Maryland's Behavioral Health and Public Safety Center of Excellence

STRATEGIC PLAN

September 2023

MARYLAND CRIME RESEARCH AND INNOVATION CENTER

About MCRIC

This document was prepared by the Maryland Crime Research and Innovation Center (MCRIC) at the University of Maryland. The Maryland Crime Research and Innovation Center engages in research to inform local, state, and national crime reduction strategy and policy through data-driven scholarship by conducting rigorous interdisciplinary basic and applied research, developing and evaluating innovative criminal justice strategies aimed at reducing crime in the state, leveraging cross-agency networks to foster data integration, and actively engaging in translational science through wide and varied dissemination of research. MCRIC leverages the broad range of expertise at the University of Maryland to engage in innovative research and interdisciplinary projects to enhance community safety and inform data-driven decision making. MCRIC works with a variety of partners including communities and community-based organizations, police and practitioners, lawmakers, academic peers, and industry, to promote data sharing, exchange knowledge and best practices, and develop new approaches.

About the Project

This is the final strategic plan for Maryland's Behavioral Health and Public Safety Center of Excellence. This work was funded by the Maryland Governor's Office of Crime Prevention, Youth, and Victim Services (GOCPYVS). The views and conclusions contained in this document are those of the authors and should not be interpreted as representing the views or policies of the GOCPYVS, or the University of Maryland. Earlier versions of this strategic plan were delivered to project sponsors in December 2022, March 2023, April 2023, and June 2023.

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List of Abbreviations

ACO	Accountable Care Organizations
ACT	Assertive Community Treatment
BHA	Behavioral Health Administration
BHPS-CoE	Behavioral Health and Public Safety Center of Excellence
BJA	Bureau of Justice Assistance
BJMHS	Brief Jail Mental Health Screen
CCAR	Connecticut Community for Addiction Recovery
CCBHC	Certified Community Behavioral Health Clinics
CDC	Centers for Disease Control and Prevention
CESAR	Center for Substance Use, Addiction & Health Research
CJS	Criminal Justice System
CIT	Crisis Intervention Training
CITCE	Crisis Intervention Team Center of Excellence
CMHS	Correctional Mental Health Screen
CO	Correctional Officer
COD	Co-occurring Disorders
CPRS	Certified Peer Recovery Specialist
CRIT	Crisis Response and Intervention Training
CRT	Crisis Response Team
CSG	Council of State Governments
DSM	Diagnostic and Statistical Manual of Mental Disorders
ED	Emergency Department
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
ESIC	Eastern Shore Information Center
FACT	Forensic Assertive Community Treatment
GOCPYVS	Governor's Office of Crime Prevention, Youth, and Victim Services
HIFA	Health Insurance Flexibility and Accountability
ICAT	Integrating Communications, Assessment and Tactics
IDD	Intellectual and Developmental Disabilities
LBHA	Local Behavioral Health Authority
LE	Law Enforcement

LEAD	Law Enforcement Assisted Diversion
MABPCB	Maryland Addiction and Behavioral Health Professionals Certification Board
MAT	Medication Assisted Treatment
MCIN	Maryland Criminal Intelligence Networks
MCRIC	Maryland Crime Research and Innovation Center
MDCSL	Maryland Community Services Locator
MOU	Memorandum of Understanding
MOUD	Medications for Opioid Use Disorder
NAMI	National Alliance on Mental Illness
NCLS	National Conference of State Legislatures
NIH	National Institutes of Health
OCBHJI	Oregon Center on Behavioral Health and Justice Integration
OIT	Opioid Intervention Team
OOCC	Opioid Operational Command Center
OOOMD	On Our Own of Maryland, Inc.
PAARI	Police Assisted Addiction and Recovery Initiative
PHQ-9	Patient Health Questionnaire
PMHC	Police-Mental Health Collaborations
PTSD	Post-Traumatic Stress Disorder
PRA	Policy Research Associates
SAMHSA	Substance Abuse and Mental Health Services Administration
SID	System Identification
SIM	Sequential Intercept Mapping
SNAP	Supplemental Nutrition Assistance Program
SMI	Serious Mental Illness
SUD	Substance Use Disorder
TANF	Temporary Assistance to Needy Families
TCUDS V	Texas Christian University Drug Screen 5
WRAP	Wellness Recovery Action Plans

Executive Summary

Note: All statistics and scientific studies are referenced in the main document.

People with behavioral health needs are disproportionately represented in the criminal justice system and have a high rate of repeat interaction with public safety and health systems. IN MARYLAND, justice-involved individuals report high rates of behavioral health needs. A 2016 report found that nearly 40% of people in Maryland jails had a current mental health disorder and 1 in 4 suffered from a serious mental illness. More than two thirds (69%) have a substance use disorder. Roughly a third have a co-occurring mental health and substance use disorder. Data are lacking on the prevalence of intellectual and developmental disabilities in Maryland, but *Activating Change* states that nationwide people with disabilities are three to four times more likely than people without disabilities to be incarcerated. As a result, although people with disabilities comprise only 20% of the U.S. population, they account for 40% of those in jail.

In 2020, a Maryland State Summit on Behavioral Health and the Justice System made clear that "Maryland has an impressive array of legislation, programs, and exemplary practices at both the state and county levels that address the needs of justice-involved individuals with mental or substance use disorders" but at the same time lacks a "central entity charged with collecting and disseminating evaluation data and information to promote expansion of programs and guide state priorities. To meet this need, during the 2021 legislative session, the General Assembly enacted Senate Bill 857 establishing the Maryland Behavioral Health and Public Safety Center of Excellence (BHPS-CoE) within the Governor's Office of Crime Prevention, Youth, and Victim Services (GOCPYVS). On April 13, 2021, Governor Larry Hogan signed the bill into law.

The statute established the BHPS-CoE's **purposes** to include: (1) act as a statewide information repository for behavioral health treatment and diversion programs related to the criminal justice system, (2) lead the development of a strategic plan to increase treatment and reduce the detention of justice-involved individuals with behavioral health disorders, (3) provide technical assistance to local governments for developing effective systems of care that prevent and minimize involvement with the justice system for individuals with behavioral health disorders, (4) facilitate local and/or regional planning workshops using the Sequential Intercept Model, (5) coordinate with the Maryland Department of Health and the Behavioral Health Administration to implement and track the progress of creating an effective systems of care related to individuals involved in the justice system, and (6) identify and inform any relevant stakeholders of federal funding available through the center to carry out its mission.

In 2022, the BHPS-CoE began the process of developing the strategic plan that would guide the center's efforts in the initial years. The strategic plan is aimed at translating the above mentioned purposes into concrete priorities, objectives, and action steps for the center to undertake. This planning process included partnering with the Maryland Crime Research and Innovation Center (MCRIC) at the University of Maryland in July 2022 to lead the development of the strategic plan. MCRIC assembled a multidisciplinary team from within the University of Maryland and contracted topic experts from Coppin State University. The multi-year statewide strategic plan draws on the recommendations of the Annual State Sequential Intercept Model Summit 2020 report and other related documents.

The BHPS-CoE focuses on the intersection of behavioral health and public safety. Behavioral health is a broad term that includes serious mental illness (SMI), substance use disorder (SUD), and intellectual and developmental disabilities (IDD). Public safety refers to the well-being and protection of everyone in the community including individuals with a history of justice-system (i.e., police contact through corrections and reentry) involvement and those at risk for justice-system involvement.

The BHPS-CoE Strategic Plan 2023 outlines **seven priority areas** with goals and action steps that provide a roadmap to carry out the mission of the center. Action steps are classified as "in progress," "immediate," and "forthcoming." Actions were prioritized based on the following criteria:

- Feasibility given the resources (e.g., data, personnel) currently available;
- Necessary prerequisite to provide the infrastructure or obtain information to meet the needs of the stated priorities and guide forthcoming actions;
- Availability of reliable and valid evidence to support the implementation of actions; and
- Value alignment with the BHPS-CoE's mission and guiding principles.

Throughout the plan, we use the term "jurisdiction" to refer to Maryland's 23 counties and Baltimore City, recognizing that these county/city designations include multiple smaller jurisdictions within them. Our identified priority areas are as follows:

Identify and Assess Local Resources for Justice-Involved Persons with Behavioral Health Disorders (Mental Health Disorders, Substance Use Disorders, and/or Intellectual and Developmental Disabilities) through Localized Sequential Intercept Model Mapping.

The Sequential Intercept Model (SIM) was developed to help communities identify ways to address the disproportionate number of people with behavioral health issues in the criminal justice system across six key "intercepts" at which people with behavioral health needs come into contact with and flow through the criminal justice system. By engaging in the SIM process, jurisdictions assess resources and determine critical service gaps; identify opportunities to divert individuals from justice system involvement into alternative treatment services; forge partnerships between different agencies, organizations, and jurisdictions; introduce practitioners to evidence-based practices; enhance relationships across systems and agencies; and create customized plans for community change. The BHPS-CoE will facilitate local-level SIM at the request of jurisdictions and in partnership with local-level stakeholders with jurisdiction expertise, promote the sustainability of SIM by providing continued technical assistance following SIM and for re-mapping efforts, and monitor and report on statewide SIM progress.

Build Community-based Crisis Response Team (CRT) Programs.

Crisis Response Team (CRT), also known as Crisis Intervention Team, programs leverage collaborative community partnerships and intensive training to respond to individuals in crisis. This community-based approach brings together law enforcement, mental health providers, emergency services, advocates, and others to improve outcomes of behavioral health crisis incidents. Whereas there are core elements of CRT that should be widely adopted, jurisdictions should complement these efforts to meet the needs of their specific challenges (e.g., homelessness, trauma, suicide) and populations experiencing behavioral health crisis (e.g., transition age youth, veterans). The BHPS-CoE will facilitate the adoption, expansion of

coverage, and sustainability of CRT through technical assistance and access to mental health and crisis intervention training; disseminate information on best practices; and monitoring training progress across the State; promote CRT partnerships by working and convening local stakeholders across the State to support communication and foster collaboration; and track ongoing developments in the use of alternatives to law enforcement responses to crisis calls.

Coordinate Within and Across Systems to Minimize Disruptions in the Continuum of Care.

A continuum of care refers to a comprehensive range of services provided through the criminal justice and public health systems that evolve as individuals progress through the systems and transition through different levels of care. Coordination within and across systems will minimize disruptions and delays in accessing services by prioritizing community-based treatment and harm reduction strategies and investing in prevention and peer services. These efforts take place at the state and local levels including promoting statewide policies, supporting direct service provision, training and supporting behavioral health specialists including peer mentors and service providers, and assisting in the expansion of the local workforce and potential employers to achieve full coverage.

Support the Development of Formal Screening Processes to Identify Candidates for Diversion.

Whereas the high prevalence of individuals with behavioral health issues in the criminal legal system is known, many agencies lack the resources to accurately identify who and how many people under their care have behavioral health needs. This greatly limits the ability to respond to these needs. Unfortunately, behavioral health issues are under-identified in part because screening in criminal justice settings is inconsistent and incomplete. The BHPS-CoE will support the development of screening processes to accurately and swiftly identify those with behavioral health needs who come in contact with the criminal justice system, develop protocols for appropriate timing and number of intervention points to administer screeners, facilitate training and provide technical assistance for selecting and administering screeners, and support data and analysis to understand the scope and patterning of behavioral health issues in Maryland's criminal justice system.

Promote Comprehensive and Consistent Data Collection, Management, and Integration.

Improving cross-system data collection, management, and integration is essential for a myriad of reasons including (but not limited to): identifying the service population (especially high-utilizers/ frequent fliers), informing client-level decisions and diversion, analyzing trends and patterns in service utilization and delivery over time, justifying the development and expansion of programs, and measuring individual and program outcomes and success. In order to promote a comprehensive behavioral health and public safety data infrastructure, the BHPS-CoE, in partnership with the appropriate advisory boards and area experts, must first develop standardized protocols that detail *what* data should be collected, *how* data should be collected, *who* is responsible for collecting these data, and *where* data integration can and should take place (BHPS-CoE or other organizations to be determined, e.g., BHA, independent agency).

Support Data-Driven Decision Making.

Justice-involved persons with behavioral health disorders are served in multiple systems. Building a comprehensive data system to support data-driven decision making begins with linking data across systems. Linking longitudinal data from multiple systems can provide answers to questions about policy and program effectiveness *and* create client-level service/treatment records to improve continuity of care for justice-involved persons with behavioral health disorders. By partnering with researchers from Maryland colleges and universities, the BHPS-CoE can leverage a network of interdisciplinary experts to navigate complex data systems, analyze behavioral health and public safety trends, evaluate program/policy outcomes, and assess performance metrics.

Facilitate Communication and Information Dissemination about Opportunities and Best Practices Across Jurisdictions, the State, and the Nation.

The BHPS-CoE will function as the State's clearinghouse for information regarding behavioral health, public safety, and their intersection. The BHPS-CoE is positioned to streamline and strengthen communication between and across agencies, organizations, and jurisdictions to leverage existing capacity and knowledge building, identify opportunities for collaboration and scaling of promising programs, and create a community of cooperation that promotes shared learning and a commitment to a safer and more supportive State. This work involves efforts including establishing standard language to facilitate shared understanding and collaboration, creating translational documents to share emergent strategies and evidence-informed approaches occurring locally and nationally, and developing a website to function as the centralized hub for accessing timely information and developments.

To facilitate the achievement of the BHPS-CoE's priorities, we highlight four key goals for 2023. These goals will enable center staff to develop collaborations with experts, practitioners, and people with lived experience and begin to identify current resources and gaps in services and provide recommendations for addressing them in future years.

Develop a comprehensive Behavioral Health and Public Safety Center of Excellence website.

A key role of the BHPS-CoE is to facilitate communication within and across agencies, organizations, and jurisdictions across the State. To do this effectively and efficiently, the BHPS-CoE should develop a comprehensive website during the next fiscal year. This website would be separate from the general GOCPYVS website, though linked on that page. We envision this website as a "one-stop shop" to accessing information on SIM, CIT, emergent evidence-informed and evidence-based practices, and innovative strategies occurring in Maryland, and to house links to other state and local resources. The website will be dynamic and evolve as new information and areas of interest emerge.

Complete the hiring process for the BHPS-CoE staff, prioritizing the need for behavioral health specialists.

Significant attention in the early years of the BHPS-CoE will be directed to facilitating SIM at the jurisdiction level. The BHPS-CoE will be the primary facilitators of this effort which will require personnel to be trained to facilitate SIM but also time devoted to education and outreach efforts to promote the

benefits of SIM, connecting with local stakeholders, agencies, and organizations to participate in SIM, and to provide ongoing technical support to those jurisdictions engaging in the SIM process. This trust building process will require a full staff to support continued and constant efforts particularly in the early years as the process builds momentum across the State.

Identify all current and relevant sources of data in Maryland on behavioral health and justice involvement at the state and jurisdiction levels.

With the goal of supporting the development of comprehensive data infrastructures, the BHPS-CoE will need to engage early on in an effort to identify current sources and types of information collected, as well as coverage periods, for behavioral health and justice involvement data. Building an understanding of current data efforts will allow for the BHPS-CoE to work with stakeholders to establish protocols for data collection and governance across agencies and jurisdictions (e.g., use the System Identification (SID) numbers), to effectively use data to draw insights to promote public safety and inform decision making, and to evaluate programs.

Identify all current agencies, working groups, task forces, and advisory groups in Maryland aimed at the intersection of behavioral health and public safety.

Meeting the needs of individuals experiencing a behavioral health crisis and reducing their interactions with the justice system are key concerns in Maryland as is evidenced by the variety of organizations aimed at addressing this challenge. To capitalize on the strength of these efforts, the BHPS-CoE should conduct a comprehensive review of existing workgroups, task forces, advisory groups, and partnerships to document mission, membership, current objectives, and status (active and inactive) to leverage accumulated knowledge; identify points of opportunity and potential redundancy; and develop a communication platform for ongoing collaboration.

Maryland's Behavioral Health and Public Safety Center of Excellence Strategic Plan

Background

People with behavioral health needs are disproportionately represented in the criminal justice system and have a high rate of repeat interaction with public safety and health systems. In 2020, a Maryland State Summit on Behavioral Health and the Justice System made clear that "Maryland has an impressive array of legislation, programs, and exemplary practices at both the state and county levels that addresses the needs of justice-involved individuals with mental or substance use disorders" but at the same time lacks a "central entity charged with collecting and disseminating evaluation data and information to promote expansion of programs and guide state priorities."[1] To meet this need, during the 2021 legislative session, the General Assembly enacted Senate Bill 857 establishing the Maryland Behavioral Health and Public Safety Center of Excellence (BHPS-CoE) within the Governor's Office of Crime Prevention, Youth, and Victim Services (GOCPYVS). On April 13, 2021, Governor Larry Hogan signed the bill into law.

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[1] Abreu, D., & Pinals, D. (2020). 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.* SAMHSA's GAINS Center.

Methodology

The MCRIC team adopted a three-phase approach to strategic planning:

- Phase 1: Information Gathering
- Phase 2: Developing Priorities and Objectives
- Phase 3: Action Planning

Phase 1 of the strategic plan process began by gathering and harnessing information within Maryland and from similarly motivated Centers of Excellence in other states. MCRIC reviewed legislation and other guiding documents pertaining to the center including (but not limited to): HB 607, SB 857, SB 781, and the State Summit on Behavioral Health and the Justice System 2020 Report. Review of these documents served to familiarize the team with pre-established priorities for the center and to guide a path forward for stakeholder interviews and the strategic plan. Team members also reviewed evaluative literature for ongoing initiatives (nationally and in Maryland) and best practices in the following areas: behavioral health screening, state health initiatives, preventative services and harm reduction, data and technology, and peer support services.

In developing the strategic plan, MCRIC conducted informational interviews with more than 30 experts from a wide variety of agencies across Maryland. These meetings allowed the team to gain a better understanding of the current landscape of behavioral health and criminal justice services in Maryland from direct service providers, practitioners, and policy makers. MCRIC also met with similarly motivated Centers of Excellence nationally, including: the *Center for Behavioral Health and Justice* (Wayne State University - Detroit, MI), the *Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center* (University of South Florida - Tampa, FL), the *Oregon Center on Behavioral Health and Justice Integration* (Greater Oregon Behavioral Health Inc. - The Dalles, OR), and the *Criminal Justice Coordinating Center of Excellence* (Northeast Ohio Medical University – Rootstown, OH). These centers serve as potential models for the Center of Excellence in Maryland. As such, conversations yielded valuable insights on the types of services a Center of Excellence can provide and how to deliver those services, such as technical assistance, program evaluation, and grant support.

Information gathered during Phase 1 informed the development of priorities and objectives during Phase 2. The identified priorities for the BHCoE were shared with local stakeholders at the Annual State Sequential Intercept Model Summit 2022 hosted by the GOCPYVS, Centers of Excellence.

Phase 3 involved reviewing and responding to feedback from national and local leaders in behavioral health and public safety on the priorities and objectives identified in Phase 2, identification of specific action steps to meet stated objectives, and the development of a timeline distinguishing short-term outcomes and longer-term vision items. These are categorized as "in progress," "immediate," and "forthcoming." Actions were prioritized based on the following criteria:

- Feasibility given the resources (e.g., data, personnel) currently available;
- Necessary prerequisite to provide the infrastructure or obtain information to meet the needs of the stated priorities and guide forthcoming actions;
- Availability of reliable and valid evidence to support the implementation of actions; and
- Value alignment with the BHPS-CoE's mission and guiding principles.

The second draft was shared with a total of 10 individuals with experience and expertise in behavioral health, public safety, and their intersection who read and responded to the strategic plan in January-February 2023. These include both local and national leaders from a diverse array of backgrounds (see the list of comprehensive and area specific readers). Their invaluable insights were incorporated into the strategic plan submitted to the GOCPYVS on March 15, 2023. MCRIC met again with the GOCPYVS team on April 19, 2023 for a comprehensive discussion of the strategic plan addressing final points of clarification. A full version of the strategic plan was shared with GOCPYVS and with feedback discussed at group meeting on April 19, 2023.

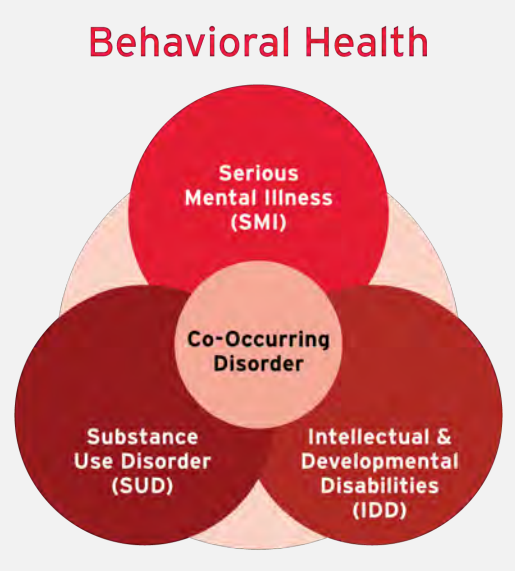
Landscape of the Intersection of Behavior Health and Public Safety

Defining the Challenge

Individuals who come into contact with the criminal legal system are disproportionately affected by behavioral health issues, an overarching term that includes mental health, substance use, and/or intellectual and developmental disabilities. Below are key terms used throughout the strategic plan.

Criminal Justice System (CJS): Contact with the criminal justice system includes interactions with public safety agents from pre-arrest to corrections and all points in between.

Serious Mental Illness (SMI): Serious mental illness is a mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria and resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.[2] Maryland has identified a list of priority SMIs including schizophrenia, bipolar illness, and major depressive disorders. An individual must have a priority diagnosis in order to be eligible for certain behavioral health services, such as ACT (assertive community treatment) programs.



Substance Use Disorder (SUD): According to the National Institutes of Health, substance use disorder encompasses varying degrees of use of licit and illicit substances affecting a person's brain and behavior. An SUD diagnosis is based on evidence of an inability to control use, social impairment, risky use, and other indicators.[3]

Intellectual and Developmental Disability (IDD): A developmental disability characterized by mild to profound limitations in cognitive function (e.g., learning, problem solving, reasoning, planning) and in adaptive behavior, impairing one's ability to acquire skills typical for one's age group as a child or necessary for one's later independent functioning as an adult.

Although comprehensive, these categories (SMI, SUD, IDD) may exclude certain disabilities or disorders (e.g., Post Traumatic Stress Disorder (PTSD), Acquired Brain Injuries) that should be considered for inclusion in the behavioral health framework in Maryland. For example, Acquired Brain Injuries, like Traumatic Brain Injury, do not fit within these three categories, but commonly co-occur. Additionally, some mental illnesses, like PTSD, can

[2] Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. U.S. Department of Health and Human Services. https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

[3] National Institute of Mental Health (NIH). (2021). *Substance Use and Co-occurring Mental Disorders, Overview*. https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health#:~:text=A%20substance%20use%20disorder%20(SUD,most%20severe%20form%20of%20SUDs).

result in serious functional impairment (especially for Veterans[4] and victims of crime) but may not be included in Maryland's list of priority SMIs.[5]

As implied by the term "behavioral" health, these conditions can be associated with problematic behaviors (e.g., drug use, self-harm), many of which can lead people to come into contact with criminal justice authorities and perhaps even to become ensnared by the system. For example, individuals with behavioral health conditions have an increased risk of arrest and are more likely to experience police aggression during encounters with law enforcement.[6] A study by the National Police Foundation estimated that 13.6% of officer-involved shootings in Phoenix involved a mental health crisis, although they note that this may be a conservative estimate.[7] Those with behavioral health issues also comprise a high proportion of the incarcerated population. Specifically, approximately 14% of individuals in state or federal prison and 26% of persons in jails report symptoms meeting the threshold for "serious psychological distress."[8-9] Moreover, 40.5% of prisoners and 44% of jail inmates have been told in the past by a mental health professional that they had a mental health disorder.[10] These numbers are even higher for substance use disorders, with more than half of state prisoners (58%) and jail inmates (63%) meeting the criteria for drug dependence and/or abuse. Estimates place the prevalence of intellectual and developmental disabilities at roughly 30% of the incarcerated population with cognitive disabilities being most common.[11] The prevalence of IDD in incarcerated populations is roughly five times greater than the general adolescent population and ten times greater than the general adult population.[12]

These estimates are comparable to what is observed in Maryland correctional facilities. A 2016 study found that 39% of people in Maryland detention centers had a current mental health disorder and 69% were estimated to have a substance use disorder.[13] The prevalence of IDD in Maryland is unknown and in general, data on the intersection of IDD, public safety, and outcomes of interventions are lacking.[14]

Notably, there are high rates of co-occurring disorders in justice-involved populations as well. Co-occurring disorders (COD) refer to cases in which at least two behavioral health disorders are observed. CODs are especially difficult to diagnose and treat successfully.[15] Nationally, an estimated 54% of female and 41% of

[4] Mental Health Fact Sheet: Serious Mental Illness (page 3). https://www.va.gov/PREVENTS/docs/PRE013_FactSheets_SeriousMentalIllness_508.pdf

[5] National Institute of Mental Health: Mental Health Information. https://www.nimh.nih.gov/health/statistics/mental-illness

[6] Walton, M. H. (2022). Barriers to justice: Inaccessibility of New York's criminal justice system for individuals with intellectual and developmental disabilities. *Government Law Review, 14*(1).

