MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

January 16, 2019

The Honorable Nancy J. King
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chair
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

Re: Joint Chairmen's Report, p. 84—Report on Statewide Review of Behavioral Health Workforce and Capacity

Dear Chairs King and McIntosh:

Pursuant to the Joint Chairmen's Report, p. 84, the Maryland Department of Health respectfully submits the attached report analyzing the behavioral health workforce and infrastructure to determine the strengths and weaknesses of the State's Public Behavioral Health System.

If you have any questions regarding this report, please contact Deputy Chief of Staff Webster Ye at (410) 767–6480 or webster.ye@maryland.gov.

Sincerely,

Robert R. Neall
Secretary

Enclosure

cc: Sarah Albert, Department of Legislative Services

Report on Statewide Review of Behavioral Health Workforce and Capacity

Submitted by the Maryland Department of Health
January 16, 2019

2018 Joint Chairmen's Report (p. 84)

Table of Contents

I. Executive Summary

This report responds to the request from the Senate Budget and Taxation Committee and House Appropriations Committee Chairmen for the Maryland Department of Health (MDH) to conduct a statewide review of the behavioral health workforce and infrastructure to determine the strengths and weaknesses of the State's Public Behavioral Health System (PBHS). The Behavioral Health Administration (BHA) reviewed the behavioral health plans of the local jurisdictions, other needs assessment reports and the PBHS and used data obtained from various sources including, BHA's information management systems and claims data from Beacon Health Options (PBHS Payer), to identify strengths and weaknesses impacting the behavioral health workforce and infrastructure.

The report provides data and an overview of (A) the number of behavioral health services by jurisdiction; (B) the occupancy rate of residential-based treatment; (C) the number of licensed mental health (MH) and substance use disorders (SUD) providers; and (D) the number of certified and non-certified peer recovery specialists (CPRS and PRS).

The report concludes that while tremendous efforts have been made both at the State and local levels to increase access to and improve services for individuals and families affected by MH, SUD and co-occurring conditions, gaps still remain in acute care services, outpatient and residential treatment services as well as other support and community-based services. An analysis of the PBHS over the past three years indicates that there are unmet needs in all of these areas. A shortage of behavioral health workforce and transportation are two of the major barriers to access to behavioral health services.

The analysis of the PBHS reveals that Maryland has made remarkable progress towards addressing the shortage of behavioral health workforce through efforts such as supported employment, accelerated licensure processes for providers, expansion of the CPRS and PRS workforce, provision of training, and promotion of professional development opportunities which are further discussed in sections V and VI of this report. However, there continues to be a shortage of psychiatrists, addictionologists, and behavioral health nurse specialists (especially in remote areas of the State) which is exacerbated by the current opioid crisis.

This report discusses weaknesses in the PBHS infrastructure related to behavioral health workforce and transportation and offers recommendations to address these issues. These include:

- increasing the availability of telepsychiatry and videoconferencing which allows access to consultation and education in remote parts of the State;
- linking consumers with local resources such as volunteers and community organizations that could provide transportation to and from behavioral health treatment services; and,
- integrating MH and SUD provider services.

Service Category	Outpatient Providers			Acute Care			Residential Treatment			Support Services			Jurisdition Total		
Years	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017
Allegany	62	71	61	1	1	1	1	2	3	9	10	10	73	84	75
Anne Arundel	224	244	239	1	1	1	1	1	5	22	31	34	248	277	279
Baltimore City	542	553	606	9	11	9	3	3	13	96	117	137	650	684	765
Baltimore County	577	580	589	3	3	3	2	2	2	35	46	56	617	631	650
Calvert	49	54	49	1	1	1	0	0	1	4	4	4	54	59	55
Caroline	5	5	7	0	0	0	0	0	0	0	0	2	5	5	9
Carroll	89	93	91	1	1	1	0	0	1	8	9	8	98	103	101
Cecil	39	44	62	1	1	1	0	0	2	9	13	14	49	58	79
Charles	37	45	50	0	0	0	0	0	1	9	12	10	46	57	61
Dorchester	25	18	19	2	2	2	0	0	0	3	3	2	30	23	23
Frederick	96	103	107	1	1	1	2	2	3	9	13	16	108	119	127
Garrett	14	19	17	0	0	0	0	0	0	3	3	3	17	22	20
Harford	94	112	126	2	2	2	0	0	0	8	12	16	104	126	144
Howard	159	163	161	3	3	3	0	0	0	7	9	13	169	175	177
Kent	11	12	14	0	0	0	0	0	1	1	2	2	12	14	17
Montgomery	400	412	440	5	6	5	0	0	2	13	17	21	418	435	468
Prince George's	282	289	312	3	3	3	1	1	1	34	42	51	320	335	367
Queen Anne's	14	13	16	0	0	0	0	0	0	1	4	3	15	17	19
Somerset	7	10	11	0	0	0	0	0	0	3	3	2	10	13	13
St. Mary's	32	31	41	1	1	1	0	0	1	7	8	8	40	40	51
Talbot	35	41	43	1	1	0	0	0	0	2	3	4	38	45	47
Washington	81	80	75	2	2	2	0	0	0	8	10	9	91	92	86
Wicomico	51	67	66	1	1	1	1	1	2	1	14	17	54	83	86
Worcester	22	29	27	0	0	0	0	0	0	4	3	2	26	32	29
Statewide Total	2,947	3,088	3,229	36	39	35	11	12	38	296	388	444	3,290	3,527	3,746

II. Data on the Availability of Behavioral Health Services

A. Services by Jurisdiction

Table 1 displays the number of behavioral health service provider entities by type of service and their distribution across Maryland jurisdictions between CY15 and CY17. Service providers were grouped into four service categories: outpatient treatment, acute care, residential treatment, and support services.

Table 1: Behavioral Health Service Provider Capacity by Provider Type, FY15 to FY17
Source: Based on public funded behavioral health claims data paid through May 31, 2018.
Note: Counts are based on calendar year and reflect all service provider locations that have submitted claims for services rendered for each year.

Between CY15 and CY17, the total number of public behavioral health service provider entities providing services increased from 3,290 to 3,746[1] statewide, representing an increase in 456 providers. The vast majority of this increase is accounted for by expansion of outpatient behavioral

[1]The total provider counts exclude counts for crisis providers to avoid duplication, since this service is often provided by the same service providers that are counted under support services.

health treatment (62%, 282/456) and support service provider capacity (32%, 148/456). As shown in Table 1, nearly all (22 out of 24) jurisdictions increased provider capacity over this time period. The largest increases occurred in Baltimore City, Montgomery, Prince George's, Harford, and Cecil Counties (See Table 1).

