Strategic Plan:
24/7 Crisis Walk-in and Mobile Crisis Team Services

As Required By:
2016 Maryland General Assembly
SB 551 (CH 405) / HB 682 (CH 406)

Maryland Behavioral Health Advisory Council
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Contents

Message from the Behavioral Health Advisory Council

Maryland is in the midst of a behavioral health crisis that is devastating families across our state. A continuing rise in overdose deaths and suicides requires bold action and a comprehensive approach with real solutions for the one in four individuals living with a mental health or substance use disorder.

Crisis services are an essential component of any comprehensive system of behavioral health care. They significantly reduce preventable behavioral health crises, and offer earlier intervention to stabilize crises more quickly and at the lowest level of care appropriate. A comprehensive crisis system will provide effective treatment of people with behavioral health needs while decreasing avoidable incarcerations, emergency room visits, hospitalizations and readmissions. These services are only effective if they are available and accessible when the crisis arises.

Since Maryland's Crisis Response System was enacted in 2002, it has become evident that a walk-in capacity is critical. In places that have implemented highly efficient crisis response systems – both in Maryland and throughout the United States – a central hub, operating 24 hours a day and seven days a week, where individuals in crisis and their families can go without an appointment or a referral, is a key to success. For people in crisis that may otherwise end up in emergency departments or jail, these walk-in hubs provide a less costly and more therapeutic alternative. They provide services necessary to stabilize the immediate crisis and linkages to the community resources that can help to maintain that stability.

Equally critical is a robust and comprehensive network of mobile crisis teams. At times when it may prove difficult or impossible for individuals in crisis to travel to a walk-in center, these teams of behavioral health professionals can be dispatched to community locations to provide immediate assessment, intervention, and treatment.

The benefits of these services – to the individual and to the system – are indisputable. It is in this context that the Maryland General Assembly enacted legislation in 2016 requiring the Behavioral Health Advisory Council to develop this report, which outlines a strategy for establishing a statewide network of 24/7 walk-in and mobile crisis services. In developing this plan the Advisory Council spent more than a year working with consultants to analyze the level of need in Maryland, review local and national model crisis systems, and identify strategies and solutions for our state. Public input was gathered through multiple rounds of surveys and targeted feedback was solicited from key constituencies, including behavioral health consumers and families, minority communities, mental health and substance use treatment providers, emergency room doctors and the judiciary.

This report provides a framework for a robust and efficient behavioral health crisis response system and a roadmap to a future where every Marylander with a mental health or substance use disorder is guaranteed access to treatment in a timely, humane and effective manner. We offer this plan with our full endorsement and stand ready to work with the State of Maryland to implement the recommendations within.

Executive Summary

This report provides a snapshot of where Maryland stands after fifteen years working towards a comprehensive crisis response system. It details where services exist across the state – highlighting gaps across jurisdictions and disparities between urban and rural programs – and it outlines a series of strategies and recommendations for addressing the unmet need.

Our understanding of an appropriate continuum of care has evolved over time. Collaboration among hospitals, community medical and behavioral health providers, law enforcement, social services and advocates is critical. Shifting from a reliance on emergency departments and law enforcement to an updated model is necessary to improve care and reduce costs. Appropriate intercepts at key points can prevent more traumatic, dangerous and expensive interventions. The existing patchwork system prevents those in need from accessing the right services at the right time. The existing decentralized system hinders comprehensive data collection and lends itself to a wide discrepancy in outcomes, both on the individual- and systems-level.

An environmental scan of effective crisis response systems throughout Maryland and across the country has resulted in a number of key findings. Funding is crucial and often the primary determinate in whether a crisis system succeeds or fails. Due to the complexity and range of services, collaborative funding offers the most impactful means of creating and maintaining such a system long-term. Crisis services can be as essential to public safety as law enforcement and/or fire service, and funding for crisis services requires a similar commitment from policymakers to ensure a capacity to respond effectively.

Through a series of stakeholder surveys and targeted questionnaires, this report demonstrates a public which lacks an understanding of what crisis services already exist and how to access them. Stated priorities among survey respondents and a review of model systems have identified core functions of an effective system – diversion of individuals in crisis from emergency departments, inpatient hospitalization and the criminal justice system.

Maryland programs highlighted in the report include Howard County Crisis Services – Grass Roots, Frederick County Crisis Walk-in Services, Montgomery County Crisis Center, and Behavioral Health Crisis Assessment and Stabilization Center (Elkton). Fourteen highly effective programs across the country are noted with particular attention paid to the Restoration Center in San Antonio, TX. The assessment of the survey results, existing programs in Maryland and other state models informs the subsequent Strategic Plan.

The Strategic Plan begins by identifying six key gaps, including the disparity of services across jurisdictions and the unknown impact of a lack of capacity and limited hours of operation. A lack of attention to substance use disorders across existing services is a serious concern. Sustainability of programs with existing funding sources is a major gap, as is access to shared and usable data. Staffing gaps include a lack of certified peers, retention of professional staff and funding constraints. A critical missing link is a mechanism for informing and updating the public about available services. Finally, a lack of coordination across the system is negatively affecting continuity of care, data collection and needs assessments.

Given the gaps identified above, the Plan lists five goals toward which the state should work in furtherance of a comprehensive crisis recovery system. These goals address the coordination and delivery of programs and services, data collaboration, the identification of funding sources and an informed public.

There are many challenges to addressing these gaps and meeting these goals. They include an uncertainty around Medicaid funding, barriers that prevent individuals with commercial insurance from accessing crisis services, and restrictive procedural requirements related to emergency mental health evaluations. As mentioned above, recruitment and retention of staff is an ongoing issue. Emerging populations require additional training. A need for language access and cultural competence is evident when considering that jurisdictions like Montgomery County have as many as 160 languages spoken in the public school system. Finally, Maryland has its geography to consider.

These challenges are daunting, but they are not insurmountable. Strategies outlined within address the goals in view of the gaps, providing an integrative plan of action. The Analysis section summarizes lessons learned, providing methods for addressing the challenges and options for regional organizational structures to support economies of scale. A summary of needed service enhancements are broken down by jurisdiction, and local proposals for the creation and/or expansion for 24/7 walk-in services and mobile crisis teams – including estimated budget requirements – are included in Appendix E. At the close of the report, eight recommendations lay out a path for establishing and maintaining a comprehensive statewide crisis response system.

Tragically, the most comprehensive and best funded crisis systems across the country have been established only after those jurisdictions have experienced a traumatic event or a situation resulting in loss of life, legal action regarding liability or a Department of Justice investigation. Fortunately, enactment this year of the Heroin and Opioid Prevention (HOPE) and Treatment Act of 2017, particularly its requirement that the state establish behavioral health crisis treatment centers consistent with these recommendations, signals a willingness among Maryland policymakers to address these issues proactively. This report outlines the next steps.

Legislative History/Charge

The legislative history of crisis response in Maryland dates to 2002, when the Maryland General Assembly unanimously passed HB 483 (CH 371), establishing the Maryland Mental Health Crisis Response System (CRS) within the Mental Hygiene Administration of the Department of Health and Mental Hygiene.

The legislature had lofty goals for the CRS. HB 483 mandated a statewide network of coordinated inter-jurisdictional services to effectively and efficiently serve all individuals in the state 24 hours a day and seven days a week. It required the CRS to provide skilled clinical intervention to prevent suicides, homicides, unnecessary hospitalizations, arrests and detentions of individuals in need of mental health services. In addition, it mandated a crisis communication center in each jurisdiction or region to provide a single point of entry to the CRS, coordination

with first responders and mental health providers, and an array of mental health interventions and linkages to social services.

Unfortunately, HB 483 made establishment of the CRS contingent on federal funding that never materialized. This forced Maryland to implement the network of care on an ad hoc basis, finding resources in difficult economic times to ensure that some level of crisis services were in place around the state to assist those most in need. All jurisdictions in Maryland currently have one or more components of a comprehensive crisis system, yet none has a complete continuum.

The legislature revisited the CRS statute in 2015. HB 367 (CH 416) was enacted to reestablish the CRS as the Behavioral Health Crisis Response System, expand the content and scope of authorized services and improve data collection. Importantly, the bill also repealed the federal funding contingency language, demonstrating legislative intent for a comprehensive CRS regardless of the funding source.

The following year the Maryland General Assembly enacted legislation designed to put the state on a path toward the availability of crisis services on demand, requiring the Behavioral Health Advisory Council to develop this strategic plan for ensuring that clinical crisis walk-in services and mobile crisis teams are available statewide around the clock. Passed unanimously and signed into law by Governor Larry Hogan, SB 551 (CH 405) / HB 682 (CH 406) requires that the plan include:

- A design that ensures the services are accessible to individuals in need of mental health and substance use disorder services;
- Consideration of regional models and other strategies for ensuring efficiency in the delivery of the services;
- Measures to monitor services and outcomes for individuals served by the Crisis Response System; and
- Methods for recovering payment for mental health and substance use crisis services delivered to individuals with private health insurance.

This year the legislature passed the Heroin and Opioid Prevention Effort (HOPE) and Treatment Act of 2017 (SB 967 (CH 572) / HB 1329 (CH 571)). Among its many provisions, the HOPE Act requires the establishment of crisis treatment centers in a manner that is consistent with the recommendations included in this strategic plan, with at least one center established on or before June 1, 2018.

Environmental Scan

Crisis Services Principles

Much of the value of crisis services is predicated upon timely access. Access can reduce the intensity and duration of the problem as well as the anxiety and trauma experienced by the person. Many times, as a crisis progresses, the options for resolving the crisis may diminish and the costs associated with addressing the crisis may increase. Access not only means 24 hours per day/7 days per week availability of services, but multiple means by which the individual can engage the services. It means constructing a system of alternatives to traditional behavioral health services that presents individuals with options who are otherwise unwilling or unable to access services. "Emergency rooms often lack staff with specialized psychiatric training as well as the time and infrastructure to appropriately address the needs of individuals experiencing psychiatric or substance abuse crises. Furthermore, an emphasis on delivering the most appropriate level of care in the most appropriate setting has led to greater care provided in the community, lessening the reliance on admitting individuals to hospitals.[1]" This situation combined with the reduction in inpatient hospital beds in the community have led to the development of a continuum of community based crisis services. However, many people are forced to utilize a local hospital Emergency Department (ED) or inpatient bed due to a lack of a more appropriate level of services in the community.

Crisis Services as Alternatives	
Traditional Programs	**Crisis Alternatives**
Emergency Departments	Walk-in Crisis Services
Psychiatric Hospitalization	Crisis Residential Beds
Law Enforcement Intervention	Mobile Crisis Team (MCT)
Jail	Pre & Post Booking Diversion
Mental Health Clinics	Assertive Community Treatment (ACT)

Many of our service delivery systems are set up to serve individuals based upon specific limiting criteria. This can be based on many factors including age, diagnosis, financial criteria, or geographic catchment areas. **In order to be truly accessible, crisis services must be open to all.** That includes not only those with a history of mental illness and/or substance use disorder (SUD), but those who have never received services in either system.

[1] U.S. Department of Health and Human Services, SAMHSA (2014), "Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies".

Another important principle of crisis services is that they be delivered in the least restrictive manner appropriate and in a community based setting. The goal is to provide services that keep the individual connected with his/her support system. Services need to be "congruent with the culture, gender, race, age, sexual orientation, health literacy, and communication needs of the individual being served[2]". In addition, crises services must be focused on taking the steps required to reduce the need for these services in the future.

Crisis services are not only behavioral health services, but also public safety services from the standpoint that they share some of the same functions in terms of responsibility for public safety and response to the broader population. In order to function optimally in this capacity, they need to be systemically connected to criminal justice services, hospital Emergency Departments (EDs), and other community emergency providers. Crisis services should serve the function of helping to divert individuals from the criminal justice system, from using EDs, and from inpatient hospitalization. In order to accomplish these goals, crisis services must involve the family, current service providers, and advocacy groups. In order to serve these complex functions in the community, continuums of crisis services have developed. An optimal continuum of crisis services is made up of a variety of resources that provide multiple means by which an individual can access services and is a system that can be utilized to manage a broad array of presenting issues successfully in the community.

A complete array of crisis services would contain the following: clinical crisis phone services, a hotline, crisis walk-in services, Mobile Crisis Teams (MCT), crisis residential beds, community based emergency psychiatric services, crisis intervention stress management (CISM) teams, Crisis Intervention Team (CIT) programs, hospital diversion programs, pre and post booking diversion programs, court based diversion programs, 23 hour holding beds, urgent care, crisis stabilization/case management, and ED psychiatric services. In addition to these mental health crisis resources, there must also be the ability to serve those in a crisis as a result of substance use issues, or co-occurring issues. "The capacity to address co-occurring disorders should be viewed as a fundamental feature of an effective comprehensive psychiatric crisis system based upon the prevalence of co-occurring disorders in the population served[3]."

Definitions of 24/7 Walk-In and Mobile Crisis Team Services

As mentioned, the two crisis services that this strategic plan is focused on are 24/7 crisis walk-in services and MCT. For the purposes of this document, 24/7 walk-in services are defined as a direct service that assists with the de-escalation of a person's clinical behavioral health crisis and, if applicable, his or her possible diversion from emergency department admission, police/incarceration, or out of home placement by providing 24/7 access to a safe environment with assessment, diagnosis, and treatment capability delivered in a timely manner and leading to stabilization. Anyone experiencing a mental health and/or substance-related crisis is eligible for acceptance regardless of age, insurance status, ethnic, cultural or linguistic (such as use of

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2 U.S. Department of Health and Human Services, SAMHSA (2009), "Core Elements in Responding to Mental Health Crises".

3 Technical Assistance Collaborative (2005). A Community-Based Comprehensive Psychiatric Crisis Response Service.

language interpreting or certified ASL interpreter) preference. The service setting, whether free standing or attached to a hospital, will serve, as needed, as an entry point to long-term, ongoing service delivery and care. The primary functions of walk-in crisis services are: screening and assessment, crisis stabilization (including medication), brief treatment, and linkage to social services and other behavioral health services[4]. A walk-in crisis service can function as the central point from which to organize the jurisdiction's array of crisis services and deploy services such as MCT as needed.

MCT is defined as community-based mobile crisis services that provide 24/7 availability of face-to-face professional and peer intervention, deployed in real time to the location of a person in crisis, whether at home or wherever the crisis may be occurring, to begin 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.

Effectiveness

Over the years, studies have been done that look at the effectiveness of various crisis services. Much of the information available is based upon data from urban settings. In terms of 24/7 walk-in services, many programs report making significant progress toward these desired outcomes:

- Decrease in emergency room use for behavioral health crises
- Decrease in involuntary detentions
- Decrease in psychiatric hospital admissions
- Decrease in hospital re-admission rates
- Decrease in calls to law enforcement and/or fire departments by persons experiencing behavioral health crises
- Increase in timely access to crisis assessments
- Increase in access to peer crisis services
- Increase in number of successful linkages to treatment and other supports post crisis episodes

There are at least four studies that show empirical evidence that MCT is effective in reaching important aspects of its goals. "The studies suggest that mobile crisis services are effective in diverting people from psychiatric hospitalization, effective at linking suicidal individuals discharged from the emergency department to service, and better than hospitalization at linking people in crisis to outpatient services.[5]"

"Community-based mobile crisis is an integral part of a crisis system of care. Mobile crisis interventions provide individuals with less restrictive care in a more comfortable environment

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[4] Ibid.

[5] U.S. Department of Health and Human Services, SAMHSA (2014), "Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies".

that is likely to produce more effective results than hospitalization or ED utilization. When collaboration exists with hospitals, medical and behavioral health providers, law enforcement, and other social services, community-based mobile crisis is an effective and efficient way of resolving mental health crisis and preventing future crisis situations[6]".

Economic Impact of Crisis Services

In terms of MCT, one study looked at the cost of its intervention compared to intervention by the police. Due to the increased frequency in which police intervention resulted in the individuals being hospitalized, the overall cost for MCT was 23% lower. Another study showed that the use of MCT reduced costs associated with inpatient hospitalization by approximately 79%[7].

A report in 2013 regarding Emergency Department visits, outpatient services, and inpatient psychiatric services found that the net benefit was $2.16 for each dollar invested in crisis stabilization services[8].

Role of Crisis Services in the Health Care System

Crisis Services are an integral part of the health care system. "There is a growing recognition that psychiatric crisis services cannot and do not operate on the fringe of the health care system, but rather are mainstream activities necessary to complete the health care continuum.[9]" These services can effectively address crises in a humane manner that hospital-based services often cannot due to their setting, time, and community treatment orientation. The standard for intervention through the traditional resources available to intervene in behavioral health crises, such as the police and hospital emergency departments, has been risk of danger to self or others. This type of issue is often dealt with using physical means such as restraint, emergency transport, or sedation. It is often viewed and/or treated as a single encounter or episode. Crisis services broaden the range of behavioral health situations that can be addressed in a way that can have both a preventative and treatment effect. While part of the population who access crisis behavioral health services have serious and persistent mental illness, many either have a less serious behavioral health diagnosis or have a situational issue that has never been diagnosed or treated. These individuals may self-identify or be referred through another system such as their family, their employer, their school, or a primary care physician. Creating a system that is more holistically focused and that can engage, assess, treat, and link to community resources is an important component of the health care system. Providing accessible intervention at these points

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6 National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc.