[7] National Police Foundation (2019). *National Police Foundation Analysis of 2018 Use of Deadly Force by the Phoenix Police Department* (p. 64). https://www.phoenix.gov/policesite/Documents/NPF_OIS_Study_Recommendations.pdf

[8] Maruschak, L. M., Bronson, J., & Alper, M. (2021). *Indicators of Mental Health Problems Reported by Prisoners*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

[9] Bronson, J., & Berzofsky, M. (2017). *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics: 1-16.

[10] Bronson, J., Zimmer, S., & Berzofsky, M. (2017). *Drug use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

[11] Leotti, S. M., & Slayter, E. (2022). Criminal legal systems and the disability community: An overview. *Social Sciences* 11(6):255; Bixby, L.,, Bevan, S., & Boen, C. (2022). The links between disability, incarceration, and social exclusion. *Health Affairs* 41(10):1460–69.

[12] Han, S., & Nath, A. 2022. Neurological conditions among the incarcerated: A medically underserved population. *Journal of Neurology and Neurophysiology* 13 (12): 1-4.

[13] Governor's Office on Crime Control and Prevention. (2016). *Substance Use and Mental Health Disorder Gaps and Needs Analysis*. https://goccp.maryland.gov/wp-content/uploads/justice-reinvestment-sa-mh-gaps-needs-20161231.pdf

[14] Krahn, G. L. (2019). A call for better data on prevalence and health surveillance of people with intellectual and developmental disabilities. *Intellectual and Developmental Disabilities*, 57(5): 357-375.

[15] Substance Abuse and Mental Health Service Administration (2019). *Screening and Assessment of Co-occurring Disorders in the Justice System*. HHS Publication No. PEP19-SCREEN-CODJS. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

male state prisoners have a COD.[16] According to the latest data from Maryland, 35% of prisoners have a COD. Certain subpopulations, such as Veterans, may be especially vulnerable to the effects of co-occurring disorders. Recent national estimates indicate that incarcerated Veterans are more likely to have multiple disorders compared to non-Veterans and are twice as likely to have PTSD.[17]

A necessary first step in addressing the complex needs of justice-involved persons with behavioral health issues is to identify these persons. This is typically accomplished via screening tools administered at intake into a detention center or correctional facility. Unfortunately, "there is all too often a failure to effectively screen and assess people with [co-occurring disorders] who are in the justice system."[18] Screening tools are typically short, easy to administer, and are designed to flag individuals who may have a particular disorder. If the results of a screener indicate a potential problem, individuals should be diverted for further assessment and if necessary, specialized programs and services. Failure to identify persons with behavioral health needs or failure to identify them early enough can have catastrophic consequences. For example, persons left untreated and mis-identified could face higher risk of overdose, suicide, and victimization if placed in a more punitive rather than treatment-oriented setting.

While most available information on prevalence comes from data collected at intake in a correctional facility, the prevalence of behavioral health issues among those who come into contact with police is certainly higher, albeit difficult to quantify. However, it is estimated that six to ten percent of police encounters involve a person with mental illness or someone experiencing a behavioral health crisis.[19] Behavioral health-related calls for service are among the most time consuming police calls.[20] This suggests that even if the relative percentage of calls involving a person with mental illness are small, the time and resources allocated to these types of calls are more pronounced.

Access to treatment can be difficult for those experiencing behavioral health concerns and crises across the various intercepts including locating services in the community, accessing treatment during periods of confinement, and confronting a myriad of challenges upon reentry.

[16] James, D. J., & Glaze, L. E. (2006). *Mental Health Problems of Prison and Jail Inmates* (Research Report No. NCJ 213600). Retrieved from https://www.bjs.gov/content/pub/pdf/mhppji.pdf

[17] Edwards, E. R., Greene, A. L., Epshteyn, G., Gromatsky, M., Kinney, A. R., & Holliday, R. (2022). Mental health of incarcerated veterans and civilians: Latent class analysis of the 2016 Survey of Prison Inmates. *Criminal Justice and Behavior,* 49(12): 1800-1821.

[18] Substance Abuse and Mental Health Services Administration (2019). *Screening and Assessment of Co-occurring Disorders in the Justice System*. HHS Publication No. PEP19-SCREEN-CODJS. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

[19] Livingston, J. D. (2016). Contact between police and people with mental disorders: A review of rates. *Psychiatric Services*, 67(8): 850-857.

[20] Lum, C., Koper, C. S., & Wu, X. (2022). Can we really defund the police? A nine-agency study of police response to calls for service. *Police Quarterly*, 25(3): 255-280.

Racial and Ethnic Disparities in Behavioral Health and Public Safety

Individuals belonging to minority racial and ethnic groups face disproportionate outcomes throughout the criminal justice and behavioral health systems. Black individuals are more likely to be arrested, relative to White individuals, even when controlling for a person's demeanor, offense severity, and prior record,[21] are more than three times more likely to be in jail,[22] receive harsher sentences,[23] and are more likely to be held awaiting parole decisions, even after controlling for sentence type.[24] Research also suggests that the mental health consequences of incarceration may be particularly concentrated among black individuals.[25]

Racial and ethnic minorities also face disparities in behavioral health systems. Black and Hispanic individuals are less likely than White individuals to receive treatment for depression[26] and complete addiction treatment, largely due to socioeconomic factors.[27] Black individuals are more reluctant to seek behavioral health treatment due to cultural mistrust of medical services.[28] An analysis of 5,926 cases involving adults aged 18 or older with a DSM code F01-F99 from the annual National Hospital Ambulatory Medical Care Survey from 2018-2020 by researchers at the CDC determined that rates of emergency department (ED) visits for any mental health disorder were significantly higher for non-Hispanic Blacks than for Hispanics and non-Hispanic Whites (96.8 per 1,000 Black adults vs. 53.4 per 1,000 White adults and 36.0 per 1,000 Hispanic adults). Blacks also had higher rates of ED visits related to substance use disorders, anxiety disorders, mood disorders, and schizophrenia.[29]

The relationship between behavioral health system and criminal justice system interaction is reciprocal. Incarceration and contact with the criminal justice system can have negative impacts on mental health; at the same time counties with fewer behavioral health services have higher incarceration rates per capita.[30] These

[21] Kochel, T. R., Wilson, D. B., & Mastrofski, S. D. (2011). Effect of suspect race on officers' arrest decisions. *Criminology*, 49(2): 473-512.

[22] Zeng, Z. (2021). *Jail Inmates in 2019*. U.S. Department of Justice, Bureau of Justice Statistics, NCJ 255608. https://bjs.ojp.gov/content/pub/pdf/ji19.pdf

[23] Steffensmeier, D., Ulmer, J., & Kramer, J. (1998). The interaction of race, gender, and age in criminal sentencing: The punishment cost of being young, black, and male. *Criminology*, 36(4): 763-798; Steffensmeier, D., & Demuth, S. (2001). Ethnicity and judge's sentencing decisions: Hispanic-Black-White comparisons. *Criminology*, 39(1): 145-178; Wooldredge, J., Frank, J., Goulette, N., & Travis III, L. (2015). Is the impact of cumulative disadvantage on sentencing greater for black defendants? *Criminology & Public Policy*, 14(2): 187-223.

[24] Young, K. M., & Pearlman, J. (2022). Racial disparities in lifer parole outcomes: the hidden role of professional evaluations. *Law & Social Inquiry*, 47(3), 783-820; Huebner, B. M., & Bynum, T. S. (2008). The role of race and ethnicity in parole decisions. *Criminology*, 46(4): 907-938.

[25] Porter, L. C., Kozlowski-Serra, M., & Lee, H. (2021). Proliferation or adaptation? Differences across race and sex in the relationship between time served in prison and mental health symptoms. *Social Science & Medicine*, 276, 113815.

[26] Alegría, M., Alvarez, K., Ishikawa, R. Z., DiMarzio, K., & McPeck, S. (2016). Removing obstacles to eliminating racial and ethnic disparities in behavioral health care. *Health Affairs*, 35(6): 991-999.

[27] Saloner, B., & Cook, B. L. (2013). Blacks and Hispanics are less likely than whites to complete addiction treatment, largely due to socioeconomic factors. *Health Affairs*, 32(1): 135-145.

[28] Campbell, R. D., & Long, L. A. (2014). Culture as a social determinant of mental and behavioral health: A look at culturally shaped beliefs and their impact on help-seeking behaviors and service use patterns of Black Americans with depression. *Best Practices in Mental Health*, 10(2): 48-62; Whaley, A. L. (2001). Cultural mistrust and mental health services for African Americans: A review and meta-analysis. *The Counseling Psychologist*, 29(4): 513-531.

[29] Peters,Z.J., Loredana, S., Davis, D., & DeFrances, C.J. (March 1 2023). *Emergency Department Visits Related to Mental Health Disorders Among Adults, by Race and Hispanic Ethnicity: United States, 2018–2020*. National Health Statistics Reports, No. 181. U.S. DHHS, CDC, NCHS. https://www.cdc.gov/nchs/data/nhsr/nhsr181.pdf.

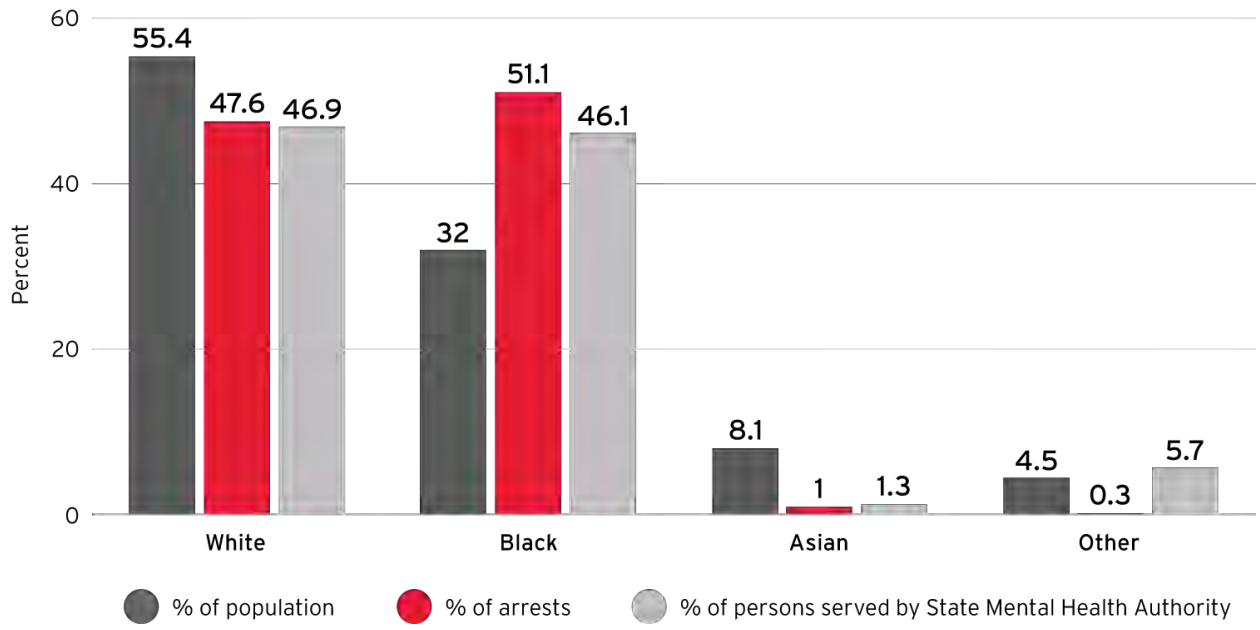
[30] Sugie, N. F., & Turney, K. (2017). Beyond incarceration: Criminal justice contact and mental health. *American Sociological Review*, 82(4): 719-743; Ramezani, N., Breno, A. J., Mackey, B. J., Viglione, J., Cuellar, A. E., Johnson, J. E., & Taxman, F. S. (2022). The relationship between community public health, behavioral health service accessibility, and mass incarceration. *BMC Health Services Research*, 22(1): 1-11.

factors, combined with existing racial/ethnic disparities in criminal justice could suggest that disproportionate criminal justice contact may exacerbate minority health inequalities.

MARYLAND faces its own racial disparities in behavioral health and criminal justice. Black (6.4%) and Hispanic (21.7%) residents are more likely to be uninsured than Whites (3.7%).[31] Racial minorities comprise a disproportionate share of the people served by the Maryland State Mental Health Authority (46.9% are Black and 45.8% are White).[32] Compared to their white counterparts in Maryland, Black individuals are more likely to be pulled over by police, are more likely to be tried as adults when they are under 18 years old, and face higher bail amounts on average.[33] Black individuals comprise 69% of the state's prison population and 52% of the jail population, but only 31% of the total population.[34]

Maryland Population & Arrest Demographics

Retrieved from 2020 Census, 2020 FBI Uniform Crime Report, and 2018 SAMHSA Report



[31] Kaiser Family Foundation. (2021, October 28). *Uninsured Rates for the nonelderly by Race/Ethnicity.* https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-raceethnicity/?activeTab=graph€tTimeframe=0&startTimeframe=4&selectedDistributions=white--black--hispanic&selectedRows=%7B%22states%22%3A%7B%22maryland%22%3A%7B%7D%7D%7D&sortModel=%7B%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D

[32] Substance Abuse and Mental Health Services Administration. (2019). *Racial/ethnic Differences in Substance Use, Substance Use disorders, and Substance Use Treatment Utilization among People Aged 12 or Older (2015-2019).* https://www.samhsa.gov/data/sites/default/files/reports/rpt35326/2021NSDUHSUChartbook102221B.pdf

[33] Governor's Office of Crime Prevention, Youth, and Victim Services. (2021). *Juveniles Charged as Adults Dashboard.* http://goccp.maryland.gov/data-dashboards/juveniles-charged-as-adults-dashboard/; Governor's Office of Crime Prevention, Youth, and Victim Services. (2021). *Race-Based Traffic Stop Data Dashboard.* https://app.powerbigov.us/view?r=eyJrIjoiZTBhNDYzMTMtZTRhMy00OWRkLTk3ZGItZmJlMGQ2OTRjMDQzIiwidCI6IjYwYWZlOWUyLTQ5Y2QtNDliMS04ODUxLTY0ZGYwMjc2YTJlOCJ9&pageName=ReportSection; Maryland Alliance for Justice Reform. (2015). *Money Bail, Pretrial Detention, and Race in Maryland.* https://www.ma4jr.org/

[34] Vera Institute of Justice. (2018). Incarceration Trends in Maryland. https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-maryland.pdf

Developing Maryland's Behavioral Health and Public Safety Center of Excellence

Roles and Activities of the Center

To be consistent with Senate Bill 857 and House Bill 1280 establishing the Maryland Behavioral Health and Public Safety Center of Excellence, the center's **activities** must include: (1) strategic planning, (2) technical assistance, (3) State and local government coordination, and (4) facilitation of train-the-trainer courses for the "Sequential Intercept Model" (SIM) for completion. In addition, the center must develop (5) a statewide model and implementation recommendations for law enforcement-assisted diversion, (6) recommendations for pretrial services and screening, (7) procedures for sharing relevant statistics between relevant State agencies, and (8) a statewide model for community crisis intervention services other than law enforcement.

To address and carry out each of these activities, we lay out three critical roles that the center will serve. Through each of these roles, the center will be responsible for initiating, accomplishing, and maintaining these activities.

First, the BHPS-CoE team will provide **technical assistance and training** to facilitate various efforts across the state. These activities will include administrative support for outreach, recruitment, and hosting training sessions and workshops such as the train-the-trainer Sequential Intercept Mapping (SIM) facilitator workshops (in collaboration with SAMHSA Gains Center) and Crisis Intervention Training (CIT). Technical assistance will also take the form of assisting with grant applications to support local or state initiatives, compiling and facilitating the distribution of evidence-based resources and training material highlighting best practices in behavioral health, public safety, and criminal justice, and facilitating local and regional SIM summits. Finally, the center may also assist with curriculum development, structuring memorandums of understanding, and the promotion of system-level integration and coordination.

Second, the BHPS-CoE will function as a **centralized communication** hub fostering inter-agency/organization and cross-jurisdiction communication and collaboration. Through the center, organizations and jurisdictions can obtain and share information about the types of programs that are being utilized across intercepts and across the State, leverage group insight to strategize responses to challenges and emergent issues, and be a centralized hub to locate resources and materials (e.g., resource website). The center will also aid jurisdictions in connecting to local resources (e.g., healthcare providers, non-profit agencies) and will facilitate seminars, workgroups and networks that bring people together working in behavioral health and criminal justice across intercepts and areas of the State.

Third, the center will play a role in **data, research, and evaluation** by building and managing a data infrastructure, informing the types of data that should be collected and how to collect those data, tracking data collected, tracking program development and implementation, and cultivating strong research and evaluation partnerships. The BHPS-CoE will work with localities to develop stronger data infrastructures, identify metrics for core measures, and assist with implementation strategies that allow for effective evaluation of interventions. It is worth noting that there is some overlap between these various roles. In this instance, technical assistance will go hand-in-hand with ensuring quality data collection, tracking, and storage.

Organizational Structure of the Behavioral Health and Public Safety Center of Excellence

The BHPS-CoE integrates and expands upon a number of existing efforts in Maryland to address behavioral health challenges including the Crisis Intervention Team Center of Excellence (CITCE), and Law Enforcement Assisted Diversion (LEAD). As a collaborative unit, the BHPS-CoE will increase efficiency and effectiveness of behavioral health and public safety initiatives by identifying and leveraging existing resources, reducing redundancy, and becoming a central repository for disseminating and advancing evidence informed strategies and opportunities.

The BHPS-CoE will function in partnership with the Behavioral Health and Public Safety Center of Excellence Advisory Group that will foster interagency collaboration and integration of the center's goals and objectives in standard operating procedures and thus maintain the center's mission across administrations. The Advisory Group will advise on a variety of BHPS-CoE initiatives such as the development and implementation of the BHPS-CoE's action plan, support the Sequential Intercept Model as a strategic planning tool, advise on potential funding streams, and facilitate creation of a best practice repository. Members include the Lieutenant Governor (or designee), Executive Director of the Governor's Office of Crime Prevention, Youth, and Victim Services (or appointee), Secretary of the Department of Health (or designee), Secretary of Department of Public Safety and Correctional Services (or appointee), Maryland Chiefs of Police appointee, Maryland Sheriff's Association appointee, A member appointed by the Senate President, a member appointed by the Speaker of the House, Designee of Mental Health Association of Maryland, Consideration for Federal Designee (U.S. Department of Health and Human Services or Office of Justice Programs), and a National Alliance on Mental Illness of Maryland appointee.

RECOMMENDATION: Build out representation of critical voices on the BHPS-CoE Advisory Group to include members impacted by or with direct lived criminal justice and behavioral health systems experience, researchers with expertise in the intersection of public safety and behavioral health, and first responders and practitioners who regularly interact with people in crisis.

Organizational Structure of the Behavioral Health and Public Safety Center of Excellence

The BHPS-CoE functions as a convener of entities working to promote behavioral health and reduce criminal justice system engagement. Housed within the BHPS-CoE are emphases firmly situated in the SIM, CIT, LEAD programs, and others that may emerge to meet the overarching goals aimed at promoting behavioral health and reducing criminal justice system involvement.

Legislation identifies a number of key roles to facilitate these objectives (mandated roles in dark gray, recommended roles in light gray, CIT linked roles in dark blue, and LEAD roles in light blue). A center director will oversee each entity within the BHPS-CoE. Alongside the center director are a mental health coordinator and CIT coordinator. These individuals may serve in these capacities for both the SIM and the CIT entities as they develop and grow. The SIM entity also includes a research coordinator and a recommendation to leverage expertise from local partners as determined to meet the BHPS-CoE's goals. Rounding out the team are the CIT policy and advocacy coordinator and data analyst, and the LEAD coordinator. In addition to the BHPS-CoE specific team are a number of groups working in Maryland to address behavioral health and public safety issues and should be engaged with in a collaborative way.

RECOMMENDATION: Incorporate CITCE within the BHPS-CoE organizational structure. In practice, these two centers currently work together to address challenges related to behavioral health and public safety. By including them formally in a shared structure, individuals external to the GOCPYVS can more easily identify how the centers work collaboratively and comprehensively.

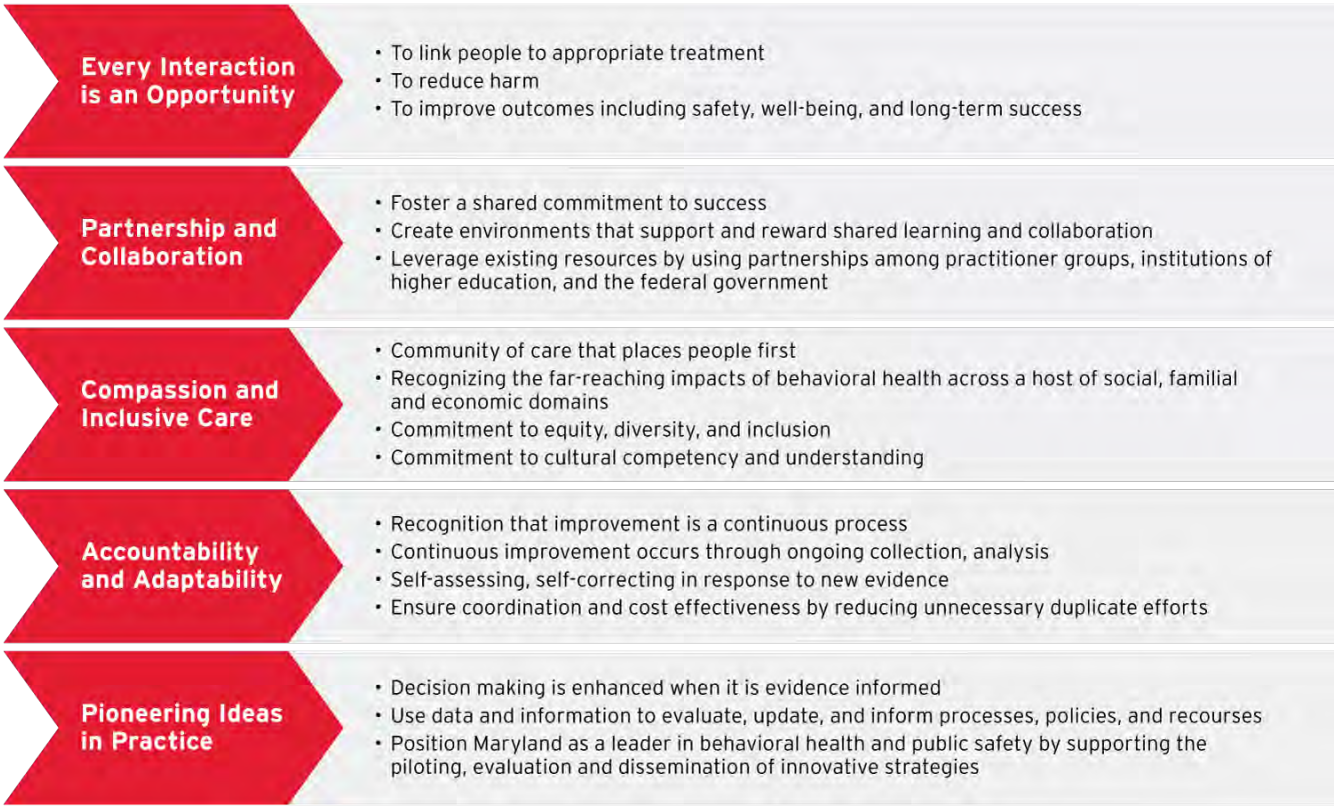
Mission Statement

To advise the GOCPYVS on efforts that support Maryland communities in improving the criminal justice response to and treatment of individuals with behavioral health needs, reducing the incarceration of individuals with behavioral health needs, and providing linkages to treatment. The center acts as a statewide clearinghouse for behavioral health related treatment and diversion programs, develops strategic plans to increase treatment and reduce detention of those with behavioral health disorders in the judicial system, provides technical

support for localities, advances crisis intervention programming, and coordinates with State agencies to measure program effectiveness.