In CY17, outpatient behavioral health treatment providers, including, individual clinical practitioners, outpatient MH clinics, federally qualified health centers, Level I SUD outpatient, opioid treatment programs and mobile treatment services, accounted for the vast majority (86.2%) of the service providers statewide. The largest concentration of outpatient treatment providers is located in the Baltimore-Washington metropolitan areas, including: Baltimore City, Baltimore, Anne Arundel, Prince George's, and Montgomery Counties. Between CY15 and CY17, the number of outpatient treatment providers increased from 2,947 to 3,229, representing a 9.5% increase or 282 additional outpatient behavioral health treatment provider entities statewide.

In CY17, a total of 35 hospitals provided psychiatric acute care services statewide. More than one-third (43%, N=9) of these facilities were located in Baltimore City, Baltimore and Howard Counties (See Table 1). The number of facilities remained relatively unchanged between CY15 and CY17.

As shown in Table 1, behavioral health residential treatment services, including MH residential treatment, SUD adult residential treatment, and SUD adolescent residential treatment are available in 14 of the 24 jurisdictions as of CY17. However, the number of providers increased from 11 in 2015 to 38 in 2017. This increase is accounted for, in part, by the transition of adult SUD residential treatment providers to fee-for-service billing through Beacon Health Options in CY17. Residential treatment providers are not evenly distributed throughout the State. Ten jurisdictions (Caroline, Dorchester, Garrett, Harford, Howard, Queen Anne's, Somerset, Talbot, Washington, and Worcester Counties) currently have no residential treatment capacity within their geographic borders. However, many residents of these counties do receive services from providers within their regions. A breakdown of residential treatment capacity by Maryland geographic regions (*i.e.*, central metropolitan, north central, northeast, southern, and western) revealed that all "regions" had at least one residential treatment facility. As of CY17, more than one-half (60%) of this capacity is in the Baltimore-Washington central metropolitan area.

Behavioral health support services include a number of services designed to facilitate access to treatment, promote recovery, and enhance treatment outcomes of individuals with behavioral health disorders. These services include, but are not limited to, psychiatric rehabilitation, residential rehabilitation, supported employment, case management, Care Coordination, SSI/SSDI Outreach Access and Recovery (SOAR),[2] Maryland RecoveryNet (MDRN), recovery residences, and other supportive housing.

[2] SOAR is a federal initiative that expedites and improves access to supplemental security income (SSI) and Social Security Disability insurance (SSDI) for individuals experiencing homelessness or at risk of homelessness and diagnosed with a mental illness and/or co-occurring disorder. Maryland Department of Health, SSI/SSDI Outreach, Access and Recovery (SOAR) (Winter 2014), online at https://health.maryland.gov/mha/Documents/SOAR%20Newsletter%20Winter%202014.pdf.

In CY17, a total of 444 providers provided support services statewide. Five jurisdictions, including Baltimore City, Anne Arundel, Baltimore, Montgomery, and Prince George's Counties have the largest concentration of support service providers, accounting for two-thirds (67%) of the provider capacity in this area. Between CY15 and CY17, 17 of the 24 jurisdictions exhibited an increase in provider capacity in this area. As shown in Table 1, the number of providers offering these services increased from 296 to 444 statewide between CY15 and CY17, representing an increase of 148 providers.

MDRN develops partnerships with service providers statewide and facilitates access to clinical and recovery support services for individuals with SUD or co-occurring MH and SUD. All MDRN service recipients receive care coordination which provides access to a variety of services including, but not limited to, funding for halfway and/or recovery housing, transportation, employment services, vital records, peer recovery coaching and medical and dental services. All services are designed to assist recipients in remaining engaged in their recovery while promoting independence, self-sufficiency, and stability.

House Bill 1411, passed during the 2016 legislative session, required MDH to establish a credentialing entity to certify recovery residences by October 1, 2017. BHA serves as the credentialing entity. BHA requires providers to obtain a certificate of compliance in order to receive state funding and call themselves a "certified recovery residence." BHA has established the Maryland Certification of Recovery Residences (MCORR) division to develop and administer the certification and re-certification process for recovery residences. Currently, there are 252 certified recovery residences and 2,329 certified beds.

B. Occupancy Rate of Residential-Based Treatment

Residential treatment services are an essential component of the comprehensive behavioral health system of care in Maryland's PBHS. BHA funds a number of alternative residential treatments for adults, children, and youth who have been diagnosed with serious MH disorders and SUD.

RTCs for Children and Youth

Currently, there are five community residential treatment facilities within the state that provide treatment services to children and youth with serious emotional and behavioral challenges and there are two-state operated Regional Institutes for Children and Adolescents (RICA). These facilities are located in four jurisdictions: Baltimore City (3) and Baltimore (2), Frederick (1), and Montgomery (1) Counties. In FY18, the RTCs and RICAs had a combined bed capacity of 351. The majority (81%, 285) of this capacity is distributed across five community RTCs and the remaining beds (19%, 66) are shared by the two RICAs located in Baltimore and Montgomery Counties. More than two-thirds (71%, 250) of the RTC beds are located in Baltimore City or Baltimore County, with the remaining beds located in Frederick (15%, 53) and Montgomery (14%, 48) Counties. Since FY15, the number of children and youth served in the community-based RTCs decreased from 825 in FY15 to 691 in FY17, reflecting a 16% reduction in utilization, while the number of children and youth served in RICAs remained relatively unchanged during that period. Based on FY17 data, the average occupancy rate for the community-based RTCs was over 90%, while the occupancy rate for the two RICAs was slightly lower at 88%. Between FY15 and FY17,

the number of bed days used in community RTCs decreased by 20% from 119,689 to 96,232, while remaining relatively stable in the two state RICAs (21,630 to 21,599).

C. Licensed MH and SUD Providers

BHA continues implementation of a significant change in the method used to license behavioral health programs across Maryland. Effective April 1, 2018, most community-based organizations had to be accredited by an MDH-approved national accrediting body as a precondition for licensure. A report on this change was presented to the Legislature last year.