7 Bengelsdorf, H., Church, J. O., Kaye, R. A., Orlowski, B., & Alden, D. C. (1993). The cost effectiveness of crisis intervention: Admission diversion savings can offset the high cost of service. Journal of Nervous and Mental Disease, 181(12), 757–762. doi: 10.1097/00005053-199312000-00008.

8 Wilder Research. (2013). Crisis stabilization claims analysis: Technical report, assessing the impact of crisis stabilization on utilization of health care services, April 2013.

9 Technical Assistance Collaborative (2005). A Community-Based Comprehensive Psychiatric Crisis Response Service.

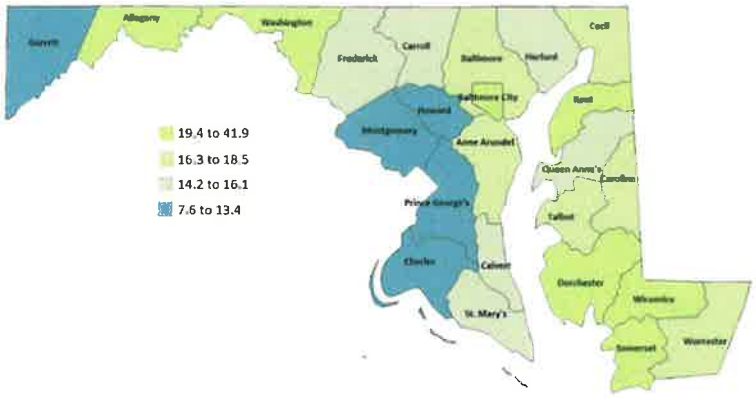
in the process often prevents a more traumatic, dangerous, and expensive level of intervention later.

Level of Need in Maryland

"In too many communities, the 'crisis system' has been unofficially handed over to law enforcement, sometimes with devastating outcomes. Our current approach to crisis care is patchwork, delivering minimal care for some people while others (often those who have not been engaged in care) fall through the cracks resulting in multiple readmissions, life in the criminal justice system, or death by suicide[10]". When services are a disorganized or fragmented patchwork, a hospital ED often becomes the default point of access.

Maryland continues to experience an increase in the number of patients seen in EDs for behavioral health problems. In 2015, there were greater than 107,000 visits, of which 64% were mental health related and 36% were substance use related[11]. (See Figure 1)

Figure 1 – Maryland Use of EDs for Behavioral Health Needs per 1000 (the higher the ratio, the more concentrated the need)



Two of the jurisdictions with the largest population – Montgomery County and Howard County seem to have relatively lower use of EDs (Figure 1). This may be, in part, due to having a more complete array of crisis services than most other jurisdictions. They are the only two jurisdictions with 24/7 walk-in crisis services, and both also have MCT programs. Montgomery's MCT is 24/7 and Howard's MCT has continued to expand its hours. The type of central coordination of crisis services found in these two counties begins to meet the requirements of the Air Traffic Control model in that it has the potential to increase access and decrease falling through the cracks. In this model, the system has an on-going way to track an individual who is navigating the crisis system. The efficiency and accuracy of this process can be significantly enhanced through the use of an integrated software infrastructure[12].

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[10] National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc.

[11] Ibid.

[12] Georgia Crisis & Access Line 10 Years Later, 2016. David Covington.

Crisis response services recommended for youth are very similar to the services needed for adults in crisis. In addition, stabilization services are an added component critical to assist families to effectively connect with on-going community services. In 2013, Maryland Coalition for Families (MCF) conducted focus groups asking families what crisis services were needed when their children were displaying behaviors that were potentially dangerous to themselves or others. EDs were the service accessed the most even though families reported that they had poor experiences there. When asked what would help families in crisis, the top three responses were mental health urgent care, mobile crisis teams and emergency respite services. While EDs and psychiatric inpatient admissions do play a role in the continuum of services needed when youth are suicidal or are experiencing psychosis, the majority of children in crisis do not need this restrictive level of intervention, but could benefit from community based services that include hotlines, mobile crisis interventions and crisis stabilization services specific to the needs of youth and their families.

In May 2013, Maryland stakeholders wrote a report that outlines the components necessary to build a robust crisis system that addresses the nuances and circumstances of youth and their families. A copy of this report can be found in Appendix C.

The FY 2016 Behavioral Health Administration Plan listed as one of its objectives "expand crisis response systems to increase utilization of intensive services to allow individuals with mental health and substance-related issues to be served in the least restrictive setting[13]". One of the indicators of accomplishment was noted as "expansion of crisis response services and crisis intervention teams (CIT's) throughout the state[14]". Maryland has developed a statewide decentralized approach to crisis services. While crisis services exist in almost all of the 24 jurisdictions, the array and intensity of services vary drastically. Figure 2 shows a complete array of mental health crisis services and which of those services are available in each jurisdiction in Maryland.

Each jurisdiction has established its own plan for building out a continuum of crisis services that meets their needs. Many of the jurisdictions have been held back from expanding their crisis services based upon prioritizing other behavioral health services and a lack of local funding. Although many have several crisis services, it is far less than a complete continuum. Also, these services have often not been tied together through a central hub. This lack of growth in crisis services in some areas of Maryland has contributed to slow and incomplete implementation of other services such as Crisis Intervention Team (CIT) programs.

Beginning in FY13, the Behavioral Health Administration began providing yearly funding to each jurisdiction to establish or enhance CIT programs. As new CIT programs have been implemented, the lack of a well-established crisis system in some jurisdictions has prevented the program from progressing as it should. Crisis Intervention Team (CIT) programs are partnerships between law enforcement, behavioral health, and advocacy organizations. The most basic

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[13] Maryland Department of Health and Mental Hygiene, Behavioral Health Administration, (2015). "FY 2016 Behavioral Health Plan".

[14] Ibid.

component of CIT is training provided to law enforcement that increases their awareness and sensitivity regarding behavioral health issues, increases their skills in managing these situations, and changes their behavior in a way that increases safety. In addition to training, CIT is focused on building out the crisis system in a jurisdiction so that individuals can have access to necessary services and law enforcement does not continue to function as the default response. In Maryland, the number of CIT programs has grown substantially during the last four years. There are currently 14 programs in place (some cover multiple jurisdictions) and two programs that are in development. Many of these CIT programs are now working with crisis systems in their jurisdictions that have not expanded or become enhanced as quickly resulting in an inability to access adequate care and achieve system goals. "CIT programs are the foundation for developing meaningful collaborations with community behavioral health. Communities must have ready access to resources that help protect the individual and the community, while avoiding unnecessary and costly uses of emergency departments and harmful incarcerations[15]."

Although local hospital EDs exist in all parts of Maryland, they are not always set up to optimally provide crisis treatment. Many times, the EDs in more rural areas do not have the ideal physical space or personnel to adequately manage those in a behavioral health crisis. One of the strategies for dealing with jurisdictions inadequate access to face to face crisis services has been to develop additional urgent care capacity. The Maryland Health Care Commission, in their 2008 white paper, advocated for an expansion of urgent care in Maryland. Notably, they recommended that these resources should include "immediate access to psychiatric assessment, including an evaluation of the need for medication and prescription drugs (either having a pharmacy on-site or a close working relationship with a nearby pharmacy). The urgent care centers should also have the ability to provide brief treatment for a short period of time (up to four visits over a two week period)[16]".

What is being described is less an urgent care service, and more a crisis walk-in service. Urgent care in its traditional sense is not a substitute for a 24/7 crisis walk-in service. Face to face crisis assessments outside of EDs are often performed by MCT. This can be a challenge due to either the geography or population density of a particular area which affects travel time, as well as the level of staffing available. In many jurisdictions, urgent care is provided as the only means of accessing behavioral health care in a timely manner. Typically, these jurisdictions rely on law enforcement as the first face to face contact, and the local EDs to assess and treat those in the most urgent need of care.

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15 National Council Magazine, Crisis to Recovery, (2016). Comprehensive Crisis System.

16 Maryland Health Care Commission, (2008). Best Practices: Crisis Response and Diversion Strategies.

Figure 2 - Crisis Services by Jurisdiction

JURISDICTION	24/7 Clinical Crisis Line	24/7 Hotline	Walk-in Crisis Svcs.	MCT	Crisis Res. Beds	Emerg. Psy. Svcs. (non hospital)	CISM Team	CIT	Hospital Diversion	Pre & Post Booking Diversion	Court-Based Diversion	23 Hour Holding Beds	Urgent Care	Crisis Stabil./ Case Mgmt.	ED Psy. Svcs.
Allegany County	X				X			X					X		X
Anne Arundel County		X		X	X		X	X	X	X		X	X	X	X
Baltimore City	X	X		X	X	X		X	X	X	X	X	X	X	X
Baltimore County	X	X		X	X		X	X					X		X
Calvert Tri County	X				X			F	X		X		X		X
Carroll County					X			X					X		X
Cecil County	X			X				I					X	X	X
Charles Tri County		X			X			F		X			X		X
Frederick County		X	X	X	X			X					X		X
Garrett County		X			X			F					X		X
Harford County				X				X			X		X	X	X
Howard County		X	X	X	X		X	X	X				X		X

JURISDICTION	24/7 Clinical Crisis Line	24/7 Hotline	Walk-in Crisis Svcs.	MCT	Crisis Res. Beds	Emerg. Psy. Svcs.	CISM Team	CIT	Hospital Diversion	Pre & Post Booking Diversion	Court-Based Diversion	23 Hour Holding Beds	Urgent Care	Crisis Stabil./ Case Mgmt.	ED Psy. Svcs.
Mid-Shore (Caroline, Dorchester, Kent, Queen Anne, Talbot Counties)	X	X		X	X			I			X		X	X	X
Montgomery County	X	X	X	X	X	X	X	X		X			X	X	X
Prince George's County	X	X		X	X	X	X	X	X		X	X	X	X	X
St. Mary's Tri County		X			X			I							X
Washington County		X		X				I					X		X
Wicomico/ Somerset Counties		X		X	X		X	X					X		X
Worcester County	X	X		X	X			X					X		X

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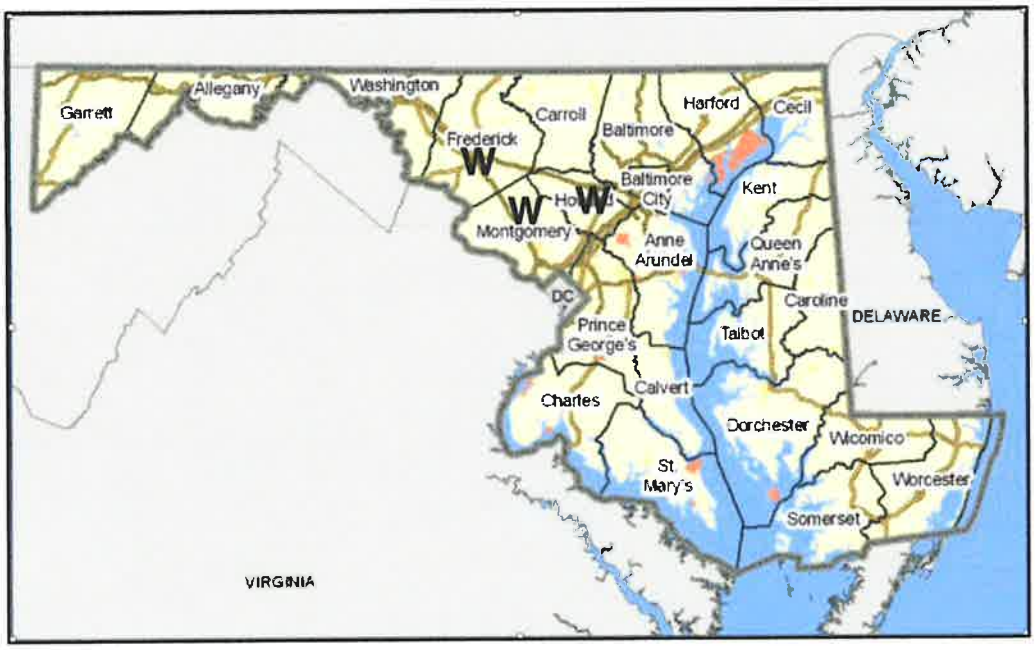
KEY
X - service currently in place
I - in process
F - funded, but program not yet developed

"A considerable factor in the heavy use of hospital emergency departments by persons experiencing a psychiatric crisis is the absence of accessible, timely alternatives[17]." It is important for jurisdictions to have access to as broad an array of crisis services as possible in order to offer what is most appropriate. In systems that only have access to partial continuums, only those services can be offered. That frequently results in individuals being treated in more restrictive environments like crisis residential beds when crisis intervention and stabilization would have been more appropriate.

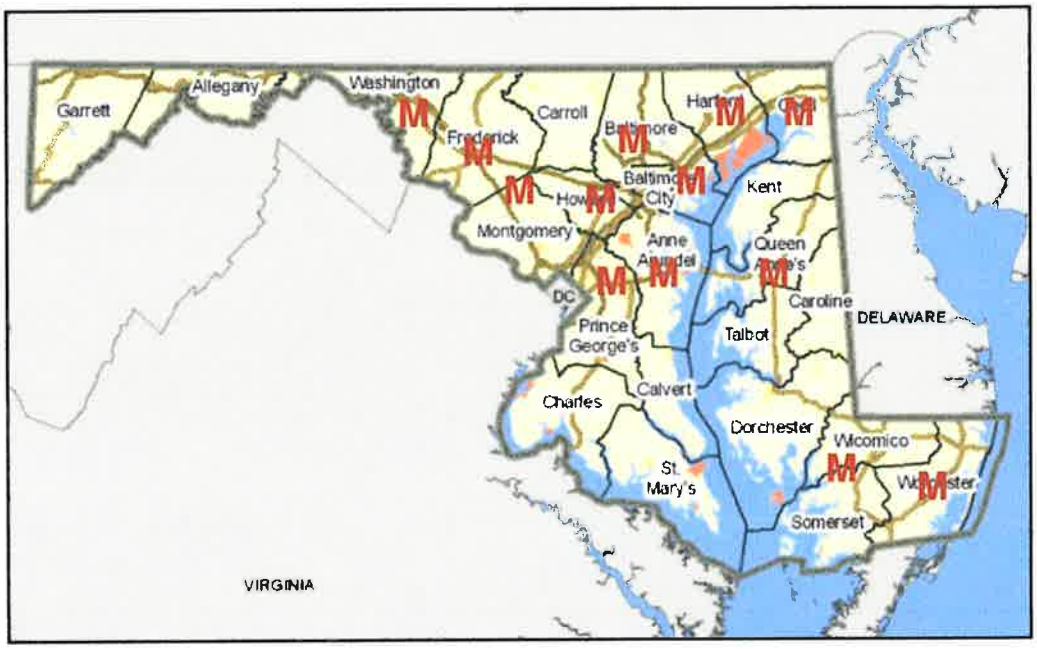
The two crisis programs that this environmental scan is focused on, crisis walk-in services and MCT services, would seem to be the most important core crisis services in the full array of services due to their capacity to increase access to immediate care and their ability to be viable alternatives to the use of EDs as well as a means to divert individuals from hospitalization and the criminal justice system. **In addition, crisis walk-in services can serve as a centralized hub from which to organize the other types of crisis services.** Currently, Maryland has three crisis walk-in programs that are all clustered in the central portion of the state. They are all in counties that are predominately urban/suburban. Two operate 24/7 and the third has extended hours. Howard County and Montgomery County are the two programs that function 24/7, and each has been in operation for greater than 30 years. The Crisis Center in Montgomery County is run by local government, and Grassroots Crisis Intervention Center in Howard County is a private, not for profit organization. They both receive local funding in addition to other sources of funds. The third crisis walk-in program is in Frederick County (Figure 3).

Figure 3 – Crisis Walk-in Services by Jurisdiction



[17] Maryland Health Care Commission, (2008). Best Practices: Crisis Response and Diversion Strategies.

Figure 4 – Mobile Crisis Teams by Jurisdiction



Maryland has a greater number and better distribution of MCT's (see Figure 4). Currently, there are 13 MCT programs spread across the state with another one in Carroll County that has just secured funding. One program serves five counties and another one serves two counties, both in rural areas. Those areas of the state that are without MCT are the west and south and are primarily rural.

It seems clear that each community's needs to address behavioral health crises warrant access to walk-in crisis services and MCT services. In terms of constructing a strategy for assuring that these resources become available to each community, it will be necessary to take into account their current level of crisis resources, geographic challenges, existing partnerships with other jurisdictions in their region, and local funding options.