The BHPS-CoE seeks to promote fair, equitable, and just treatment of individuals with behavioral health needs before, during, and after justice system interaction; foster evidence-based, data-driven decision making; and be a leader in implementing innovative approaches to connecting individuals with behavioral health needs to the services they need as part of a continuum of care.

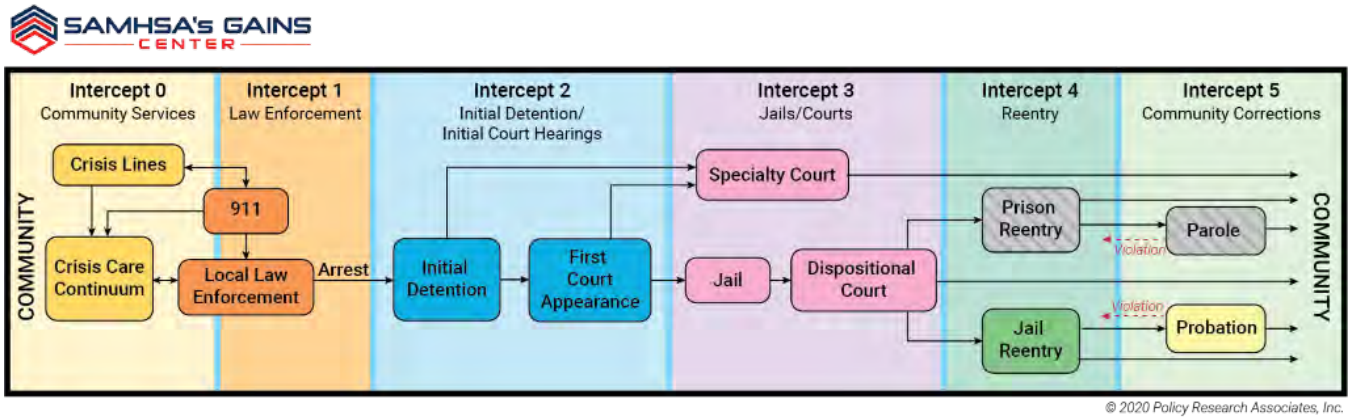
Guiding principles for this work include:



Core to this work is the notion of ***active assistance****: Taking action with the intent to assist others*. When engaging with individuals in a behavioral health crisis, the first response is one that actively assists with connecting individuals to resources and treatment to address immediate needs. Individuals responding to crisis activity should assist each other as partners in response, resource sharing, and accountability. For example, a "warm" hand off refers to the sharing of information between one organization transferring responsibility of an individual to another (e.g., police to treatment program). This way, the individual is not starting out "cold" in their interactions and experiences with the staff of the receiving agency. The BHPS-CoE ***actively assists*** State and local level efforts to develop and share emergent and evidence-informed strategies, in funding opportunities for the development, scaling, and replication of behavioral health practices, and in using data to inform decision-making to effectively and efficiently use resources.

Sequential Intercept Model Framework

The Sequential Intercept Model (SIM, shown below) was developed to help communities identify ways to address the disproportionate number of people with behavioral health issues in the criminal justice system. Involving both community and system touchpoints, the SIM framework illustrates six key points or "intercepts" at which people with behavioral health needs come into contact with and flow through the criminal justice system: Community Services, Law Enforcement, Initial Detention/ Initial Court Hearings, Jails/Courts, Reentry, and Community Corrections. A SIM framework recognizes that stakeholders across multiple systems (justice, behavioral health, addiction, etc.) share responsibility for identifying viable non-criminal justice system alternatives.[35]



Through SIM, jurisdictions assess resources and determine critical service gaps, identify opportunities to divert from justice system involvement into alternative treatment services, forge partnerships between individuals from different agencies, organizations, and jurisdictions, introduce practitioners to evidence-based practices, enhance relationships across systems and agencies, and create customized plans for community change. Ultimately, the goal of these activities is to prevent individuals with behavioral health disorders from entering the criminal justice system, divert individuals from further penetration into the criminal justice system, and engage individuals in appropriate and continuous treatment as they exit the criminal justice system.

The Maryland BHPS-CoE uses SIM as its guiding framework recognizing the importance of establishing connections and partnerships both within and across intercepts.

[35] Munetz, M. R., & Griffin, P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, 57(4): 544-549.

Key Goals for Fiscal Year 2023

To facilitate the achievement of the BHPS-CoE's priorities, we highlight **key goals** for FY 2023. These goals will enable center staff to develop collaborations with experts, practitioners, and people with lived experience and begin to identify current resources and gaps in services and provide recommendations for addressing them in future years.

Develop a comprehensive Behavioral Health and Public Safety Center of Excellence website.

A key role of the BHPS-CoE is to facilitate communication within and across agencies, organizations, and jurisdictions across the State. To do this effectively and efficiently, the BHPS-CoE should develop a comprehensive website during the next fiscal year. We envision this website as a "one-stop shop" to accessing information on SIM, CIT, LEAD, emergent evidence-informed and evidence-based practices, innovative strategies occurring in Maryland, and to house links to other resources at the state and jurisdiction-levels. The website will be dynamic and build as new information and areas of interest emerge.

Complete the hiring process for the BHPS-CoE staff, prioritizing the need for behavioral health specialists.

Significant attention in the early years of the BHPS-CoE will be directed to facilitating SIM at the jurisdiction level. The BHPS-CoE will be the primary facilitators of this effort which will require personnel to be trained to facilitate SIM but also time devoted to education and outreach efforts to promote the benefits of SIM, connecting with local stakeholders, agencies, organizations to participate in SIM, and to provide ongoing support to those jurisdictions engaging in the SIM process. This trust building process will require a full staff to support continued and constant efforts particularly in the early years as the process builds momentum across the State.

RECOMMENDATION: Other similarly focused Centers of Excellence in the U.S. highlighted the benefits of housing the technical assistance and training components of the center outside a government office. Though operationally supported by the state, an external organization functions outside of the political domain and is less impacted by changes in administration. Additionally, the external positioning situates the group as a neutral voice and opens lines of communication for all constituencies. We recommend that the Maryland BHPS-CoE create a task force to identify the capacity, strengths/weaknesses, and practical implications of a structural reorganization that would relocate the Technical Assistance and Training components in a partner organization. This group would remain part of the BHPS-CoE team, participating in joint efforts to meet the goals of the center, but would perform technical assistance tasks such as facilitating SIM and re-mapping efforts, offering crisis intervention training, and informing and providing training on how to implement best practices across intercepts.

Identify all current and relevant sources of data in Maryland on behavioral health and justice involvement at the State and jurisdiction levels.

With the goal of supporting the development of comprehensive data infrastructures, the BHPS-CoE will need to engage early on in an effort to identify current sources and types of information collected, as well as coverage periods, for behavioral health and justice involvement data. Building an understanding of current data efforts will allow for the BHPS-CoE to work with stakeholders to establish protocols for data collection and governance across agencies and jurisdictions (e.g., use the System Identification (SID) codes), to effectively use data to draw insights to promote public safety and inform decision making, and to evaluate programs.

Identify all current agencies, working groups, task forces, and advisory groups in Maryland aimed at the intersection of behavioral health and public safety.

Meeting the needs of individuals experiencing a behavioral health crisis and reducing their interactions with the justice system are of key concern to a number of individuals in Maryland as is evidenced by the variety of organizations aimed at addressing this challenge. To capitalize the strength of these efforts, the BHPS-CoE should conduct a comprehensive review of existing workgroups, task forces, advisory groups, and partnerships to document mission, membership, current objectives, and status (active and inactive) to leverage accumulated knowledge, identify points of opportunity and potential redundancy, and develop a communication platform for ongoing collaboration.

Priorities, Objectives, and Action Steps

PRIORITY 1

Identify and Assess Local Resources for Justice-Involved Persons with Behavioral Health Disorders (Mental Health Disorders, Substance Use Disorders, and/or Intellectual and Developmental Disabilities) through Localized Sequential Intercept Model (SIM) Mapping

The BHPS-CoE will provide technical assistance and guidance to support the development and sustainability of SIM within county-level jurisdictions. The BHPS-CoE will continue to host the annual statewide Sequential Intercept Mapping summit. While the annual summit provides an opportunity for stakeholder networking and identification of overarching gaps and needs, it is crucial for additional mappings to occur at the local level to respond to the unique characteristics and challenges that localities face. Counties across Maryland differ greatly in terms of service populations, staffing capacity, access to technology, and more. Local level mappings will provide insight into these kinds of variations that cannot be parsed out during statewide mappings. Additionally, information gleaned from local mappings can be leveraged to identify promising programs for statewide expansion and opportunities for regional collaborations, as well as funding opportunities supported by, for instance, the BHPS-CoE, Behavioral Health Authority, and federal opportunities.

IN MARYLAND, ten counties/regions have conducted or are in the planning phases of engaging in SIM mapping or remapping at the local or regional levels (Calvert County 2019, Caroline County 2022 Regional Mapping, Cecil County 2022, Dorchester County 2022 Regional Mapping, Harford County 2005, Kent County 2022 Regional Mapping, MidShore 2014 Regional Mapping, Prince George's County 2021, Queen Anne County 2022 Regional Mapping, and Talbot County 2022 Regional Mapping).

Objective 1a: Facilitate the development of SIM across the State

SIM is designed to leverage local expertise across system intercepts to collaboratively describe how people with behavioral health needs come into contact with the criminal justice system within each jurisdiction and then to use this information to identify opportunities and resources for diversion. Conducting SIM at the local level allows each jurisdiction to recognize its diverse needs and populations to develop community specific plans and locally driven responses. The process of SIM, drawing together voices from a variety of agency and organization stakeholders, is important for identifying system gaps and resources, but also for developing cross-agency/organization partnerships that are critical to successful implementation and follow through.

Because the SIM process fosters a nuanced understanding of the gaps and opportunities within a jurisdiction, and strengthens collaborative partnerships with common understanding and objectives, jurisdictions will be positioned to apply for and increase the likelihood of successful grant applications to support programmatic efforts. The BHPS-CoE will work to identify subsequent opportunities to continue to support actions identified through SIM, such as further technical assistance and funding avenues (e.g., State opportunities such as through the BHPS-CoE, BHA, and federal options).

Though local level expertise is critical for the success of SIM, recommendations from trainers from Policy Research Associates and staff from other similarly motivated centers (e.g., Oregon Center on Behavioral Health and Justice Integration: OCBHJI) recommends that the facilitation of SIM be supported by two SIM facilitators who bring expertise from different intercepts and are *not* members of the jurisdiction being mapped. Individuals trained in SIM who are not BHPS-CoE staff can provide support when conducting SIM mappings in neighboring jurisdictions. Facilitators work to promote cross-system stakeholder collaboration, aid in the identification of community and regional resources, and develop the summary report that identifies recommendations stemming from the SIM work. The BHPS-CoE staff will be trained SIM facilitators and will conduct SIM at the request of local jurisdictions at no cost to the jurisdiction.

Notably, prior evidence suggests that early education about the purpose, process, and goals of SIM before conducting local workshops are a critical step for successful mapping.[36] Each jurisdiction in Maryland has a Local Behavioral Health Authority (LBHA) responsible for planning, managing, and monitoring public behavioral health services at the local level. The BHPS-CoE will facilitate the development of SIM across the State by working closely with LBHA's to identify local agencies, organizations, and individuals to participate in the SIM, engage in outreach efforts to share insight into the benefits and process of SIM to encourage buy-in from local jurisdictions, and act as local level touchpoints to help identify where and how SIM identified action steps will be followed-up on after the SIM event. To build connections with criminal justice stakeholders in their jurisdictions, LBHA's may start with county and regional Maryland Criminal Intelligence Network (MCIN) sites, which include key partners like law enforcement agencies, state's attorney's offices, etc.

Action Steps **Technical Assistance and Training**

- **In Progress**: Assist with outreach and education about SIM at the local level to build understanding of its goals and process among stakeholders.
    - Begin with an outreach effort to LBHAs to ensure awareness and understanding of SIM resources.
- **Immediate**: Collaborate with LBHAs to identify jurisdiction-specific stakeholders.
- **In Progress**: Identify and recruit SIM facilitators to assist with SIM mapping workshops in local jurisdictions to achieve local and regional coverage.
- **In Progress**: Ensure that BHPS-CoE staff have access to SIM training and refresher courses focused on best and promising practices on a regular basis and/or when needed (e.g., special issue/population training).

Action Steps **Centralized Communication**

- **Immediate**: Identify and disseminate information regarding diverse modes of workshop delivery for conducting SIM workshops (e.g., regional, sequential) to help meet the unique needs of jurisdictions (e.g., see OCBHI variety of SIM engagement platforms).
- **Forthcoming**: Provide a toolkit with examples of successful systems integration, promising programs, and emergent collaboration from across Maryland and around the United States.

[36]Willison, J., McCoy, E. F., Vasquez-Noriega, C., Reginal, T., & Parker, T. (2018) *Using the Sequential Intercept Model to Guide Local Reform: An Innovation Fund Case Study* https://www.safetyandjusticechallenge.org/wp-content/uploads/2018/10/2018.10.11_Using-the-SIM_finalized.pdf

Objective 1b: Promote the Sustainability of SIM across the State by conducting initial mapping and re-mapping sessions at jurisdictions' request

SIM is a dynamic process that begins with an initial mapping and is sustained through subsequent follow-up and re-mapping efforts. Whereas oversight of local level activities should be led by local leaders such as the LBHAs, routine follow-up by the SIM facilitators allows for ongoing technical support and to help address any challenges to implementing action steps that may arise as jurisdictions work to meet their objectives. Re-mapping is central to the guiding principle that meeting the needs of this population involves a continuous improvement process to identify changes over time and emergent areas of need.

The BHPS-CoE will work to promote the sustainability of SIM across the State providing technical assistance during the initial mapping process, subsequent check-ins at regular intervals, as well as re-mapping sessions at jurisdictions' request. The BHPS-CoE will leverage its statewide lens to foster the identification and development of cross-jurisdictional and regional collaborative support as more jurisdictions complete the SIM process.

Action Steps **Technical Assistance and Training**

- **In Progress**: Provide technical assistance and facilitation of SIM for local and regional SIM mapping workshops.
- **Forthcoming**: Follow-up with SIM jurisdictions approximately every six months to provide a continuous source for technical assistance as jurisdictions work to address identified gaps in services.
- **Forthcoming**: Provide technical assistance to facilitate and support local and regional SIM re-mapping workshops. PRA recommends that remapping occur every two years.
- **In Progress**: Develop and maintain SIM learning community by organizing and hosting a bi-annual learning community to foster collaboration, continuing education, and skill development across the State.

Objective 1c: Monitor statewide progress in SIM

Program monitoring allows for a relatively straightforward tracking of activity progress through the collection of routine data such as the number and frequency of jurisdictions completing SIM, identified gaps, regional clusters of resources, and changes in trends over time. This information can be aggregated to identify statewide and/or regional patterns in gaps and resources, and identify localities that have initiated the SIM process to aid in cross-jurisdictional communication and collaboration (see example from OCBHJI).

Action Steps **Technical Assistance and Training**

- **In Progress**: Track and maintain data on SIM progress across jurisdictions including when a jurisdiction has been (re)mapped, gaps in service, and resources.

- **Forthcoming**: Leverage local level and statewide SIM Action Plan data to identify potential cross-jurisdictional and/or regional supports to address gaps in services and optimize the use of local and/or underutilized resources.
- **Forthcoming**: Disseminate state-level progress, gaps, strengths, opportunities, and examples of SIM efforts on the BHPS-CoE webpage.

Action Steps Centralized Communication

- **Immediate:** Track, maintain, and publish a directory of agencies and individuals in attendance (names, titles, contact information) at SIM mapping sessions for continued collaboration.

Action Steps Data, Research, and Evaluation

- **Forthcoming**: Use the data to:
  - Develop a statewide database on mapping program progress, gaps, and priorities;
  - Conduct a resource assessment for cross-jurisdictional collaborative opportunities; and
  - Monitor progress in responding to gaps in services

INNOVATION: Oregon Center on Behavioral Health & Justice Integration (OCBHJI) Leverages Website to Promote Data Transparency and Collaboration

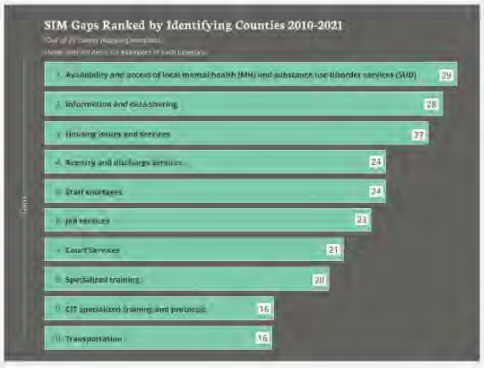
The OCBHJI website (www.ocbhji.org) presents data from Sequential Intercept Model mappings across the state of Oregon. Sharing data in this way promotes data transparency and provides opportunities for stakeholders to interact with ongoing initiatives.

SIM Mapping Progress across Oregon

OCBHJI presents a map showcasing the history of SIM mapping in Oregon counties from January 2018. The map is interactive and is updated quarterly to highlight ongoing progress in SIM mapping.

Summary of Gaps and Priorities

OCBHJI also provides a summary of the top 10 gaps and priorities identified by Oregon jurisdictions. Using bar charts, the display ranks gaps and priorities by the number of counties that identified that gap/priority as a salient concern. This visualization allows consmuers to better understand localized, regional, and statewide objectives.



PRIORITY 2
Build Community-based Crisis Response Team (CRT) Programs

Crisis Response Team (CRT), also known as Crisis Intervention Team, programs leverage collaborative community partnerships and intensive training to respond to individuals in crisis. This community-based approach brings together law enforcement, mental health providers, emergency services, advocates, and others to improve outcomes of behavioral health crisis incidents. Relationships are the cornerstone of successful CRT programs[37] and must be fostered to develop an ongoing collaborative approach to problem solving, resource sharing, a collective commitment, and mutual trust and respect.

CRT programs aim to improve safety for everyone involved in the incident, resolve the crisis with minimal or no legal system contact, and reduce trauma for those in crisis. While there are global best practices to guide the development and expansion of CRT programs, local communities should complement these standards to meet the needs of their specific challenges (e.g., homelessness, trauma, suicide) and populations experiencing a behavioral health crisis (e.g., transitional age youth, Veterans).

Throughout this section, we use the acronyms CRT to refer to *team-based* programs/responses (one component of which may be CIT training) and CIT to refer to *specialized training for individual officers*.

INNOVATION: Anne Arundel County CIT Today Podcast

In January 2023, the Anne Arundel County Police Department Crisis Intervention Team launched the CIT Today podcast. Podcasts provide an innovative method of translating important information to diverse audiences including practitioners from other jurisdictions and members of the general public.

Hosted by Steve Thomas and Jen Corbin, the podcast discusses vital behavioral health topics, including "the crisis response system of care that provides community member experiencing a crisis with supportive assistance and connection to resources." Co-hosts are joined by members of the criminal justice and behavioral health community who shared their experiences working with individuals with behavioral health needs.

Objective 2a: Expand law enforcement mental health and CIT training coverage

Interactions between law enforcement and individuals experiencing a behavioral health crisis are common. For instance, nearly one in four people with serious mental illness have a history of involvement with law enforcement and police arrest, and one in ten of these interactions occurred as individuals were en route to seeking mental health care.[38] CIT is a widely adopted model to improve safety during police response to

[37] Usher, L., Watson A.C., Bruno, R., Andriukaitis, S., Kamin, D., Speed, C. & Taylor, S. (2019). *Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises*. Memphis: CIT International.

[38] Livingston, J. D. (2016). Contact between police and people with mental disorders: A review of rates. *Psychiatric Services*, 67(8): 850-857.

persons experiencing behavioral health crises. When officers are trained in CIT, they have more knowledge of behavioral health challenges, are more likely to divert individuals from the justice system and instead refer to treatment programs, have a heightened level of officer satisfaction and lower levels of self-perceived use of force.[39] CIT training has also been shown to decrease mental illness and substance use stigma.[40]

CIT training is most effective when it draws on the strengths of the jurisdiction to support and facilitate its training efforts such as the Maryland Police and Correctional Training Commission. Engaging local stakeholders is critical to the success of CIT. Moreover, whereas core components of CIT should be standardized to allow for the development of common language and shared goals, jurisdictions should identify modules to best meet the needs in its community (e.g., county-specific focus).

The BHPS-CoE encourages the implementation and expansion of mental health and CIT training across Maryland with respect to the number of individuals trained to achieve full 24/7 and geographic coverage. Jurisdictions should aim to

1) Provide all officers with basic mental health first aid training (8 hour program); and
2) Offer intensive CIT training (40 hour program) for all self-selected (i.e., volunteer) agents.

The Tucson Police Department model suggests that CIT training should be offered to individuals with aptitude for working with the population. According to the Memphis model, a successful CIT program will have trained 20-25% of the agency's patrol division.

Police play a unique role in rural communities as they may be the only resource available for individuals experiencing behavioral health crises.[41] Yet, smaller and rural law enforcement agencies face unique challenges to delivering CIT training including funding, support services, and staffing. In addition, smaller jurisdictions need higher rates of trained officers to achieve 24/7 coverage. CIT is flexible and accommodates incremental crisis response system development as a long-term goal working with and in recognition of different resource availability and capacity. For instance, in Missouri, smaller jurisdictions with limited capacity to implement CIT training sent officers to larger jurisdictions offering the training.

Beyond patrol officers, there is a growing recognition of the need for broad CIT training across intercepts including all dispatchers, jail, prison, and community correctional officers, as well as fire and emergency medical technician (EMT) responders. Dispatchers are the first responders who engage with individuals in crisis and serve a vital role in the cycle of engagement and response when a crisis becomes known via a 911 or 988 call for service. While we know that individuals in jails and prisons report disproportionately high levels of behavioral health issues, much less is known about if and how correctional officers (CO) are trained to work with these individuals. Whereas institutions may have specialized mental health staff, COs routinely shoulder the bulk of responsibility in monitoring, interacting with, and de-escalating crisis situations involving

[39] Rogers, M. S., McNiel, D. E., & Binder, R. L. (2019). Effectiveness of police crisis intervention training programs. *The Journal of the American Academy of Psychiatry and the Law*, 47(4): 414-421; Seo, C., Kim, B., & Kruis, N. E. (2021). Variation across police response models for handling encounters with people with mental illnesses: A systematic review and meta-analysis. *Journal of Criminal Justice*, 72, 101752; Comartin, E. B., Swanson, L., & Kubiak, S. (2019). Mental health crisis location and police transportation decisions: The impact of crisis intervention team training on crisis center utilization. *Journal of Contemporary Criminal Justice*, 35(2): 241-260.

[40] Nick, G. A., Williams, S., Lekas, H. M., Pahl, K., Blau, C., Kamin, D., & Fuller-Lewis, C. (2022). Crisis Intervention Team (CIT) training and impact on mental illness and substance use-related stigma among law enforcement. *Drug and Alcohol Dependence Reports*, 5, 100099.

[41] Yang, S. M., Gill, C., Kanewske, L. C., & Thompson, P. S. (2018). Exploring police response to mental health calls in a nonurban area: A case study of Roanoke County, Virginia. *Victims & Offenders*, 13(8): 1132-1152.

incarcerated individuals including those with behavioral health needs.[42] Additionally, fire and EMT responders arrive to situations that may necessitate the identification and specialized response to an individual in crisis. In recognition of this, CIT has been adapted for broad application in public safety agencies (e.g., from dispatch to correctional teams).

Notably, both local and national stakeholders recognized the benefits of hosting combined CIT training sessions including individuals from across agencies as well as members from behavioral health organizations and advocates. Doing so allows participants to understand perspectives and experiences of others engaged in serving individuals with behavioral health needs and fosters a collaborative team effort when responding to behavioral health calls. CIT training opportunities should be delivered with an intent to convene diverse representation from agencies and organizations.

