los Angeles courts that Maryland might characterize as mental health courts. This competency court has witnessed a significant increase in volume during the last decade: from under 1,000 defendants per year to now over 5,000 defendants yearly. Improved screening, significant public interest, remarkable criminal justice partnership and proactive clinician

[13] App. pp. 5-9.
[14] App. p. 9.

involvement seem to be significant factors. The long- term effect of Meth in exacerbating psychotic symptoms is also evident. The court does not handle nuisance cases. Assault charges predominate. The severity of its cases seems equivalent to a combined docket of competency cases that would be seen in Baltimore's Circuit and District Mental Health Courts.

The professional staff supporting the Competency and ODR Housing Court is excellent. Judges, District Attorneys and Public Defenders are experienced and possess a well-developed feel for the blend of collaboration and advocacy needed in this subtle area of practice. Most impressive are the clinicians who work with the court. The court benefits from the well-established USC and UCLA forensic psychiatry programs. The one-day competency evaluations performed by their well-qualified evaluators are on a par with those done by our Circuit Court Medical Office.

Conversations with ODR Providers, Clients and Staff.

The ODR staff and contractors are young and dedicated. There is an abundance of focused and knowledgeable social workers, case managers and peer support specialists. During our judges visit to Los Angeles we had the opportunity to speak with not only with professionals located in the courthouses, but also with residence-based peer support specialists, various treatment and services providers and their clients. Many questions by the other visiting judges and myself were pointed. I felt that the answers were candid.

Uniformly, the responses corroborated that the variously advertised wrap-around services, were available when needed. Fidelity to the principle of clinically appropriate individualized treatment and service plans is maintained. Plans are not cookie cutter. Services are adjusted appropriately to adapt to changed circumstances. I asked a case manager in an interim supportive house if trauma treatment, in truth, was promptly available when it became evident that a resident had a significant trauma history. Her emphatic assurance of the prompt availability of trauma treatment was believable. Local funds to augment Medi-Cal was cited as a key factor as was the close working relationships within the local treatment community. I was very impressed with the clarity of vision and the absence of silos.

Housing and service providers were comfortable with the appropriate return to the interim house of clients who had "run away." There is not a sentiment that the clients had "failed out", but rather an appreciation of the prevalence of relapse with substance use disorder. The consistent presence of staff and an abundance of activities may serve to deter assaults and the development of other problematic situations. The staff seems proactive in anticipating and avoiding difficulties.

The supply of interim and more permanent supportive houses has expanded dramatically. ODR seemingly has contracted with savvy real estate persons who understand the neighborhoods and the landlords. A house that we visited was a former drug dealing location which had frustrated the landlord, upset neighbors and diminished the value of houses on the block. Now neighbors view the ODR house as an upgrade on their block.

Forensic Psychiatrist Kristen Ochoa MD, the clinical director of ODR, was asked by members of our group if the energy that we observed was be found across the program and if she anticipated difficulty in recruiting well qualified staff and contractual providers for her expanding program. Her response was that the staff and contractors were young, talented, and committed to the programs mission. Their work was generally perceived as valuable and praiseworthy. This youthful enthusiasm may hit a wall. But I suspect that momentum and the program's solid footing within the Health Department will carry through into the foreseeable future.

Los Angeles Delay.

Los Angeles' size also brings problems. The detention center houses many incompetent seriously mental ill defendants for long periods. Many incompetent and dangerous defendants in Los Angeles, who are not amenable to placement in ODR housing or otherwise in the community, face over a 90-day jail detention awaiting admission to a psychiatric unit following the adjudication of incompetency. As excellent as the ODR program may be, there remains an unacceptable delay in admission for those defendants who require true in-hospital placement. Litigation continues in California regarding this issue with speculation as to the likelihood of extensive federally ordered remedies.

Community psychiatric units are near gridlock. There is little access to prompt hospitalization when such hospitalization is clinically appropriate – even when very symptomatic incompetent defendant cannot be maintained in the community. The competency court faces a significant dilemma when an incompetent defendant absconds or is otherwise unable to be maintained in ODR housing: a bench warrant with a likely two-week jail detention or a problematic return to ODR housing. An off-stated priority for the Los Angeles mental health courts is a hospital stabilization unit dedicated to defendants who cannot be maintained in the ODR program.

Some Maryland and Baltimore Questions:

Assuming an effort in Maryland and Baltimore to expand supportive housing with wrap-around treatment and services, the following questions may be relevant:

1. What entity (state, local, regional) should assume day to day managerial leadership?
2. How to attract energetic, proactive leadership to not only further the creation of supportive housing with quality wrap around treatment and services, but also to break through silos and positively manage staff and providers?[15]
3. How to attract enthusiastic and well-trained staff, providers, peer support specialists etc.?
4. How to tightly connect supportive housing with quality services to key criminal justice sequential intercepts such as crisis response, pretrial release, conditional release, probation and reentry?
5. How to best leverage Medicaid and other insurance funding? Modify fee for service models, as needed?
6. How to incentivize development and seamless use of clinically appropriate treatment and services using general funds and documenting cost savings: detention, prison, revolving door individuals, hospital?
7. How to use the Justice Reinvestment model to further the development of robust wrap-around treatment with supportive housing at its core?
8. How would this sequential intercept/criminal justice focus dovetail with hospital/ER diversion efforts?