Funding

"Funding is a huge issue in crisis response because it is unclear who pays for what. When you have a fire at your house, they don't ask you what type of insurance you have. They must show up, and communities have a way to pay for that. In behavioral health we're not quite in the same situation[18]". The majority of behavioral health services are supported through public funding. Sixty percent of mental health funds are public, and 69% of substance use treatment funding is public. As of 2012, all 50 states and the District of Columbia use Medicaid funds to finance some form of crisis services. Twelve states are currently receiving Medicaid funding for MCT services. Other federal sources of funding for mental health crisis services include SAMHSA

[18] National Council Magazine, Crisis to Recovery, (2016). Comprehensive Crisis System.

mental health block grants and social service block grants[19]. The most frequently used sources for funding crisis services are Medicaid waivers and state and county general funds. County or local funds are often used for services not covered by Medicaid such as hotlines or facility based crisis services. Although private insurance can include crisis services in some benefit packages, it is generally not included in most. Typically, less than half of all funding comes from a source that is dedicated and reliable such as a state funds. "This is problematic, since dedicated state mental health funding is threatened by the transition of services paid by Medicaid, which is typically delivered per unit of care (i.e., the visit), not of the 24/7 infrastructure essential for crisis care[20]." The 2015 Crisis Services Survey conducted by the National Council for Behavioral Health identified that 70% of those responding said that funding was the most difficult program barrier[21].

Crisis services are difficult to fund using one stream due to their complexity and range. By their very nature, crises require an immediate response that often limits the ability to establish eligibility based upon diagnostic criteria or financial resources. "Overcoming eligible individual limitations imposed by a categorical and single service dedicated funding streams requires mobilizing multiple resources to address the diverse needs of individuals experiencing a behavioral health crisis. Such a collaborative funding approach would create an overall strategy that reconciles the many separate funding strands, and would have a greater potential to meet the immediate need of individuals in crisis…[22]". Crisis services systems need to be driven based on need.

In terms of funding strategies, the model of collaborative funding in which services are provided to an individual based on insurance coverage would insure that no one would be turned away. The funding stream that could cover the individual would be used. Currently, in some systems, those with private insurance but whose policies do not cover crisis services are not eligible for services that those who are indigent or receive Medicaid may receive. Deciding whether what is being funded are individual services or capacity to respond will help to determine the source of funds. Those crisis services that are considered to be essential to public safety in much the same manner as law enforcement or the fire service will need to be funded for a specific level of capacity to respond. This level of funding would be reserved for the highest priority crisis services such as 24/7 crisis walk-in services and MCT services.

Wisconsin is an example of a state that has both walk-in and MCT services. The counties are responsible for development of their continuums of services and provision of services. The state requires a minimum of services which includes a walk-in center, MCT, and a crisis hotline. The funding sources utilized are: state general funds, Medicaid funds [Rehabilitation Option, Medicaid 1915(b) Waiver, and Medicaid 1115 Waiver], Mental Health Block Grant, local government funds, and Federal Emergency Management Agency (FEMA) funds. States like

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[19] U.S. Department of Health and Human Services, SAMHSA (2014), "Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies".

[20] National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc.

[21] National Council for Behavioral Health, (2015). Crisis Services Survey.

[22] National Gains Center for People with Co-occurring Disorders in the Justice System, 2004.

Michigan "provide crisis services to individuals who are eligible for Medicaid through contracts with managed care organizations. Services for individuals who are not Medicaid eligible are covered under contracts or agreements between state mental health agencies and managed care organizations[23]". Under the law in Wisconsin, crisis services are eligible for third party reimbursement, but private insurance companies are not required to provide reimbursement.

As of 2016, Maryland had just under $30 million in crisis funding. The funding included: federal funding - $4,142,348, state funding - $9,867,014, and local funding - $15,091,736 (see Appendix A for full chart). The largest infusions of funding into jurisdictions for crisis services are from local sources. Amounts in excess of $1,000,000 are part of the total crisis funding in four jurisdictions. Sixty-one percent of local funding, however, is concentrated in two jurisdictions. Baltimore City receives $4,216,598 and Montgomery County receives $5,437,464. Local funding seems to play a significant role in some jurisdictions being able to build out their crisis continuums more completely than other jurisdictions. For example, in Howard County MCT has primarily been funded by the county since its inception in 2001. In jurisdictions such as Frederick County that have relied on multiple sources of funding outside of state funding through the Behavioral Health Administration, the experience has been that these other sources often become difficult to sustain. Although data exists to substantiate the financial benefit derived through the community's use of Frederick's crisis walk-in service instead of the ED, the funding was not made part of the local hospital's operating budget.

Stakeholder Input

Maryland Crisis Walk-in/MCT Survey and Targeted Group Response

The data for this survey was collected during the period from October 26, 2016 through January 31, 2017. The survey was conducted online and the community was invited to participate through direct email and also through the use of participating organizations' websites to provide information about the survey. After reviewing the responses on the original cutoff date, the time limit for participating in the survey was extended in order to increase the number of people participating and broaden the response to include specific groups whose responses seemed to be underrepresented. The survey collected a total of 1059 responses, which was a 93% increase over the initial response. The survey was composed of 10 questions. The first five questions focused on describing those who completed the surveys. This was done to ensure that a broad level of participation was captured in this process. The responses from the survey that pertain primarily to the two services, 24/7 crisis walk-in and MCT, will be presented, and the survey itself as well as further detailed results of the survey including the narrative comments may be found in Appendix B.

The breakdown of participants by race/ethnicity showed an over-representation of Whites and an under-representation of Blacks, Hispanics, and Asians based upon percentages of those populations in Maryland[24]. All the jurisdictions in Maryland were represented, and at least the

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[23] U.S. Department of Health and Human Services, SAMHSA (2014), "Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies".

[24] United States Census Bureau, (2010). www.census.gov.

largest ones had representation in proportion to their population[25]. The largest group participating (31%), were community-based behavioral health providers. Some of the other categories of responders to the survey were: hospital behavioral health providers - 14%, friends or family members of an adult/child receiving or in need of behavioral health services - 21%, those who receive behavioral health services - 8%, advocates - 6%, those who provide peer support - 3%, and employees of the criminal justice system - 2%.

In response to the question that asked what services currently exist in the person's community, 28% of respondents said they did not know what exists, 28% - crisis walk-in services, 52% - Mobile Crisis Team (MCT) services, 39% - clinical crisis phone line, and 37% - CIT. In answer to the question regarding what if any services have you used, 19% had used crisis walk-in services and 41% had used MCT services. When asked to prioritize what the five most important gaps in the current crisis system are, the responses were:

1. Lack of consistent follow up care for those released from institutions
2. Lack of timely 24/7 access to community based crisis services
3. Uneven ability to address substance-related disorders, psychiatric disorders, and co-occurring disorders
4. Lack of adequate information regarding what crisis services are available and how to access them
5. Need for improved relationships in the community between behavioral health care providers, social services programs, hospitals, law enforcement, etc.

The participants rank ordered which priorities should guide decision making about expanding and enhancing the clinical walk-in crisis services and the MCT services in Maryland as follows:

1. Ensure prompt access to quality clinical crisis services 24/7.
2. Assure that all jurisdictions have at least a basic level of clinical crisis services.
3. Ensure coordination between clinical crisis services providers and all other community agencies.

The following are representative of the narrative comments made:

- 24/7 services are needed.
- Need a way for people to find out what services exist
- Unequal access based on insurance coverage
- More comprehensive crisis services needed
- An adequate crisis system can reduce the overuse of the health care system.
- Services do not exist in many areas - particularly rural areas.
- Where services do exist, there is not capacity for timely response.
- EDs are a bad environment for those in a behavioral health crisis.
- Decrease use of local jails as a substitute for crisis services.

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[25] Ibid.

- 24/7 crisis intervention for substance use is needed.
- Crisis residential beds are needed.

The specific groups targeted for responses were: ED physicians, Black Mental Health Alliance for Education and Consultation, MD Recovery Organization, Maryland Coalition of Families, MD judges, NAMI MD, MD Addiction Directors Council, and On Our Own of MD. The following are representative of the comments this group made:

Which behavioral health crisis services are most important to your organization/constituents/colleagues?

- Ability to access SUD detox services within 24 hours following an initial request
- Increase timely access to inpatient hospitalization
- Case management
- Mental health crisis walk-in services
- MCT
- Every jurisdiction should have at least one crisis stabilization center.
- Maryland should ensure increased access to Crisis Stabilization Units (CSU), small inpatient facilities of less than 16 beds.
- A statewide crisis line with community specific information should be available 24 hours-a-day and seven-days a week.

What do your organization/constituents/colleagues perceive as the gaps that currently exist in the crisis services system?

- Lack of adequate, mandated funding to expand crisis services
- Lack of a paid certified peer workforce
- Lack of centralized bed coordination
- Lack of crisis walk-in services, MCT, and emergency detox beds
- Lack of information about what crisis services exist
- Lack of telepsychiatry

Please provide any other brief comments regarding clinical crisis walk-in services and MCT services that relate to your organization/constituents/colleagues.

- I believe we could do a better job in making the community, families specifically, aware of the existence of crisis services ....
- The use of peer support and family peers would be helpful
- In order for crisis systems to be effective, they have to provide continuity of care.

While the survey provided important information from the community, it would have been beneficial to have received greater participation of those from other groups such as the criminal justice system that work closely with the behavioral health system toward shared goals. Other groups whose input would have been valuable were consumer organizations and addictions

services. The response to the survey showed that while everyone had equal access to this survey, not everyone had an equal level of interest.

In terms of analyzing the survey responses, one fact that stands out is that there is a general lack of knowledge about what crisis services exist in the communities throughout Maryland. Based on current information that exists regarding where specific resources are located, responses showed that sometimes people may think a service exists in their jurisdiction when it does not, or not know it exists when it does. The primary point that was made throughout the survey in a variety of different ways is that 24/7 crisis walk-in services and MCT are seen as important resources for managing behavioral health crises in an effective and humane manner. People seem to prefer this type of setting and ability to respond over the traditional ED setting. Adding peer support specialists to both services would significantly enhance them.

Local Proposals in Response to Strategic Plan

In August 2017 a copy of the Strategic Plan was sent to the local Core Service Agencies (CSAs), Local Addiction Authorities (LAAs) and Local Behavioral Health Authorities (LBHAs) throughout the state with the request that each jurisdiction submit a unified proposal regarding how that jurisdiction would use any additional crisis funds. Specifically, each jurisdiction was requested to review the Strategic Plan, particularly the section on *Local and National Model Crisis Systems* and the features and services for 24/7 Walk-In and Mobile Crisis Services identified in the *Recommendations* section, and submit a brief proposal of how their jurisdiction would use any additional funding to operationalize these recommendations to establish new 24/7 Walk-In Crisis Centers and Mobile Crisis Services or expand existing Walk-In and MCT crisis services. Responses were received from every jurisdiction by the deadline established with the exception of Montgomery County, which already has a well-established 24/7 Walk-In Crisis Center and 24/7 Mobile Crisis Services, which several jurisdictions mentioned in their proposals as the "model" they would like to establish. A summary of the CSA/LAA/LBHA proposals as well as copies of proposals submitted by each jurisdiction can be found in Appendix E.

Review of Local and National Model Crisis Systems

In order to develop a strategy to implement 24/7 crisis walk-in services and MCT services throughout Maryland, a process was implemented to identify existing models of those services both in Maryland and on a national basis. All models seem to share similar goals which include diverting individuals from EDs into community based walk-in services, diverting from hospitalization into an array of alternative community based crisis services, and diverting from the criminal justice system. Crisis walk-in services and MCT services can function effectively as an important component of the Sequential Intercept Model that is focused on systematically diverting those with behavioral health issues from the criminal justice system. In the Intercept 1 component of this framework for intervention, both of these programs in conjunction with law enforcement can be effective in meeting this goal[26]. All the models reviewed vary based on

[26] Substance Abuse and Mental Health Services Administration, (2016). "SAMHSA's Efforts on Criminal and Juvenile Justice Issues".

jurisdictional needs, but are focused on increasing access to care. All models have had to accommodate specific challenges such as rural models dealing with the geographic challenge of hundreds of square miles, and urban models dealing with population density and volume. In order to be effective, all of the models have been based on partnerships between community behavioral health, hospitals, and law enforcement. Nearly all of the models that are most complete and best funded occur in jurisdictions that have experienced a traumatic event or situation resulting in loss of life, legal action regarding liability, or a Department of Justice investigation.

MCT was initially set up to respond to mental health crises in the community. The program has typically provided assessments, crisis intervention, linkage to community programs, and whatever disposition was required. Over time, it has evolved to focus on the presenting behavior which has included working with those with substance use problems, and those with developmental or intellectual disabilities.

The 13 MCT programs in Maryland vary programmatically and in the hours that they are available (see Appendix A). Currently, there are four programs that function 24/7 - Anne Arundel County, Frederick County, Montgomery County, and Prince George's County. Ten of the programs can respond to people of all ages. They generally break down into two models that are used. The model that involves sending two behavioral health staff into the community is by far the most prevalent. These teams are typically staffed by two licensed clinicians, or one licensed clinician and a paraprofessional. Several jurisdictions have encountered challenges in being able to recruit and retain professional staff. All of these teams work closely with law enforcement, and most respond in tandem with law enforcement. The role of law enforcement is to secure the scene, and assure safety for all involved. Only a few teams have the policy to involve the police based on what they assess the situation to be. These teams generally have only one team available during a given shift. The second model is in use in Baltimore County, and this involves using a team that is made up of one licensed clinician and one police officer (a similarly structured pilot began recently in Baltimore City).

As discussed earlier, there are three crisis walk-in services that are functioning in Maryland. While the models are somewhat similar, they do have different components. In addition, a new model is currently in the process of development that is a partnership between Union Hospital in Elkton and University of Maryland Upper Chesapeake Health.

State and national model programs are outlined below.

Howard County Crisis Services - Grass Roots
Columbia, Maryland

Features:

- Not for profit - started in 1970
- $3.1M total budget - $1.5M of which is local funding
- MCT funding is $495,000 of which is 80% is local and 20% is state funding
- MCT always responds in tandem with police

- Well-developed CIT program in Howard County
- single point of entry for any person entering the homeless system
- Certified by the American Association of Suicidology.

Services:

- 24/7 clinical crisis lines - behavioral health, domestic violence, sexual assault, and the MD Crisis Hotline
- 24/7 walk-in services
- MCT - 9AM - 11PM; 7 days/week
- Urgent care psychiatric appointments
- CISM
- Runaway Intervention Program
- Survivors of Suicide Loss Group
- 51 bed shelter for homeless adults and families

Frederick County Crisis Walk-in Services
Frederick, Maryland

Features:

- Started by the Mental Health Association of Frederick County in 2014
- Demand for services has been substantial - number of unduplicated clients increased by 42% in FY16 over the previous year
- Multiple streams of funding - state funding through BHA, local funding through the Community Health Resources Commission (CHRC) and Frederick County Government. In addition, Frederick Memorial Hospital provided funding in FY 15 and FY16. All local and hospital funding ends this year. State funding is the only remaining source of funding.

Services:

- Open 7 days/week for a total of 48 hours/week
- 24/7 call center with multiple lines including 211 for all of Western Maryland
- MCT not co-located, but dispatched through crisis walk-in service

Montgomery County Crisis Center
Rockville, Maryland

Features:

- Part of Montgomery County Government, so it is integrated with all other health and human services (began in 1970's)
- Locally funded - $5.4M budget
- All crisis services provided in Montgomery County are housed and/ or coordinated out of the Crisis Center

- Covers population of 1,000,000 in a county that has urban, suburban, and rural geographic areas

Services:
- 24/7 clinical crisis lines for behavioral health, domestic violence, and sexual assault
- 24/7 walk-in services for assessment, stabilization, and linkage to other services for all ages
- Psychiatric evaluation service
- 24/7 Mobile Crisis Team (MCT) for all ages
- Six crisis residential beds for adults
- Crisis stabilization services as a bridge to treatment
- Linkage to all Montgomery County health and human services
- Linkage to all other community based behavioral health services
- Montgomery County Public School - Assessment of Children in a Psychiatric Crisis Program
- CISM
- Provides behavioral health component for CIT program

Behavioral Health Crisis Assessment and Stabilization Center
Elkton, Maryland

Features:
- Done as a partnership between Union Hospital of Cecil County and University of Maryland Upper Chesapeake Health
- To be operational in late 2017 or early 2018
- $2.8M operating expenses
- 24/7
- Will serve adults 18 and older
- Peer driven incorporating principles of recovery, resilience, and wellness
- Accepts all referrals when a behavioral health issue is primary
- Public/private partnership developed and funded by the hospital, county, state, and foundational funding
- The planned direction is to continue to incorporate additional community partners

Services:
- 16 bed crisis residential services
- Another community provider will offer basic detox, IOP, and outpatient
- MCT and outpatient services will be co-located
- Services address mental health, substance use with detox available onsite, and primary physical health

In addition to the models existing in Maryland, there a number of different crisis service models that exist in other states. The following is a review of those that have been identified by various organizations like the Council of State Governments, the GAINS Center, NAMI, through Sam Cochran, a national consultant for CIT services, and through a literature search.