BHA has completed transitioning almost all providers from the previous licensing system based on Code of Maryland Regulations (COMAR) 10.21 and COMAR 10.47 to the new accreditation-based licensing system based on COMAR 10.63. Those that have not transitioned are awaiting a site visit from their chosen accrediting body. The accrediting bodies have informed BHA that they are backlogged on site visits because of the large number of agencies seeking accreditation as a result of the new requirement. To date, 1,259 service sites have received initial COMAR 10.63 licensure, and only 141 sites are awaiting licensure pending an on-site review by their selected accreditation body. Sites which operated under the old regulations have been able to continue operations under COMAR 10.21 or COMAR 10.47 while awaiting approval from an approved accrediting body. Once accreditation is achieved, new licenses are quickly issued to qualifying agencies.

The detailed statistics presented in the tables below reflect those organizations licensed under the COMAR 10.63 to date.

Table 2: Number of COMAR 10.63 Licensed Outpatient SUD Provider Sites by Program Type and Jurisdiction

Jurisdiction	DUI Education	0.5 Early Intervention	Integrated BH Treatment*	Outpatient Treatment			Assess/ Referral	Opioid Treatment Service	Withdrawal Management
				Level 1	Level 2.1	Level 2.5			
Allegany	4	1	0	5	7	2	0	2	1
Anne Arundel	21	10	1	35	27	10	0	6	10
Baltimore City	69	40	21	126	111	21	0	28	18
Baltimore Cnty	28	10	3	34	26	4	0	6	5
Calvert	2	6	5	12	9	2	0	1	0
Caroline	3	1	3	4	1	0	0	0	0
Carroll	7	5	0	7	6	0	0	2	1
Cecil	3	2	0	8	5	2	1	3	3
Charles	2	1	0	8	7	2	0	1	1
Dorchester	3	1	2	8	6	1	0	0	3
Frederick	5	5	1	12	11	1	1	1	2
Garrett	1	1	2	2	1	0	0	0	0
Harford	11	3	3	11	8	4	0	6	4
Howard	13	9	1	10	10	2	0	1	1
Kent	0	1	2	4	1	1	0	0	2
Montgomery	12	9	2	29	22	7	1	3	6
Prince George's	24	13	8	30	22	5	0	2	2
Queen Anne's	3	1	1	3	2	1	2	0	1
St. Mary's	3	2	0	12	10	2	0	1	2
Somerset	2	2	2	6	4	2	0	0	3
Talbot	3	1	3	8	1	0	1	1	0
Washington	5	3	2	14	10	0	0	2	1
Wicomico	5	3	2	14	9	4	0	3	5
Worcester	3	0	4	4	3	0	0	1	0
Grand Total	**232**	**130**	**68**	**406**	**319**	**73**	**6**	**70**	**71**

Data Source: BHA COMAR 10.63 License Tracker.

Note: This data only includes data on COMAR 10.63 licensed providers. Providers still operating under COMAR 10.21 or COMAR 10.47 are not included.

*Integrated behavioral health programs are listed both under substance use treatment and MH counts.

Table 3: Number of COMAR 10.63 Licensed Outpatient MH Provider Sites by Program Type and Jurisdiction

Jurisdiction	Integrated BH* (duplicate)	OMHC	Mobile Treatment	Partial Day Treatment	PRP** - Adult	Adult Group Homes	PRP - Minors	Residential Rehab	Supported Employment	Residential Crisis
Allegany	0	5	1	0	6	1	5	1	2	1
Anne Arundel	1	15	1	1	23	15	12	3	4	4
Baltimore City	21	71	13	2	131	12	99	8	11	1
Baltimore Cnty	3	40	5	1	77	17	63	7	7	2
Calvert	5	7	0	0	1	1	3	0	0	0
Caroline	3	6	0	0	3	0	3	2	2	0
Carroll	0	6	1	0	6	5	4	1	2	1
Cecil	0	8	1	1	6	2	6	1	3	0
Charles	0	7	1	0	6	0	5	2	0	1
Dorchester	2	6	1	0	5	2	5	3	3	0
Frederick	1	14	1	1	4	10	6	1	1	1
Garrett	2	2	0	0	1	1	0	1	1	1
Harford	3	10	0	0	16	3	15	2	3	0
Howard	1	8	0	0	9	15	6	2	2	1
Kent	2	5	0	0	3	3	3	1	1	0
Montgomery	2	24	1	1	14	24	7	5	9	5
Prince George's	8	36	1	1	57	30	43	4	4	2
Queen Anne's	1	5	0	0	3	2	4	1	1	0
St. Mary's	0	4	0	0	2	2	2	0	0	0
Somerset	2	6	0	0	3	0	5	1	0	0
Talbot	3	4	0	0	4	0	4	2	2	0
Washington	2	11	0	0	9	3	8	1	1	0
Wicomico	2	10	01	0	10	2	9	4	0	1
Worcester	4	3	0	0	6	0	5	1	0	0
GRAND TOTAL	**68**	**313**	**43**	**8**	**405**	**150**	**322**	**54**	**59**	**21**

Data Source: MDH BHA COMAR 10.63 License Tracker
Note: This data only includes data on COMAR 10.63 licensed providers. Providers still operating under COMAR 10.21 or COMAR 10.47 are not included.
*Integrated behavioral health programs are listed both under substance use treatment and MH counts.
**PRP stands for "psychiatric rehabilitation program."

D. Number of CPRS and Non-certified Peer Recovery Specialist (PRS)

The State of Maryland utilizes both PRS and CPRS within our PBHS. PRS support individuals who are in the process of initiating or maintaining their recovery from serious mental illness, substance use, or co-occurring disorders. A PRS is an individual who uses their lived experience to help others navigate pathways of recovery and overcome personal barriers which hinder the consumer's recovery. PRS are able to meet with individuals during any stage of their recovery and help the consumer work towards their recovery goals. Utilizing local treatment systems and community-based supports, a PRS will link individuals with the resources and tools needed to support their recovery.

The CPRS credential was developed in order to demonstrate that an individual had received formal training to facilitate support groups and work one-on-one with individuals engaging in a recovery process. Currently, there are 271 individuals credentialed as a PRS in Maryland(See Table 4). This demonstrates an increase of 40% for this workforce in FY18. BHA anticipates a continued

increase in this workforce in the coming years due to the investments made in system infrastructure and provider training that occurred during the current fiscal year. Additionally, House Bill 772/Senate Bill 765 (2018) required the Department to convene a workgroup and issue a report on issues related to reimbursement for CPRS. While some of the issues are due to how providers utilize CPRS, many of the recommendations of the workgroup focused on reimbursement through Medicaid. As the recommendations are evaluated and implemented, the need for and the number of individuals holding the CPRS credential would likely increase.[3]

Each local authority (local addiction authority, core service agency, and local behavioral health authority) is responsible for the management and oversight of individuals operating as PRS in their jurisdiction. Table 4 outlines the number of funded PRS positions in each jurisdiction across the State.