While considered the "gold standard",[43] CIT is not without limitations. For example, CIT was not designed to address racial disparities in behavioral health, criminal justice system contact, or their intersection and therefore are not a direct solution to racial inequities. A recent systematic review of CIT law enforcement training noted that the curriculum

> *"does not adequately address issues of race, gender, culture, and language (Hall, Hall, and Perry 2016; President's Task Force on 21st Century Policing 2015)."*[44]

Moreover, evidence on the effectiveness of CIT training for observed outcomes including use-of-force and arrests is weak.[45]

These findings underscore that CIT training should be leveraged as ***one*** component of a broader crisis response. Complementary training programs could include available programs with a specific focus such as de-escalation (e.g., Integrating Communications, Assessment and Tactics), and responding to drug addiction (e.g., Police Assisted Addiction and Recovery Initiative) as well as the development of modules to address critical issues such as racial disparities and working with special populations (e.g., youth in transition, Veterans).

Action Steps **Technical Assistance and Training**

- **Immediate**: Assist in identifying CIT core competencies to prioritize for statewide coverage.
- **Forthcoming**: Assist local jurisdictions in identifying modules that meet local level needs and emergent issues, in part by utilizing information gleaned from SIM mapping events.
- **In Process**: Provide technical assistance for statewide training, networking opportunities, and the establishment of partnerships.

[42] Appelbaum, K. L., Hickey, J. M., & Packer, I. (2001). The role of correctional officers in multidisciplinary mental health care in prisons. *Psychiatric Services*, 52(10): 1343-1347; Dvoskin, J. A., & Spiers, E. M. (2004). On the role of correctional officers in prison mental health; *Psychiatric Quarterly*, 75: 41-59.

[43] Watson, A.C., Compton, M.T. & Draine, J.N. (2017). The Crisis Intervention Team (CIT) model: An evidence-based policing practice? *Behavioral Sciences & the Law*, 35(5-6): 431-441. The original Memphis Model has been colloquially referred to as the "gold standard" with evidence of effectiveness and evidence-based for improving several outcomes.

[44] Peterson, J., & Densley, J. (2018). Is Crisis Intervention Team (CIT) training evidence-based practice? A systematic review. *Journal of Crime and Justice*, 41(5): 521-534.

[45] Seo, C., Kim, B., & Kruis, N. E. (2021). Variation across police response models for handling encounters with people with mental illnesses: A systematic review and meta-analysis. *Journal of Criminal Justice*, 72, 101752.

- **Immediate**: Leverage established training frameworks developed by other behavioral health and public safety centers of excellence such as in Ohio and Oregon, and local jurisdictions (e.g., Anne Arundel County's integrated training sessions) to increase accessibility of CIT training for individuals across intercepts (e.g., regional training, split session training).
- **Immediate**: Identify and assist with applying for funding to support access to training (e.g., SAMHSA's Mental Health Awareness Training Grants) by providing examples of application materials, and notifying localities of forthcoming and open opportunities.
- **Immediate**: Provide funding opportunities to allow for access to training opportunities including, but not limited to, supporting travel costs and staffing needs as necessary to expand CIT trained officer coverage across jurisdictions and time of day.

Action Steps — Centralized Communication

- **Immediate**: Assess evidence on emergent practices such as technology assisted (e.g., virtual mental health co-responder) crisis response models to increase the availability of specialized mental health responses 24/7 throughout the State.
- **Forthcoming**: Identify and disseminate information on emergent training programs such as the:
  - Bureau of Justice Administration's Crisis Response and Intervention Training (CRIT), an extension of CIT that incorporates responses to individuals with IDD and information on an array of crisis response models including, but not limited to CIT;
  - Complementary training programs such as those aimed at:
    - De-escalation and reducing use of force that could help attend to weaknesses in outcomes of CIT (e.g., ICAT: Integrating Communications, Assessment and Tactics);[46]
    - Assisting individuals with addiction to identify non-arrest pathways to treatment and recovery (e.g., PAARI: Police Assisted Addiction and Recovery Initiative); and
    - Racial disparities to make clear known racial differences in behavioral health, justice system involvement, and their intersection, and illustrate how racial competency is embedded within a CIT mindset.
- **Immediate**: When evidence-based programs are identified, work with Maryland jurisdictions to identify opportunities for a standardized core curriculum to be adopted across the State to ease communication, the sharing of resources, and evaluation efforts. Jurisdictions would include additional program modules to attend to their unique challenges.

Action Steps — Data, Research, and Evaluation

- **Immediate**: Within each jurisdiction, assess the current state of mental health and CIT training across public safety agencies and identify opportunities to increase the prevalence of CIT trained individuals across intercepts (from dispatch to supervision).

[46] Engel, R., Corsaro, N., Isaza, G., & McManus, H. (2020). *Examining the Impact of Integrating Communications, Assessment, and Tactics (ICAT) De-escalation Training for the Louisville Metro Police Department: Initial Findings*.

- **Immediate**: Assess and track resource needs in agencies across the State to use to inform and identify potential multi-jurisdictional CIT programs to meet the needs of rural and/or geographically isolated areas in the State (e.g., joint training sessions, hybrid training).
- **Immediate**: Convene a task force to grapple with the challenges that smaller jurisdictions face in offering CIT training, learn from other jurisdictions (locally and nationally) who are adopting innovative strategies to train more of their agents, and to identify opportunities to offer training for any jurisdiction that opts to adopt CIT.

Objective 2b: Foster sustainability of CIT training and programs

CIT training is not the end outcome of a CIT program, but one step in an ongoing process. Three core elements help to foster sustainability. First, CIT trained individuals must have access to refresher courses, opportunities to learn about engaging with populations with additional needs, updated lessons as the knowledge base expands or challenges change, and advanced training. Ongoing efforts should aim to incorporate and/or develop companion courses to increase cultural competence and understanding of diverse populations and experiences.

Second, when interacting with individuals in crisis, a CIT response requires touchpoints with individuals at the moment of crisis as well as a follow-up in the immediate 1-2 days following the crisis that initiated the call. Individuals with behavioral health concerns account for a disproportionate number of repeat interactions with the police - often termed "frequent flyers" - with estimates that many repeat encounters occur within 14 days of an original encounter.[47] Repeat encounters likely exacerbate behavioral health issues of the individual in crisis. CIT offers a mechanism to disrupt this cycle by following-up with individuals at risk for repeat encounters as trained individuals can help to address unmet needs and link individuals to resources before another crisis call for service is initiated. Follow-ups also provide an opportunity to increase rapport between police and persons in crisis for whom traditional police contact may be traumatic, and to engage with individuals' support networks to expand the responsibility of families, friends, and other to reduce reliance on the criminal justice system.

Third, tracking, organizing, and maintaining data is essential to program monitoring, outcomes evaluation, and program adaptability over time. Data collection and analysis also "arms [leaders in law enforcement and behavioral health systems] with concrete data to present to local officials and the public at large to garner buy-in and support."[48] To aid in measuring whether a program is achieving its objectives, jurisdictions should establish ***baseline metrics*** such as the number of incoming behavioral health calls for service, average time to respond to calls, duration of time spent responding to call, number of officers deployed to behavioral health calls, as well as program ***outcome metrics*** such as officer confidence in responding to crisis incidents, injury rates, crisis response times, community perceptions and satisfaction, community-based treatment and diversion, and efficiency of the CRT program. Plans for data collection should be developed early in the process.

[47] Akins, S., Burkhardt, B. C., & Lanfear, C. (2016). Law enforcement response to "frequent fliers" an examination of high-frequency contacts between police and justice-involved persons with mental illness. *Criminal Justice Policy Review*, 27(1): 97-114; White, M. D., Goldkamp, J. S., & Campbell, S. P. (2006). Co-occurring mental illness and substance abuse in the criminal justice system: Some implications for local jurisdictions. *The Prison Journal*, 86: 301-325.

[48] Council of State Governments (2018). *Police-Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement Response for People who have Mental Health Needs*.

Action Steps Technical Assistance and Training

- **Forthcoming**: Encourage and assist with the development of companion, specialized and advanced training opportunities to meet the specific needs of jurisdictions and populations (e.g., youth, developmental disabilities, cultural competency).
- **Forthcoming**: Identify and provide technical assistance for access to refresher training and elective modules for CIT certified officers and staff.

Action Steps Centralized Communication

- **Immediate**: Disseminate innovative models for supporting follow-up CIT programs (e.g., CIT units, mobile units, peer support services).
- **Forthcoming**: Identify and disseminate information on emergent CIT opportunities such as CIT+ Advanced Training.

Action Steps Data, Research, and Evaluation

- **Immediate**: Leverage available resources (e.g., PMHC data collection to measure success) to identify and adapt key measures that should be collected by all jurisdictions implementing mental health training, CIT, and companion courses to track program development (e.g., trained staff, coverage) and outcomes (e.g., cultural competency, diversion, arrest, use of force).
- **Immediate**: Assist with the collection and coordination of data for implementation and outcomes analysis and evaluation.
- **Immediate**: Provide technical assistance for peer and third-party evaluations to foster the assessment of outcomes of CIT training and program development over time.

Objective 2c: Promote crisis response teams (CRTs) and other police-behavioral health program partnerships

The complexity and time-consuming nature of these calls have resulted in police departments increasingly seeking out connections to local behavioral health supports, generally known as police-mental health collaborations (PMHCs) such as crisis response teams, co-responders, and mobile crisis intervention teams. Though each PMHC approach has unique features, they share a commonality in their commitment to integrating responses to behavioral health crises into the day-to-day functions of all officers (e.g., including it as an agency mission rather than the domain of a specialized unit).[49]

Given that partnerships are the first core element of successful PMHCs including CRT programs, the BHPS-CoE aims to facilitate the development and strengthening of partnerships across agencies/organizations, systems, and communities. Efforts will be made to foster the development of partnerships by, for instance, assisting with the development of shared policies, and facilitating pathways for open communication.

[49] Council of State Governments (2018). *Police-Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement Response for People who have Mental Health Needs.*

IN MARYLAND, a national survey conducted by the Justice Center at The Council of State Governments (CSG) identified four jurisdictions in Maryland with Police-Mental Health Collaboration Programs: Baltimore City (3 programs), Baltimore County (1 program), Montgomery County (7 programs), and Prince George's County (2 programs).

Action Steps Technical Assistance and Training

- **Immediate**: Work with local jurisdictions to conduct a comprehensive review of current policies and procedures for when police encounter people who have behavioral health needs to develop a full understanding of how people flow through the system (e.g., dispatch and disposition outcomes), current agency collaborations, and transfer practices.
    - Jurisdictions that have completed the SIM process will already have this review completed. Evidence from area experts note that CIT training is a good opportunity to introduce and expand officer knowledge of local resources for individuals in crisis.
- **Immediate**: Use the comprehensive review to identify an appropriate PMHC response that takes into account jurisdictional needs and resources, including, but not limited to, CIT.

Action Steps Centralized Communication

- **Immediate**: Encourage collaboration and communication by providing sample policies or Memorandum of Understandings (MOUs) around mental health crisis response and CIT, such as, assisting with the development of policies to guide the transfer and handling (e.g., restraint procedures, language for de-escalation) of individuals between agencies such as emergency rooms, crisis centers, clinics, and law enforcement agencies; and the linking of individuals to peer support services.
- **Immediate**: Maintain a roster of active CIT officers by jurisdiction for use in recruitment and collaboration efforts.
- **Immediate**: Develop and maintain a CIT coordinator email list.
- **Immediate**: Organize and facilitate monthly virtual meetings of the CIT coordinator community to support neighboring communities and encourage a learning community environment across Maryland.
- **Immediate**: Support the continuation of the Maryland CIT Conference to share best practice ideas, recent developments and innovative ideas in Maryland and across the nation.

Objective 2d: Track developments in the use of non-law enforcement resources to respond to crisis calls

Police have become de facto response agents to behavioral health crises, however, they lack appropriate training to deal with individuals in crisis such as administering medication assisted treatments.[50] Persons with a serious mental illness have an increased risk of injury or death during police encounters. A recent study finds

[50] Mital, S., Wolff, J., & Carroll, J. J. (2020). The relationship between incarceration history and overdose in North America: a scoping review of the evidence. *Drug and Alcohol Dependence*, 213, 108088.

that persons with serious mental illness comprise 17.0% of all use of force cases and 20.2% of injury cases.[51] Nearly a quarter of individuals killed during interactions with the police displayed signs of mental illness and this risk of death is significantly greater for Black men with mental illness.[52]

The complexity and time consuming nature of these calls have resulted in police departments increasingly seeking out connections to local behavioral health supports, generally known as PMHCs such as crisis intervention teams, co-responders, and mobile crisis intervention teams. Though each PMHC approach has unique features, they share a commonality in their commitment to integrating responses to behavioral health crises into the day-to-day functions of all officers (e.g., including it as an agency mission rather than the domain of a specialized unit).[53]

Whereas CIT has become a well-known law enforcement tool to respond to individuals in crisis, it is not solely a law enforcement program. At its core, the CIT training program brings together a community of individuals to build crisis response systems. The BHPS-CoE will help educate the community about the various coordinated response models including non-justice response alternatives that exist locally, maintain a repository of best practices and evidence on different response models to crisis situations, and build a toolkit to identify and make easily accessible information on/links to available crisis services within and across jurisdictions.

IN MARYLAND, House Bill 271 requires the appropriation of $12,000,000 to the 9-8-8 trust fund to maintain 9-8-8 as the universal telephone number for a national suicide prevention and mental health crisis hotline. The funds will also serve the purpose of developing and implementing a statewide initiative for the coordination and delivery of behavioral health crisis responding services in the State.

Action Steps **Technical Assistance and Training**

- **Immediate**: Work with local jurisdictions to conduct a comprehensive review of current policies and procedures for 9-8-8 dispatch to ensure that behavioral health crisis calls are responded to by CIT trained individuals and/or transferred to a warm line. Where needed, assist jurisdictions in developing the infrastructure identifying procedures for transferring and dispatching crisis calls.
- **Forthcoming**: When infrastructure is established, promote the use of the 9-8-8 call system for individuals experiencing crisis.

[51] Fuller, D.A., Lamb, H. R., Biasotti, M., & Snook, J. (2015). *Overlooked and undercounted: The role of mental illness in fatal law enforcement encounters*. Office of Research and Public Affairs: Treatment Advocacy Center; Laniyonu, A., & Goff, P.A. (2021). Measuring disparities in police use of force and injury among persons with serious mental illness. *BMC Psychiatry*, 21: 500

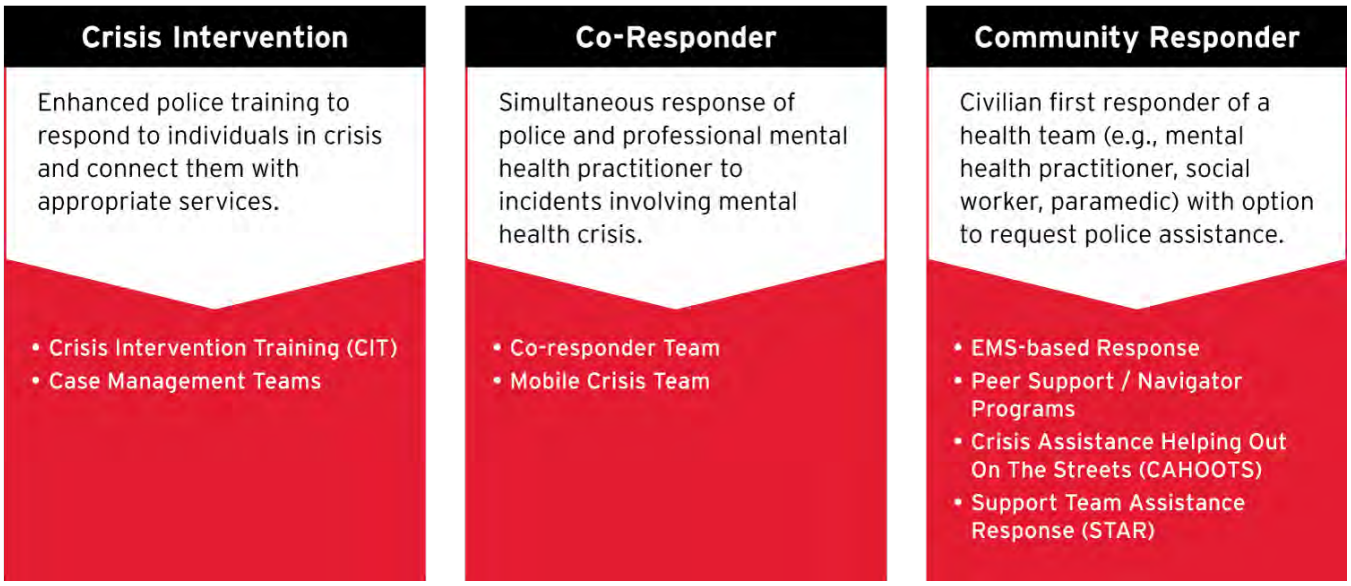
[52] Saleh, A. Z., Appelbaum, P. S., Liu, X., Stroup, T. S., & Wall, M. (2018). Deaths of people with mental illness during interactions with law enforcement. *International Journal of Law and Psychiatry*, 58: 110-116.

[53] Council of State Governments. 2018. Police-Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement Responses for People who have Mental Health Needs.

Action Steps Centralized Communication

- **Immediate**: Develop and maintain an interactive map of available crisis services within and across jurisdictions with evidence-based designations (e.g., under evaluation, promising, evidence-based) such as mental health receiving centers, crisis respite centers, recovery resource centers, and 24-hour crisis stabilization.
- **Immediate**: Maintain an active presence in the national CIT network to stay abreast of evidence-informed and evidence-based practices, maintain connections with regional groups, and liaise with State advocacy organizations such as National Alliance on Mental Illness (NAMI) regarding CIT efforts.
- **Immediate:** Evaluate the capacity to create a position that is a liaison between the BHPS-CoE and the Justice Reinvestment Act to bridge the communication gap between the two entities at the GOCPYVS and identify collaborative supports to enhance diversion opportunities for those with behavioral health needs.
- **Forthcoming**: Maintain an active repository that identifies best practices for non-justice response alternatives such as 1) co-responder and crisis responder team (e.g., CAHOOTS) interventions that utilize law enforcement strategically during crisis situations (e.g., imminent threat to safety) such as clinical or social worker first responder units, co-responder models that couple mental health professionals with certified peer specialists, and 2) Opioid Intervention Teams (OITs) already active in each Maryland jurisdiction. Importantly, the evidence-base on civilian-only responses to behavioral health crises is small and care should be taken when considering the adoption of these strategies to maintain the safety of all individuals in the response interaction.

Response Models



PRIORITY 3

Coordinate Within and Across Systems to Minimize Disruptions in the Continuum of Care

A continuum of care refers to a comprehensive range of services provided through the criminal justice and public health systems that evolve as individuals progress through the systems and transition through different levels of care. A sustainable and inclusive continuum of care incorporates resources and services for supporting people with behavioral health concerns in all levels of care. Coordination within and across systems will minimize disruptions and delays in accessing services by prioritizing community-based treatment and harm reduction strategies and investing in prevention and peer services.

The BHPS-CoE will reinforce and expand the efforts of already established agencies addressing behavioral health concerns such as the Maryland Department of Health (MDH) Behavioral Health Administration, Maryland Developmental Disabilities Administration, Maryland Division of Rehabilitation Services, Maryland Re-Entry Initiative, Maryland's ongoing response to the opioid crisis, Before It's Too Late, the CITCE, the new Special Secretary of Opioid Response/Director of the Opioid Operational Command Center (OOCC), the new Department of Service and Civic Innovation, and the GOCPYVS, through technical assistance and community outreach for providers and people in need. The BHPS-CoE will also facilitate data collection and collaborations with local researchers for program evaluations and targeted research. These activities will help ensure that services are efficiently and effectively reaching those in need.

SUD & SMI in Criminal Justice Populations

Indicators of substance use and mental disorders from the 2016 Survey of Prison Inmates published by the U.S. Department Justice, Bureau of Justice Statistics (BJS) in 2021, show that nearly 40% of state prisoners and more than 30% of federal prisoners reported using drugs at the time of their offense and nearly two-thirds reported use of at least one drug in the 30 days prior to their arrest. Female state prisoners were more likely than males to report using at least one drug at the time of their offense (49% vs 39%) and to have met the DSM-IV criteria for SUD in the 12 months prior to their incarceration (58% females, 48% males). Hispanic prisoners were less likely than white prisoners in both state and federal prison to report using at least one drug at the time of their offense, but White state prisoners (58%) were more likely to have met the DSM-IV criteria for SUD than Hispanic (46%) or black (39%) state prisoners. Only a third of state prisoners and 46% of federal prisoners meeting the criteria participated in treatment during incarceration. And, only 12% of state prisoners and 15% of federal prisoners meeting the criteria received treatment in a residential unit/facility since their incarceration.[54]

A second BJS report states that more than 40% of state prisoners (43%) and nearly 1 in 4 (23%) federal prisoners had a history of mental health problems and approximately 1 in 10 (14% state, 8% federal) met the threshold of past 30-day serious psychological distress (SPD). The most frequently reported mental health disorder was major depressive disorder. Female prisoners in both state and federal prisons were more likely than males to have a history of mental health problems. White state and federal prisoners were more likely than black prisoners to have met the threshold for past 30-day SPD.[55]

[54] Maruschak, L., Bronson, J., and Alper M. (2021). *Survey of Prison Inmates, 2016 Alcohol and Drug Use and Treatment Reported by Prisoners*. DOJ, OJP, BJS. https://bjs.ojp.gov/library/publications/alcohol-and-drug-use-and-treatment-reported-prisoners-survey-prison-inmates

[55] Maruschak, L., Bronson, J., and Alper M. (2021). *Survey of Prison Inmates, 2016 Indicators of Mental Health Problems Reported by Prisoners*. DOJ, OJP, BJS. https://bjs.ojp.gov/library/publications/indicators-mental-health-problems-reported-prisoners-survey-prison-inmates

Behavioral health impacts many Marylanders and their families. For instance, SAMHSA has reported that 14.2% (85,000) of young adults aged 18-25 in Maryland experienced SUD in the past year and 6.3% (320,000) of Marylanders aged 12 or older.[56] Moreover, 781,000 adult Marylanders have a mental health condition and 181,000 have a SMI[57] including approximately one in ten (9.8%, 59,000) young adults with a past year SMI.[58] In addition, 11% (652,374) of Marylanders have disabilities such as intellectual or developmental disorders.[59]

These conditions can often co-occur and individuals with a history of incarceration and justice-involved populations have a higher risk of overdose and fatal overdose than those without a history of incarceration.[60] Unintentional poisoning (e.g., drug overdose) has been found to be the leading cause of death post incarceration.[61] The highest risk of fatal unintentional poisoning was reported by several studies to be the period immediately following release.[62] Recent research has found that this risk can be diminished by the provision of treatment, recovery, and prevention services during and after incarceration.[63] Findings like these have led to an increased demand for evidence-based overdose prevention interventions in jails and prisons and for other justice-involved populations. The need for diversion, treatment, and recovery services in addition to prevention interventions is further highlighted by recent results from the National Survey of Prison Inmates (sidebar).[64]

Data from a 2016 study of Maryland correctional facilities found that 39% of people incarcerated in Maryland jails had a current mental health disorder.[65] Approximately 1 in 4 suffered from an SMI such as schizophrenia or bipolar disorder and an estimated 69% have an SUD. Approximately one-third of Maryland prisoners have a co-occurring disorder. Clearly the unmet need for treatment and services is high in both state and federal prisons. Most of these prisoners will be released back to their communities after their sentence is served and will need healthcare and other support. A supportive cross system and cross jurisdiction continuum of care is essential to connect individuals to services. The SIM intercepts and CIT process can offer regular opportunities to identify Marylanders with behavioral health concerns and improve their awareness of and access to services and resources. In addition, each of Maryland's 24 jurisdictions have both a Law Enforcement coordinator and a mental health coordinator based in local criminal justice and public health agencies. Coordinators like these guide local efforts such as conducting local community outreach and technical assistance, developing measurable objectives, and collecting relevant statistics.