Alliance Mental Health Services
Shelby County, Tennessee

Features:

- Recommended by Sam Cochran, National Consultant for CIT Services
- Jurisdiction has worked closely with Sam Cochran regarding the link between law enforcement and behavioral health, and was part of the initial CIT program
- Private not for profit organization
- Covers city of Memphis & three counties. Also provides care for individuals from Mississippi which is a neighboring state.
- Budget is $4.5M through Tennessee Dept. of Behavioral Health and TennCare
- Operates two 24/7 walk-in crisis services - primary service is located in a state psychiatric hospital and other service is located in a general hospital
- Current volume of services - 600 assessment/month for individuals brought in by police and 600 assessments/month of individuals coming in or brought in by others
- No law in Tennessee that requires medical clearance prior to evaluation for psychiatric crisis
- Police who bring in individuals can leave within 15 minutes
- Staffing includes RN's, a Nurse Practitioner, and contract for primary care MD
- Memphis has a VA Court, Drug Court, and a Mental Health Court

Services:

- 24/7 walk-in services
- 24/7 MCT
- multiple crisis beds - 15 crisis stabilization beds with 72 hr. length of stay(LOS), three intensive respite beds with 24 hr. LOS, and nine medically monitored detox beds
- Detox beds are a cross between a social model detox and a medical detox which allows them to accept and manage more difficult situations
- Actively participates in all CIT training
- Has MOU's with eight of the 11 local hospitals. Responds to the ED's to evaluate individuals, and provides consultations and treatment for patients on inpatient services that have a behavioral health crisis.

Central Mississippi Residential Center
Newton, Mississippi

Features:

- recommended by Sam Cochran, National Consultant for CIT Services

- $1.9M budget; $1.5M - state general funds & $400K in Medicaid fee for service
- Jurisdiction has worked closely with Sam Cochran regarding the link between law enforcement and behavioral health
- Provides services for nine primarily rural counties
- One CIT trained law enforcement agency
- Staffed by family nurse practitioners, a psychologist, and a consulting psychiatrist
- 8% of individuals wind up requiring hospitalization

Services:

- 16 crisis residential beds with 3-5 day length of stay. Beds may also be used for 23 hour observation.
- 85% of individuals served are voluntary, 15% are committed and are awaiting a bed
- Individuals in a mental health crisis including those who are co-occurring are dropped off by police, or are brought in by the MCT that is part of the local Community Mental Health Center

CIT Assessment Centers (CITAC)
State of Virginia

Features:

- Recommend by NAMI and Dr. Amy Watson, Behavioral Health Researcher at University of Illinois
- Virginia does not require that an individual in a psychiatric emergency be taken to an ED for medical clearance. Individuals are only sent to an ED if they are exhibiting physical symptoms, have a medical history, or are assessed to need psychiatric inpatient hospitalization. If an individual is taken to a CITAC that is located in a hospital, most of the hospitals require that the individual be medically cleared.
- Currently there 32 CITAC's across VA with the plan to have one in every jurisdiction
- Each CITAC is budgeted for approximately $270K and paid for with State of Virginia General Funds
- Runs with state guidance, jurisdictions may individualize the implementation and use the funding based on local needs
- Most CITAC's located adjacent to ED's, but some are free-standing
- Several operate 24/7, but most operate for a set of hours based on highest volume. During off hours, the Community Service Board (CSB) for that jurisdiction does evaluations.
- Staffed by a behavioral health professional from local CSB's and a law enforcement officer. During daytime hours, peer recovery specialists also work with the individual. They remain involved until the person is linked with services and attends first visit.
- Structured to create an incentive for officers to divert individuals in a behavioral health crisis out of the criminal justice system and to get them back in service as soon as possible.
- Four data elements are captured for each interaction: clinical outcome, injuries, arrest status, and time spent. A data warehouse is currently being utilized to connect behavioral data from all CSB contacts and criminal justice involvement.

Services:

- 24/7 access to immediate assessment
- Law enforcement officers may bring individuals directly to CITAC and transfer custody, which allows them to return to service quickly
- Disposition determined and a direct connection is made for follow up services
- If psychiatric inpatient hospitalization is required, the State must find a bed

Community Crisis Center
Oakland County, Michigan

Features:

- 24/7 services for a county of 1.2M people - urban model
- Primary funding is Medicaid, and state general funds cover an increasingly small percentage. The funding is through a carve-out for behavioral health services created under federally approved 1915(b) and 1915(c) waivers.
- Services are organized centrally
- Multi-disciplinary staff including RN's and certified peer counselors
- 80% diversion rate from EDs
- Regulation does not require that individuals be transported to an ED - can be transported directly to Crisis Center. Regulation in Mental Health Code for Michigan requires the establishment of a Preadmission Screening Unit.

Services:

- Clinical crisis line
- Crisis walk-in services - triage, assessment, psychiatric evaluation, and health appraisal
- Law enforcement drop off
- MCT can respond in the community or go to ED's
- Crisis residential services (alternative to hospitalization and respite)
- Short term crisis stabilization with medication management
- Telepsychiatry
- Detox and access to substance use services
- Pre-booking diversion initiative with law enforcement
- Six bed crisis home for youth ages 10-17.
- Transitional. living arrangements for homeless young adults

CONNECTIONSAZ (Transforming Psychiatric Care)
The Crisis Response Center (CRC)
Tucson, AZ

Features:

- $25M in state funding which is administered by the Maricopa County Regional Behavioral Health Authority

- The CRC operates as a Level I inpatient facility and an Outpatient Behavioral Health clinic for both adults and children
- The UPC is an *Adult-Only* Level I Sub-acute facility
- Walk-in service is staffed by psychiatrists and psychiatric nurse practitioners
- Psychiatric Care Center is staffed by 50 RN's, 48 behavioral health specialists, and 16 recovery support specialists
- Certified peer support training provided to all recovery support specialists

Services:
- Walk-in crisis service is available 7 days/week from 7:00AM - 7:00PM. Serves 40-50/day.
- 24/7 Psychiatric Care Center accepts both voluntary and involuntary admissions
- Observation Unit is a 50 chair, 23 hour service
- 16 bed inpatient unit
- Assessment and consultation
- Medication services
- Individual, group and family crisis counseling
- Provides both mental health and substance abuse services. Approximately 30% require mental health services; 30% require substance abuse treatment, and 40% require co-occurring treatment.
- Works closely with law enforcement. Police can drop off an individual and be back in service in 10 minutes.
- Recovery support specialists provide direct support to individuals and link them back to the community. They stay connected to individuals for 72 hours following stabilization.

Comprehensive Psychiatric Emergency Program (CPEP)
Washington, DC

Features:
- Free standing 24/7 operation housed at one location that acts as a hub for emergency psychiatric services, crisis beds, MCT, and homeless services
- Length of stay of crisis beds is 18-20 hours; maximum length of stay is 24-72 hours
- 3600 visits per year
- Funding is primarily local since fee for service has not proven adequate to fund crisis services
- Annual budget is approximately $10M
- Liaisons with multiple Federal and local law enforcement agencies
- many consumers have poly substance use disorder, but no onsite detox capability
- Those on emergency petition can be brought directly to CPEP instead of an ED - approximately 60% of individuals come on an emergency petition

Services:
- 24/7 walk-in services with full psychiatric coverage

- Law enforcement brings individuals on petition directly to CPEP (can go on re-route if at capacity)
- 19 crisis beds and observation unit
- Limited medical interventions
- MCT available midnight to 1:00AM & 9:00AM - midnight/7 days. Responds only to adults. Provides assessments for voluntary and involuntary hospitalization and linkage to community services such as substance abuse detox and treatment. Can dispense meds.
- Homeless Outreach 9AM - 9:00PM - engagement and case management
- Capability to develop a medical assessment of risk and need for medical rule out in ED

Cumberland County Crisis Response (Opportunity Alliance)
Portland, Maine

Features:
- Recommended by Council of State Governments
- Private not for profit
- $2.7M budget
- Provides crisis line coverage for three counties
- Portland PD has 100% of officers trained in CIT
- Maine does not require that an individual in a psychiatric crisis be taken to an ED for medical clearance
- Maine currently has 11 not for profit programs operating state-wide. Now an RFP is out to move to one crisis program for the state
- Private practice clinicians must develop an MOU with Cumberland Crisis Service to use them to deal with their patients' crises.

Services:
- 24/7 Clinical Crisis Line
- 24/7 walk-in services for assessment, stabilization, and linkage to other services. Police may drop off individuals in crisis.
- psychiatric evaluation service
- 24/7 Mobile Crisis Team (MCT) for adults responds primarily without police. Follow up is done by phone or face to face.
- Portland Police also have an embedded behavioral health program that is mobile.
- Eight crisis residential beds for adults in community

Harris Center for MH & IDD
Houston, Texas

Features:
- Recommended by Council of State Governments
- Population - 4.4M

- State/county hybrid - local mental health authority
- State/local funding - $4M
- Houston Police Department is listed in Council of State Governments as one of six Criminal Justice/Mental Health Learning Sites. Has a well-developed CIT program in 7000 person department.

Services:

- 24/7 clinical crisis line - provides coverage for 12 other counties (1/3 of Texas)
- ED Diversion - 7 days/9AM - 9PM
  - Police may transport and clients may walk in. 600 police admissions per month
  - Need for medical clearance is determined by each jurisdiction or by facility. Houston does not require medical clearance.
- 24/7 Neuro Psychiatric Center - housed within general hospital next door. All individuals brought in by ambulance go to this facility.
- Crisis Stabilization Facility - 16 beds (3-5 day Length of Stay)
- MCT - M-F, 7AM - 11PM. Only work with voluntary individuals. Staffed by psychiatrist, RN's, and behavioral health professionals.
- 2nd MCT embedded with Houston PD. Staffed by CIT officers and behavioral health professionals. Available 24/7.
- Triages individuals to Houston Center for Sobriety and Co-Occurring Disorder Residential Program
- Embedded mental health professionals at 911 center. 20 codes for calls are triaged directly to them.
- Intensive case management for high utilizers of emergency medical services

Mental Health Partners
Boulder, CO

Features:

- $50M budget - MA, federal grants, state grants, & local funding
- Private not for profit
- Recommended by the GAINS Center as a model for peer integration
- Peers integrated into all of the services. Colorado has a peer certification process, and this organization also does a 40 hour training and provides specialized supervision.

Services:

- 24/7 walk-in service co-located with detox program — 2 peers are utilized for triage, case management, outreach, and to obtain survey feedback
- Emergency Psychiatric Team - provides MCT services
- Project EDGE (Early Diversion Get Engaged) - behavioral health staff embedded with Sheriff's Office to provide mobile services. Peers are dispatched with clinicians to do de-

escalation, linkage to services, and follow-up. Primary goals are to divert individuals from the criminal justice system and hospitalization.
- 16 crisis beds - used as an alternative to hospitalization

PEOPLe Inc. (Projects to Empower and Organize the Psychiatrically Labeled)
Poughkeepsie, NY
Dutchess County (population 300,000)

Features:
- recommended by the GAINS Center as a model for peer integration
- Five organizations focused on helping stabilize people in crisis co-located in one facility
- Staffed by certified peers (certified through NY Academy of Peer Services), RN's, LPN's, & counselors
- $2.5M budget - locally funded, but exploring Medicaid and other sources of funding.
- No one turned away - all ages
- Services are voluntary
- Focused on wellness - wellness menu & education
- Guided by SAMHSA Dimensions of Wellness
- Modeled on Restoration Center in San Antonio
- "Gateway to treatment" vs. treatment center
- Co-located with 24/7 Mobile Crisis Team (MCT), Dept. of Social Services, domestic violence program
- Partners with local law enforcement which has 40% of its officers CIT trained

Services:
- Stabilization Center open 24/7 for walk-ins. Provides assessment, direct services, and direct handoff to community services.
- Works with all individuals in a mental health, substance use, or co-occurring crisis
- Runs Hospital Diversion Houses - 6 houses with a total of 17 beds in 4 counties
- 23 hour unit for observation & detox. Direct connection for on-going detox in 24 hours.
- Performs a self-report physical rule out interview and partners with a hospital for ED transfer
- Peer specialists follow individuals to assure that connections for treatment are made
- Law enforcement officers transport individuals directly to the Stabilization Center who do not require an involuntary psychiatric evaluation

Restoration Center
San Antonio, Texas (Bexar County)

Features:
- Recognized by multiple sources as a national model
- The Center for Health Care Services is the umbrella organization - provides comprehensive services for mental health, substance abuse, and Intellectual and Developmental Disabilities.

The Restoration Center is one of its 5 divisions. The organization has an annual budget of $100M.

- Primary factor that drove the creation of the crisis and addictions programs in the Restoration Center was that San Antonio was running out of space in their jail
- integrated with homeless services and primary care
- Saves $10M per year from having individuals wind up in hospitals and the criminal justice system. Study by health care economist available.
- 17 FTE's
- Currently all services are voluntary
- Current volume of services reports available for all programs
- Integrated closely with all organizations in the community that are stakeholders for these populations

Services:

- 24/7 Crisis & Substance Use Hotline - 30,000 calls/year
- Mobile Crisis Outreach Team (MCOT) - 24/7 - approximately 280 responses/month
- 24/7 Crisis Care Center - individuals may walk-in or be brought in by police.
- Sobering Unit - observation
- Detox Unit - 28 beds. LOS is 3-7 days.
- Minor Medical Clinic - treats many of the related injuries that those who are intoxicated incur that result in ED admission. Provides sutures, x-rays, and medical clearance.
- Crisis Observation Unit - 16 beds. Length of stay (LOS) is up to 72 hrs with average LOS of 48 hrs.
- Opioid Addiction Treatment Service
- Ambulatory Detox Program
- Intense Outpatient Treatment Program
- Mommies Program - treatment for women who are pregnant and are IV drug users
- Monarch Program - treatment for victims of sexual trauma who present in other systems
- Josephine Recovery Center - residential respite program with 16 beds to help individuals transition back to the community
- Centercare Clinic - provides primary care for individuals receiving behavioral health treatment

RI Crisis
Phoenix, Arizona

Features:

- $20M budget - state grant and MA fee for service
- Parent company, RI International has 12 crisis recovery and response centers in 5 states and New Zealand
- Guided by philosophies of "Never Say No" and "No Force First" in interaction with those in crisis

- No medical clearance is required at largest location in Arizona as well as in their centers in Delaware and North Carolina. Only 5% sent for medical clearance based on medical clearance checklist completed by RN's.
- Licensed as outpatient facilities
- Recent article in National Council of Behavioral Health Magazine regarding their philosophy
- Peer support specialists account for over 1/2 of staff. Services are peer based and recovery focused.

Services:
- Walk-in capability and also drop off by law enforcement and EMS. Systems are integrated with law enforcement and EMS.
- Capacity for thirty-two 23 hour beds for observation - 75% are diverted from hospitalization.
- Small inpatient units with average length of stay of 2 days
- Capability to do non-hospital detox
- Certified peer support specialists help connect the individuals to the facilities and follow them throughout the treatment process

Valeo Behavioral Health
Topeka, Kansas (Shawnee County)

Features:
- Recommended by the Council of State Governments
- Covers population of 175,000
- Private not for profit agency
- Primary payer is Medicaid; private insurance is not billable
- System of services
- Police may bring anyone in a behavioral health crisis to them directly - not required to get medical clearance in ED
- Waiting list for involuntary patients
- CIT outcomes: 2015 - 852 contacts; 46% diverted from the criminal justice system. Also track use of force, attempted suicide, and injury to individual/officer.
- Staff includes psychiatrists and a DNP

Services:
- Walk-in clinic: M-F, 9-5. Staffed by behavioral health screeners.
- Crisis Diversion Services - work with individuals in their homes; Co-Responder Team - embedded with police. Respond M-F, 8AM - 10:30PM; 10 crisis case managers respond 24/7 to community.
- 26 crisis residential beds (10 are 23 hour beds) - LOS is 3-5 days
- Recovery Center - social detox with 10 beds

- CIT - 65% of police dept. is CIT trained. Training done the last week of the academy, but any officer may attend.

Western Montana Mental Health
Missoula, Montana

Features:

- Setting is rural/frontier
- Private not for profit with catchment area that covers 16 counties (up to 600 miles between facilities)
- One state hospital in Montana and 2 general hospitals with behavioral health units in this catchment area
- Crisis services were developed since the only state hospital was at capacity and also due to geographic reasons
- Services are billed to Medicaid and paid on a fee for service basis
- Local funding comes from all counties
- General hospitals provide some funds and share staff, but this varies by jurisdiction
- State pays $500/day when beds are empty for maintenance
- Despite being the state with the highest suicide rate, most problems treated are situational and substance use (more than 50% of those treated have not previously received behavioral health services.)