Table 4: Number of CPRS and PRS by County[4]

Jurisdiction	CPRS	PRS	TOTAL Peer Workforce
Allegany	2	9	11
Anne Arundel	8	12	20
Baltimore City	67	31	98
Baltimore County	11	12	23
Calvert	1	3	4
Caroline	1	1	2
Carroll	4	4	8
Cecil	1	6	7
Charles	0	6	6
Dorchester	0	3	3
Frederick	1	11	12
Garrett	1	3	4
Harford	2	6	8
Howard	0	7	7
Kent	0	8	8
Montgomery	3	4	7
Prince George's	0	7	7
Queen Anne's	0	1	1
St. Mary's	3	10	13
Somerset	1	4	5
Talbot	0	4	4
Washington	2	0	2
Wicomico	1	5	6
Worchester	2	3	5
Total	**111**	**160**	**271**

III. Treatment Capacity Gaps in Service and Disparity

[3] For more information, please see House Bill 772, Chapter 323 of the Acts of 2018, and Senate Bill 765, Chapter 324 of the Acts of 2018-Maryland Department of Health-Reimbursement for Services Provided by Certified Peer Recovery Specialists-Workgroup and Report.

[4] This table accounts for peer positions funded by BHA.

BHA and the local jurisdictions continue to identify gaps in the PBHS and review data to address any disparities within the system. In this regard and as part of the Maryland Opioid Rapid Response (M.O.R.R.) initiative funded by the SAMHSA's State Targeted Response (STR) grant, a statewide needs assessment was conducted last year to increase access and enhance services for individuals with an opioid use disorder through targeting high risk regions and populations and reducing gaps in services through the PBHS and the State.

Table 5: Behavioral Health Service Needs and Utilization

Jurisdiction	Total County Population	Average Medicaid Eligible	Est. Behavioral Health Population: 21.2% of Total Population	Number Receiving Behavioral Health Services	Rate per 1,000 people: Total Population in Need who Receive PBHS Services
Allegany	72,528	21,757	16,972	6,077	358.07
Anne Arundel	564,195	91,333	132,022	20,316	153.88
Baltimore City	621,849	260,682	145,513	70,185	482.33
Baltimore County	831,128	192,163	194,484	37,533	192.99
Calvert	90,535	14,206	21,185	3,577	168.84
Caroline	32,579	11,833	7,623	2,305	302.36
Carroll	167,628	23,330	39,225	5,728	146.03
Cecil	102,382	26,444	23,957	7,405	309.09
Charles	156,118	30,981	36,532	5,067	138.70
Dorchester	32,384	12,787	7,578	3,014	397.74
Frederick	245,322	39,358	57,405	8,230	143.37
Garrett	29,460	8,749	6,894	1,790	259.66
Harford	250,290	43,905	58,568	10,374	177.13
Howard	313,414	44,225	73,339	6,133	83.63
Kent	19,787	4,992	4,630	1,151	248.59
Montgomery	1,040,116	182,644	243,387	19,564	80.38
Prince George's	909,535	219,834	212,831	22,538	105.90
Queen Anne's	48,904	8,572	11,444	1,859	162.45
St. Mary's	111,413	22,603	26,071	2,055	78.82
Somerset	25,768	8,735	6,030	4,496	745.64
Talbot	37,512	8,289	8,778	1,772	201.87
Washington	149,585	43,377	35,003	10,740	306.83
Wicomico	102,370	33,767	23,955	7,217	301.28
Worchester	51,540	13,427	12,060	3,173	263.09
STATEWIDE	**6,006,342**	**1,367,993**	**1,406,949**	**262,299**	**186.63**

Sources: Maryland Vital Statistics Estimated Maryland Population, July 1, 2015; "Average Medicaid Eligible" was supplied by UMBC Hilltop Institute (data through May 31, 2018); and United States Census Bureau, American Community Survey, online at https://www.census.gov/quickfacts/fact/table/md,US/PST045217. Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015 and 2016, available online at, online at https://www.samhsa.gov/data/report/2015-2016-nsduh-state-specific-tables; and National Survey of Children's Health, 2003, online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3225084/.

It is estimated that nearly one in four (23.4%, 1,405,484) Maryland citizens experience MH or substance abuse challenges serious enough to require treatment. This estimate includes 22% (330,765) children and youth (birth to 18 years) and 23.9%, (1,076,184) adults (18 years and older) statewide. Behavioral health treatment need estimates for children/youth were derived from two national population surveys: the National Survey on Child Health, which provides the percent of

children (3 to 17 years) with any MH condition (18%), and the National Survey on Drug Use and Health (NSDUH), which provides the percent of youth (12 to 17 years) with a SUD without a co-occurring MH disorder (4%). Adult need estimates were based on the NSDUH survey estimates of adults with any mental illness without a co-occurring SUD (16.1%) and past year estimates of any SUD (7.8%). These estimates reflect the number of children/youth and adults with MH and SUD who may be in need of treatment based upon the above-mentioned national measures, but do not reflect the actual demand for services.

The "demand" for behavioral health treatment—the number of people seeking treatment—is likely far less than the estimated "need." Nationally, in 2014, the vast majority (~96%) of people classified as needing but not receiving treatment for an illicit drug or alcohol problem reported that they did not feel that they needed treatment.[5] Similarly, research has shown that between 55% and 74% of individuals with a diagnosed mental illness do not seek treatment.[6]

As shown above in Table 5, five jurisdictions account for two-thirds (66%, 928,237) of individuals in need of behavioral health services, including Baltimore City (145,513) and Baltimore (194,484), Prince George's (212,831), Montgomery (234,387), and Anne Arundel (132,022) Counties. These jurisdictions also have the highest number of Medicaid eligible individuals.

In FY17, a total of 262,299 individuals received behavioral health (MH or SUD) services through the PBHS. This translates to a statewide service rate of 186.6 individuals per 1,000 Maryland population in need of behavioral health services. Maryland's PBHS predominantly serves children and adults with MH disorders and SUD who are enrolled in Medicaid or who are uninsured. As shown in Table 6, those jurisdictions with the highest PBHS service rates generally have a higher proportion of Medicaid eligible individuals. While the behavioral health need estimates derived for this analysis were based on the overall population of Maryland, multiple national surveys have documented that Medicaid beneficiaries are more likely to have behavioral health conditions compared to the general and uninsured populations with estimates ranging from 27% to as high as 48%.[7] In 2017, the Medicaid eligible population in Maryland was 1,367,993.