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[56] Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Maryland, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services*. HHS Publication No. SMA-20-Baro-19-MD. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

[57] National Alliance on Mental Illness (NAMI). (2021). *Mental Health in Maryland*. https://www.nami.org/NAMI/media/NAMI-Media/StateFactSheets/MarylandStateFactSheet.pdf

[58] Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Maryland, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services*. HHS Publication No. SMA-20-Baro-19-MD. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

[59] University of New Hampshire, Institute on Disability. (2020). *2019 Maryland Report for County-Level Data: Prevalence*. Annual Disability Statistics Compendium. https://disabilitycompendium.org/compendium/2019-state-report-for-county-level-data-prevalence/MD

[60] Mital,S., Wolf, J., & Carroll, J. (2020). The relationship between incarceration history and overdose in North America: A scoping review of the evidence. *Drug and Alcohol Dependence*, Vol. 213.

[61] Brinkley-Rubinstein, L., Zaller, N., Martino, S. Cloud, D. H., McCauley, E., Heise, A., & Seal, D. (2018). Criminal justice continuum for opioid users at risk of overdose. *Addictive Behaviors*, Vol. 86:104-110.

[62] Ibid. Mital et al. (2020).

[63] Malta, M., Varatharajan, T., Russell, C., Pang, M., Bonato, S., & Fischer, B. (2019) Opioid-related treatment, interventions, and outcomes among incarcerated persons: A systematic review. *PLoS Med* 16(12): e1003002. https://doi.org/10.1371/journal.pmed.1003002.

[64] Maruschak, L. M., Bronson, J., & Alper, M. (2021) *Survey of Prison Inmates, 2016: Alcohol and Drug Use and Treatment Reported by Prisoners*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. NCJ 252641. https://bjs.ojp.gov/data-collection/survey-prison-inmates-spi#publications-0

[65] Governor's Office on Crime Control and Prevention. (2016). *Substance Use and Mental Health Disorder Gaps and Needs Analysis*. https://goccp.maryland.gov/wp-content/uploads/justice-reinvestment-sa-mh-gaps-needs-20161231.pdf

The Moore administration has requested a record amount of funds in the FY2024 State budget - $1.4 billion - to support mental health and substance use programs. The following objectives and Action Steps were identified to help the BHPS-CoE coordinate with other State and local agencies to provide a continuum of care to meet the needs of Maryland residents particularly those experiencing behavioral health needs/crisis. They will position the BHPS-CoE to work with new and existing programs and agencies to support local criminal justice and public health practitioners placing and treating people with mental health and substance use disorders by building a more coordinated approach for identifying these individuals, connecting them with peer recovery specialists and the services they need, updating their case management plans as needed, and monitoring their progress.

LOCAL INNOVATION: Garrett Resource Center

Garrett Resource Center is committed to addressing the recovery needs of those who struggle with SUD whether they are seeking recovery for the first time or a re seeking recovery again. Garrett Resource Center's recovery team works with prople in recovery and their families confidentially to meet their needs through peer support, recovery services, employment readiness, adn other resources. The Resource Center works with community partners to foster collaboration and build the capacity of the local recovery infrastructure. Staff regularly participate in community events such as county health and job fairs and host special events such as sover jam sessions, homeless outreach, women's networking luncheons, and walk-in days at a community library to enable residents to meet with a recovery coach.

facebook.com/garrettresourcecenter

GARRETT
RESOURCE CENTER

Objective 3a: Promote State-level health initiatives that support continuity in care and healthcare integration

The BHPS-CoE will encourage the promotion of a continuum of care that fosters communication and data sharing across systems and improves awareness of and access to services by those in crisis. This will involve adopting a system linking administrative data across agencies and systems to enable public health and criminal justice staff to communicate more effectively and monitor access to and use of services as individuals transition from one system to another. In addition, information sharing allows for "warm" as opposed to "cold" hand-offs. A warm hand-off refers to the ability for one entity (e.g., jail) to actively share information with another entity (e.g., treatment program) at the time responsibility for an individual is transferred.[66] While this may be done at times on a more informal and/or less standardized basis, a system linking data would make this process more seamless. Warm vs. cold handoffs increase patient follow-up.[67] These efforts in combination with the SIM and CIT objectives will help Maryland's systems identify the services needed by individuals under their care and supervision and monitor the availability of these services.

[66] Taylor, R. M., & Minkovitz, C. S. (2021). Warm handoffs for improving client receipt of services: A systematic review. *Maternal and Child Health Journal*, 25 (2021), pp. 528-541, 10.1007/s10995-020-03057-4

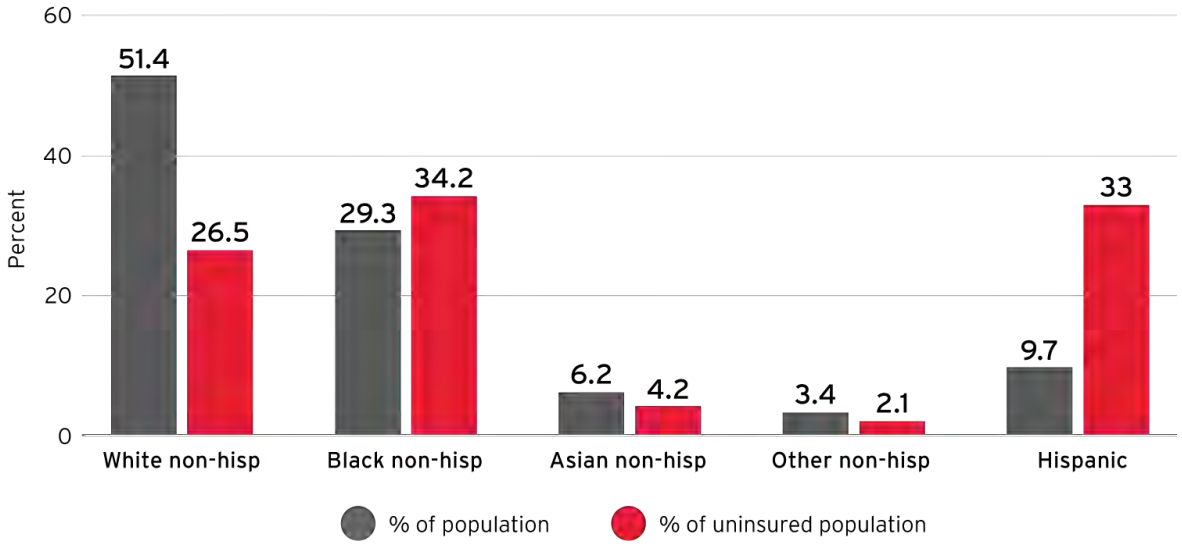
[67] Pace, C.A., Gergen-Barnett, K., Veidis, A., D'Afflitti, J., Worcester, J., Fernandez, P., & Lasser, K. E. (2018). Warm handoffs and attendance at initial integrated behavioral health appointments. *The Annals of Family Medicine*, 16 (4): 346-348

Research routinely links a lack of access to healthcare coverage with an increased risk of incarceration and death following periods of confinement.[68] This association is largely due to the loss of access to mental health care.[69] Expanding access to Medicaid is cost-effective,[70] associated with lower crime rates, and may hold greater impacts on minority youth.[71] To expand Medicaid coverage and allow for increased access to substance use disorder treatment some localities have used Health Insurance Flexibility and Accountability (HIFA) waivers.[72] Moreover, states are seeking Medicaid waivers through petitions filed with the U.S. Department of Health and Human Services that modify the "inmate exclusion policy" and allow avenues for access to health care services pre-release. This may be particularly useful for individuals with behavioral health needs.

IN MARYLAND, there are large racial and ethnic disparities in the percent of the uninsured population with Black non-Hispanic, and Hispanic individuals disproportionately more likely to be uninsured. The state of Maryland adopted Medicaid suspension as its policy in 2005. Stakeholders shared concerns that this policy has not been universally adopted across the State. In 2017, Maryland adopted an Inmate Presumptive Eligibility model which authorizes state and local correctional facilities to make presumptive eligibility determinations prior to release, further supporting continuity in coverage and care by improving access to health care.

Maryland Population & Uninsured Demographics

Retrieved from 2018 Census Estimates and SAMHDA



[68] Jácome, E. (2020). *Mental health and criminal involvement: Evidence from losing Medicaid eligibility*. Job Market Paper, Princeton University; Arenberg, S., Neller, S., & Stripling, S. (2020). *The impact of youth Medicaid eligibility on adult incarceration*. The University of Texas at Austin Working Paper; Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison—a high risk of death for former inmates. *New England Journal of Medicine*, 356(2): 157-165.

[69] Jácome, E. (2020). *Mental health and criminal involvement: Evidence from losing Medicaid eligibility.* Job Market Paper, Princeton University.

[70] Aslim, E. G., Mungan, M. C., Navarro, C. I., & Yu, H. (2022). The effect of public health insurance on criminal recidivism. *Journal of Policy Analysis and Management,* 41(1): 45-91; Vogler, J. (2017). *Access to health care and criminal behavior: Short-run evidence from the ACA Medicaid expansions*. Available at SSRN 3042267.

[71] Arenberg, S., Neller, S., & Stripling, S. (2020). *The impact of youth Medicaid eligibility on adult incarceration*. The University of Texas at Austin Working Paper

[72] Wen, H., Hockenberry, J. M., & Cummings, J. R. (2017). The effect of Medicaid expansion on crime reduction: Evidence from HIFA-waiver expansions. *Journal of Public Economics*, 154, 67-94.

Notably, access to other social benefits such as the Supplemental Nutrition Assistance Program (SNAP) have also been shown to have crime reduction benefits, which may be linked to increased physical and mental health and decreased food insecurity.[73] Access to these benefits may be particularly important during reentry which is a vulnerable time when people have limited means and need additional access to resources to promote success. While Maryland does not currently have a full ban on access to social benefits, stakeholders spoke of challenges in access to State ID/identification cards during the reentry process that stopped individuals from accessing these resources. In 2019, the U.S. Commission on Civil Rights recommended eliminating SNAP benefit restrictions based on criminal convictions recognizing bans as a collateral consequence that create barriers to successful reintegration. Social benefit bans based on felony convictions disproportionately affect people of color and those with low incomes.

Action Steps Technical Assistance and Training

- **Immediate:** Provide technical support to promote collaboration in healthcare related initiative planning and development.
- **Immediate:** Aid local jurisdictions in connecting local behavioral health authorities (LBHA's) and criminal justice system healthcare providers (e.g., jail and prison medical personnel) to foster a community of shared responsibility for correctional and community health.
- **Forthcoming:** Provide technical support to jurisdictions that have not implemented Medicaid suspension to achieve full implementation across the State.

Action Steps Data, Research, and Evaluation

- **Immediate:** Survey localities to understand the current implementation of and barriers to implementing Medicaid suspension to enable a quicker and more efficient re-connection of healthcare services for those exiting carceral settings.
- **Forthcoming:** Review successful programs in other states (e.g., My Health My Resources (MHMR) and Klaras Center for Families (KCF) programs in Texas) to assess utilization of these models to fill gaps in service provision and support continuity of care.

Action Steps Centralized Communication

- **Forthcoming:** Support the integration of data systems and communication across agencies to enable "warm hand-offs" when a person is being transferred from one organization to another.
- **Forthcoming:** Convene workgroups, advisory groups, and task forces working on behavioral health issues and state-level health initiatives to identify opportunities for expanding access to healthcare and healthcare adjacent resources. Tasks would include the following:

[73] Testa, A., & Jackson, D. B. (2020). Criminal justice system involvement and food insufficiency: Findings from the 2018 New York City Community Health Survey. *Annals of Epidemiology*, 52: 42-45; Tuttle, C. (2019). Snapping back: Food stamp bans and criminal recidivism. *American Economic Journal: Economic Policy*, 11(2): 301-27.

- Assessing potential for continuity of Medicaid coverage policy during periods of confinement drawing on national evidence of effectiveness including continuity in access to care (e.g., medication, services).
- Identifying behavioral health and criminal justice adjacent social policies to increase access to resources found to reduce behavioral health and criminal justice issues (e.g., Assistance to Needy Families such as SNAP and TANF benefits).
- Assess potential for eliminating all bans on access to SNAP, TANF, other social policies that have empirical evidence demonstrating crime control and/or health promoting benefits.

EMERGENT EVIDENCE: Public Health Policy is Public Safety

The percentage of individuals held in jails with serious mental illness is five times greater than in the general population. Yet, access to treatment and care in institutional settings is extremely low. Moreover, conditions of confinement in jails that lack stable services and daily routines can exacerbate behavioral health challenges.

Behavioral health service accessibility and affordability in the community can reduce the strain on jails and provide individuals with necessary treatment and services. Comparing characteristics of all U.S. counties, research finds that when access to services is higher (e.g., more psychiatrists, lower health care costs, higher percent of drug treatment paid by Medicaid), the per capita jail population is lower. More limited access to health services in smaller counties may be a driver of their higher incarceration rates.

Public health policy enhances public safety, diverting individuals from the criminal legal system into programs and services. However, the effectiveness of diversion rests on the availability of community treatment resources. Improvements in community services are likely to reduce demand for jail beds, particularly in smaller, resource challenged counties.

Objective 3b: Support continuum of care by improving awareness of and access to devices for those in crisis

The BHPS-CoE will further support the needed continuum of care by expanding awareness of and access to evidence-based mental health and drug treatment programs (e.g., medications for opioid use disorder - MOUD),[74] harm reduction, recovery services, and alternative options for accessing healthcare. Continuity in access to and consistent use of medications to assist with substance use disorder (SUD) are important for reducing the risk of overdose and mortality, and to improve retention in treatment programs.[75] Evidence suggests that this continuity in care is critical during reentry.[76]

[74] Stahler, G. J., Mennis, J., Stein, L. A. R., Belenko, S., Rohsenow, D. J., Grunwald, H. E., ... & Martin, R. A. (2022). Treatment outcomes associated with medications for opioid use disorder (MOUD) among criminal justice-referred admissions to residential treatment in the US, 2015-2018. *Drug and Alcohol Dependence*, 109498.

[75] Joudrey, P. J., Khan, M. R., Wang, E. A., Scheidell, J. D., Edelman, E. J., McInnes, D. K., & Fox, A. D. (2019). A conceptual model for understanding post-release opioid-related overdose risk. *Addiction Science & Clinical Practice*, 14(1), 1-14; Malta, M., Varatharajan, T., Russell, C., Pang, M., Bonato, S., & Fischer, B. (2019). Opioid-related treatment, interventions, and outcomes among incarcerated persons: a systematic review. *PLoS Medicine*, 16(12), e1003002.

[76] Ibid.

Leveraging new technology to link individuals to healthcare providers and more effectively utilize administrative data will increase access to and continued participation in treatment and education programs. These action steps will support the identification and coordination of services at key points in the continuum of care. Evidence suggests that behavioral nudges like text message reminders can reduce things like failure to appear for court[77] and may have utility in helping individuals maintain contact with treatment.

IN MARYLAND, Senate Bill 362 Requires the Maryland Department of Health to establish certified community behavioral health clinics (CCBHCs). A CCBHC is a nonprofit comprehensive community mental health or substance use treatment organization licensed by the State that offers, directly or indirectly through formal referral relationships with other providers, several behavioral health services. One such service includes peer support.

Action Steps **Technical Assistance and Training**

- **Immediate:** Encourage more efficient and effective case management through use of a standardized records management system that can be accessed by service providers across systems and jurisdictions (e.g., Eastern Shore Information Center).
- **Immediate:** Develop and maintain a comprehensive online resource locator for behavioral health disorders to increase awareness of and access to resources before, during, and after incarceration. Locating resources for individuals with histories of involvement in the criminal legal system can be particularly challenging. To meet this end, consider leverage existing service locator structures such as:
    - Reactivating and updating the Maryland Community Services Locator (MDCSL) originally developed by the Center for Substance Use, Addiction & Health Research (CESAR) at the University of Maryland, College Park. The MDCSL was a database of health, social service and public safety resources programs throughout Maryland.
    - Link to and promote "FindHelp.org," a national online service locator identifying resources (i.e., food, housing, goods, transit, health, money, care, education) by zip code, and other existing resources such as the 988 crisis lifeline, mobile response and stabilization services, and pressone.211md.org.
- **Immediate:** Collaborate with DPSCS and MDH to identify challenges to providing and expanding access to SMI and SUD treatment (e.g., medication assisted treatment (MAT), medication for opioid use disorder (MOUD)) and IDD services, in correctional facilities and detention centers and to identify recommendations for moving forward.
- **Immediate:** Encourage use of alternative options for accessing healthcare such as telehealth, mobile clinics, health apps, etc.
- **Forthcoming:** Promote awareness of community-based behavioral health treatment and other harm reduction and recovery services through local resource fairs, local health department events and presentations, social marketing campaigns, etc.

[77] Fishbane, A., Ouss, A., & Shah, A. K. (2020). Behavioral nudges reduce failure to appear for court. *Science*, 370(6517), eabb6591.

- **Forthcoming:** Promote the development of transitional care programs at both entry and exit from incarceration.

Action Steps Data, Research, and Evaluation

- **Immediate:** Assess the expansion potential of accountable care organizations (ACOs) to include correctional health.

Objective 3c: Develop standardized protocol for diversion and placement of people with behavioral health crises

A recent analysis of emergency medical service (EMS) incidents and booking events in Indianapolis revealed that one in ten EMS responses to overdoses resulted in incarceration.[78] Diversion strategies provide opportunities for individuals to avoid formal processing in the criminal justice system. Instead, these strategies offer individuals entering the criminal justice system through avenues, such as arrest, the opportunity to avoid prosecution or sentencing by taking part in treatment, education, community service or other pro-social activities. Diversion often involves linking criminal justice and public health. For instance, an individual in crisis may be taken to a local emergency department (ED). However, there is not currently a protocol for hospital staff and law enforcement officials to follow. These action steps will help to provide needed training and improve communication.

Action Steps Technical Assistance and Training

- **Immediate:** Improve interaction/coordination of local ED and law enforcement by assisting with the development of protocols for law enforcement based in EDs and transporting people in crisis to EDs.
- **Immediate:** Work with local health departments to facilitate first responder education (e.g., increase awareness of diversionary options, naloxone administration, current laws and policies, current drug trends).
- **Immediate:** Ensure that the CIT Coordinators' meeting includes development of a standardized protocol as a goal.
- **Forthcoming:** Improve communication by facilitating mixed agency appreciation events to recognize efforts aimed at improving diversion and seamless transfer of individuals experiencing a crisis.

Objective 3d: Invest in preventive service systems

Preventive service systems refer to community-based, multidisciplinary interventions for persons with serious mental illness who may have co-occurring substance use disorders and who are at risk for, or are involved in, the criminal justice system. Assertive Community Treatment is one well-known preventive service program; however, following evidence that ACT was not effective in preventing arrest and incarceration, a revised program has emerged to respond to persons with SMI and histories of repeated arrest and incarceration:

[78] Ray, B., Hedden, B. J., Carroll, J. J., Del Pozo, B., Wagner, K., Kral, A. H., ... & Huynh, P. (2022). Prevalence and correlates of incarceration following emergency medical services response to overdose. *Drug and Alcohol Dependence*, 238, Article 109571.

Forensic Assertive Community Treatment (FACT). This approach builds in efforts that address criminogenic risks and needs. Research indicates that FACT is associated with fewer criminal justice system interactions (i.e., conviction, days in jail) and behavioral health outcomes (i.e., engagement with treatment, fewer days in the hospital) and is a financially sustainable program.[79]

Emergent research calls for improvements to traditional preventive service approaches. These approaches must recognize developmental changes that occur from childhood through adolescence, young adulthood, adulthood, and into older ages referred to broadly as processes that occur over the life course. These developmental changes influence the incidence and prevalence of behavioral health disorders as well as the approaches needed to prevent and treat individuals.

Because preventive service systems like FACT use multidisciplinary teams such as licensed mental health treatment agents and criminal justice system professionals, information sharing between agencies is a critical component. The BHPS-CoE will provide technical assistance identifying ways to share information while maintaining client confidentiality such as obtaining client consent and/or establishing formal data agreements between agencies.

Action Steps **Technical Assistance and Training**

- **Immediate:** Assess the capacity for resuming and expanding the Eastern Shore Information Center (ESIC)[80] or a similar client-centered database for serving as regional or statewide information centers to promote a more efficient and effective client referral and transfer process (e.g., data on demographics, identification of needs).
- **Immediate:** Partner with existing agencies/programs such as fatality reviews, MDH's Rapid Analysis of Drugs (RAD), and Maryland Emergency Department Drug Surveillance (MD-EDDS) system to identify areas in need of early prevention.
- **Forthcoming:** Facilitate local implementation of evidence-based prevention services (e.g., FACT).

Objective 3e: Support needs-based re-entry procedures that ensure more seamless transitions between correctional facilities and community treatment

Formerly incarcerated persons with behavioral health needs are unlikely to be linked to care post-release. Care discontinuity in these instances can be traced to a variety of problems, including inadequate pre-release planning and a lack of follow-up in the community.[81] Indeed, individuals returning to the community face a series of challenges, including finding employment and housing. Seeking continued healthcare may be

[79] Lamberti, J. S., Weisman, R. L., Cerulli, C., Williams, G. C., Jacobowitz, D. B., Mueser, K. T., ... & Caine, E. D. (2017). A randomized controlled trial of the Rochester forensic assertive community treatment model. Psychiatric Services, 68:1016–1024; Maeng, D., Tsun, Z. Y., Lesch, E., Jacobowitz, D. B., Strawderman, R. L., Harrington, D. K., ... & Lamberti, J. S. (2022). Affordability of forensic assertive community treatment programs: A return-on-investment analysis. *Psychiatric Services*, 74: 358-364.

[80] Recognized as one of three regional information centers participating in an established MOU for the Regional Drug Task Force Model, supported by the Maryland Coordination and Analysis Center.

[81] Hopkin, G., Evans-Lacko, S., Forrester, A., Shaw, J., & Thornicroft, G. (2018). Interventions at the transition from prison to the community for prisoners with mental illness: A systematic review. Administration and Policy in Mental Health and Mental Health Services, 45, 623–634.

perceived as less urgent than some of these other needs.[82] In addition, formerly incarcerated persons struggle to navigate the complexity of healthcare and related systems, especially if connections with community providers were not forged before release. For example, necessary information and services may not be centralized or linked, and members of this population may also struggle to navigate internet resources. As such, research has increasingly emphasized the importance of pre-release planning, follow-up in the community, and easing navigational barriers via peer support and navigation programs.[83]

Action Steps Technical Assistance and Training

- **Immediate:** Create reentry checklists that will be available in a centralized location for those reentering society (a one-stop shop) leveraging and promoting existing resources for housing, health, employment, etc.
- **Immediate:** Encourage caseworkers to draft a plan in collaboration with currently incarcerated person at least two months prior to release.
- **Forthcoming:** Support the adoption of a Maryland-wide phone number that returning community members can use, which they are supplied with *before* release (not at release) to help connect them to services.
- **Forthcoming:** Encourage local peer navigation programs to assist returning community members with connecting, understanding, and managing treatment.
- **Immediate:** Build in access to ID cards prior to release for ease of access to social services that promote continuity of health care delivery.

Action Steps Centralized Communication

- **Forthcoming**: Encourage jail personnel to make connections and expedited appointments with community treatment programs as early as possible before an individual is released.

Objective 3f: Expand access to Certified Peer Recovery Specialists (CPRS) to support patients with behavioral health needs across healthcare and public safety systems

Peer recovery specialists/coaches are people with personal lived experience with mental health and/or substance use disorder who provide mentoring and support to individuals with similar life experiences. Peers can provide unique insights and valuable life skills across all intercepts such as helping to identify and access healthcare resources, advocating for and understanding processes and procedures related to involvement with the criminal justice and healthcare systems, and navigating reentry and the transition to work. SAMHSA recommendations for best practices highlight the need to integrate peer support specialists throughout intercepts to best support individuals in crisis and help them develop life skills.

Expanding peer crisis services will help connect people who are experiencing a crisis with a Certified Peer Recovery Specialist to help navigate community-based treatment resources and prevent future crises.

[82] Porter, L. C., Testa, A., Kozerra, M., Philippon, C., Remrey, L., Bijole, P., ... & Rosenthal, E. (2022). "I got so much on my plate": Understanding care discontinuity for HIV and HCV among formerly incarcerated persons. *Health Services Research*, 58: 865-872.
[83] Samost, D., Hwang, J., & Yanos, P. T. (2022). *New Directions in the Treatment of Justice-Involved Individuals with Severe Mental Illness*. Handbook of Issues in Criminal Justice Reform in the United States, 443-462.