Services:

- MCT is 24/7, but each program has its own restrictions. Some will only respond to agencies, and some respond only with law enforcement.
- Stabilization centers provide voluntary residential services that function as an alternative to hospitalization. In addition to the voluntary section, there is also a detention center in the same building. Individuals are brought in by law enforcement.
- System also has urgent care access

Strategic Plan

This Strategic Plan will examine the vision, mission, and guiding principles that the BHAC has articulated as important and utilize these as a guide in addition to the literature search, community survey results, and opportunities and challenges that currently exist to do an analysis of crisis models, and to formulate strategies and recommendations.

Vision

All Maryland residents will have ready access to 24 hour/7 day/week behavioral health crisis walk-in services and mobile crisis team services that can provide effective care in the least restrictive, consumer and family focused manner and environment.

Mission

The focus of this strategic plan is to identify the need in Maryland for crisis walk-in and MCT services and to describe them as important components that will enhance the existing crisis system for mental health and provide crisis access for substance use crises. This will be accomplished through analysis of the available models of these services, which will result in recommendations regarding selection and implementation.

Guiding Principles

- Serves everyone
- No wrong door
- Accessible regardless of geographic area
- Accessible regardless of ability to pay
- Culturally and linguistically competent
- Services delivered in a manner that meet the needs of people of all ages
- Integrated care that provides timely access to mental health and SUD intervention and treatment
- Measurable improvement in cross-agency behavioral health coordination
- Marylanders will have greater awareness of and access to mental health, substance abuse and physical health care services in order to reduce the likelihood that persons with behavioral health disorders become involved in the criminal justice system, die from co-morbid conditions earlier than the average adult, or require inpatient psychiatric hospitalization.
- Staffing is multidisciplinary with certified peers integrated in multiple functions
- "New partnerships at the state, local, or community level and across health and social service agencies are being implemented to develop legislation, policies, management, and monitoring mechanisms, and funding streams to support, disseminate and sustain new and emerging trends in behavioral health crisis response."[27]

Gaps

Through the process of doing an environmental scan, a number of gaps in behavioral health crisis services have been identified that currently exist in Maryland.

Gap 1 - Uneven Distribution and Insufficient Capacity of Community Based Behavioral Health Crisis Services

In terms of need, the Maryland Hospital Association's Environmental Scan done in 2016 identified gaps in community based behavioral crisis services that result in an increasing use of EDs and inpatient hospital resources. The data presented shows that there were 107,000 ED visits in 2015. In terms of which jurisdictions had the highest rates/1000, Figure 1 indicates that

[27] National Council Magazine, Crisis to Recovery, (2016). Comprehensive Crisis System.

it is not just the large urban jurisdictions that have the greatest volume. Many of the predominately rural jurisdictions on the Eastern Shore and in Western Maryland had high rates of use with fewer crisis services available.

It is clear from the information presented in the Crisis Services Array by Jurisdiction (Figure 2) that there is an uneven distribution of crisis services throughout Maryland in general, but in particular in relation to 24/7 crisis walk-in and MCT services upon which this plan is focused. This has undoubtedly come about for a number of different reasons. These include: uneven access to funding, uneven level of perceived need based on population and local issues including geography, a range of different planning and programmatic priorities based on current knowledge of best practices, and history. What is not available at this time is information regarding how jurisdictions that do have services are impacted by lack of capacity of those services.

Adding access to 24/7 walk-in crisis services would affect 19 jurisdictions (one jurisdiction is made up of five counties). Crisis Walk-in Services in Maryland are present in three of the larger and most affluent jurisdictions in Maryland. Currently none of these programs are set up to also provide crisis services to those in a substance use crisis that requires immediate detox. Implementing MCT would affect six jurisdictions. While many of the MCT programs have extended hours, only four have 24/7 coverage. In jurisdictions that do have MCT, response time is an issue due to capacity. This has resulted in unmet behavioral health care needs which strain Maryland's health care system and often require law enforcement to be the default response. In some cases, the time during which behavioral health crisis services are unavailable constitutes almost two thirds of the total time since they may not be available after hours, weekends, and holidays.

Gap 2 - Lack of Sustainable Local and Other Funding Sources for Crisis Services

Although the Maryland Behavioral Health Administration sets the focus and goals for crisis services in conjunction with local jurisdictions, the state is not in control of the total funding that is required to run these programs. The two jurisdictions that do have 24/7 crisis walk-in services both have local funding as one of their crisis funding sources. Although there are 12 jurisdictions across the state that have some level of local funding for crisis services, 72% of the local funding resides in three jurisdictions. Federal funding for crisis services accounts for a total of $4,142,348 of the total $29M spent on crisis services within Maryland. Each jurisdiction faces challenges in securing sufficient funding to implement or enhance crisis programs. Often, funding from other than government sources is for the startup of projects, and therefore is not viable as an on-going source. As previously mentioned, Frederick County's crisis walk-in program has relied on several sources of funding, but these sources have not proven to be stable over time. Individuals who are covered by private insurance can access some crisis services, such as MCT, hotlines and walk-in crisis services which are grant funded, however they are often unable to access additional services such as Crisis Beds and ACT teams which often are not reimbursed by the private insurance industry.

Gap 3 - Cross System Shared and Useable Data

Although data is available through organizations such as the Maryland Hospital Association that can show the impact of the need for behavioral health crisis care on the health care system, it is not available through other systems such as the criminal justice system. Data is collected locally and in such a manner that prevents obtaining accurate totals of calls for behavioral health crisis situations within jurisdictions and across the state. Partnership with these two systems is key to being able to adequately address the goal of providing services in the least restrictive community based setting, and preventing unnecessarily use of EDs, inpatient hospitalization, and interaction with the criminal justice system.

Gap 4 - Lack of Use of Promising Practices

In reviewing the literature regarding behavioral health crisis services and analyzing current national models, it is clear that several practices are in use that have improved the quality and the accessibility of services. One in particular that stands out is incorporating certified peers into practice. This is being done innovatively in both crisis walk-in services as well as with MCT. Programs have found that certified peers working with behavioral health clinicians increase effectiveness in the engagement process, are able to keep individuals supported and motivated through the crisis intervention and stabilization processes, as well as assure that the person is handed off and connected to on-going treatment. In addition, in areas of the country that experience difficulty recruiting and retaining an all professional staff due to their geography or funding constraints, the use of peers can help make providing crisis services viable. Current research indicates that peer support services decrease substance use, and reduce utilization of inpatient and emergency room care. "Increasing access to peer support services offers a cost-effective strategy for expanding the behavioral health workforce and reducing reliance on crisis, inpatient, and other more restrictive types of care. Peers can also play an important role in crisis response and critical transitions, including community re-entry after hospitalization and incarceration.[28]"

The practice of using telepsychiatry also warrants further evaluation in terms of its applicability in making professional behavioral health crisis services available in areas that do not have ready access to that medical specialty. This service is currently in use in the areas of the country that are most challenged geographically in terms of distance to travel, but also in some urban areas in which population density makes it difficult to access services in a timely manner.

Gap 5 - Public Information

Based on the Maryland Clinical Crisis Walk-in and Mobile Crisis Team Survey and Targeted Group Response conducted by the BHAC, it is clear that whatever the current strategy for disseminating information about existing crisis services has not been effective. There are a number of different sources this information should come from such as the state BHA, local CSA's and LAA's, local government, advocacy organizations, and other community systems

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[28] Texas Health and Human Services Commission, Statewide Behavioral Health Coordinating Council, (2016). Statewide Behavioral Health Strategic Plan.

such as law enforcement and hospitals. In many situations, it seems that when a behavioral health crisis occurs, it is not clear what to do or which resources are available.

Gap 6 - Lack of Coordination

Absent a central hub to coordinate crisis resources both internally and externally, responses are variable and follow-up is not consistent. Each incidence is treated as a standalone encounter rather than as part of the person's overall treatment history. Further, it becomes difficult to track outcomes and report systemic data.

As a result of not having online health records, a uniform data base for capturing program data within crisis services, or a uniform data base for behavioral health calls within law enforcement, it is a challenge to use program measures to describe and quantify the impact of crisis programs.

Goals

1. **Program and Service Coordination** - design and implement a state-wide system of behavioral health crisis services that has at its core 24/7 crisis walk-in and MCT services.
2. **Program and Service Delivery** - ensure that services are structured such that they can be as responsive and accessible to all residents of Maryland and effective in dealing with a wide variety of behavioral health crises.
3. **Data Collaboration** - collect and provide access to data across systems in a comprehensive manner that allows information pertinent to intervening in a crisis to be available and information that documents the effectiveness and impact of programs to be able to be produced.
4. **Identification of Funding Sources** - ensure that crisis services are adequately funded.
5. **Informed Public** - ensure that the public is aware of existing behavioral health crisis services in their jurisdiction and how to access them.

Opportunities to Address Gaps

This section will briefly discuss some of the current factors that may make the effort to implement 24/7 crisis walk-in services and MCT services more feasible. Currently, there seems to generally be increased visibility and understanding at every level of the need for comprehensive behavioral health crisis response based on personal, local, and national experiences. There is a recognition that many of the most comprehensive crisis systems were built and funded following tragedies or as a result of federal government oversight. **Crisis services are not just behavioral health services. They also function as public safety services.**

Although there has been legislative support over the years for behavioral health services, it is now evident in at least two recent bills that were signed into law that crisis services are a priority. Senate Bill 551/HB 682 (2016), to which this strategic plan is responding, is a recognition by the Maryland legislature that these services are critically important components for a comprehensive crisis system for Maryland. This bill did not presume that these services should only be available in the largest urban jurisdictions and either unavailable or available on a restricted basis in

smaller, rural jurisdictions. Senate Bill 967/HB 1329 (2017), the Heroin and Opioid Prevention Effort (HOPE) and Treatment Act of 2017, requires the Behavioral Health Administration (BHA) to establish 24/7 behavioral health crisis treatment centers in a manner that is consistent with this strategic plan. At least one of these centers must be established by June 1, 2018. Maryland's behavioral health crisis has created greater visibility for the need for these services. In addition, a statewide 24/7 crisis hotline will be in place to respond to callers in crisis and connect them with the appropriate resources.

Sufficient models are available locally and nationally from which to pull various components to create a customized model that will meet the needs of Maryland. Jurisdictions in other states that are faced with similar challenges of dealing with complicated and prevalent behavioral health crises that occur across a variety of settings from urban to rural and which impact their health care and criminal justice systems have been successful in structuring crisis walk-in and MCT programs that have proven to be effective.

Challenges

This section of the Strategic Plan will look at issues that are challenges specifically for Maryland. Issues that may negatively impact the implementation of these services or their effectiveness will be identified. Funding for crisis services is always difficult to secure and maintain. Local funding is not available at present for most of the jurisdictions in Maryland. When other sources of funding outside of the state government are secured, they are often not stable over time. From a federal perspective, potential decreases in Medicaid funding are a definite political possibility that may further constrain the funding that is available. Commercial insurance will most often not pay for community based behavioral health crisis services.

Maryland law presents another challenge to creating a system that could get the most benefit from having 24/7 crisis walk-in and MCT services. Maryland Code, Health-General Article §10-624 requires that individuals subject to a petition for an emergency mental health evaluation (aka EP) be taken to the closest emergency facility. Unfortunately, the only facilities that have been interpreted as meeting the definition of "emergency facility" under the Health General §10-620 are hospitals with emergency rooms. Systems that do not have this requirement have a much greater chance of building a system that is able to routinely divert individuals from the ED or psychiatric hospitalization. In those systems, medical clearance is not always needed, and is only sought if, based on a screening or history it is indicated.

Emerging populations have become a challenge due to the need for additional training and lack of access to appropriate resources for disposition. An example is the population with Intellectual and Developmental Disabilities. Behavioral health crisis services are increasingly utilized to intervene outside of the traditional intervention with mental health or substance use crises. They are utilized to deal with managing any issue related to behavior.

Language and cultural competence are major challenges in many of the larger jurisdictions in Maryland. Jurisdictions like Montgomery County have as many as 160 spoken languages in their public school systems. In order to effectively and legally intervene with whoever presents, there

is a need to have access to language translation capability, but also a diverse staff that is aware and competent as it relates to specific cultural issues that will affect their ability to engage and treat successfully.

Recruiting and retaining qualified behavioral health professional staffing is an on-going issue. Some rural states use primarily bachelor's level staff, and still have difficulty recruiting and retaining them. Recruiting sufficient diverse staff with other language capability is not always easy even in large urban areas.

Maryland also has challenges in terms of its geography with which to contend. Adequate access to services in areas like the Eastern Shore and Western Maryland where there are large expanses of area to cover, and individual jurisdictions are relatively small in population will require different strategies than suburban and urban areas of the state. Access is relative, however, and these challenges have been met in some states such as Montana which deals with much larger versions of these issues since much of the area is not even rural, but is considered "frontier" by their description.

Strategies for Implementation

Goals	Strategies	Gaps Addressed
Goal 1: Program & Service Coordination	1. Require formalized collaboration with partners that are reviewed on a regular basis: hospitals, ED's, hospital associations, and law enforcement. Many jurisdictions have standing partnerships with these groups, but usually not formal or at the executive level. As an example, implementing and enhancing CIT programs in Maryland required an enhancement of the partnerships at all levels between law enforcement and behavioral health. Moving forward took a commitment at the executive level. 2. Develop consensus regarding models for crisis walk-in services and MCT that will be funded and best fit with the needs of Maryland. 3. Define specific needs for each jurisdiction based on utilization requirements and geographic issues to determine which jurisdictions could benefit from a regional approach. 4. Determine a timeline for staggered implementation of new services that phase them in in a way that will be manageable.	1, 2, 3, 5, 6

	5. Make implementation/enhancement of these two programs in all jurisdictions part of a comprehensive behavioral health crisis plan. 6. Work with local hospital systems and local/state government for facility locations and funding & use in kind funding from the community for functions such as security. 7. Identify and change any regulations that run counter to system goals such as decreasing use of EDs, diverting from psychiatric hospitalization, and diverting from the criminal justice system. 8. Designate or develop a standing multi-agency committee that will track progress in implementing these programs. 9. Require accreditation of crisis walk-in and MCT services.	
Goal 2: Program & Service Delivery	1. Expand the use of best, promising, and evidence-based practices in delivering behavioral health crisis services. Integrating practices such as telepsychiatry should be explored. 2. Define program components including staffing. The use of certified peers should be considered for staffing both walk-in crisis programs and MCT. 3. Use of a mix of clinical and paraprofessional staff should be considered. 4. Recruit and retain diverse staff with other language capability and cultural competence. 5. Staffing strategies such as on-call, use of part-time temporary pools, use of a staff mix, and cross training for all staff to perform all functions of the program should be considered in making these programs function smoothly and be cost efficient. 6. Construct a plan for access to these services that will result in maximum utilization by individuals in crisis as well as community partners.	4, 6
Goal 3: Data Collaboration	1. Decisions going forward should be data driven 2. Develop a state-wide mechanism for tracking data online for each crisis provider. 3. Determine data elements to track to measure impact of programs implemented.	1, 3, 5

	4. Design & implement a single online behavioral health care record. 5. Develop a system that will allow law enforcement data regarding interactions relating to a behavioral health crisis to be available to behavioral health crisis programs for intervention and follow-up.	
Goal 4: Identification of Funding Sources	1. Develop a budget projection of cost involved in bringing these programs online or enhancing existing programs across all jurisdictions. 2. Identify viable and sustainable funding sources for behavioral health crisis walk-in and MCT. 3. Explore possibilities across MD for localities to leverage their funds by contributing to state funded crisis services. 4. Work with private health care organizations to secure funding for crisis services.	1, 2, 3
Goal 5: Informed Public	1. Develop a formal communications plan regarding the crisis services that exist throughout the state and how to access them. 2. Work to disseminate this information on an on-going basis through all forms of media in conjunction with partners such as the health care system, law enforcement agencies, and advocacy organizations.	2, 5

Analysis

While several of the models reviewed have a desirable feature set, none of the models have all of the features that would be optimal for Maryland. As an example, the three crisis walk-in programs that now exist in Maryland are primarily focused on dealing with mental health crises and none have a component that allows them to manage individuals in a substance use crisis who require detox services. As a result, all of the programs reviewed were analyzed to identify which of their components would best fit into a feature set that would be most effective in Maryland.

As a matter of policy, it would seem important that all jurisdictions in Maryland have access to a basic array of crisis services that will include 24/7 crisis walk-in services and MCT services. These crisis services should operate with a common set of principles. Each jurisdiction could then build out their crisis system based upon the crisis plan they formulate in conjunction with BHA and update annually to include those services in an ideal crisis continuum that are most needed locally.