As shown in Table 5, Baltimore City (70,185) and Baltimore (37,533), Prince George's (22,538) and Anne Arundel (20,316) Counties had the highest numbers of individuals receiving behavioral health services, accounting for slightly over one-half (57%) of all individuals served statewide.

The jurisdictions exhibit substantial variation in rates of behavioral health service use among those with behavioral health needs (see Table 5) with rates ranging from a low of 78.8 per 1,000

[5] United States Substance Abuse and Mental Health Services Administration, Results from the 2014 National Survey on Drug Use and Health: Detailed Tables (Sep. 10, 2015), online at http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.pdf (all Internet materials as last visited Aug. 6, 2018).

[6] Mojtabai, Olfson, Sampson, Jin, Druss, Wang, Wells, Pincus, & Kessler, Barriers to Mental Health Treatment: Results from the National Comorbidity Survey Replication (NCS-R), Psychological Medicine, 41(8), pp. 1751–1761 (2011).

[7] Henry J. Kaiser Family Foundation, Medicaid and the Uninsured: Role of Medicaid for People with Behavioral Health Conditions (Nov. 2012), online at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_bhc.pdf; Adelman, Mental Health and Substance Use Disorders among Medicaid Recipients: Prevalence Estimates from Two National Surveys, Administration Policy in Mental Health, Nov. 31 (2), pp. 111–129 (2003).

population in need of behavioral health services in St. Mary's County to a high of 745.6 per 1,000 in Somerset County. Four jurisdictions—Baltimore City (482.3) and Somerset (745.6), Dorchester (397.7), and Allegany (358.1) counties—exhibit the highest rates of service use among individuals in need while St. Mary's (78.8), Montgomery (80.4), Howard (83.6), and Prince George's (105.9) Counties have the lowest rates of service use.

IV. Analysis of Behavioral Health Workforce and Infrastructure

Federal projections indicate a 31% deficit of needed social workers and 25% deficit of needed psychiatrists in the United States. In 2018, Community Behavioral Health Association of Maryland conducted a salary survey report for Maryland's Community Behavioral Health Services. Twenty-five organizations responded to the survey, which represents a response rate of 53%. Participants responded to questions about the impact of the $15 minimum wage, staff turnover, and other personnel related topics. The study indicates a two-pronged workforce problem; an inability to recruit staff in rural areas, and an inability to retain staff in those areas of the state that do not have shortages. Notably, the study found that:

- Raising the minimum wage to $15/hour would have a significant impact on the cost of delivering behavioral health treatment, raising providers' cost by 16% on average;
- Average turnover has increased by 37% in the last two years;
- Workforce shortages limit capacity in rural areas of the state, while providers in high-density areas lack the resources to retain staff, with turnover of rehabilitation staff 50% higher and clinicians turning over at a rate nearly 2.5 times higher;
- Providers with $6 million or less in annual revenue reported an average of four management positions, while large providers reported an average of nine. As new analytical skills and changes are demanded of providers, small providers will face challenges finding the management band width to absorb and implement change effectively.

BHA's Office of Workforce Development and Training (Office) collaborates with federal, state, local, and community stakeholders. These collaborations lead to many opportunities to disseminate and promote core competencies for the behavioral health (BH) workforce including clinicians, primary care providers, somatic care providers, social workers, drug and alcohol counselors, prevention specialists, and PRS. Core competencies have been identified for each provider and the Office adheres to the training needs, recommendations, and exam requirements, as outlined by the various credentialing and licensing boards. The Office also works with the Maryland licensing boards to ensure that continuing education opportunities are ample, accessible, and meet the various criteria required for each level of certification and license. It provides guidance to various boards to assist in the expansion of trained and skilled professionals in the BH field.

The Office works to strengthen the capacity of the BH workforce, to deliver effective evidence-based strategies and to facilitate opportunities for the workforce to pursue new opportunities, including the development of partnerships and alliances. In addition, the Office partners with various higher education providers throughout Maryland by assisting advisory boards responsible for behavioral health curriculum development and in promoting professional development

opportunities. The Office provides information on available financial assistance opportunities such as internships, paid internships, loan forgiveness, loan repayment assistance programs, and scholarship programs which translates to an increased number of students entering the behavioral health field. The Office is committed to heightening the awareness, knowledge, skills and abilities of the BH workforce.

Within local jurisdictions, the Office continues efforts in collaboration and partnerships with Maryland's local health departments, local behavioral health authorities, core service agencies, and local addiction authorities in providing in-person training, web-based training, and continuing education opportunities for all behavioral health workforce. The Office also partners with rural communities and behavioral health providers to offer low cost customized in-person trainings. Additionally, BHA, the University of Maryland, Evidence-Based Practice Center and the University of Maryland Training Center develop and execute several annual BHA conferences and evidence-based trainings. The annual conferences attract upwards of 500 participants each and the evidence-based trainings attract an average of 30 per classroom style training event and up to 200 for symposium and forum style training events.

In a joint project with the SAMHSA Region III, the Office is improving employment pathways for social workers and peers as well as increasing field placements and internship opportunities. The Office is currently working with the University of Maryland School of Social Work, Coppin State University, Morgan State University, Frostburg, and other stakeholders to demonstrate the benefits of infusing current curriculum with SUD topics including Screening, Brief Intervention, and Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT). The Office provides leadership and support to the Universities with Master's in Social Work Programs in Maryland, provides technical assistance in training students in SBIRT and MAT, and endorses the benefits of working within the behavioral health field to students enrolled in bachelor and Master of Social Work programs.

The Office works in concert with the Central East Addiction Technology Transfer Center Network (ATTC). In response to the emerging shortages of qualified BH professionals, a national workforce data collection effort ensued. The findings, published in the 2012 Vital Signs National Workforce Study[8], conducted by the Network, found that more BH professionals will be needed in the next five years, that providers faced significant challenges with filling vacant positions due to the lack of a qualified candidate pool, and that the BH workforce needs to become more diversified to work in more integrated settings. In response to the findings and recommendations, the Office has partnered with the Central East ATTC on a number of initiatives including providing an increase of MAT, Motivational Interviewing, American Society of Addiction Medicine (ASAM) and Diagnostic and Statistical Manual of Mental Disorders (DSM-5) training opportunities as well as providing SBIRT and MAT Training-of-Trainer sessions and technical assistance post training. These training events continue to be provided statewide and have resulted in an increase of specialty trainers. Building a cadre of specialty trainers statewide will allow for programs put into place to sustain post-award by ensuring continuous training and technical assistance availability for BH professionals already practicing as well as the emerging workforce.