IN MARYLAND, the Department of Health's Behavioral Health Administration (BHA) expanded peer recovery support through behavioral health crisis walk-in centers and urgent care clinics to help connect individuals in crisis with a Certified Peer Recovery Specialist. Program expansion will initially support more than 1,300 individuals in Harford, Howard, Frederick, St. Mary's and Worcester Counties. BHA's goal is to reach up to 12 jurisdictions by 2025.

Whereas the expansion of peer recovery specialists is now a key component of treatment and recovery support services in Maryland,[84] there are a number of challenges in building a workforce equipped with necessary skills and training to meet the current need. First, certification training is not easily accessible. For instance, residents of rural communities lack access to training to support a peer support workforce.

Second, even among those with access to training, conversations with Maryland stakeholders and peer support experts note the financial barriers that block access to training among potential peer support providers. For example, the nationally recognized CCAR Recovery Coach Academy costs $800+ to attend.

Third, certification is a lengthy and time consuming process. Maryland has structured guidelines for certification but lacks standardized metrics to guide training, certification, and support of peer mentors. For instance, the Maryland Addiction and Behavioral Health Professionals Certification Board (MABPCB) requires peer recovery specialists to complete 46 hours of training (in addition to 500 service hours, paid or volunteer) before becoming credentialed. The training hours fall across four domains: Ethics (16 hours), Advocacy (10 hours), Mentoring and Education (10 hours), and Wellness and Recovery (10 hours). A list of training opportunities, along with their corresponding domains, can be found here. While hours and themes are structured by the MABPCB, the content and effectiveness of the mode of delivery of the training is not consistent.

The action steps listed below will increase the number of certified peer recovery specialists, make them more accessible to people in crisis, and increase awareness of peers by people transitioning from incarceration back to their community.

Action Steps **Technical Assistance and Training**

- **Immediate:** Promote utilization of SIM Mapping workshops to identify opportunities in which peer recovery specialists can be integrated into local crisis response systems. For example, PRA provides this model.
- **Immediate:** Facilitate local access to peer certification training by building awareness of training opportunities through links on a BHPS-CoE website and potential regional training workshops to expand statewide coverage.
    - Connect with On Our Own of Maryland, Inc (OOOMD) to assess training options to achieve statewide coverage.

[84] Department of Health Behavioral Health Administration. *Consumer Affairs*. https://health.maryland.gov/bha/Pages/Consumer-Affairs.aspx#%3a~%3atext=Certified%20Peer%20Recovery%20Specialist%20%28CPRS%29%20Program

- **Immediate:** Convene regional and statewide virtual learning collaboratives for certified peer recovery specialists to share best practices, seek support, and strategize about local challenges.
- **Forthcoming:** Support provision of consistent peer hours at local EDs, recovery houses, and resource centers.
- **Forthcoming:** Ensure that links to peer recovery/support specialists are included in resource and recovery plans provided to justice-involved persons with behavioral health needs at the time of release from incarceration.

Action Steps **Centralized Communication**

- **Immediate:** Coordinate communication and dissemination efforts with the CIT Coordinators (e.g., include updates in the CIT Coordinators' meetings).
- **Immediate:** Conduct and maintain review of scientific literature on the implementation and impact of peer recovery specialists.
- **Immediate:** Identify and disseminate information on nationally recognized, evidence-based, training curriculums for peer recovery specialists such as:
    - Wellness Recovery Action Plans (WRAP) assist individuals in discovering tools to maintain wellness, develop plans to stay on track with goals, identify triggers and stressors, and maintain control in times of crisis.
        - Additionally, WRAP offers an adaptation, *Wellness Recovery Action Plan for Reentry: Moving Forward from Incarceration*, designed specifically to support individuals who are incarcerated and those who were previously incarcerated or who had contact with the criminal justice system.
    - The Connecticut Community for Addiction Recovery (CCAR) Recovery Coach Academy is a 5-day intensive training academy focusing on providing individuals with the skills needed to guide, mentor and support individuals seeking long-term recovery from an addiction to alcohol or other drugs.
    - CCAR Ethical Considerations for Recovery Coaches: According to CCAR, peer recovery specialists need an understanding of ethics that goes beyond that of general practitioners. CCAR's Ethical Considerations for Recovery Coaches curriculum includes defining the coaching service role and functions, coaching standards, issues of vulnerability, ethical decision making, performance enhancement and legal issues.
    - CCAR Recovery Coaching in Justice Settings: Like WRAP, CCAR also offers specialized training for peers working in justice settings. The CCAR Recovery Coaching in Justice Settings educates peers about different justice settings (e.g., jail, prison, etc.) and barriers that justice-involved persons can face, explores ethical considerations of serving in these systems, and discusses how culture and stigma can affect persons involved with the justice system throughout their recovery.
- **Forthcoming:** Convene a group to identify opportunities for working with local institutions of higher education to assess capacity for building a Peer Support Certificate program.

- In 2018, Rutgers University launched the nation's first Peer Support Certificate program, which doesn't require a prior degree.[85]

EMERGENT EVIDENCE: Peer Navigators for Reentry Support

Incarcerated people with substance use disorders are at heightened risk of overdose during the reentry process, with a particularly high risk in the two weeks after release. The reentry process itself can pose numerous challenges as individuals try to navigate complex systems to access and maintain treatment supports while also experiencing myriad barriers to recovery such as housing insecurity, unemployment, and limited social support.

Peer navigation services provide a resource during this transition period to aid the reentry and reintegration process. Peer navigators have shared lived experiences that provides a bridge to facilitate relationship building, trust, empathy, and compassion.

Recent research from the Intensive Recovery Treatment Support (IRTS) program finds that peer navigators provide crucial ***emotional support*** (e.g., relapse prevention, goal setting and action planning), ***informational support*** (e.g., resource access), and ***instrumental support*** (e.g., community resources for treatment and services, transportation, material needs) to aid in the reentry process for people with opioid use disorder.

Objective 3g: Support recruitment and retention efforts to attract and retain behavioral health practitioners

A common refrain in conversations with Maryland behavioral health and criminal justice stakeholders was the concern about the quantity and quality of the existing workforce across SIM intercepts. Without an appropriately skilled workforce, efforts to strengthen the continuum of care through program development/expansion and strategies to intervene with individuals in crisis will not be adequately implemented and supported.

IN MARYLAND, Senate Bill 283 seeks to establish the Behavioral Health Workforce Investment Fund to provide reimbursement for costs associated with educating, training, certifying, recruiting, placing, and retaining behavioral health professionals. The bill will require the Maryland Health Care Commission to conduct a comprehensive behavioral health workforce needs assessment on or before December 1, 2023 to determine the immediate, intermediate, and long-term unmet need and capacity of the behavioral health workforce in the State, including demographics and gaps in specific professions. This could assist in alleviating overburdened behavioral healthcare professionals. The bill will also generate findings and recommendations regarding the types of training, education, and tuition assistance programs necessary to certify, recruit, place, supervise, and retain additional behavioral health professionals.

Retention of trained behavioral health staff is critical. There are a number of factors unique to members of the behavioral health team that impact retention efforts. First, working with individuals in crisis is demanding and

[85] Verbanas, P. (N.d.) *Rutgers Provides Hope for Ex-Offenders Navigating Recovery and a Life Beyond Bars.* https://impact.rutgers.edu/irts/

can itself manifest in secondary trauma or other behavioral health needs for practitioners.[86] Healthcare staff report higher rates of PTSD especially when exposed to aggression in the workplace and those who are working in correctional care capacities report more exposure to potentially psychologically damaging and traumatic events.[87] This can lead to compassion fatigue, burnout, and may influence retention.

Second, the full behavioral health team should include individuals with diverse backgrounds, perspectives, and experiences. For instance, CPRS will have histories of behavioral health crises and/or justice system involvement. While this experience is an asset and requirement for these roles, evidence suggests that these individuals face stigma from other behavioral health specialists. To increase retention and build collaborative behavioral health teams, jurisdictions should increase access to anti-stigma workshops. For instance, OOOMD's Anti-Stigma Project provides a series of anti-stigma workshops that challenge attendees to examine the impact of stigma on both their professional and personal lives. Facilitators encourage participants to engage in ongoing dialogue about attitudes, behaviors, and practices that are stigmatizing. These workshops are intended to broaden the understanding and awareness of how stigma affects everyone in the behavioral health community. In 2012, a team of independent researchers used randomized controlled trials to assess the Anti-Stigma Project workshop and found that participants (both persons with mental illness and mental health providers), were more aware of stigma, had lower levels of prejudice, and increased belief in recovery and self-determination of people with mental illness.[88]

Action Steps **Technical Assistance and Training**

- **Immediate**: Identify certification/skill needs for practitioners working with behavioral health populations.
- **Immediate**: Identify opportunities to support access to certifications (e.g., financial assistance, release time).
- **Immediate**: Identify opportunities for planning workshops to meet specific needs (e.g., cultural competency, engaging with youth in transition, developmental disabilities, trauma-informed care, reentry support) such as the Trauma Involved Care and Community Resilience Initiative.
- **Forthcoming**: Plan and host/sponsor workshops that meet specific needs to recruit, retain, and equip behavioral health care specialists to meet community specific needs.
- **Forthcoming**: Identify and support mental and behavioral health supports for practitioners working in crisis fields (e.g., mindfulness-based stress reduction).

Action Steps **Centralized Communication**

- **Immediate**: Contribute to the behavioral health workforce needs assessment conducted by the Maryland Health Care Commission.

[86] Cieslak, R., Shoji, K., Douglas, A., Melville, E., Luszczynska, A., & Benight, C. C. (2014). A meta-analysis of the relationship between job burnout and secondary traumatic stress among workers with indirect exposure to trauma. *Psychological Services*, 11(1): 75.

[87] Fusco, N., Ricciardelli, R., Jamshidi, L., Carleton, R. N., Barnim, N., Hilton, Z., & Groll, D. (2021). When our work hits home: Trauma and mental disorders in correctional officers and other correctional workers. *Frontiers in Psychiatry*, 11, 493391.

[88] Michaels, P. J., Corrigan, P. W., Buchholz, B., Brown, J., Arthur, T., Netter, C., & Macdonald-Wilson, K. L. (2014). Changing stigma through a consumer-based stigma reduction program. *Community Mental Health Journal*, 50(4): 395–401.

- **Immediate**: Work with academic institutions including the University of Maryland System, HBCUs, and local community colleges to identify current programming with appropriate training and recruitment options.
- **Forthcoming**: Continue to partner with academic institutions to promote programming, training, and recruitment options.
- **Forthcoming**: Work with academic institutions to strategize ways to increase access to behavioral health and related programs such as offering credited internships, tuition reimbursement, and/or apprenticeship opportunities to attract and retain behavioral health practitioners.

Action Steps **Data, Research, and Evaluation**

- **Immediate**: Assist with the implementation of behavioral health workforce exit interviews to monitor and evaluate retention challenges.
- **Forthcoming**: Assist with the analysis of behavioral health workforce exit interviews to monitor and evaluate retention challenges.

PRIORITY 4

Support the Development of Formal Screening Processes to Identify Candidates for Diversion

Whereas the high prevalence of individuals with behavioral health issues in the criminal legal system is known, many agencies lack the resources to accurately identify who and how many people under their care have behavioral health needs. Without accurate identification, agencies are unable to identify inter- and intra-agency strategies and responses to meet these needs. The center will support the development of screening processes to accurately and swiftly identify those with behavioral health needs who come in contact with the criminal justice system. A recent report indicates that 39% of jail inmates in Maryland suffer from a mental health disorder and national estimates indicate that nearly 70% of prisoners have substance use disorders. Moreover, there is a high incidence of co-occurring disorders in this population. In Maryland, 9 out of 10 inmates with a mental health problem also report substance abuse.[89] Indeed, these figures reinforce the need for valid and reliable screening tools in the first place. Such tools (1) make it possible to understand the scope and patterning of behavioral health needs in Maryland, and (2) identify those in need of diversion and/or specific services.

Unfortunately, behavioral health issues are under-identified in part because screening in criminal justice settings is inconsistent and incomplete.[90] This is especially the case for substance use and co-occurring disorders. For example, research suggests few criminal justice agencies screen for opioid use disorder, potentially contributing to incidents of overdose and subsequent death among this population.[91] Even if both mental health and substance use disorders are screened for, they often are screened with a parallel approach rather than an integrated one. That is, the issues are screened separately, which may result in an incomplete understanding of the complex needs of individuals.

IN MARYLAND, 96% of jails screened for Opioid Use Disorder as of June 2019.[92] A smaller percentage (68.8%) of jails provided medications for individuals experiencing opioid withdrawals. Of persons admitted to Maryland jails, 87% were screened for OUD and 23% of screenings returned positive for OUD.

In 2017, a focus group of 25 Maryland stakeholders convened to discuss issues related to criminal justice and behavioral health. They noted the importance of proper screening while also highlighting that "there is no uniform screening system" across Maryland correctional facilities.[93] While the adoption of a standard screener may still be advantageous, it is essential for correctional facilities to adopt screeners that are valid (i.e., accurate, comprehensive) and reliable (consistent across groups). The implementation of screeners is also as

[89] National Alliance on Mental Illness & Maryland Alliance for Justice Reform. (2018). *Pretrial Mental Health Screening and Services in Maryland: Stakeholders' Focus Group Report*.

[90] Substance Abuse and Mental Health Services Administration. *Screening and Assessment of Co-occurring Disorders in the Justice System*. HHS Publication No. PEP19-SCREEN-CODJS. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

[91] Brinkley-Rubinstein, L., Zaller, N., Martino, S., Cloud, D. H., McCauley, E., Heise, A., Seal, D. (2018) Criminal justice continuum for opioid users at risk of overdose. *Addictive Behaviors*, 86: 104-110.

[92] Maruschak, L. M., Minton, T. D., & Zeng, Z. (2023) *Opioid Use Disorder Screening and Treatment in Local Jails, 2019*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

[93] National Alliance on Mental Illness & Maryland Alliance for Justice Reform. (2018). *Pretrial Mental Health Screening and Services in Maryland: Stakeholders' Focus Group Report*.

important, or perhaps even more important, than the screening tool itself. Staff play a critical role in administering the screeners, interpreting results, and making diversionary decisions. False negatives and false positives may result from inadequate training and implementation.[94]

Reliability of screeners across racial/ethnic groups and gender also warrants attention. Ramirez and colleagues (2005)[95] identify two important sources of error that can be introduced with behavioral health screeners. The first relates to the assumption that the items in the screener will be interpreted in the same way across groups. Second, many screening tools rest on the assumption that mental illnesses present the same way symptomatically across groups. Third and fourth generation tools have been more successful at reducing bias, which incorporate structured professional judgment into the interpretation of symptoms and responses to screeners.

While most behavioral health screening happens at intake into jails or prisons, 911 call centers and dispatchers play a crucial role as well. A recent study conducted by PEW Charitable Trusts finds that there is no national standard practice in emergency-call taking to identify a behavioral health crisis.[96] Call dispatchers often make the critical decision of whether an event is a behavioral health crisis or not, which then spurs a particular chain of events. These decisions can shape criminal justice trajectories down the line, since - for example - interactions with police officers may end differently than interactions with mobile crisis units. As such, it is imperative for the center to play a role in the development of screening processes at this intercept as well.

In summary, the BHPS-CoE should pursue the following objectives:

Objective 4a. Inform and monitor the collection of data from screeners and diversionary outcomes

Collecting and recording data from screeners will be instrumental to understanding the scope and patterning of behavioral health issues in Maryland's criminal justice system. For example, it will be important to understand the level and nature of this issue by jurisdiction as well as by intercept. This information can inform decisions about where to direct programming and resources. The most crucial data required to answer these questions will be obtained from screeners, which are used to identify individuals with behavioral health needs. We also recognize the importance of adaptable and mobile technologies in this endeavor. For example, the use of tablets can improve efficiency and coverage.[97] Data collection of this nature is also essential for any type of research, whether that research is aimed at understanding how programs are being implemented or if certain programs are working. While we do not propose that the center perform the task of data collection, the center should be a dependable resource for best practices in terms of data collection, methodology and measurement with respect to screeners and diversionary decisions. Specifically, we propose the following action steps for the BHPS-CoE center:

[94] Ford, J. D., Trestman, R. L., Wiesbrock, V. H., & Zhang, W. (2009). Validation of a brief screening instrument for identifying psychiatric disorders among newly incarcerated adults. *Psychiatric Services*, 60(6), 842-846.

[95] Ramírez, M., Ford, M. E., Stewart, A. L., & A. Teresi, J. (2005). Measurement issues in health disparities research. *Health services research*, *40*(5p2), 1640-1657.

[96] PEW Charitable Trusts. 2021. *New Research Suggests 911 Call Centers Lack Resources to Handle Behavioral Health Crises*.

[97] Patel, V., Hale, T. M., Palakodeti, S., Kvedar, J. C., & Jethwani, K. (2015). Prescription tablets in the digital age: a cross-sectional study exploring patient and physician attitudes toward the use of tablets for clinic-based personalized health care information exchange. *JMIR Research Protocols*, 4(4), e3806.

Action Steps Data, Research, and Evaluation

- **Immediate:** Promote data collection as part of the training process for administering screeners.
- **Immediate:** Encourage the adoption of electronic data entry/management, including the potential adoption of tablets for easier and mobile data collection and management.
- **Immediate:** Offer materials and presentations on "best practices" in data collection.

Objective 4b. Inform evidence-based adoption of standardized screeners within each intercept across the State

The adoption of evidence-based screeners is a first step toward an accurate and comprehensive identification of Marylanders with behavioral health needs who come into contact with the criminal justice system. Behavioral health screeners are typically short questionnaires assessing symptoms, behaviors, and other background information that may indicate a behavioral health problem. The results of a screener are typically used to "flag" an individual for further assessment, which is a "lengthier and more intensive review of psychosocial problems that can lead to diagnoses and placement in different types or levels of treatment and supervision services."[98] In 2017 a group of Maryland stakeholders recommended the adoption of the Brief Jail Mental Health Screen (BJMHS) across correctional facilities. This screening tool consists of eight items assessing delusions, paranoia, activity level, weight gain, talking fast vs. slow, feeling useless, and whether the person has ever been medicated or hospitalized.

While the BJMHS is an effective tool for identifying severe mental health disorders, it suffers from a number of limitations, including varying performance across gender and racial groups and limited ability to detect disorders related to anxiety or personality. [99, 100, 101] The Correctional Mental Health Screen (CMHS) is another tool that has been validated for use in justice settings. It is an attractive tool because there are separate versions for males and females. Moreover, the version for females performs better than the BJMHS at detecting mental health disorders among this subgroup. The CMHS is also designed to detect a wider range of mental health disorders than the BJHMS. There are perhaps two known drawbacks to the CMHS, however, which are that it yields higher false negative rates than the BJMHS and that its reliability across offender subpopulations, such as across racial groups, is not well understood.[102] [103]

Regardless, neither tool is intended to screen for co-occurring disorders which are prevalent among justice-involved populations. Specifically, the tools do not ask about trauma or substance use, so they may be best utilized in tandem with another screener designed for this aim. Further, items related to trauma and substance

[98] Substance Abuse and Mental Health Services Administration. *Screening and Assessment of Co-occurring Disorders in the Justice System*. HHS Publication No. PEP19-SCREEN-CODJS. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

[99] Steadman, H. J., Robbins, P. C., Islam, T., & Osher, F. C. (2007). Revalidating the Brief Jail Mental Health Screen to increase accuracy for women. *Psychiatric Services*, 58(12), 1598-1601.

[100] Prins, S. J., Osher, F. C., Steadman, H. J., Robbins, P. C., & Case, B. (2012). Exploring racial disparities in the brief jail mental health screen. *Criminal Justice and Behavior*, 39(5), 635-645.

[101] Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60(6), 761-765.

[102] Ford, J., & Trestman, R. L. (2005). Evidence-based enhancement of the detection, prevention, and treatment of mental illness in the correction systems (Document No. 210829).

[103] Steadman, H. J., Scott, J. E., Osher, F., Agnese, T. K., & Robbins, P. C. (2005). Validation of the Brief Jail Mental Health Screen. *Psychiatric Services*, 56(7), 816-822.

use may be particularly relevant to veterans, who suffer from comparably high rates of PTSD and certain SUDs such as alcohol abuse.[104] Unfortunately, veterans are also less likely to report mental health symptoms due to stigma, which is more pronounced in military culture.[105] For veterans specifically, tools such as the Patient Health Questionnaire (PHQ-9) may be more effective at screening for mental illness.[106] Although originally designed as a screening tool for major depression, evidence suggests that the tool also performs well at detecting the presence of mental health symptoms more generally, including co-occurring disorders.[107]

Finally, none of the above mentioned tools were developed to screen for intellectual and developmental disabilities. Screening for such conditions may be challenging in justice settings. Most screening tools are developed for children, are quite lengthy, and contain items that may be unobservable to justice personnel, such as whether individuals properly handle work equipment and clean up after themselves.[108,109] Oftentimes school records can be used to assess the presence of an IDD, which may include information on history of special education courses or intelligence scores. Other organizations note that personnel can ask a few standard questions to gauge possible IDD, including, "Can you tell me about school?", "How do you spend your days?" and by assessing functionality with respect to whether they are able to complete other paperwork without assistance.[110]

In short, adoptions of screening tools should consider evidence relating to the validity of tools to correctly identify those with behavioral health needs, keeping in mind the entire scope of behavioral health issues, and to perform well across groups. We propose the following action steps:

Action Steps **Technical Assistance and Training**

- **Immediate**: Follow up on 2018 report to assess whether BJMHS has been adopted across Maryland jails and prisons.
- **Immediate:** Promote compliance with Senate Bill 846 which requires opioid use disorder screening and treatment in all correctional facilities.
- **Immediate**: Encourage correctional facilities to incorporate a question in screeners about veteran status.
- **Forthcoming**: Provide relevant evidence and information to criminal justice entities to assist with the adoption of the most appropriate and best-performance screener(s).

[104] Teeters, J. B., Lancaster, C. L., Brown, D. G., & Back, S. E. (2017). Substance use disorders in military Veterans: prevalence and treatment challenges. *Substance Abuse and Rehabilitation*, 8, 69.

[105] P Johnson, H., & Agius, M. (2018). A Post-Traumatic Stress Disorder review: the prevalence of underreporting and the role of stigma in the military. *Psychiatria Danubina*, 30(suppl. 7), 508-510.

[106] K. Kroenke, R.L. Spitzer, J.B. Williams (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16(9): 606-613.

[107] Katz, I. R., Liebmann, E. P., Resnick, S. G., & Hoff, R. A. (2021). Performance of the PHQ-9 across conditions and comorbidities: Findings from the Veterans Outcome Assessment survey. *Journal of Affective Disorders*, 294: 864-867.

[108]Harrison, P., Oakland., T (N.d.) *Adaptive Behavior Assessment System II: Technical Report* http://images.pearsonassessments.com/images/tmrs/tmrs_rg/abas_ii_tech_rpt.pdf

[109] Ben-David, N., Lotan, M., & Moran, D. S. (2022). Development and validation of a functional screening tool for adults with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 35(6): 1281-1296.

[110] Centre for Addiction and Mental Health (CAMH). IDD – Screening. https://www.camh.ca/en/professionals/treating-conditions-and-disorders/intellectual-and-developmental-disabilities/idd---screening

- **Forthcoming**: Where/when possible, encourage the use of tools that incorporate structured professional judgment at the assessment stage, which have been shown to be more reliable for detecting mental health problems among racial/ethnic minorities.[111]
- **Forthcoming:** Encourage and assist with the adoption of multiple tools that allow for the screening of co-occurring disorders, such as IDDs and SUDs (e.g. TCU Drug Screen (TCUDS V)).
- **Forthcoming:** Assist police departments in producing a standard script to screen for behavioral health calls.