The two oldest models in Maryland, Howard County and Montgomery County, do have some of the features that are needed which include: they function 24/7, they work with people of all ages, they function as hubs in that they have clinical crisis phone lines, MCT programs that are co-

located with them, and crisis residential beds that they coordinate. Both are also directly tied into other health and human services. In the case of Howard County, they are also the entry point for the homeless system, and in Montgomery County, they are co-located with and structurally an organizational component of all county health and human services. The newest crisis walk-in service which will open within the next year in Elkton, Maryland is co-located with several providers of behavioral health services and has the capacity for onsite detox services. The three centers are examples of three different structural models: Howard County's center is a private not for profit, Montgomery's center is local government, and Elkton's is a public private partnership. Given the success of the first two and the potential of the third, it appears that whatever crisis walk-in services and MCT services models are chosen can be administered by a variety of organizational structures that best suit the jurisdiction in which the services reside. This is borne out in the review of 14 national models which, in terms of organizational structure, nine were private not for profits, three were local government, and two were for profit.

Systems reviewed included those serving large metropolitan areas with populations approaching four million, those serving multiple rural counties, and those serving large geographic areas characterized as "frontier". The programs reviewed have adapted to all the challenges that jurisdictions in Maryland face in terms of locating services in a manner that is fully accessible, as well as contending with requirements for differing capacity based on local population and need. All jurisdictions in Maryland would provide all the services of these two programs, but local volume of service requirements would dictate program capacity.

A system such as that of the Center for Health Care Services of San Antonio, TX of which the Restoration Center is one of five divisions, provides a truly comprehensive array of behavioral health and other related services, but is not financially feasible outside of a large metropolitan area such as the one it is operated in with a population of two million.

The primary models for MCT programs require either having two behavioral health staff (clinician and paraprofessional or clinician and peer) respond in tandem with local law enforcement or having behavioral health staff embedded with a local law enforcement agency. Los Angeles County originated the model to embed behavioral health clinicians with police, and have developed it over time to become an integral part of their department's comprehensive strategy in responding to behavioral health crises. In Maryland, Baltimore County and Anne Arundel County have the latter of these two models. Anne Arundel also has an MCT staffed by two clinicians. Among the national models reviewed, all but two have the former model. Harris Center for Mental Health and IDD in Houston, TX and Cumberland County Crisis Response in Portland, ME have one team of each model. Some MCT programs only make one visit with any need for follow-up provided by other programs in the community. Other programs have the capacity to briefly follow the individual and make additional visits to help stabilize the situation. Each jurisdiction could be left to develop whichever model is the best fit with the understanding that the need to provide follow-up to assure linkage to needed community services/resources is addressed. Standardizing on one model that requires all jurisdictions to have behavioral health staff embedded with law enforcement would place the implementation of these teams outside the control of behavioral health, and may not be possible in some jurisdictions where there is more than one law enforcement entity that covers the jurisdiction. Particularly since there are currently

11 MCT programs in Maryland that use behavioral health staff to respond in tandem with law enforcement, changing their model would prove to be counterproductive.

As previously discussed, crisis walk-in programs can provide an alternative to an individual being evaluated in an ED both in terms of the actual experience, disposition, and outcome. Systemic support is necessary in order for a crisis system to be as effective as possible in accomplishing goals such as diverting individuals from EDs and psychiatric hospitalization. It is necessary to have state regulations that do not require the individual to receive a medical rule out or be evaluated in a local hospital ED. The regulations need to support evaluations being done in the community in the least restrictive and patient focused manner. Twelve of the 14 national programs reviewed function in systems that do not require evaluations be done in an ED for medical rule out. In Maryland, this will mean a clarification of interpretation of the current regulation that seems to only require that the individual be evaluated in a facility that is a Designated Emergency Facility (DEF). Although it is BHA's responsibility to determine which facilities are listed as such, in practice the interpretation of this regulation seems to be that this can only be local hospital EDs. As a result, each year the DEF list is updated, but only lists EDs in Maryland.

Despite the complexities of developing and running crisis programs, the funding of crisis programs remains one of the primary challenges. All programs reviewed rely upon multiple sources of funds. While many rely primarily on state funding, some have also been able to leverage local funding. As an example, Montana requires that all counties contribute to funding crisis services. Federal funding through Medicaid is available for some crisis services, and is used in all 50 states for some form of crisis services. In Maryland this is currently limited to crisis residential beds and peer services. Twelve states currently receive Medicaid funding for MCT. Those programs that have been able to secure the highest percentage of Federal funds seem to have done so through waivers. These include Medicaid 1915(a), 1915(b), and 1115 waivers[29]. Another potential source of local funding for crisis services that is relatively untapped is through local general hospitals. Although many crisis services have relationships with local general hospitals, often these relationships are not formalized through MOUs. In addition, despite data in some jurisdictions which demonstrates the impact on reducing ED overcrowding by managing behavioral health crises outside of an ED, there is most often no financial contribution to these services. In addition to direct financial support, another source of support through local hospitals that some models have been able to take advantage of through their partnerships is in kind contributions. A number of the models reviewed such as Alliance Mental Health Services in Memphis which is housed in a renovated portion of a state psychiatric hospital have been able to benefit from in kind contributions. Other in kind contributions such as providing security services, assisting with medical services, or providing transportation should be explored. Since the newest crisis walk-in center in Elkton, Maryland will be partially funded in this manner, it would be important to explore how this model could be relevant in other jurisdictions.

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[29] U.S. Department of Health and Human Services, SAMHSA (2014), "Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies".

Although Maryland has 24 jurisdictions, its Core Service Agencies are set up such that one of them represents five counties on the Eastern Shore (Kent, Queen Anne's, Caroline, Dorchester and Talbot). This has been done in geographic areas of the state that are primarily rural or less densely populated. This system seems to have functioned well from the standpoint of organizing and providing services on the Eastern Shore. In terms of locating 24/7 crisis walk-in programs and MCT programs, it would make sense both in terms of program delivery and the financial impact to use a similar strategy. For geographic areas such as the Eastern Shore, Southern Maryland and Western Maryland, it may even be necessary to further combine current jurisdictions in order to be programmatically and fiscally feasible. As an example, the Lower Shore counties (Somerset, Wicomico and Worcester) could be combined to cover that area. Cecil County will be covered by the new Behavioral Health Crisis Assessment and Stabilization Center, which will become the first crisis walk-in program in Maryland that will treat both mental health and substance use crises. That would mean that the Eastern Shore may be able to be adequately covered by three crisis walk-in programs. It is already covered by four MCT programs. In Southern Maryland, the three counties serving that area (Charles, Calvert and St. Mary's) could be combined to serve that part of the state. The other two jurisdictions that may be able to benefit from a shared crisis walk-in center are Garrett and Allegany Counties. Neither jurisdiction currently has either of these services. Among the national models reviewed, there are centers that are able to successfully cover larger geographic areas like this. All of the decisions about how these crisis services are distributed across the state would need to incorporate local input, and be able to adequately address the current level of need experienced. The following chart shows what services that currently exist need to be enhanced, and what additional services will be required if the service areas are organized as described above.

Jurisdictional/Regional Crisis Services Needed		
Jurisdictions	**Services in Place**	**Services/Enhancements Needed**
Allegany/Garrett Counties	Neither	• 24/7 crisis walk-in services • detox services for ASAM Level III.2-D • MCT
Anne Arundel County	MCT	• 247 crisis walk-in services • detox services for ASAM Level III.2-D
Baltimore City	MCT	• 24/7 crisis walk-in services • increase MCT to 2/47
Baltimore County	MCT	• 24/7 crisis walk-in services • detox services for ASAM Level III.2-D • increase MCT to 2/47

Calvert/Charles/St. Mary's Counties	Neither	• 24/7 crisis walk-in services • detox services for ASAM Level III.2-D • MCT
Carroll County	Neither (funding available for MCT)	• 24/7 crisis walk-in services • detox services for ASAM Level III.2-D • increase MCT to 24/7
Cecil County	MCT	• increase MCT to 24/7
Frederick County	Crisis walk-in services & MCT	• increase both services to 24/7 • detox services for ASAM Level III.2-D
Harford County	MCT	• 24/7 crisis walk-in services • detox services for ASAM Level III.2-D • increase MCT to 24/7
Howard County	Crisis walk-in services & MCT	• detox services for ASAM Level III.2-D • increase MCT to 24/7
Mid-Shore	MCT	• crisis walk-in services • detox services for ASAM Level III.2-D • increase MCT to 24/7
Montgomery County	Crisis walk-in services & MCT	• detox services for ASAM Level III.2-D
Prince George's County	MCT	• 24/7 crisis walk-in services • detox services for ASAM Level III.2-D
Washington County	MCT	• 24/7 crisis walk-in services • detox services for ASAM Level III.2-D • increase MCT to 24/7
Wicomico/Somerset/Worcester Counties	MCT	• 24/7 crisis walk-in services • detox services for ASAM Level III.2-D • increase MCT to 24/7

Ideally, crisis walk-in centers should be sited in a building that is accessible to the public in terms of transportation, handicapped access, and represent a non-threatening environment. A

number of practical trade-offs may need to be made in order to obtain the necessary space. As previously mentioned, it is ideal to have crisis services co-located to enhance access and continuity. Several of the model systems reviewed have co-located their services in or near hospitals, or in local government or state buildings.

Recommendations

1. Establish a crisis walk-in and MCT program model for each jurisdiction or region that has the features and services represented in the best of all models reviewed. The following chart represents that model. Currently existing programs would be enhanced to include these features and services.

Maryland Crisis Walk-in & MCT Models
Features • Function 24/7 • Serves everyone with a behavioral health crisis - mental health, substance use, & co-occurring • Access via walk-in, law enforcement drop off, MCT • Crisis walk-in service functions as a hub to coordinate all crisis services in jurisdiction/region and co-located where practical • Multiple organizational structures possible to administer these programs • Jurisdictional & regionally based programs • Multiple location types - standalone, housed at another facility, co-located with other programs • Recovery focused • Staffing is multi-disciplinary: psychiatrists, RN's, behavioral health professionals, para professionals, & certified peers • System does not require individuals on an Emergency Evaluation Petition (EEP) first go to an ED for medical clearance & evaluation. Police may drop off individuals for evaluation. • Programmatic integration with law enforcement focused on shared goals • MCT uses one of two models: - Responds with a clinician and a paraprofessional/certified peer in tandem with local law enforcement - Has behavioral health staff embedded in a local law enforcement agency to respond • MCT responds anywhere in the community including ED's and schools • Local primary law enforcement agency is CIT trained and other agencies are in the process of becoming trained • System goals: diversion from ED, diversion from psychiatric hospitalization, & pre-booking diversion from criminal justice system • Budget: state grants, Medicaid fee for service, local funds, other sources
Services • On-site evaluation • Crisis intervention (individual & family) • Short-term crisis stabilization with medication management

- On-site detox services for up to ASAM Level III.2-D and follow-up placement in community substance use services
- Medical assessment for risk performed
- Certified peers utilized for triage/engagement, support & case management with both crisis walk-in and MCT services
- Disposition that requires additional services accomplished thru case manager providing warm handoff
- Telepsychiatry available to increase access to services particularly in rural jurisdictions/regions

2. A delegation from Maryland composed of representatives from the BHAC, BHA, the Maryland Legislature, and other stakeholder groups should make a site visit to one or more of the comprehensive crisis services that have many of the elements needed for these programs to be successful in Maryland. These sites include: The Center for Healthcare Services in San Antonio, TX which is a comprehensive urban model, and Alliance Mental Health Services, Shelby County, TN, which covers the city of Memphis and three counties. In addition, it would be important to visit the most comprehensive crisis walk-in service in Maryland which is the Montgomery County Crisis Center.

3. BHA with input from the BHAC, CSA and LAA Directors, and other groups determines how the jurisdictions can be divided into regions for purposes of siting these services. They also determine the priority order for bringing these programs online across the state.

4. Each jurisdiction should develop an on-going crisis services advisory group chaired jointly by the CSA Director and the LAA Director. It should be composed of stakeholder representatives including law enforcement and local hospitals to work on development and implementation of their crisis plan in general and specifically to work on the implementation of these services.

5. BHA should explore Medicaid 1915(b) and 1915(c) waivers for behavioral health crisis services as one source of a comprehensive funding strategy. Local government funding strategies and potential funding from community organizations such as general hospitals and private insurance providers should also be developed.

6. Develop a plan to work with the legislature regarding the necessary change in regulation, statute or interpretation regarding the location at which an individual must be psychiatrically evaluated when detained on an Emergency Evaluation Petition (EEP).

7. Require that each crisis walk-in center as the hub for organizing crisis services capture a set of outcome data that include at a minimum: clinical outcome, disposition, reduction in EEPs issued, diversion rate from EDs, diversion rate from hospitalization, and diversion rate from the criminal justice system. Project jurisdiction cost savings due to the use of these crisis services.

8. Require accreditation of all crisis walk-in and MCT programs.

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Appendix A: Maryland Crisis Funding

FY '16 BHA FUNDED MENTAL HEALTH CRISIS SERVICES

General Funds	Allegany	A.A.	Baltimore City	Balto Co	Calvert	Carroll	Cecil	Charles	Frederick	Garrett	Harford	Howard	Kent County	Mid-Shore	Mont	P.G.	St. Marys	Washing	Wicom/Som	Worcester	TOTAL
23 Hour Crisis Beds																55,180					55,180
CIT	52,632	52,632	52,632	52,632		52,632	52,632	157,896	52,632	52,632	52,632	52,632		52,632	52,632	52,632		52,632	52,632	52,632	1,000,008
Crisis Hotline									172,324			216,916		160,043	89,333	155,082					793,297
Crisis Response	52,627	47,703	987,389	171,297		36,881	49,693	115,183	54,849	38,448	75,627	94,092		345,030	148,892	138,082		53,154	47,169	98,234	2,029,314
Crisis/ C&A			478 960	297,000																	775,960
Crisis Stabilization		103,000					50,000														153,000
Hotline			47,433																		47,433
M/C & Stabilization	109,080	105,080	230,170	133,400							105,080			105,080		158,000		105,080	95,527		1,142,447
Mobile Crisis			1,457,856	482,240							393,000			669,500		78,623					3,081,219
Mobile Crisis/Psychiatrist											74,870										74,870
Urgent Care					11,000			18,670						170,557	100,150						250,377
Residential Crisis Beds													250,000								250,000
Eastern Shore Operations Center - Anne Coombs														263,909							263,909
TOTAL STATE FUNDING	210,139	353,415	7,654,589	1,136,569	11,000	109,513	152,325	311,749	279,804	91,080	651,204	363,240	250,000	1,756,721	391,007	637,599	0	210,866	205,328	90,866	9,867,014

FEDERAL FUNDED MENTAL HEALTH CRISIS SERVICES

Federal Funds Federal Block Grant	Allegany	A.A.	Baltimore City	Balto Co	Calvert	Carroll	Cecil	Charles	Frederick	Garrett	Harford	Howard	Kent County	Mid-Shore	Mont	P.G.	St. Marys	Washing	Wicom/Som	Worcester	TOTAL
Crisis Services									87,370												87,370
Crisis Response	61,005	1,429,000														1,111,551				335,338	2,936,894
Crisis Services/ C&A			264,000																		264,000
Hotline				198 866					33,866												232,732
Mobile Crisis			611,352																		611,352
Crisis Outreach		10,000																			10,000
TOTAL FEDERAL FUNDING	61,005	1,439,000	875,352	198 866	0	0	0	0	121,236	0	0	0	0	0	0	1,111,551	0	0	0	335,338	4,142,348