[8] Ryan, Murphy, and Krom, Vital Signs: Taking the Pulse of the Addiction Treatment Workforce, A National Report, Version 1, Kansas City, MO: Addiction Technology Transfer Center National Office in residence at the University of Missouri-Kansas City (2012).

V. Service Delivery Strengths and Weaknesses

A. Strengths

- **Supported Employment**: Supported Employment programs in Maryland provide job development, job coaching, and ongoing employment support services to individuals with serious mental illness for whom competitive employment has not occurred, has been interrupted, or has been intermittent. These individualized services are provided to enable eligible individuals to choose, obtain, maintain, or advance within independent competitive employment, within a community-integrated work environment, consistent with their interests, preferences and skills. There are 59 provider sites licensed under COMAR 10.63 to provide supported employment services. Of those 59 provider sites, 27 (46%) of these supported employment providers are delivering services at the evidence-based practice fidelity threshold and are receiving an enhanced rate for supported employment.

- **Assertive Community Treatment**: There are 43 provider sites licensed under COMAR 10.63 to provide mobile treatment services. Of those 43 provider sites, 23 (54%) offer services with fidelity or in accordance with empirically-supported standards and are approved as assertive community treatment providers therefore eligible for an enhanced rate. The goal is to increase the 54% penetration rate of evidence-based practice as research supports that the use of these practices leads to positive treatment outcomes and ultimately improved quality of life for individuals. BHA believes that evidence-based practices should be widely available to individuals seeking services.

- **Targeted MH Case Management**: There are currently 29 targeted case management providers. Targeted MH case management is available in all jurisdictions. Critical time intervention (CTI) is a time-limited evidence-based case management practice that mobilizes support for the most vulnerable individuals (individuals experiencing homelessness, individuals with a diagnosis of serious mental illness, SUD, or co-occurring) during periods of transition. Transitions include homelessness to permanent supportive housing, residential rehabilitation programs to permanent supportive housing, jail or prisons to permanent supportive housing, SUD residential services to permanent supportive housing, or nursing home to permanent supportive housing. Research supports that the use of these practices leads to positive outcomes and ultimately improved quality of life for individuals. BHA currently funds CTI in two jurisdictions under the auspices of a time-limited federal grant which ends in September 30, 2019. BHA is exploring mechanisms for sustainability of the grant-funded services and, as funding permits, widespread dissemination and replication of CTI statewide.

- **MAT**: MAT is an evidence-based practice that has been shown by research to be an effective approach to treating individuals with an opioid use disorder. To address the opioid epidemic, BHA has established MAT programs across the state. MAT expansion efforts have been strengthened by the award of three SAMHSA grants: Medication Assisted Treatment Prescription Drug Opioid Addiction (MAT PDOA), Maryland Medication Assisted Treatment Recovery Services (MD MATRS), and STR M.O.R.R.

These grants were designed to increase access to and enhance services for individuals with an opioid use disorder by addressing unmet treatment need and enhancing prevention efforts, increase the use of MAT among opioid overdose survivors, increase adherence to MAT treatment, decrease illicit drug use by those receiving MAT, increase the length of stay in MAT, and reduce the number of patients leaving MAT against medical advice. As a result, MAT services are available in every jurisdiction in the state.

Despite its statewide availability, this service is underutilized due in part to stigma surrounding the use of pharmacological interventions to individuals who abuse or misuse substances. BHA will continue to work to eradicate the stigma surrounding MAT and exposing those who are in need to this life-saving, life restoring intervention. BHA was recently awarded two federal grants, the MAT PDOA Pregnant Women and Women with Children grant, and the Maryland State Opioid Response (MD-SOR) grant, both of which took effect on September 30, 2018. Both grants will enhance and expand access to MAT Services, the former for Pregnant Women and Women with Children with an opioid use disorder, and the latter by increasing access to MAT using the three Federal Drug Administration approved medications for the treatment of opioid use disorder. In addition, the SOR grant will address the opioid crisis by fulfilling unmet treatment needs and reducing opioid overdose related deaths through the provisions of prevention, treatment and recovery activities for opioid use disorder (including prescription opioids, heroin and illicit fentanyl and fentanyl analogs).

- **Peer Recovery Specialist Services**: During FY18, BHA worked to expand the peer recovery specialist workforce and its supporting infrastructure. First, BHA integrated the oversight of both adult MH and substance use peer recovery support services.

  Second, BHA expanded funding to support peer recovery specialist positions, training and education programs, and leadership and networking conferences. As a result of this additional funding, the peer workforce increased 40% during FY18. Due to the increase in the peer workforce, other state agencies, such as the Maryland Department of Human Services, Maryland Department of Public Safety and Correctional Services, and Maryland Department of Labor, Licensing and Regulation, are better able to serve individuals with behavioral health needs through their increased use of peer specialists.

  Third, in partnership with Maryland Medicaid and stakeholders, BHA developed recommendations for the reimbursement of services provided CPRS under the Maryland Medicaid program in response to House Bill 772, Chapter 323 of the Acts of 2018, and Senate Bill 763, Chapter 324 of the Acts of 2018.

BHA is working closely with local jurisdictions and other stakeholders in addressing service system delivery gaps. One of the major initiatives underway is the development of a plan to integrate behavioral health systems management at the state and jurisdictional levels. The goal is to build an integrated PBHS with an infrastructure that delivers person-centered services, available as needed 24/7 through "no wrong door." This involves ensuring that approaches are high quality, linguistically and culturally appropriate, coordinated within and beyond behavioral health including somatic care and community services, and effective in improving health for individuals

and families. All of this is more feasible when system management oversight is integrated, not fragmented.

B. Weaknesses

With regard to behavioral health workforce, throughout the State of Maryland there continues to be a shortage of MH and SUD professionals, particularly, psychiatrists, addictionologists, and behavioral health nurse specialists. This is not only a concern in small, rural, and remote areas of local jurisdictions but also in the larger counties and metropolitan areas. The current opioid crisis has put additional pressure on the PBHS capabilities and the capacity of behavioral health workforce to meet the needs of Maryland's communities. Several strategies such as telemedicine, workforce development as part of the M.O.R.R. program, and the use of CPRS and PRS within our PBHS have been proposed and initiated to build the capacity of the behavioral health workforce.