Objective 4c. Develop protocols for appropriate timing and number of intervention points to administer screeners

In general, it is considered best practice to administer a behavioral health screener as soon as possible in criminal justice processing, which would most commonly be during intake to a holding cell or correctional facility.[112] Importantly, this is also the intervention point and setting for pretrial services, a recognized gap and center of discussion for the abovementioned focus group held in 2018. Stakeholders recommended at this time that starting in 2019, uniform screening procedures should be initiated across the state of Maryland for those held in pre-trial detention. Furthermore, the center should support research and implementation of additional intervention points across intercepts and potentially repeat-screeners within intercepts. For example, Zottola and colleagues (2019) find that the odds of a positive screening increase with repeated jail bookings, suggesting that screeners may be more likely to identify individuals with behavioral health needs when administered on a repeat-basis.[113] Locally, correctional facilities are taking innovative steps to repeat screenings early in the intake process that may yield greater identification of individuals with behavioral health needs. In particular, we propose the following action steps:

Action Steps Technical Assistance and Training

- **Forthcoming:** Explore initiatives already underway locally and consider for broader adoption across the State.
- **Forthcoming:** Support and inform the piloting of screening tools at the arrest stage.
- **Forthcoming:** Encourage a minimum of two screenings at correctional facilities, one at intake and one at release.
- **Forthcoming**: Develop protocols for appropriate timing and number of intervention points.

Action Steps Data, Research, and Evaluation

- **Forthcoming:** Investigate changes in screening results across repeated time points for those in jail or prison.

[111] Singh, J. P., Fazel, S., Gueorguieva, R., & Buchanan, A. (2014). Rates of violence in patients classified as high risk by structured risk assessment instruments. *The British Journal of Psychiatry*, 204(3): 180–187.

[112] Substance Abuse and Mental Health Services Administration. Screening and Assessment of Co-occurring Disorders in the Justice System. HHS Publication No. PEP19-SCREEN-CODJS. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

[113] Zottola, S. A., Desmarais, S. L., Neupert, S. D., Dong, L., Laber, E., Lowder, E. M., & Van Dorn, R. A. (2019). Results of the Brief Jail Mental Health Screen across repeated jail bookings. *Psychiatric Services*, 70(11): 1006-1012.

Objective 4d. Facilitate training and support of staff who are involved in screening and diversionary decisions

Supporting and training staff are crucial steps to reducing turnover and to improving the implementation of screening tools. While the tools are intended to be objective, inadequate training and bias can affect their implementation (McGregor et al., 2019).[114] For example, in the criminal justice context, Ford and colleagues (2007)[115] find that most inmates who screened "positive" with the BJMHS were not referred to mental health services by jail personnel. Another study finds that female correctional officers are more likely to refer inmates for mental health services, regardless of the rating on the instrument (Steadman et al., 2007).[116] In addition to training, frontline staff require support to adequately perform this task. This support may be more instrumental or social in form, but staff should feel supported in a way that equips them with the tools and energy required. Such support can also prevent burnout and turnover (Linos et al., 2022).[117] To meet this objective, we propose the following action steps:

EMERGENT EVIDENCE: Light-touch Peer-based Support for Dispatchers

Across intercepts, individuals responding to behavioral health crises are at a greater risk of experiencing burnout. This has negative consequences for their own health, can affect how they respond to individuals in crisis, and results in high turnover.

Emergent evidence finds that low-cost affirmation techniques can reduce dispatcher burnout and increase retention with significant personnel savings.

This technique consists of weekly online reflective interactions among dispatchers aimed at developing social ties and belongingness.

Action Steps — Technical Assistance and Training

- **Forthcoming:** Promote hiring of culturally competent staff to administer screeners.
- **Forthcoming:** Seek out connections with local Veterans Affairs offices to promote hiring of veterans to administer screeners.
- **Forthcoming:** Encourage yearly training sessions for jail/prison personnel and 911 dispatchers.
- **Forthcoming:** Promote an incentivizing structure to encourage attendance at training sessions.

Action Steps — Centralized Communication

- **Forthcoming:** Encourage a (virtual) space in which 911 call dispatchers can share experiences, reflect, and develop support networks.

[114] McGregor, B., Belton, A., Henry, T. L., Wrenn, G., & Holden, K. B. (2019). Improving behavioral health equity through cultural competence training of health care providers. *Ethnicity & Disease*, *29*(Suppl 2): 359.

[115] Ford, J. D., Trestman, R. L., Wiesbrock, V., & Zhang, W. (2007). Development and validation of a brief mental health screening instrument for newly incarcerated adults. *Assessment*, *14*(3): 279-299.

[116] Steadman, H. J., Robbins, P. C., Islam, T., & Osher, F. C. (2007). Revalidating the Brief Jail Mental Health Screen to increase accuracy for women. *Psychiatric Services*, *58*(12): 1598-1601.

[117] Linos, E., Ruffini, K., & Wilcoxen, S. (2022). Reducing burnout and resignations among frontline workers: A field experiment. *Journal of Public Administration Research and Theory*, *32*(3): 473-488.

Objective 4e. Provide technical assistance to jurisdictions in terms of training and implementation of screeners

Jurisdictions and the service providers within them will require technical assistance to select and administer screeners, answer questions, facilitate training, and provide content. Technical assistance may also take the form of visiting jurisdictions to provide hands-on guidance. Specifically, we propose the following action steps:

Action Steps **Technical Assistance and Training**

- **Immediate:** Field questions related to screeners (e.g., how to interpret scores).
- **Immediate**: Provide a "best practices" toolkit to all Maryland organizations screening for behavioral health.
- **Forthcoming:** Assist with content to be used in training sessions, which can be provided on a case-by-case basis and made available on the center's website.
- **Forthcoming:** Provide presentations on the use of screeners for knowledge building.
- **Forthcoming:** Explore the potential utility of technology (e.g., tablets) for self-reporting of symptoms.

PRIORITY 5
Promote Comprehensive and Consistent Data Collection, Management, and Integration

According to SAMHSA, "tracking and understanding data across the intercepts is a critical part of developing a robust continuum of behavioral health services and reducing justice system involvement for people with [behavioral health] disorders." Improving cross-system data collection, management, and integration is essential for a myriad of reasons including (but not limited to): identifying the service population (especially high-utilizers/ frequent fliers), informing client-level decisions and diversion, analyzing trends and patterns in service utilization and delivery over time, justifying the development and expansion of programs, and measuring individual and program outcomes and success.[118]

In order to promote a comprehensive behavioral health and public safety data infrastructure, the BHPS-CoE, in partnership with the appropriate advisory boards, must first develop standardized protocols that detail *what* data should be collected, *how* data should be collected and *who* is responsible for collecting these data and sharing it with the BHPS-CoE (or other agencies to be determined, e.g., BHA).

Specifically, the BHPS-CoE should prioritize the following objectives:

Objective 5a: Identify key indicators designed to assess utilization of resources that will be measured consistently across intercepts and systems/agencies

The first step in coordinating comprehensive and consistent data collection is determining which indicators or metrics should be tracked. Specific types of data are required to answer specific types of questions. For example, aggregate data (e.g., number of calls to 988 crisis lines) may help stakeholders understand the scope of the BHPS-CoE's target population (justice-involved persons with behavioral health disorders), track trends over time, and provide insight on issues related to service utilization, system capacity, and resource/funding allocation. Alternatively, individual-level indicators (e.g., diagnosis, discharge outcome, length of stay, etc.) can be used to track Marylanders as they move through the intercepts and to improve continuity in the receipt of behavioral health and other social services.

Action Steps Data, Research, and Evaluation

- **Immediate:** Convene a task force composed of local practitioners and data scientists/researchers to identify key measures/metrics to be captured by agencies and organizations at each intercept point. The task force should consider reviewing SAMHSA's *Data Collection Across the Sequential Intercept Model* report and other resources such as *Justice Counts Metrics*.[119]
- **Immediate:** Inventory data stored in major data systems (police, fire/EMS, jails, courts, homeless services, healthcare providers/ hospitals) to develop a better understanding of what

[118] Substance Abuse and Mental Health Services Administration. (2019). *Data Collection Across the Sequential Intercept Model*. https://store.samhsa.gov/sites/default/files/d7/priv/pep19-sim-data.pdf

[119] Justice Counts Metrics. (n.d.). *Justice Counts*. https://justicecounts.csgjusticecenter.org/metrics/justice-counts-metrics/

information is currently collected and how it could be used to track individuals and the services they receive.

- **Forthcoming:** Investigate utility of screening tools for data collection purposes (e.g., screeners used at jail booking can provide information for service delivery and for understanding the population of jail inmates with specific behavioral health needs).

IN MARYLAND, currently five counties (Anne Arundel 2016; Calvert 2016; Harford 2016; Montgomery 2015, Prince Georges 2015) have registered as Stepping Up program participants.[120] This initiative aims to reduce the number of people in jails with mental illnesses by outlining the steps to help counties become more data driven and increase access to community mental health services. National-level evidence suggests that adopting counties were more likely to collect and use baseline data to make data-informed decisions and implement identified programming needs.[121]

Objective 5b: Develop standardized/ best-practice procedures for data collection and sharing

The BHPS-CoE shall also be responsible for coordinating *how* (and by *whom*) the above-identified data (Objective 1) is collected, managed/stored, and shared with the BHPS-CoE. Because data collection will occur at the local-level, it is important to have standardized protocols to promote consistent data collection across jurisdictions. If the identified standard/best-practice information does not already exist within an agency/system, the BHPS-CoE should advocate for the use of evidence-based tools and provide explicit directions for who should administer the tool and when. To leverage existing administrative data (e.g., calls for service, hospital admissions), the BHPS-CoE should provide recommendations for data organization (e.g., spreadsheet templates). In order to develop a better understanding of trends in Maryland as a whole, it is critical that jurisdictions regularly submit their data to a statewide data repository (discussed below, Priority 6, next). Therefore, the BHPS-CoE should establish a timeline for regular (e.g., quarterly) submission to the repository as well as submission guidelines (e.g., submit to the attention of whom, in what format, through what system).

Action Steps Data, Research, and Evaluation

- **Immediate:** Set clear parameters for how data will be protected and used; what people, policies, and procedures will manage that data and prioritize client confidentiality.
- **Immediate:** Provide access to Results-Based Accountability (RBA) training for identified data personnel.
- **Immediate**: Identify and disseminate information on what platforms/systems will be utilized for data collection.
- **Forthcoming:** Develop and maintain a system for ongoing, real time data collection and submission.

[120] Home. (n.d.). *Step Up Together.* https://stepuptogether.org

[121] Stepping Up Innovator Counties: Leading the Way in Justice System Responses to People with Behavioral Health Needs. (2021). https://csgjusticecenter.org/wp-content/uploads/2021/08/Stepping-Up-Innovator-Brief_Accessible.pdf

- **Forthcoming**: Provide technical support to aid in the transition from paper forms to electronic data systems where needed.
- **Immediate:** Develop and enter into data-sharing agreements with local agencies in each jurisdiction to formalize established protocols.

PRIORITY 6
Support Data Driven Decision Making

It is important not just to systematically collect data (as detailed in Priority 5, above), but also to make sure that data is translational. In other words, once data are collected they should be linked, analyzed, and reported for use by decision-makers.

Building a comprehensive data system to support data-driven decision making begins with linking data across systems. Justice-involved persons with behavioral health disorders are served in multiple systems. Current methods for understanding the complete picture of multi-system involvement are limited because each agency within the justice, human services, and health systems uses its own independent data system. Therefore, system-specific information exists in isolation. In accordance with the SIM model and with the goal of minimizing disruptions in Marylander's care continuum, it is imperative for the BHPS-CoE to forge alliances between agencies (i.e., data owners) and develop data linkages across systems. To assist with data linking, the BHPS-CoE should actively engage in conversations regarding the universal adoption of System Identification (SID) codes.

Linking longitudinal data from multiple systems can provide answers to questions about policy and program effectiveness *and* create client-level service/treatment records to improve continuity of care for justice-involved persons with behavioral health disorders. For example, through their participation in SAMHSA's *Data-Driven Justice and Behavioral Health Design Institute,* Prince George's County developed a process for sharing data across health, social services, and corrections systems. Their "Efforts to Outcomes" initiative is a case management and data platform that combines data from each system to track service provision pre- and post-release for individuals who pass through the county's jail system and coordinate referrals to available programs and services.[122]

In order to address Priority 6, the BHPS-CoE should establish long-term, collaborative partnerships with third-party experts from the University System of Maryland, Maryland Historically Black Colleges and Universities, and/or other local research organizations. The BHPS-CoE can leverage expertise from such research-practitioner partnerships to link complex data systems (as discussed above), analyze behavioral health and public safety trends, and evaluate specific policies or programs and their intended (and unintended) outcomes while maintaining the confidentiality of individuals with system involvement.

Additionally, once data is integrated and analyzed, it is the responsibility of the BHPS-CoE to disseminate de-identified findings to the appropriate stakeholders and the general public via research briefs, data dashboards, and other outlets (to be determined). Public-facing data dashboards (like the ones seen here, from the Center for Substance Use, Addiction & Health Research),[123] give community members the ability to access data on key indicators and understand how their jurisdiction compares to others across Maryland on metrics of behavioral health and public safety. According to the National Conference of State Legislatures (NCLS), decision-makers

[122] National Association of Counties (N.d.) *Building Data-Driven Justice* https://www.naco.org/sites/default/files/documents/DDJ%20Case%20Study%20Franklin%20PA%20Final_0.pdf

[123] Baltimore Area – CESAR Data. (n.d.). https://data.cesaresearch.org/edds/md/baltimore/, https://cesar.umd.edu/landingtopic/about-edds

also depend on access to "reliable, digestible, and comparable data" to guide policy and budgetary decisions that promote better outcomes and more efficient use of public resources.[124]

Objective 6a: Promote research-practitioner partnerships to facilitate ongoing data analysis, evaluation, and performance monitoring

By partnering with researchers from Maryland universities, the BHPS-CoE can leverage a network of interdisciplinary experts to navigate complex data systems, analyze behavioral health and public safety trends, evaluate program/policy outcomes and assess performance metrics. When not already available, these partnerships can also help produce systematic reviews to identify promising and evidence-based practices to inform approaches and funding opportunities in Maryland. Other similarly motivated Centers advocate for data analysis and evaluation to be conducted by an independent third party (e.g., institutions of higher education) in order to protect the privacy and confidentiality for justice-involved persons with behavioral health disorders and the systems that serve them.

Action Steps Data, Research, and Evaluation

- **Immediate:** Recruit research collaborators from the University System of Maryland, Maryland Historically Black Colleges and Universities, and other local research agencies.
- **Immediate:** Develop systematic reviews of the evidence-base and maintain an inventory of promising and evidence-based practices (see Objective 7c).
- **Immediate:** Assess currently available data management systems to provide recommendations and options for Maryland agencies and programs.
- **Forthcoming:** Identify research questions and analyses to be conducted.
- **Forthcoming:** Facilitate access to data (e.g., data sharing agreements, IRB approval).

Objective 6b: Build a comprehensive data repository as part of the CoE data hub to support information sharing and improve understanding of resource utilization

As described above (Priority 5b), the BHPS-CoE will provide guidance for the submission of data from local jurisdictions. Using this data, the BHPS-CoE should establish a combined data repository that links cross-system data. As stated above, advancing data linkages across systems fosters the BHPS-CoE's overarching SIM framework and promotes the goal of minimizing disruptions in justice-involved Marylander's behavioral health care.

As of 2016, great progress was being made in developing a data sharing initiative (Maryland DataLink) in each jurisdiction.[125] As a means of advancing data linkages, the BHCoE should update and assess the current status of this initiative and provide technical assistance to support full jurisdictional participation. Though the DataLink initiative was originally intended to promote the continuity of care for individuals

[124] BJA. (N.d.) *Policymaker's Use of Data to Inform Criminal Justice Decisions*. https://bja.ojp.gov/doc/policymakers-use-data-inform-cj-decisions.pdf

[125] Maryland Mental Health and Criminal Justice Partnership (2016) *11 Year Review* https://www.mhamd.org/wp-content/uploads/2015/04/MHCJP-11-yr-Review-Sept-2016.pdf

with serious mental illness that interact with law enforcement, linked data could provide valuable insight for the establishment of a cross-system data repository.

It is important to note that the BHPS-CoE does not have to wait until sophisticated software or dashboards (longer-term goals) are purchased or developed to begin building a statewide repository. As long as secure mechanisms of storing and sharing data are established, statewide datasets may be exported to encrypted Excel or other spreadsheet formats to allow for analysis. Analysis of cross-system data from each jurisdiction will provide insight into statewide trends for behavioral health and public safety indicators.

Action Steps Data, Research, and Evaluation

- **Immediate:** Collaborate with BHA's Administrative Services Organization (Optum) to assess current adoption of the Maryland DataLink initiative and promote enrollment of non-participating counties.[126]
- **Immediate:** Facilitate collaboration between BHPS-CoE Data Analyst/Team and Maryland Statistical Analysis Center (MSAC) to ensure proper protection and management of data.
- **Forthcoming:** Link administrative data across multiple agencies to monitor service provision and support clients across programs and systems.

Action Steps Centralized Communication

- **Immediate:** Host a learning community to learn from other state-level data hubs (e.g., Minnesota's Minn-LInK)[127] or area specific consultants (e.g., Criminal Justice Coordinating Center of Excellence - Ohio) on topics such as information sharing, record linking, confidentiality, HIPAA protections, MOUs, data output, etc.[128]

Objective 6c: Regularly analyze data, conduct evaluations, and publicly disseminate findings

Regular data analysis and evaluation are essential for building evidence-based, data-driven programs and policies. Recurring analysis of statewide data and provide insight into longitudinal changes in behavioral health and public safety trends. For example, such analysis can inform whether the number of calls of 9-8-8 crisis lines is increasing over time. Additionally, evaluations can provide important evidence to support (or refute) the adoption or expansion of pilot programs. For example, research partners can evaluate the effectiveness of screening protocols for diverting persons with behavioral health needs from traditional to specialty courts. In addition to evaluating programs' effects on their anticipated outcomes (e.g., increasing diversion) it is also important for evaluations to consider unintended consequences like racially disparate service provision. For example, specialty courts aimed to divert people with behavioral health issues from the criminal justice system, such as mental health courts and drug courts, are not immune to racial inequalities but do show promise in

[126] Maryland DataLink Initiative. (n.d.). https://marylandbh.optum.com/content/ops-maryland/maryland/en/bh-providers/datalink.html
[127] admin. (n.d.). Minn-LInK. Center for Advanced Studies in Child Welfare. https://cascw.umn.edu/community-engagement-2/minn-link/
[128] Ohio Criminal Justice Coordinating Center of Excellence (CJCCoE). (n.d.). NEOMED. https://www.neomed.edu/cjccoe/

their ability to reduce such disparities.[129] Findings from such assessments can be translated to recommendations for program improvement.

Straightforward reporting of behavioral health and public safety statistics and research findings will benefit stakeholders including community members, criminal justice and behavioral health practitioners, and legislators/policy makers will benefit from regular reports. The BHPS-CoE shall serve as the disseminating entity for this information and should consider multiple forms of delivery such as public-facing data dashboards (like those published by the Center for Substance Use, Addiction, and Health Research)[130], de-identified public datasets (like those provided by OpenBaltimore)[131], and/or research/ policy briefs (like those published by the Bureau of Justice Statistics)[132].

Action Steps Data, Research, and Evaluation

- **Immediate**: Develop and implement strategy for producing regular reports (e.g., template, timeline, performance indicators, etc.) for publication in advance of legislative sessions in order to promote meaningful translation.
- **Forthcoming:** Standardize a "data request"/"project proposal" process for jurisdictions to request analysis and/or partnering agencies to propose research questions.
- **Forthcoming:** Design and publish public-facing data dashboards to provide stakeholders and community members with frequently updated information on behavioral health and public safety indicators and initiatives and links to existing dashboards like the Maryland Overdose Data dashboards.

Action Steps Centralized Communication

- **Immediate**: Upon completion, publish data reports on the BHPS-CoE website for public access.

IN MARYLAND, Senate Bill 154 requires the development and implementation of a public awareness campaign to encourage the use of mental health advance directives in the State. A mental health advance directive is a legal document that allows a person with a mental illness to state their wishes and preferences in advance of a mental health crisis. The bill will require a study of the feasibility of establishing a centralized statewide database for these directives.

[129] Dannerbeck, A., Harris, G., Sundet, P., & Lloyd, K. (2006) Understanding and responding to racial differences in drug court outcomes. *Journal of Ethnicity in Substance Abuse* 5: 1-22; Han, W., & Redlich, A. (2018). Racial/ethnic disparities in community behavioral health service usage: A comparison of mental health court and traditional court defendants. *Criminal Justice and Behavior* 45: 173-194.
[130]Center for Substance Use, Addiction, and Health Research https://data.cesaresearch.org/edds/md/baltimore/

[131] Open Baltimore. (n.d.). https://data.baltimorecity.gov/

[132] Maruschak, L. M., Bronson, J., & Alper, M. (2016) *Indicators of Mental Health Problems Reported by Prisoners*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

PRIORITY 7

Facilitate communication and information dissemination about opportunities and best practices across Jurisdictions, the State, and the Nation

Whereas myriad programs, policies, and interventions are occurring across Maryland, these efforts are often undertaken in siloed capacities. The BHPS-CoE is positioned to streamline and strengthen communication between and across agencies, organizations, and jurisdictions to leverage existing capacity and knowledge building, identify opportunities for collaboration and scaling of promising programs, and create a community of cooperation that promotes shared learning and a commitment to a safer and healthier State.

Objective 7a: Enhance and streamline communication across jurisdictions, agencies, and similarly-motivated workgroups, task forces, and advisory boards

A clear theme that emerged in our conversations with key stakeholders across the State and irrespective of agency, organization, or jurisdiction was the desire for continued conversation and information sharing. The BHPS-CoE is well positioned to be the conduit by which this communication occurs. Communication strategies should include convening methods where individuals can engage in shared discourse.

While there is a need to increase opportunities for greater communication and information sharing, conversations with Maryland stakeholders also made clear that there is confusion in the roles and responsibilities across various similarly-motivated workgroups, task forces, and advisory boards aimed at improving services, healthcare, and access to treatment for individuals with behavioral health needs who become involved with the criminal justice system (e.g., Behavioral Health System of Care Workgroup, Behavioral Health and Criminal Justice Partnership, Crisis Intervention Team Center of Excellence). The efforts, some of which have a long history in Maryland, should be systematically leveraged to identify opportunities for collaboration and reduce the likelihood of duplicative efforts.

Action Steps **Centralized Communication**

- **Immediate:** Create opportunities for communication and information sharing by facilitating meetings with stakeholders (e.g., lunch and learn sessions, quarterly stakeholder meetings). The frequency of these meetings should be established in conversation with constituencies and what would best meet each group's needs.
- **Immediate:** Survey stakeholders to inquire about preferred communication platforms (e.g., listserv, group messaging, virtual community, virtual meeting).
- **Immediate:** Establish an online community/forum/website to facilitate ongoing/continuous communication to share challenges, opportunities, and strategies across Maryland jurisdictions as part of regular operating procedures.
- **Forthcoming:** Convene meeting of similarly-motivated workgroups, task forces, and advisory boards to identify actions/efforts and coverage (i.e., people and places), opportunities for collaboration, and potential duplicative efforts.

- **Forthcoming:** Encourage workgroups, task forces, and advisory boards working at the intersection of behavioral health and the criminal justice system to include among their members individuals with justice-system experience.

Objective 7b: Standardize Language and Policies

Agencies often use different language and terms to refer to similar things. This can create challenges for shared understanding and collaboration. To facilitate more effective communication across agencies, organizations, and jurisdictions, the BHPS-CoE will establish and routinely update a glossary with standardized definitions of behavioral health and public safety terms for broad dissemination with the aim of improving consistency and collaboration within and between agencies, drawing on federal terms and definitions. If there are discrepancies between terms and/or definitions, the BHPS-CoE will support focused deliberation across statewide organizations to identify common terms and definitions moving forward. A component of this shared language is the promotion of the use of common, culturally inclusive, person focused, affirming language (i.e., terms, concepts, definitions) for use by criminal justice and behavioral health/ healthcare providers to support more effective communication across programs and decrease harm caused by stigma.

Action Steps Centralized Communication

- **Immediate:** Develop and disseminate a glossary of terms with definitions (a working draft can be found here, developed by CITCE and MCRIC) for practitioners and the public.[133]
- **Immediate:** Promote the use of culturally inclusive, person focused language to decrease harm caused by stigma.
- **Immediate:** Promote focused deliberation across agencies to ensure use and acceptance of common terms and definitions.