LOCALLY FUNDED MENTAL HEALTH CRISIS SERVICES

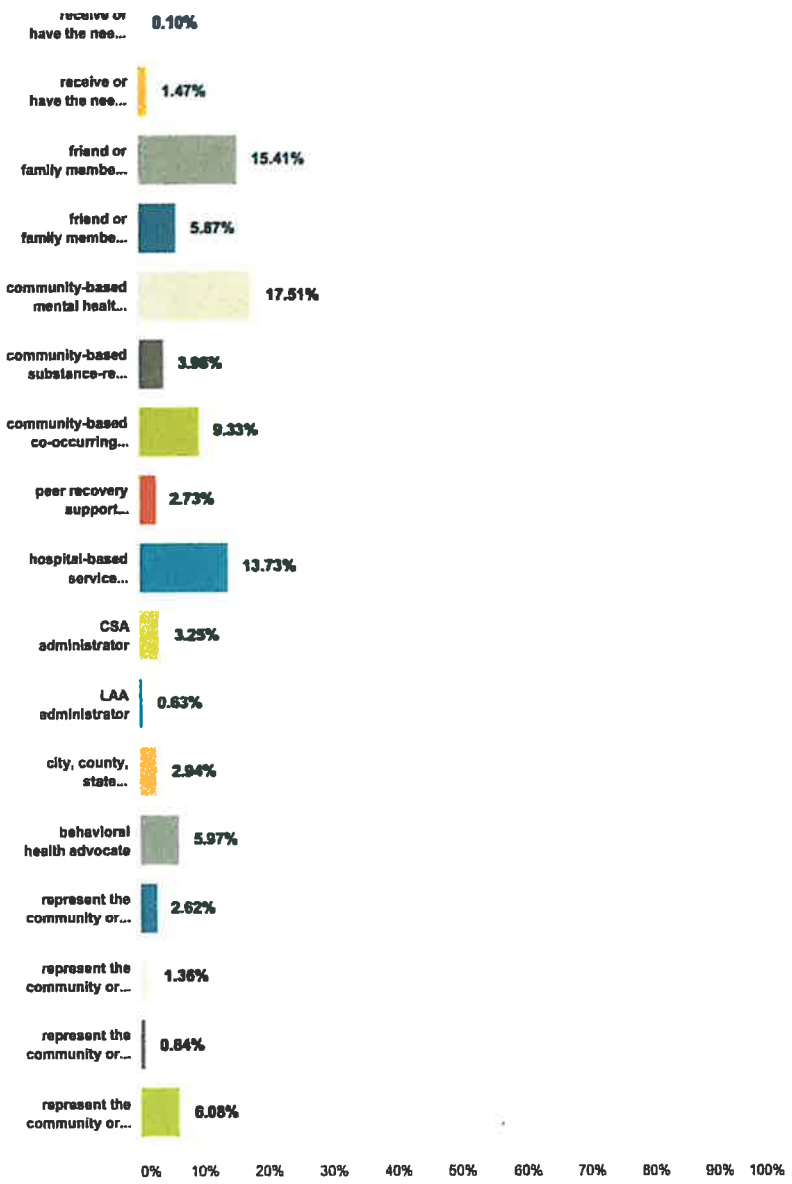
Walk-in Crisis Services									200,732												200,732
23 Hour Crisis Beds																55,180					55,180
CIT			86,750																		86,750
Crisis Hotline				954,400					206,189			211,246			121,416	378,019					1,431,272
Crisis Response																					0
Crisis/Child & Adolescent			1,564,356	250,950												117,650					1,972,956
Crisis Stabilization		237,000														158,000					395,000
Hotline																155,082					155,082
MCT		160,000					200,000		142,219	19,250		514,092				642,304				373,572	2,051,437
Mobile Crisis/Psychiatrist		80,000		754,810												52,250					887,060
Urgent Care	16,000			183 031						19,198					100,150	46,505				11,000	375,884
Residential Crisis Beds						100,000															100,000
Unified Crisis Budget			2,565 492												4,824,891						7,390,383
TOTAL LOCAL FUNDING	16,000	467,000	4,216 598	1,743,191	0	100,000	200,000	0	549,140	38 448	0	725,340	0	0	5,046,457	1,604,990	0	0	0	384,572	15,091,736
TOTAL FUNDING	287,144	2,259,415	7,746,539	3,078 626	11,000	209,513	352,325	311,749	950,180	129,528	651,204	1,088,580	250,000	1,756,721	5,437,464	3,354,140	0	210,866	205,328	810,776	29,101,098

Latest: 2/3/2016

Appendix B: MD Crisis Survey and Targeted Response Results

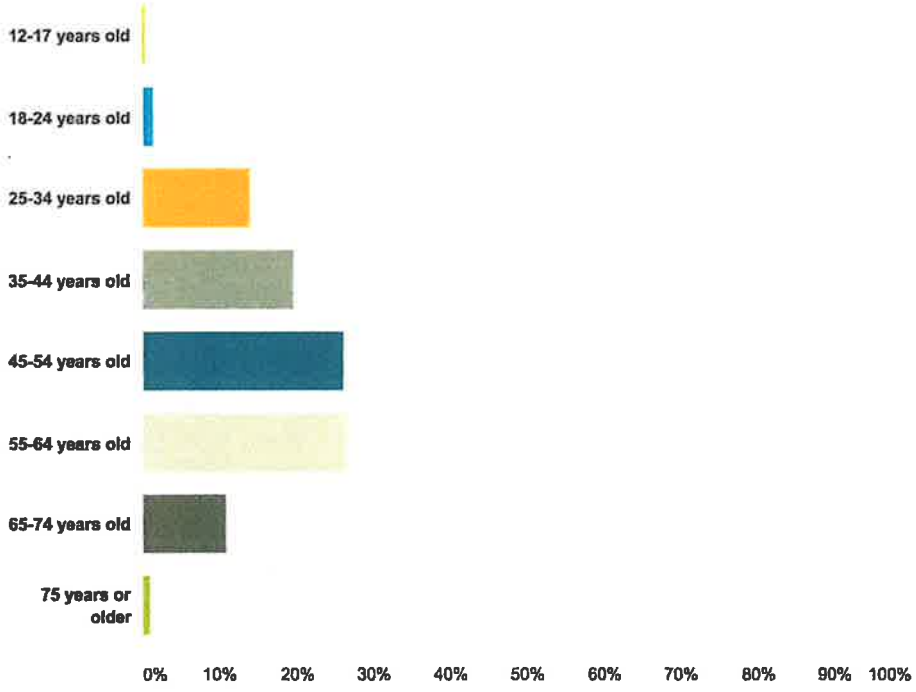
Q1 Which one of these categories best describes you for the purpose of this survey?

Answered: 954 Skipped: 105



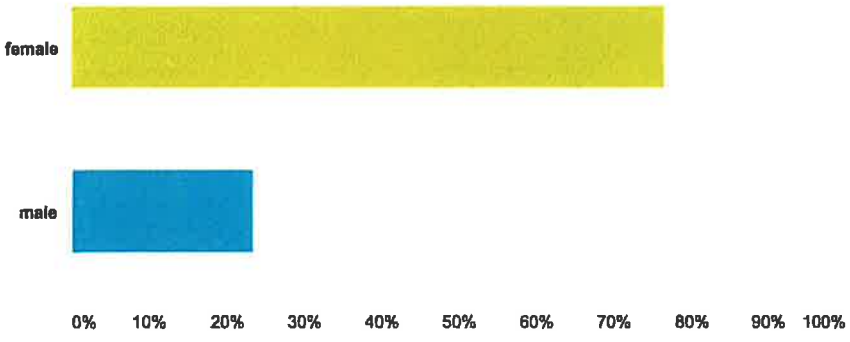
Q2 Please select your age category:

Answered: 1,050 Skipped: 9



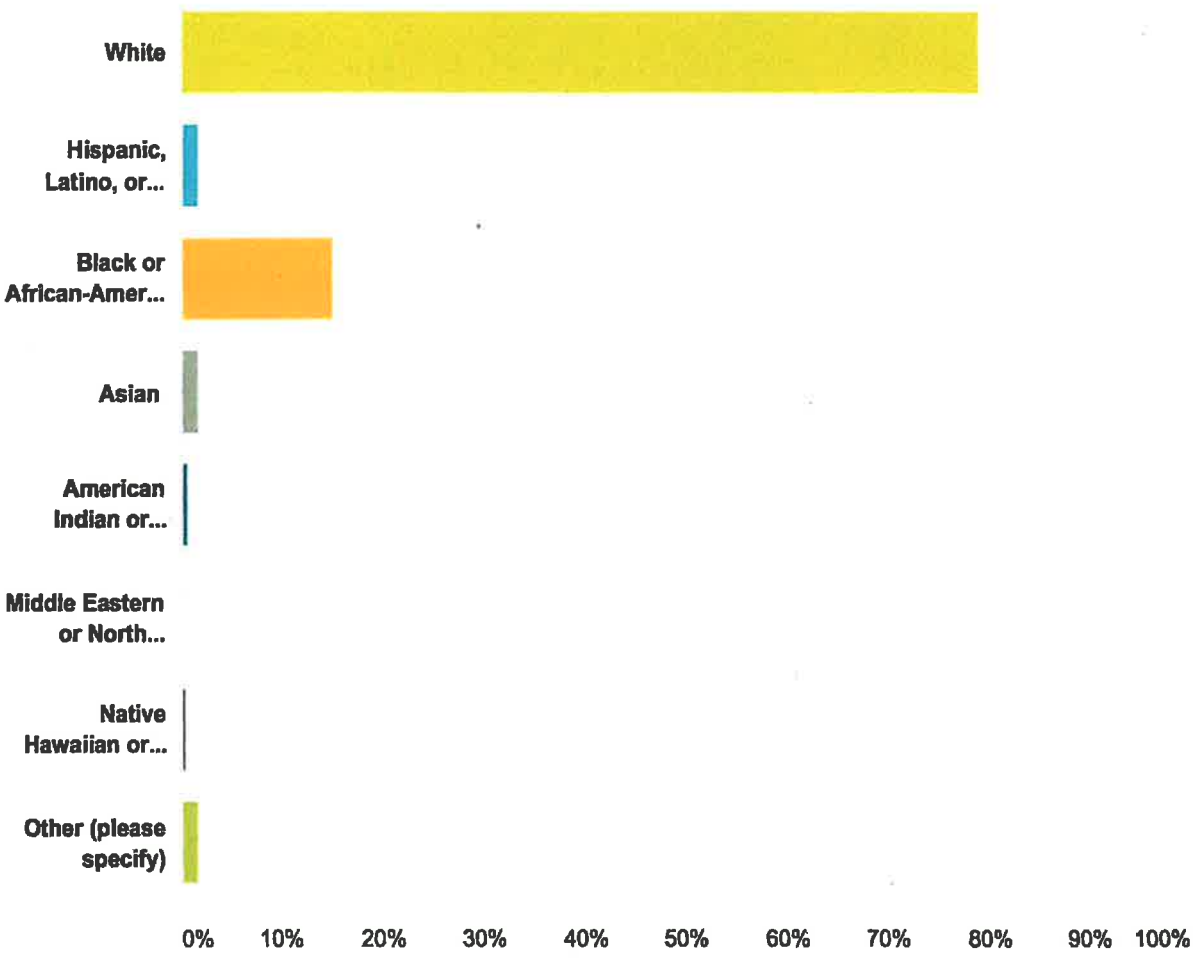
Q3 Please indicate your gender

Answered: 1,051 Skipped: 8



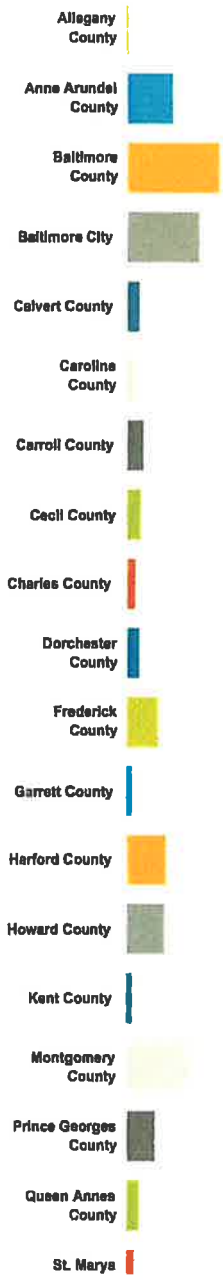
Q4 Which category best describes you?

Answered: 1,051 Skipped: 8



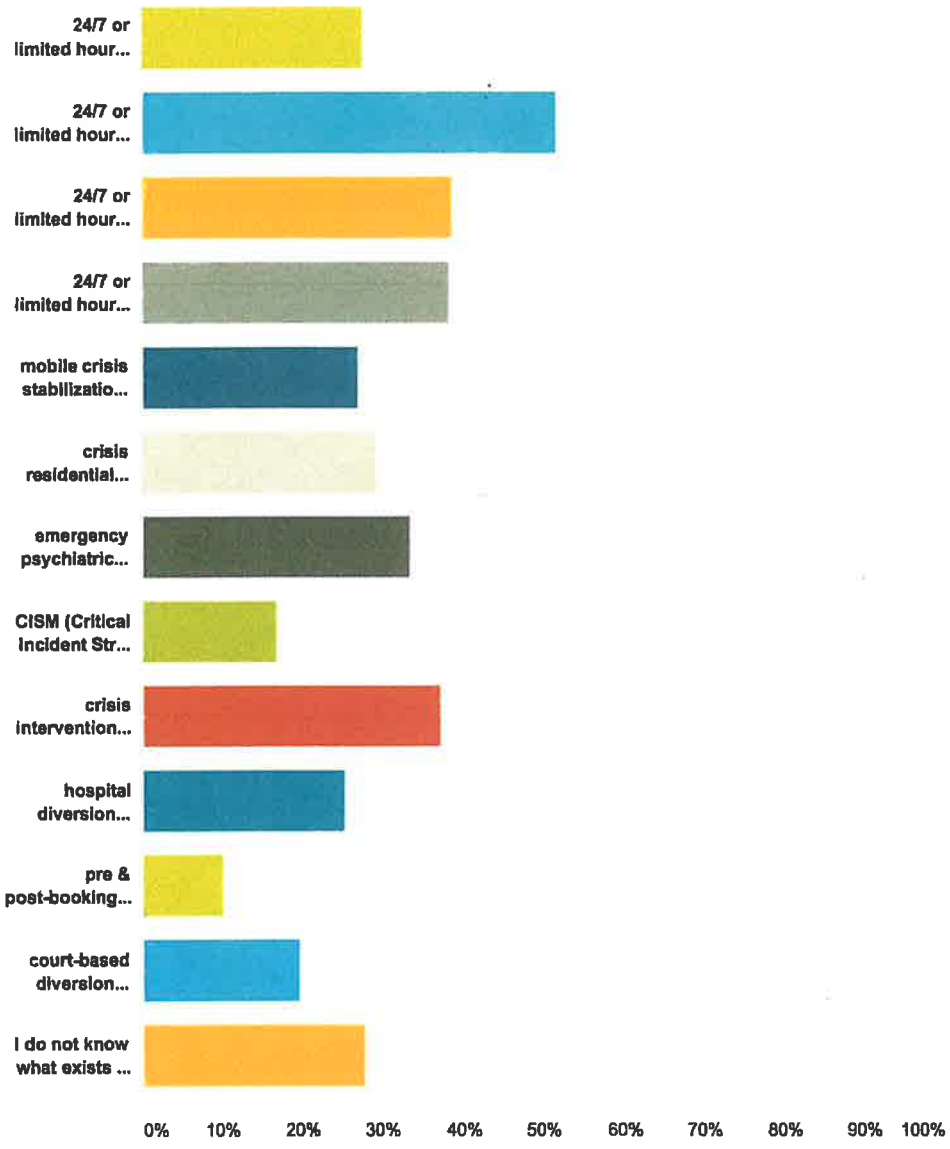
Q5 Please select the county or city in which you currently live:

Answered 1,046 Skipped 13



Q6 Choose all of the services listed below that CURRENTLY exist in your community:

Answered: 1,024 Skipped: 35



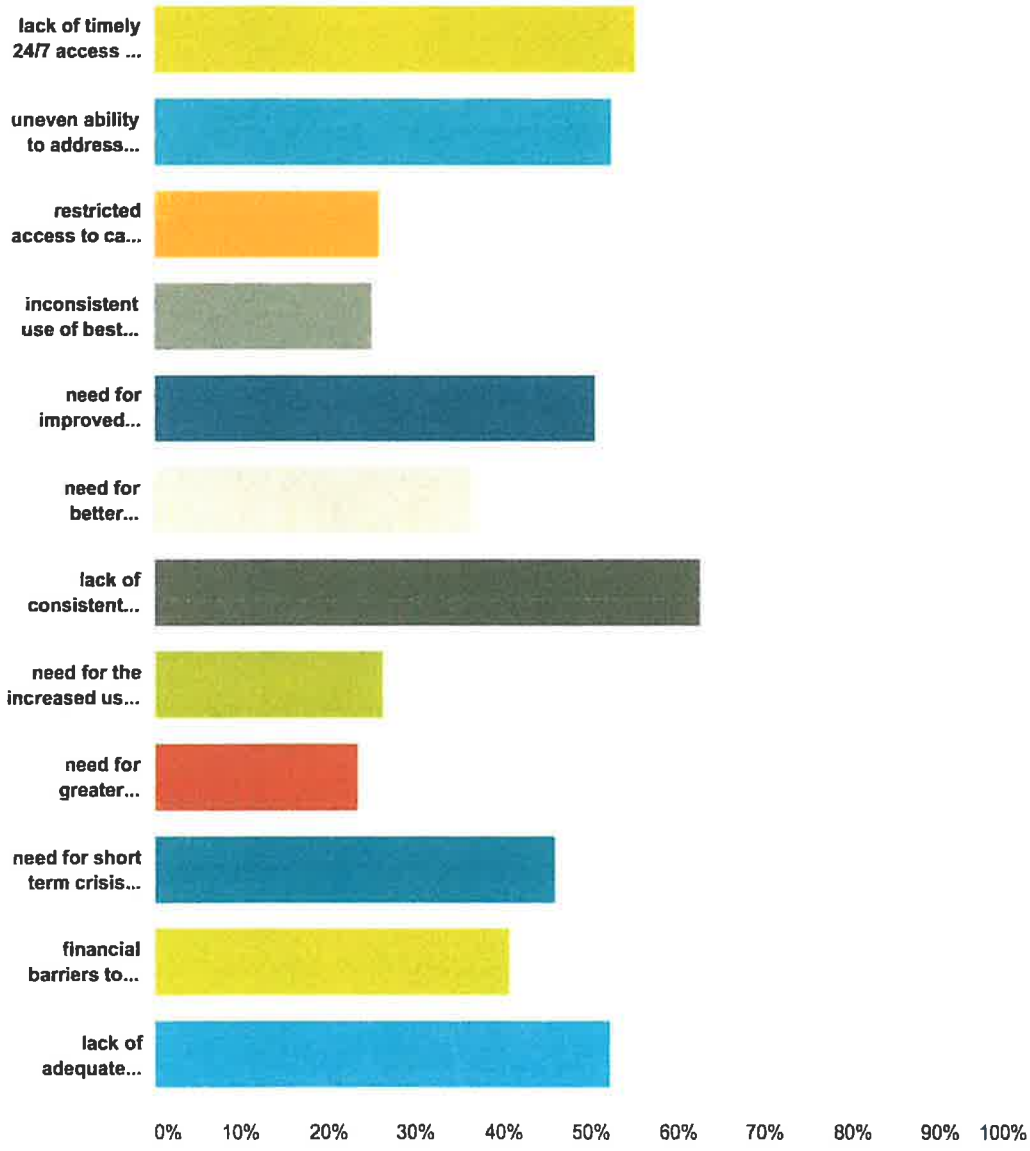
Q7. Which, if any, of the above services (in question 6) have you used?