In addition to the behavioral health workforce shortage, other areas affected by health professional shortage are primary care and dental care, which is vital to addressing the healthcare needs of individuals with MH and SUD. The Health Resources and Services Administration provides grant funding to the Maryland Primary Care Office (PCO) as well as the other PCOs throughout the nation to improve access to healthcare by identifying areas or populations that can be approved as a shortage designation. A shortage designation can be a health professional shortage area (HPSA) or a medically underserved area or population (MUA/P). A HPSA can be designated as having a shortage of primary medical care, dental or MH physicians. A HPSA can be for the residential population of an area identified, a population group (low income, Medicaid, homeless), or a type of facility (prison, federally qualified health center, etc.). Once a HPSA has been established, communities can use workforce programs and other state and federal resources to recruit providers into the underserved area. Areas with a geographical HPSA are also eligible for Centers for Medicare and Medicaid Services Physician bonuses. The MUA/P shortage designation ranks primary care provider, infant mortality rate, poverty and elderly population data through a federal methodology for eligibility. Areas designated as a MUA/P are eligible to apply to the U.S. Health Resources and Services Administration for approval of federal health centers, *i.e.*, federally qualified health centers, look-alikes, or rural health centers.

Transportation is another major challenge affecting the PBHS infrastructure. Several rural jurisdictions, especially those in the eastern and western regions of Maryland, report transportation barriers for individuals trying to obtain behavioral health treatment. Individuals who receive PBHS services in rural areas are geographically dispersed and have fewer transportation options which limits their access to treatment. Strategies such as the provision of transportation through peer recovery support services, care coordination, case management, use of public and Medicaid transportation, and mobile crisis services have been utilized to address the unmet needs of individuals. Through the M.O.R.R., MD-SOR grant, and the Substance Abuse Treatment Outcome Partnership (STOP) grant, BHA has been able to provide state and federal resources to assist with filling some of the transportation gaps. BHA will continue to work together with the local behavioral health authorities to build the capacity of the BH workforce and the capabilities of the PBHS.

VI. Recommendations

A review of local behavioral health plans identified gaps in current capabilities and capacity of the behavioral health workforce of the local PBHS. These include:

1. hiring and retention of psychiatrists, especially in rural areas, which affect MAT services;
2. hiring and retention of nurses throughout the system;
3. lack of providers trained in co-occurring disorders, licensed social workers, counselors, SUD providers, and culturally and linguistically competent providers and interpreters; and
4. high turnover of the behavioral health workforce related to burnout and non-competitive salaries offered by the PBHS.

BHA has been working with the local behavioral health entities (core service agencies, local addiction authorities, and local behavioral health authorities) to build and strengthen the capacity of the behavioral health workforce through workforce development, provider trainings, and the use of CPRS and PRS.

Maryland has also implemented telemedicine to enhance access to care particularly in rural and remote areas. In FY10, telepsychiatry services were introduced into Maryland's Public Mental Health System in an effort to combat workforce deficiencies in rural areas of the state. Medicaid expanded efforts in FY13 to approve applications to originating sites throughout the state. Since FY15, the number of providers participating in tele-mental health services increased 135%, from 14 to 33 providers accounting for 64 unduplicated provider locations. In that same timeframe, the number of individuals served via telemedicine grew 258%. By FY17, providers conducted outpatient MH services to almost 5,000 Marylanders, approximately 3% of all outpatient MH services, via telemedicine. Total expenditures associated with telemedicine services in FY17 was $1,658,406. In an effort to address the shortage of psychiatrists in rural areas, Maryland has launched inpatient telemedicine program at the Thomas B. Finan Center, BHA's state facility in Western Maryland. Maryland is one of the few states in the nation that provides this service as a means to extend telepsychiatry in this workforce area.

A. Strategies

BHA will be working with local jurisdictions, state, regional and federal partners as well as higher education institutions to implement strategies that will build the capacity of the behavioral health workforce and other HPSA's. These strategies include:

- Increase the availability of telepsychiatry and videoconferencing which allows access to consultation and education in remote parts of the State.

- Hire nurse practitioners and other physicians licensed to prescribe medication to reduce the unmet needs of MAT services.

- Assist local provider networks to develop and enhance the knowledge and skills of staff including those working with minorities and underserved populations through workforce

development training and other events such as low-cost conferences where continuing education units are offered to BH professionals.

- Encourage regional collaboration between the PBHS and private providers.

- Continue to assist providers with the accreditation process and provide funds to cover the accreditation costs. Beginning in May 2017, BHA has provided funds to the local jurisdictions to assist providers with becoming accredited.

- Integrate providers serving MH and SUD individuals.

- Provide continuing workforce training for peers in the required performance domains to increase and maintain the CPRS working in Maryland.

- Assist behavioral health and other healthcare providers working in HPSAs designated facilities in accessing federal and state loan repayment programs.

- Assist HPSAs in providing financial and other incentives to recruit and retain healthcare professionals.

- Collaborate with higher education institutions to provide scholarships to students who are willing to work for a designated period of time in HPSAs upon graduation.

- Enhance resources and capacity at the behavioral health facilities to ensure more efficient provision of services and reduce wait lists for state hospitals. This would include exploring additional and new job classifications to assist in staff recruitment.

- Expand tele-health support through Behavioral Health Integration in Pediatric Primary Care (BHIPP) for primary care and other grant programs to support rural areas to address the shortage of child psychiatrists in their regions.

- Expand availability of buprenorphine through use of tele-medicine.

B. Transportation

Transportation is one of the major unmet needs of individuals and families in rural communities in central, eastern, and western regions of Maryland affecting their access to BH treatment services. In many of these rural communities, public transportation options are non-existent or are extremely limited, particularly in off-hours. Consumers often rely on families and friends. Individuals living on low, fixed incomes who lack transportation are likely to take an ambulance to the emergency department when they are in crisis. They are also less inclined to accept follow-up treatments due to lack of transportation. Some PBHS providers in rural areas have also reported that transportation is not only an impediment to consumers but also to PRS and other outreach workers.

- Link consumers with local community resources such as volunteers and community organizations that could provide transportation to and from BH treatment services.

- Provide funding to local PBHS to expand transportation services.

- Establish local transportation working group within jurisdictions to find solutions including local and regional transit authorities where possible.