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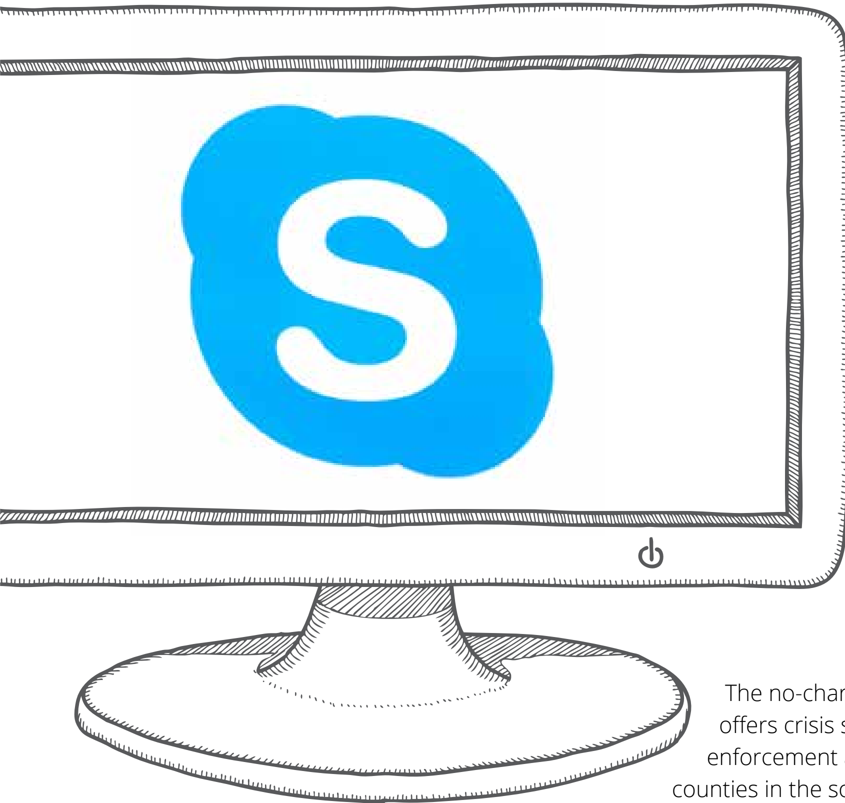
[15] Not a judge: needs a person skilled in getting the most from providers and breaking down silos.

Appendix 2



SKYPING DURING A CRISIS?

Telehealth is a 24/7 Crisis Connection

Arnold A. Remington
Program Director, Targeted Adult Service Coordination Program

When Nebraska law enforcement officials encounter people exhibiting signs of mental illness, a state statue allows them to place individuals into emergency protective custody. While emergency protective custody may be necessary if the person appears to be dangerous to themselves or to others, involuntary custody is not always the best option if the crisis stems from something like a routine medication issue.

Officers may request that counselors evaluate at-risk individuals to help them determine the most appropriate course of action. While in-person evaluations are ideal when counselors are readily available, officers often face crises in the middle of the night and in remote areas where mental health professionals are not easily accessible.

The Targeted Adult Service Coordination program began in 2005 to provide crisis response assistance to law enforcement and local hospitals dealing with people struggling with behavioral health problems. The employees respond to law enforcement calls to provide consultation, assistance in recognizing a client's needs and help with identifying resources to meet those needs.

The no-charge service program offers crisis services to 31 law enforcement agencies in 15 rural counties in the southeast section of the Cornhusker state.

Six months ago, the program offered select law enforcement officials a new crisis service tool: telehealth. The Skype-like technology makes counselors available 24/7, even in remote rural parts of the state. Officers can connect with on-call counselors for face-to-face consultations through secure telehealth via laptops, iPads or Toughbooks in their vehicles.

The technology, which is in use in select jails and police and sheriff departments, is proving to be a win-win for both law enforcement officers and clients. Officers no longer have to wait for counselors to arrive for consultations. In rural communities, it is too common for officers to wait for up to two hours for counselors traveling from long distances.

Telehealth also supports the Targeted Adult Service Coordination program's primary goal of preventing individuals from being placed under emergency protective custody. The program maintains an 82 percent success rate of keeping clients in a home environment with proper supports. The technology promotes faster response times that mean more expedient and more appropriate interventions for at-risk individuals, particularly those in rural counties.

So far, the biggest hurdle has been getting law enforcement officers to break out of their routines and adopt the technology. Some officers still want in-person consultations, a method that is preferable when counselors are available and nearby. But when reaching a counselor is not expedient and sometimes not even possible, telehealth can play an invaluable role.

Police officers' feedback on telehealth has been mainly positive. Officers often begin using the new tool after hearing about positive experiences from colleagues. As more officers learn that they can contact counselors with a few keystrokes from their cruisers, telehealth will continue to grow. The Targeted Adult Service Coordination program plans to expand the technology next year by making it available to additional police and sheriff departments.