Objective 7c: Facilitate the dissemination and adoption of best practices in behavioral health and criminal justice policies and programs

A focal point of the BHPS-CoE will be its information dissemination efforts that provide for easy access to timely information on local and national best practices, emergent programs and policies, and translation of scientific evidence for real-world consumption. Scientific evidence evaluating programs, practices, policy impacts related to behavioral health and criminal justice are appearing at a rapid pace, but the traditional venues to access this information are often hard to reach (i.e., paywalls) and are not easily and quickly consumable. The BHPS-CoE will function as a repository of new information on best practices and work to translate and distill the emergent evidence for widespread consumption by Maryland behavioral health and criminal justice system stakeholders. A common strategy employed by similarly-motivated centers of excellence is the use of a newsblog to share information. Oregon's center of excellence has received accolades for their podcast which shares information broadly.

In addition, it is clear that localities are developing innovative strategies to attend to unique features of jurisdictions or augmenting standard approaches (e.g., CIT training). The BHPS-CoE will work with local

[133] BHCoE Glossary of Terms. https://docs.google.com/document/d/14kckxYpT-MkuLFpsJI3mtJvUnOmJ9GnUh2rig8bje3U/edit

stakeholders to promote these actions, identify opportunities for evaluation, and work with jurisdictions to identify resources for scaling strategies. Maryland will work to harness this innovative energy and situate itself as a leader in advancing policy, practice, and research in serving individuals at the intersection of behavioral health and criminal justice crisis.

Action Steps Centralized Communication

- **Immediate:** Develop a website to function as a centralized location for information sharing and organizing and routinely updating evidence-based/informed approaches and best practices, such as:
  - Curriculum and outcomes of CIT training
  - Models and effectiveness of preventive services
  - Implementation and impact of peer recovery specialists/coaches
- **Immediate:** Develop a method for regular communication (e.g., newsletter, blog) of timely information on evidence-based/informed and promising practices across the State and nation.

Action Steps Technical Assistance and Training

- **Immediate:** Provide communication and dissemination assistance to promote innovative, evidence-based/informed practices occurring across Maryland.
- **Immediate:** Provide resources and technical assistance for evaluative opportunities.

Timelines

The information presented in the timelines parallels the content from the action steps identified in each priority, ordered by 1) activities that are currently in progress and are continuing (In Progress Action Steps), 2) activities to initiate during FY2023 that may continue in future years (Immediate Action Steps), and 3) activities for near future efforts (Forthcoming Action Steps). Each action step is linked to one of the three core roles of the BHPS-CoE:

 Technical Assistance and Training

 Centralized Communication

 Data, Research, and Evaluation

In Progress Action Steps

Priority 1: SIM	Assist with outreach and education about SIM at the local level to build understanding of its goals and process among stakeholders.	
	Identify and recruit SIM facilitators to assist with SIM mapping workshops in local jurisdictions to achieve local and regional coverage.	
	Ensure that BHPS-CoE staff have access to SIM training and refresher courses focused on best and promising practices on a regular basis and/or when needed (e.g., special issue/population training).	
	Provide technical assistance and facilitation of SIM for local and regional SIM mapping workshops.	
	Develop and maintain SIM learning community by organizing and hosting a bi-annual learning community to foster facilitator collaboration, continuing education, and skill development across the State.	
	Track and maintain data on SIM progress across jurisdictions including when a jurisdiction has been (re)mapped, gaps in service, and resources.	
Priority 2: CRT	Provide technical assistance for statewide training, networking opportunities, and the establishment of partnerships.	

Immediate Action Steps

Priority 1: SIM	Collaborate with LBHAs to identify jurisdiction-specific stakeholders.	
	Track, maintain, and publish a directory of agencies and individuals in attendance (names, titles, contact information) at SIM mapping sessions for continued collaboration.	
	Identify and disseminate information regarding diverse modes of workshop delivery for conducting SIM workshops (e.g., regional, sequential) to help meet the unique needs of jurisdictions (e.g., see OCBHI variety of SIM engagement platforms).	
Priority 2: CRT	Assist in identifying CIT core competencies to prioritize for statewide coverage.	
	Leverage established training frameworks developed by other behavioral health and public safety centers of excellence such as in Ohio and Oregon, and local jurisdictions (e.g., Anne Arundel County's integrated training sessions) to increase accessibility of CIT training for individuals across intercepts (e.g., regional training, split session training).	
	Identify and assist with applying for funding to support access to training (e.g., SAMHSA's Mental Health Awareness Training Grants) by providing examples of application materials, and notifying localities of forthcoming and open opportunities.	
	Provide funding opportunities to allow for access to training opportunities including, but not limited to, supporting travel costs and staffing needs as necessary to expand CIT trained officer coverage across jurisdictions and time of day.	
	Assess evidence on emergent practices such as technology assisted (e.g., virtual mental health co-responder) crisis response models to increase the availability of specialized mental health responses 24/7 throughout the State.	
	When evidence-based programs are identified, work with Maryland jurisdictions to identify opportunities for a standardized core curriculum to be adopted across the State to ease communication, the sharing of resources, and evaluation efforts. Jurisdictions would include additional program modules to attend to their unique challenges.	
	Within each jurisdiction, assess the current state of mental health and CIT training across public safety agencies and identify opportunities to increase the prevalence of CIT trained individuals across intercepts (from dispatch to supervision).	
	Assess and track resource needs in agencies across the State to use to inform and identify potential multi-jurisdictional CIT programs to meet the needs of rural and/or geographically isolated areas in the State (e.g., joint training sessions, hybrid training).	
	Convene a task force to grapple with the challenges that smaller jurisdictions face in offering CIT training, learn from other jurisdictions (locally and nationally) who are adopting innovative strategies to train more of their agents, and to identify opportunities to offer training for any jurisdiction that opts to adopt CIT.	
	Disseminate innovative models for supporting follow-up CIT programs (e.g., CIT units, mobile units, peer support services).	
Priority 2: CRT	Leverage available resources (e.g., PMHC data collection to measure success) to identify and adapt key measures that should be collected by all jurisdictions implementing mental health	

Priority 2: CRT	training, CIT, and companion courses to track program development (e.g., trained staff, coverage) and outcomes (e.g., cultural competency, diversion, arrest, use of force).	
	Assist with the collection and coordination of data for implementation and outcomes analysis and evaluation.	
	Provide technical assistance for peer and third-party evaluations to assist in assessing outcomes of CIT training and program development over time.	
	Work with local jurisdictions to conduct a comprehensive review of current policies and procedures for when police encounter people who have behavioral health needs to develop a full understanding how people flow through the system (e.g., dispatch and disposition outcomes), current agency collaborations, and transfer practices. a. Jurisdictions that have completed the SIM process will already have this review completed. Evidence from area experts note that CIT training is a good opportunity to introduce and expand officer knowledge of local resources for individuals in crisis.	
	Use the comprehensive review to identify an appropriate PMHC response that takes into account jurisdictional needs and resources, including, but not limited to, CIT.	
	Encourage collaboration and communication by providing sample policies or Memorandum of Understandings (MOUs) around mental health crisis response and CIT, such as, assisting with the development of policies to guide the transfer and handling (e.g., restraint procedures, language for de-escalation) of individuals between agencies such as emergency rooms, crisis centers, clinics, and law enforcement agencies; and the linking of individuals to peer support services.	
	Maintain a roster of active CIT officers by jurisdiction for use in recruitment and collaboration efforts.	
	Develop and maintain a CIT coordinator email list.	
	Organize and facilitate monthly virtual meetings of the CIT coordinator community to support neighboring communities and encourage a learning community environment across Maryland.	
	Support the continuation of the Maryland CIT Conference to share best practice ideas, recent developments, and innovative ideas in Maryland and across the nation.	
	Work with local jurisdictions to conduct a comprehensive review of current policies and procedures for 9-8-8 dispatch to ensure that behavioral health crisis calls are responded to by CIT trained individuals and/or transferred to a warm line. Where needed, assist jurisdictions in developing the infrastructure identifying procedures for transferring and dispatching crisis calls.	
	Develop and maintain an interactive map of available crisis services within and across jurisdictions with evidence-based designations (e.g., under evaluation, promising, evidence-based) such as mental health receiving centers, crisis respite centers, recovery resource centers, and 24-hour crisis stabilization.	
	Maintain an active presence in the national CIT network to stay abreast of evidence-informed and evidence-based practices, maintain connections with regional groups, and liaise with advocacy organizations such as NAMI regarding CIT efforts.	

Priority 2: CRT	Evaluate the capacity to create a position that is a liaison between the BHPS-CoE and the Justice Reinvestment Act to bridge the communication gap between the two entities at the GOCPYVS and identify collaborative supports to enhance diversion opportunities for those with behavioral health needs.	
Priority 3: Continuum of Care	Provide technical support to promote collaboration in healthcare related initiative planning and development.	
	Aid local jurisdictions in connecting LBHA's and criminal justice system healthcare providers (e.g., jail and prison medical personnel) to foster a community of shared responsibility for correctional and community health.	
	Survey localities to understand the current implementation of and barriers to implementing Medicaid suspension to enable a quicker and more efficient re-connection of healthcare services for those exiting carceral settings.	
	Encourage more efficient and effective case management through use of a standardized records management system that can be accessed by service providers across systems and jurisdictions (e.g., Eastern Shore Information Center).	
	Develop and maintain a comprehensive online resource locator for behavioral health disorders to increase awareness of and access to resources before, during, and after incarceration. Locating resources for individuals with histories of involvement in the criminal legal system can be particularly challenging.	
	Collaborate with DPSCS and MDH to identify challenges to providing and expanding access to SMI and SUD treatment (e.g., medication assisted treatment (MAT), medication for opioid use disorder (MOUD)) and IDD services in correctional facilities and detention centers and to identify recommendations for moving forward.	
	Encourage use of alternative options for accessing healthcare such as telehealth, mobile clinics, health apps, etc.	
	Assess the expansion potential of accountable care organizations (ACOs) to include correctional health.	
	Improve interaction/coordination of local ED and law enforcement by assisting with the development of protocols for law enforcement based in EDs and transporting people in crisis to EDs.	
	Work with local health departments to facilitate first responder education (e.g., increase awareness of diversionary options, naloxone administration, current laws and policies, current drug trends).	
	Ensure that the CIT Coordinators' meeting includes development of a standardized protocol as a goal.	
	Assess the capacity for resuming and expanding the Eastern Shore Information Center (ESIC) or a similar client-centered database for serving as regional or statewide information centers to promote a more efficient and effective client referral and client transfer process (e.g., data on demographics, identification of needs).	

Priority 3: Continuum of Care	Partner with existing agencies/programs such as fatality reviews, MDH's Rapid Analysis of Drugs (RAD), and Maryland Emergency Department Drug Surveillance (MD-EDDS) system to identify areas in need of early prevention.	
	Create reentry checklists that will be available in a centralized location for those reentering society (a one-stop shop) leveraging and promoting existing resources for housing, health, employment, etc.	
	Encourage caseworkers to draft a plan in collaboration with currently incarcerated person at least two months prior to release.	
	Build in access to ID cards prior to release for ease of access to social services that promote continuity of health care delivery.	
	Promote utilization of SIM Mapping workshops to identify opportunities in which peer recovery specialists can be integrated into local crisis response systems. For example, PRA provides this model.	
	Facilitate local access to peer certification training by building awareness of training opportunities through links on the CoE website and potential regional training workshops to expand statewide coverage. a. Connect with On Our Own of Maryland, Inc (OOOMD) to assess training options to achieve statewide coverage.	
	Convene regional and statewide virtual learning collaboratives for certified peer recovery specialists to share best practices, seek support, and strategize about local challenges.	
	Coordinate communication and dissemination efforts with the CIT Coordinators (e.g., include updates in the CIT Coordinators' meetings).	
	Conduct and maintain review of scientific literature on the implementation and impact of peer recovery specialists.	
	Identify and disseminate information on nationally recognized, evidence-based, training curriculums for peer recovery specialists such as WRAP and CCAR.	
	Identify certification/skill needs for practitioners working with behavioral health populations.	
	Identify opportunities to support access to certifications (e.g., financial assistance, release time).	
	Identify opportunities for planning workshops to meet specific needs (e.g., cultural competency, engaging with youth in transition, developmental disabilities, trauma-informed care, reentry support) such as the Trauma Involved Care and Community Resilience Initiative. (Planning and hosting/sponsoring workshops would happen in forthcoming years).	
	Contribute to the behavioral health workforce needs assessment conducted by the Maryland Health Care Commission.	
	Work with academic institutions including the University of Maryland System, HBCUs, and local community colleges to identify current programming with appropriate training and recruitment options.	

Priority 3: Continuum of Care	Assist with the implementation (year 1) and analysis (years 2+) of behavioral health workforce exit interviews to monitor and evaluate retention challenges. (Implementation in Year 1; analysis and reporting in years 2-3.)	
Priority 4: Screeners	Follow up on 2018 report to assess whether BJMHS has been adopted across Maryland jails and prisons.	
	Promote compliance with Senate Bill 846 which requires opioid use disorder screening and treatment in all correctional facilities.	
	Encourage correctional facilities to incorporate a question in screeners about veteran status.	
	Field questions related to screeners (e.g., how to interpret scores).	
	Provide a "best practices" toolkit to all Maryland organizations screening for behavioral health.	
Priority 5: Data Collection & Management	Convene a task force composed of local practitioners and data scientists/researchers to identify key measures/metrics to be captured by agencies and organizations at each intercept point. The task force should consider reviewing SAMHSA's *Data Collection Across the Sequential Intercept Model* report and other resources such as *Justice Counts Metrics*[134].	
	Inventory data stored in major data systems (police, fire/EMS, jails, courts, homeless services, healthcare providers/ hospitals) to develop a better understanding of what information is currently collected and how it could be used to track individuals and the services they receive.	
	Set clear parameters for how data will be protected and used; what people, policies, and procedures will manage that data and prioritize client confidentiality.	
	Provide access to Results-Based Accountability (RBA) training for identified data personnel.	
	Identify and disseminate information on what platforms/systems will be utilized for data collection.	
	Develop and enter into data-sharing agreements with local agencies in each jurisdiction to formalize established protocols.	
Priority 6: Data Driven Decision Making	Recruit research collaborators from the University System of Maryland, Maryland Historically Black Colleges and Universities, and other local research agencies.	
	Develop systematic reviews of the evidence-base and maintain an inventory of promising and evidence-based practices.	
	Assess currently available data management systems to provide recommendations and options for Maryland agencies and programs.	
	Host a learning community to learn from other state-level data hubs (e.g., Minnesota's Minn-LInK) or area specific consultants (e.g., Criminal Justice Coordinating Center of Excellence -	

[134] Justice Counts Metrics. (n.d.). Justice Counts. Retrieved March 15, 2023, from https://justicecounts.csgjusticecenter.org/metrics/justice-counts-metrics/

Priority 6: Data Driven Decision Making	Ohio) on topics such as information sharing, record linking, confidentiality, HIPAA protections, MOUs, data output, etc.	
	Collaborate with BHA's Administrative Services Organization (Optum) to assess current adoption of the Maryland DataLink initiative and promote enrollment of non-participating counties.	
	Facilitate collaboration between BHPS-CoE Data Analyst/Team and Maryland Statistical Analysis Center (MSAC) to ensure proper protection and management of data.	
	Develop and implement strategy for producing regular reports (e.g., template, timeline, performance indicators, etc.) for publication in advance of legislative sessions in order to promote meaningful translation.	
	Upon completion, publish data reports on the BHPS-CoE website for public access.	
Priority 7: Communication & Dissemination	Create opportunities for communication and information sharing by facilitating meetings with stakeholders (e.g., lunch and learn sessions, quarterly stakeholder meetings). The frequency of these meetings should be established in conversation with constituencies and what would best meet the group's needs.	
	Survey stakeholders to inquire about preferred communication platforms (e.g., listserv, group messaging, virtual community, virtual meeting).	
	Establish an online community/forum/website to facilitate ongoing/continuous communication to share challenges, opportunities, and strategies across Maryland jurisdictions as part of regular operating procedures.	
	Develop and disseminate a glossary of terms with definitions (a working draft can be found here, developed by CITCE and MCRIC) for practitioners and the public.	
	Promote the use of culturally inclusive, person focused language to decrease harm caused by stigma.	
	Promote focused deliberation across agencies to ensure use and acceptance of common terms and definitions.	
	Develop a website to function as a centralized location for information sharing and organizing and routinely updating evidence-based/informed approaches and best practices, such as: ◆ Curriculum and outcomes of CIT training ◆ Models and effectiveness of preventive services ◆ Implementation and impact of peer recovery specialists/coaches	
	Develop a method for regular communication (e.g., newsletter, blog) of timely information on evidence-based/informed and promising practices across the State and nation.	
	Provide communication and dissemination assistance to promote innovative, evidence-based/informed practices occurring across Maryland.	
	Provide resources and technical assistance for evaluative opportunities.	

Forthcoming Action Steps

Priority 1: SIM	Provide a toolkit with examples of successful systems integration, promising programs, and emergent collaboration from across Maryland and around the United States.	
	Follow-up with SIM jurisdictions approximately every six months to provide a continuous source for technical assistance as jurisdictions work to address identified gaps in services.	
	Provide technical assistance to facilitate and support local and regional SIM re-mapping workshops. PRA recommends that remapping occur every two years.	
	Use the data to: ➔ Develop a statewide database on mapping program progress, gaps, and priorities; ➔ Conduct a resource assessment for cross-jurisdictional collaborative opportunities; and ➔ Monitor progress in responding to gaps in services.	
	Leverage local level and statewide SIM Action Plan data to identify potential cross-jurisdictional and/or regional supports to address gaps in services and optimize the use of local and/or underutilized resources.	
	Disseminate state-level progress, gaps, strengths, opportunities, and examples of SIM efforts on a BHPS-CoE webpage.	
Priority 2: CRT	Assist local jurisdictions in identifying modules that meet local-level needs and emergent issues, in part, by utilizing information gleaned from SIM mapping events.	
	Identify and disseminate information on emergent training programs such as the: ● Bureau of Justice Administration's Crisis Response and Intervention Training (CRIT), an extension of CIT that incorporates responses to individuals with IDD and information on an array of crisis response models including, but not limited to CIT; ● Complementary training programs [such as ICAT, PAARI, racial disparities]	
	Encourage and assist with the development of companion, specialized and advanced training opportunities to meet the specific needs of jurisdictions and populations (e.g., youth, developmental disabilities, cultural competency).	
	Identify and provide technical assistance for access to refresher training and elective modules for CIT certified officers and staff.	
	Identify and disseminate information on emergent CIT opportunities such as CIT+ Advanced Training.	
	When infrastructure is established, promote the use of the 9-8-8 call system for individuals experiencing crisis.	
	Maintain an active repository that identifies best practices for non-justice response alternatives such as 1) co-responder and crisis responder team (e.g., CAHOOTS) interventions that utilize law enforcement strategically during crisis situations (e.g., imminent threat to safety) such as clinical or social worker first responder units, co-responder models that couple mental health professionals with certified peer specialists, and 2) Opioid Intervention Teams (OITs) already active in each Maryland jurisdiction. Importantly, the evidence-base on civilian-only responses to behavioral health crises is small and care should be taken when	

	considering the adoption of these strategies to maintain the safety of all individuals in the response interaction.	
Priority 3: Continuum of Care	Provide technical support to jurisdictions that have not implemented Medicaid suspension to achieve full implementation across the State.	
	Review successful programs in other states (e.g., My Health My Resources MHMR and Klaras Center for Families (KCF) programs in Texas) to assess utilization of these models to fill gaps in service provision and support continuity of care.	
	Support the integration of data systems and communication across agencies to enable "warm hand-offs" when a person is being transferred from one organization to another.	
	Convene workgroups, advisory groups, and task forces working on behavioral health issues and state-level health initiatives to identify opportunities for expanding access to healthcare and healthcare adjacent resources.	
	Promote awareness of community-based behavioral health treatment and other harm reduction and recovery services through local resource fairs, local health department events and presentations, social marketing campaigns, etc.	
	Promote the development of transitional care programs at both entry and exit from incarceration.	
	Improve communication by facilitating mixed agency appreciation events to recognize efforts aimed at improving diversion and seamless transfer of individuals experiencing a crisis.	
	Facilitate local implementation of evidence-based preventive services (e.g., FACT).	
	Support the adoption of a Maryland-wide phone number that returning citizens can use, which they are supplied with *before* release (not at release) to help connect them to services	
	Encourage local peer navigation programs to assist returning community members with connecting, understanding, and managing treatment.	
	Encourage jail personnel to make connections and expedited appointments with community treatment programs as early as possible before an individual is released.	
	Support provision of consistent peer hours at local EDs, recovery houses, and resource centers.	
	Ensure that links to peer recovery/support specialists are included in resource and recovery plans provided to justice-involved persons with behavioral health needs at the time of release from incarceration.	
	Convene a group to identify opportunities for working with local institutions of higher education to assess capacity for building a Peer Support Certificate program.	
	Identify and support mental and behavioral health supports for practitioners working in crisis fields (e.g., mindfulness-based stress reduction).	
	Plan and host/sponsor workshops that meet specific needs to recruit, retain, and equip behavioral health care specialists to meet community specific needs.	

Priority 3: Continuum of Care	Continue to partner with academic institutions to promote programming, training, and recruitment options.	
	Continue to partner with academic institutions to promote programming, training, and recruitment options.	
	Work with academic institutions to strategize ways to increase access to behavioral health and related programs such as offering credited internships, tuition reimbursement, and/or apprenticeship opportunities to attract and retain behavioral health practitioners.	
Priority 4: Screeners	Promote data collection as part of the training process for administering screeners.	
	Encourage the adoption of electronic data entry/management, including the potential adoption of tablets for easier and mobile data collection and management.	
	Offer materials and presentations on "best practices" in data collection.	
	Provide relevant evidence and information to criminal justice entities to assist with the adoption of the most appropriate and best-performance screener(s).	
	Where/when possible, encourage the use of tools that incorporate structured professional judgment at the assessment stage, which have been shown to be more reliable for detecting mental health problems among racial/ethnic minorities.	
	Encourage and assist with the adoption of multiple tools that allow for the screening of co-occurring disorders, such as IDDs and SUDs (e.g., TCU Drug Screen (TCUDS V)).	
	Assist police departments in producing a standard script to screen for behavioral health calls.	
	Explore initiatives already underway locally and consider for broader adoption across the State.	
	Support and inform the piloting of screening tools at the arrest stage.	
	Encourage a minimum of two screenings at correctional facilities, one at intake and one at release.	
	Develop protocols for appropriate timing and number of intervention points.	
	Investigate changes in screening results across repeated time points for those in jail or prison.	
	Encourage a (virtual) space in which 911 call dispatchers can share experiences, reflect, and develop support networks.	
	Promote hiring of culturally competent staff to administer screeners.	
	Seek out connections with local Veterans Affairs offices to promote hiring of veterans to administer screeners.	

Priority 4: Screeners	Encourage yearly training sessions for jail/prison personnel and 911 dispatchers.	
	Promote an incentivizing structure to encourage attendance at training sessions.	
	Assist with content to be used in training sessions, which can be provided on a case-by-case basis and made available on the center's website.	
	Provide presentations on the use of screeners for knowledge building.	
	Explore the potential utility of technology (e.g., tablets) for self-reporting of symptoms.	
Priority 5: Data Collection & Management	Investigate the utility of screening tools for data collection purposes (e.g., screeners used at jail booking can provide information for service delivery and for understanding the population of jail inmates with specific behavioral health needs).	
	Develop and maintain a system for ongoing, real time data collection and submission.	
	Provide technical support to aid in the transition from paper forms to electronic data systems where needed.	
Priority 6: Data Driven Decision Making	Identify research questions and analyses to be conducted.	
	Facilitate access to data (e.g., data sharing agreements, IRB approval).	
	Link administrative data across multiple agencies to monitor service provision and support clients across programs and systems.	
	Standardize a "data request"/ "project proposal" process for jurisdictions to request analysis and/or partnering agencies to propose research questions.	
	Design and publish public-facing data dashboards to provide stakeholders and community members with frequently updated information on behavioral health and public safety indicators and initiatives and links to existing dashboards like the Maryland Overdose Data dashboards.	
Priority 7: Communication & Dissemination	Encourage workgroups, task forces, and advisory boards working at the intersection of behavioral health and the criminal justice system to include among their members individuals with justice-system experience.	
	Convene meeting of similarly-motivated workgroups, task forces, and advisory boards to identify actions/efforts and coverage (i.e., people and places), opportunities for collaboration, and potential duplicative efforts.	

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