- Expand mobile crisis services that could respond to individuals in BH crisis.

- Enroll consumers in need of transportation into care coordination programs that provide assistance with trips to medical appointments, treatment and other social services through PRS, public and Medicaid transportation services.

C. Crisis support services

With a combination of state and federal dollars, the State supports a wide array of crisis services including Maryland's Crisis Connect (#211, press 1), mobile crisis teams, crisis intervention teams, walk-in centers, safe stations, crisis stabilization centers, and crisis beds.

Maryland Crisis Connect is available 24 hours/7 days a week to callers in need of crisis intervention, risk assessment for suicide, homicide or overdose prevention, support, guidance, and information or linkage to community behavioral health providers. The MCH also provides assistance to access resources such as naloxone education, recovery support, veteran's services and family services as available/appropriate for the individual. Trained crisis counselors are available to assist individuals struggling with issues such as substance use, depression, anxiety, suicidal/homicidal ideation or intent, physical and sexual abuse, eating disorders, sexual identity concerns, running away, relationship problems, divorce, sexually transmitted disease, school issues or any other identified concern. Marylanders can access Maryland Crisis Connect by calling 211 and pressing option 1, texting 898-211, or visiting MDCrisisConnect.org to chat with a counselor or use the resource database. In FY18, a total of 17,667 callers were assisted. To date in FY19, 5,599 callers have been assisted.

Funding is provided to each jurisdiction to train law enforcement professionals in crisis intervention. This training is a first-responder model of police-based crisis intervention and builds community partnerships. Law enforcement professionals have provided feedback that the training has increased their awareness and understanding of the problems people with MH and substance related disorders experience. The "hearing voices" exercise is particularly effective to understand the difficulty managing daily activities while experience auditory hallucinations. Crisis intervention teams are established in 19 jurisdictions. An ongoing goal is to have a team in each jurisdiction able to provide services 24/7.

Mobile crisis teams provide community-based services that provide 24/7 availability of face-to-face professional and peer intervention. The teams are deployed in real time to the location of a person in crisis, whether at home or wherever the crisis may be occurring and begins the process of assessment and definitive treatment outside of a hospital or health care facility. A multi-disciplinary team, including peer support workers, works to de-escalate the person's behavioral

health crisis, engages the person in other therapeutic interventions, and assists with continuity of care by providing support that continues past the crisis period. Fiscal Years 2018 and 2019 have seen an increase in mobile crisis teams, with expansion in Harford County, Carroll County, and the mid-shore region.

Walk-in centers and safe stations are similar yet distinct services. Walk-in centers are 24/7 services that assist with the de-escalation of a person's behavioral health crisis and assists in stabilization. Safe stations are a newer crisis service, which uses fire and police stations as access hubs for entry into the treatment system 24 hours a day, seven days per week for interested individuals. Both services can assist in diversion from emergency department admission, and police involvement/incarceration. Walk-in centers and safe stations are slated to operate in 15 jurisdictions.

Crisis stabilization centers offer a safe place for individuals under the influence of drugs and/or alcohol to "sober up" and receive short-term interventions—often involving medications and medical screening. This service also offers the individual the opportunity to connect with behavioral health treatment, peer, and recovery support services, as well as case management assistance. In addition to the Maryland Crisis Stabilization Center in Baltimore City, state funding has supported the opening of a new crisis stabilization center in Harford County. As of September 2018, the Maryland Crisis Stabilization Center has served 133 individuals in FY19.

Crisis bed prevalence and availability is growing across the state, due to increased demand. There are different types of crisis beds, and different ways they are funded. Historically, BHA funded residential crisis beds, which are programs that are designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, shorten the length of inpatient stay, or reduce the pressure on general hospital emergency departments. However, due to the opioid epidemic, the current focus is on increasing the availability of crisis beds for those suffering from opioid-use disorder. The State has seen an expansion in SUD crisis beds as a result of federal funding. Currently, there are 65 "on-line" beds in four jurisdictions. The mid-shore region, Allegany and Carroll Counties will add an additional eight beds. As of September 2018, SUD crisis beds have served 765 individuals in FY19.

The State continues to work towards its goal of having a walk-in center supported by a robust mobile crisis team in each jurisdiction. BHA will expand access to crisis services through the additional funding provided by the MD-SOR grant from SAMHSA. This includes the expansion of walk-in crisis services and stabilization services, safe stations, mobile crisis services, and residential crisis bed for individuals who have an opioid use disorder and other comorbid behavioral health disorders.

D. Outreach and engagement

BHA receives funding to support outreach and engagement through the Projects for Assistance in Transition from Homelessness (PATH), a federal formula grant designed to provide outreach, case management, housing assistance and a variety of other supports to connect individuals to services. Additionally, BHA funds outreach services to individuals who are homeless through SOAR to increase access to social security disability benefits. The expansions and enhancements of care

coordination are essential and will enable Maryland's service system to more effectively reach out to individuals and families who have either not engaged with the system or are utilizing only emergency room services. By expanding the availability of care coordinators and peer support specialist for the individuals of all ages served within BHA is essential. These individuals can follow-up with people in care after hospitalizations, detentions, and out-of-home placements, we will improve connection and engagement with the behavioral health service system. More training is needed for clinicians and care coordinators in techniques known to facilitate client engagement for particularly difficult to reach populations (*e.g.*, young adults) and to encourage ongoing fully engaged participation in treatment and support services.

E. Diverse workforce

MDH, through BHA, is committed to establishing and maintaining an integrated behavioral health system that addresses the needs of Maryland's diverse citizenry. In light of this commitment, BHA has developed a Cultural and Linguistic Competency Strategic Plan with the following five distinct goals:

- establish and maintain culturally and linguistically competent behavioral health services;
- eliminate cultural and linguistic barriers to access of behavioral health services;
- create a system of data driven decision-making processes that result in the formation of culturally and linguistically competent policies and practices;
- support the usage of evidence-based practices to address the unique needs of individuals served in Maryland's PBHS; and
- advocate for and institute culturally and linguistically competent workforce development programs reflective of Maryland's diverse population.

These goals are supported with strategies and outcome measures aligned with the National Culturally and Linguistically Appropriate Services (CLAS) standards. In addition to providing orientation to new staff and regularly training existing staff on culturally and linguistically appropriate policies and practices, strategies to creating a diverse behavioral health workforce include: the recruitment, promotion and support of a culturally and linguistically diverse governance, leadership and workforce that are responsive to the community we serve.