Telehealth has furthered the Targeted Adult Service Coordination program's goal of diverting people from emergency protective custody and helping them become successful, contributing members of the community. This creative approach to crisis response provides clients with better care and supports reintegration and individual autonomy.

Resources

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Brain Injury

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Housing

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- Local Program Examples:
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  - Mental Health Association of Nebraska. Keya House is a four-bedroom house for adults with mental health and/or substance use issues, staffed with Peer Specialists.
  - Mental Health Association of Nebraska. Honu Home is a peer-operated respite for individuals coming out of prison or on parole or state probation.
  - MHA NE/Lincoln Police Department REAL Referral Program. The REAL referral program works closely with law enforcement officials, community corrections officers and other local human service providers to offer diversion from higher levels of care and to provide a recovery model form of community support with the help of trained Peer Specialists.

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SSI/SSDI Outreach, Access, and Recovery (SOAR)

Increasing efforts to enroll justice-involved persons with behavioral disorders in the Supplement Security Income and the Social Security Disability Insurance programs can be accomplished through utilization of SSI/SSDI Outreach, Access, and Recovery (SOAR) trained staff. Enrollment in SSI/SSDI not only provides automatic Medicaid or Medicare in many states, but also provides monthly income sufficient to access housing programs.

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Education, Health, and
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THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

Testimony in Support of SB857- Health - Maryland Behavioral Health and Public Safety Center of Excellence - Establishment

March 11th, 2021

Chairwoman Kelley, Vice-Chair Feldman, and members of the Senate Finance Committee:

Thank you for your consideration of Senate Bill 857. Over the past year, I have had the honor to serve as the co-chair of the Public Safety and Judicial Systems Subcommittee of the Lieutenant Governor's Commission to Study Mental and Behavioral Health. The Commission has offered me the unique opportunity to hear from advocates who are working with individuals with behavioral health disorders, many of whom are stuck in a cycle that leads to incarceration due to untreated mental and behavioral health needs. In 2020, my co-chair Dr. Lynda Bonieskie and I, in collaboration with Opioid Operational Command Center Executive Director Steve Schuh, obtained funding from the Substance Abuse and Mental Health Administration (SAMHSA) and organized the first Maryland State Summit on Behavioral Health and the Justice System, using the Sequential Intercept Model (SIM) as a framework to review opportunities for improvement in the State of Maryland.

The Maryland State Summit on Behavioral Health and the Justice System brought together a diverse set of stakeholders from across Maryland to evaluate strengths and areas of improvement for mental and behavioral health services across the justice system. Advocates, community service providers, healthcare and justice professionals all participated in the Summit to develop 13 recommendations to strengthen services, close gaps, and create a continuum of care. Maryland needs an implementation body accountable for these goals, and to carry on the work of implementing the Sequential Intercept Model, improving access to behavioral health services for justice involved individuals, and to divert individuals with behavioral health illnesses towards treatment and away from the Justice system.

To begin implementation of the ambitious recommendations of the report, and to continue implementing the Sequential Intercept Model with the goal of increasing the treatment and decreasing the incarceration of individuals with behavioral health disorders, SB857 creates the Behavioral Health and Public Safety Center of Excellence. This Center of Excellence would:

- Act as the statewide information repository for behavioral health treatment and diversion programs related to the criminal justice system;
- Develop a strategic plan for the State of Maryland to reduce incarceration and increase treatment of justice-involved individuals with behavioral health disorders;
- Host an annual State Sequential Intercept Model Summit, and include in their strategic plans implementation strategies for the recommendations arising from those summits.
- Identify and inform stakeholders of grant funding that would support the missions of the Center;
- Facilitate Sequential Intercept Model train-the-trainer programs, with the goal of training 50 SIM facilitators, utilizing funding already secured by my office in 2020;
- And provide technical assistance to localities for the implementation of best practices at the intersection of behavioral health and the justice system;

This legislation also requires that local jurisdictions develop 2-year behavioral health and public safety plans, in collaboration with their local behavioral and criminal justice planning bodies and key stakeholders to assess their behavioral health systems. Through that process, they will come up with solutions to build an adequate behavioral health system of care with due consideration for the unique impacts of their policies on racial minorities throughout the State as well as for the provision of culturally competent care.

According to the Maryland Alliance for Justice Reform, at least 39% of local jail inmates in Maryland have a mental health disorder. It is estimated that 9 out of 10 of those individuals also struggle with a co-occurring substance abuse disorder. According to research conducted by the Treatment Advocacy Center, their jail and prison stays will likely be longer than that of the average incarcerated individual. Their incarceration is also more costly than for those inmates without a mental illness, and they are more likely to present behavioral management problems during their incarceration. This is a systemic problem that fails everyone in our behavioral health, criminal justice, and public safety systems; and it requires a systematic solution. While this Center is by no means a panacea, having a State body dedicated to improving behavioral health, criminal justice, and public safety outcomes for some of our most vulnerable community members will set us on the path to a more just and equitable future. For these reasons **I respectfully request a favorable report for Senate Bill 857 .**

Sincerely,

Senator Katie Fry Hester
Carroll and Howard Counties