There were 647 narrative responses (412 skipped the question & 284 provided either an answer of "no" or an answer that did not have relevance - final N was 363. Many responders listed multiple services) that had to coded into categories and tabulated. The results were as follows

Services	% Used
24/7 or limited hours clinical crisis walk-in services (see Survey Overview)	19%
24/7 or limited hours mobile crisis team (MCT) (see Survey Overview)	41%
24/7 or limited hours clinical crisis line (phone line answered by behavioral health professionals)	21%
24/7 or limited hours hotline (phone line answered by volunteers)	19%
mobile crisis stabilization for children/adolescents	14%
crisis residential beds (community-based beds used as an alternative to or step-down from psychiatric hospitalization)	17%
emergency psychiatric services (community-based outpatient psychiatric services)	15%
CISM (Critical Incident Stress Management) (intervention to help manage the reaction to community critical incidents)	12%
crisis intervention team (CIT) (community partnership which includes law enforcement training to increase knowledge, awareness, and skills in interacting with those with behavioral health issues)	17%
hospital diversion (diverting individuals in a behavioral health crisis to less restrictive, community-based services)	14%
pre & post-booking diversion (diverting individuals in a behavioral health crisis out of incarceration and into community-based services)	12%
court-based diversion (diverting individuals with behavioral health issues out of the criminal justice system)	15%
school	1%
ED	10%

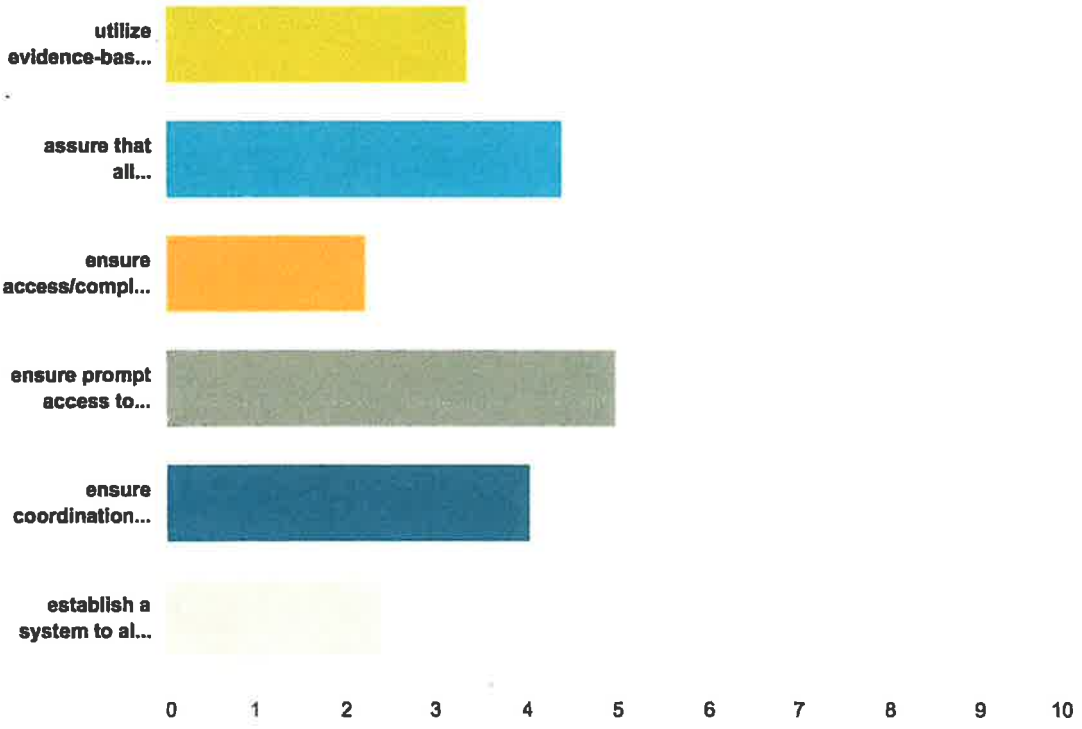
Q8 Please identify the 5 most important gaps regarding clinical crisis services that currently exist in your community:

Answered: 1,912 Skipped: 47



Q9 Please rank order these priorities that should guide decision-making about expanding and enhancing the clinical walk-in crisis services and mobile crisis team services in Maryland [1=highest and 6=lowest]:

Answered: 1,027 Skipped: 32



Q10 provided an opportunity for any other brief comments. There were 344 responses (715 skipped the question). While many of the responses were brief, numerous responses were a paragraph long. The following are representative categories of the input provided:

1. 24/7 services needed
2. need a way for people to find out what services exist
3. services should include the deaf community
4. unequal access based on insurance coverage
5. more comprehensive crisis services needed
6. inadequate follow-up
7. an adequate crisis system can reduce the overuse of the health care system
8. better assessments needed that involve families
9. more supports for families are needed
10. services do not exist in many areas - particularly rural areas
11. increase inpatient beds for problems with substance use
12. adequate funding needed to attract and retain skilled professional staff
13. stepdown services needed
14. where services do exist, not the capacity for timely response
15. need for medical records sharing
16. increase coordination between programs
17. increase language capacity and cultural competence of programs
18. EEP law needs revision
19. crisis services need to truly be an alternative to hospitalization
20. more accountability is needed for the current crisis services
21. increase training for law enforcement personnel
22. increase emphasis on the medical aspects of behavioral health
23. the complement of crisis services available in a jurisdiction needs to include services that can help stabilize the situation in the environment and services that can help the individual outside the environment
24. ED's are a bad environment for those in a behavioral health crisis
25. more outreach to the homeless is necessary
26. regional centers are needed with adequate competent staffing
27. increase voluntary, community based services
28. crisis walk-in services need to provide a welcoming environment
29. improve care available in ED's - wait time for assessments & wait time for placements
30. need outpatient commitment law
31. rape/crisis & DV need to be included in crisis services provided
32. decrease use of local jails as a substitute for crisis services
33. 24/7 crisis intervention for substance use is needed. Crisis residential beds are needed.
34. transportation is needed for access to crisis services
35. 24/7 walk-in crisis services are not needed since ED's exist. Clinicians in the community should be focused on working with individuals once they have been admitted to the ED.
36. too much emphasis on using peer counselors
37. services need to include older adults with medical problems

Survey Targeted Group Questions

The following is a compilation of the responses received:

1. Which behavioral health crisis services are most important to your organization/constituents/colleagues?

   - Ability to access SUD detox services, within 24 hours following initial request
   - Emergency referrals and placements to certified recovery residences
   - Establishment and funding of a formal system of recovery support services, to be accessed following formal treatment engagement
   - Inpatient hospitalization. The average wait for inpatient placement from the time of ED arrival at most Maryland EDs is measured in days, not hours. This is due to a shortage of available beds, lengthy workups insisted upon by psychiatric facilities out of overcaution of a medical problem (related or unrelated to the crisis) entering a psychiatric facility unrecognized, time consuming "shopping" of patients to inpatient facilities in serial fashion with no central coordination, and insurance-related delays relating to preauthorization and "shopping" the patient to one or more reviewers who generally always approve the admission but serve a nominal and largely functionary gatekeeping role. Patients with any unusual traits including infection histories (ie MRSA history) (even if not active or clinically irrelevant), any violent tendencies, the elderly or children, or developmental delay of any sort increases the delay exponentially.
   - Aggressive short term mental health follow-up. Patients whose crisis is more limited and who have sufficient community resources can often be discharged provided they can be seen the next day in some sort of supervised setting. So-called "Day hospitals," or daily visits, or even just single or a series of appointments with providers including psychiatrists, psychologists, social workers, or other providers can be configured in many ways to meet the needs of this population depending on the need and exact circumstances. Short term medication management can often avert a hospitalization and this cannot be typically done by an emergency department. In some cases, an option might be available but just out of geographic reach or not secure enough; in those cases, other resources including family, friends, or external resources can bridge the gap and help a patient avoid hospitalization.
   - Substance abuse treatment. "I just said I was going to kill myself because I thought that would get me detox" is a frequently admitted statement approximately 6-8 hours into an ED stay on an uncomfortable stretcher. Aside from consuming critical ED resources, these patients often have nowhere to turn and need extrication from an environment which will simply perpetuate the substance being abused. Many resources are private, require extensive medical pre-clearance, and full.
   - Housing. Many chronically mentally ill patients are simply in need of housing; their illness is "meta-stable" to the point that they are dischargeable but conditions outside (weather) preclude their safe discharge. Invariably, their homelessness exacerbates their social isolation and can worsen their psychosis or depression. Short term

housing, such as hotel rooms, are often extremely helpful in these situations, and county-level teams often facilitate these services.

- Case Management. Many patients have co-occurring medical problems which complicate their ability to manage their behavioral illness. The behavioral illness, in turn, limits their ability to manage their medical problems. This spiral of neglect typically conspires to produce far greater cost and morbidity than an ideal state. Staff who can monitor patients' entire health picture [ie not just medical and not just behavioral] are in short supply and programs are neither coordinated nor sustained (ie 30 days of case management following an acute problem).
- The health crisis services most important to our organization/constituents/colleagues are those that are culturally competent and have a diverse staff. The lack of African American male and female practitioners especially psychiatrists to deliver crisis services is a crisis in and of itself. Persons of color comprise only 2% of mental health professionals nationwide.
- In the Crisis Services focus groups, when asked what crisis services they would find most helpful, overwhelmingly the #1 response was "Mental Health Urgent Care Services." This was defined as "a walk-in clinic where you can take your child when in crisis to see licensed mental health clinicians for support, evaluation, and referrals without an appointment." Families dreaded taking their child to the emergency room, but did this because it was the only option.
- The second most desired crisis service was "Mobile Crisis Teams," but most families who had accessed MCT services expressed great frustration with the existing MCTs in their areas – 69% were disappointed by the limited help that was offered, complaining of long response times (or teams not coming out at all).
- In the substance use focus groups, the crisis service in greatest demand was immediate access to detox beds.
- As a predicate, it should be noted that unavailability of or gaps in crisis services often result in involvement by the criminal trial courts, while relevant crisis intervention often diverts cases from the criminal courts. Appropriate crisis intervention often effectively diverts assault cases. Exacerbated assaultive encounters often results in arrest, detention and further criminal processing. For defendants on probation, pretrial release, or mental health conditional release supervision, effective crisis intervention may allow defendants to continue in community settings and prevents re-incarceration or re- hospitalization.
- From a statewide perspective, it is difficult to isolate which particular crisis service intervention modality is most valuable. However, the need for real time intervention and the importance of continuity of care after the emergency intervention phase ends are paramount.
- Every jurisdiction, although many counties in Maryland cover large geographic areas, should have at least one crisis stabilization center. A goal for the future may to have some type of satellite stabilization center in larger counties or access to teletherapy/crisis assistance. Stabilization centers should also serve as drop-off centers for law enforcement to reduce unnecessary arrests and reduce emergency room utilization.

- Maryland should ensure increased access to Crisis Stabilization Units (CSU), small inpatient facilities of less than 16 beds, for people in a mental health crisis whose needs cannot be met safely in residential service settings. CSUs may be designed to admit on a voluntary or involuntary basis when the person needs a safe, secure environment that is less restrictive than a hospital. CSUs try to stabilize the person and get him or her back into the community quickly.
- Maryland should implement a mandatory bed registry as a means to identify potential bed availability at various hospitals, maximizing precious time during a crisis situation.
- It is important for communities to not only offer crisis services, but ensure that materials related to crisis situations are also available in every jurisdiction and should include information for caregivers and family members on what to include in a crisis plan of action.
- A statewide crisis line with community specific information should be available 24 hours-a-day and seven-days a week. A robust crisis line would include assessments, screenings, triage, preliminary counseling and information and referral services.

2. What do your organization/constituents/colleagues perceive as the gaps that currently exist in the crisis services system?

- Lack of services, and staffing- by peers, based on a "pre-treatment" approach to outreach and engagement, targeting men/women actively using
- Funding and expansion of peer-led SBIRT services to be delivered at the community-based level (Ex: within existing Recovery Community Centers)
- Lack of adequate, mandated, funding to expand crisis services
- Utilization of a 'paid" certified peer workforce in delivering crisis services
- lack of global coordination contributes to misuse of available resources. At least three kinds of coordination are worth noting:
- Crisis intervention teams. Many patients are followed by crisis intervention teams. When such patients are recognized early in an ED visit and contact made, the crisis team can often dispatch mobile resources to the patient on the spot [or at minimum provide valuable information]. That team could arrive at an ED, help interface between the patient and the ED, and cut short what might otherwise be a lengthy evaluation and information-gathering period. Because of the familiarity of the crisis team with the patient, they can more quickly triage a client's situation. Resourcing mobile crisis teams and promoting their integration with Maryland's emergency departments, police services, and EMS departments is critical.
- Data coordination. The MHA and HSCRC have promoted the use of "care alerts" or other small snippets of information intended to quickly familiarize EDs with a given patient's issues, risks, and available resources (ie a relative who knows the patient well and typically has a keen barometer on the patient's immediate situation or functioning). While these early ideas have promise, many organizations have simply regurgitated problem lists or visit lists in an effort to comply with care alert volume creation expectations (ie 20% of highest risk population defined by the HSCRC)

rather than thoughtful, insightful distillates of patients' problems. Moreover, our large health care systems (Hopkins and UMMS) have the [defendable] position that data sharing between organizations around behavioral health problems should be forbidden out of a concern for privacy. Originally driven by an intention to safeguard notes about psychotherapy sessions in which patients must have the absolute trust of their therapist, this standard has led these tertiary systems to shut down data exchange of behavioral health consults and ED-related visit notification to, for instance, patients' primary care providers. This self-imposed information blocking is the definition of care discoordination, albeit done out of concern for patients' ability to reveal and work through fundamental fears, events, or memories without fear of scattering this information to "just anyone" even in the health care space. More work needs to be done to resolve this problem.

- Centralized bed coordination. In Maryland, as in many states, dozens (if not hundreds) of patients sit in emergency departments awaiting placement in an inpatient bed. These placements happen point-to-point with no central view of matching the most appropriate statewide bed to a given patient taking into account a patient's support system, outpatient provider(s), geography, and needed services. It is as if each patient must find their way over a mountain range of bureaucracy and gatekeepers, rather than having someone optimize resources against needs with regard to the big picture. The best we see is [seriously] a listserv maintained by psychiatric unit nursing directors with occasional pleas for "Does anyone have a male VRE handicapped accessible bed?" with no security/encryption and haphazard responses; while this is very well intended (this group has my utmost respect), it is far from ideal. Multiple attempts have been made to start a "psychiatric bed registry" or some entity to coordinate inpatient psychiatric placement; these attempts (by MIEMMS and others) invariable end with hospitals refusing to commit to keeping a bed registry current enough to be useful, objecting to the possible manipulation of bed registry data as the basis of systematic EMTALA violation complaints, and simply not wanting to add any additional layers to the process even if it might mean FTE redirection or savings in the medium to long term [not to mention better matching for patients and more rapid and appropriate placements]. Whether these ideas should be raised yet again in spite of likely widespread opposition, whether Beacon should be the gatekeeper and take over assignments (which would have upsides and downsides) even for non-Beacon clients, and whether the repeal of the ACA, aging population, and ED/hospital overcrowding will change this debate – these are all important questions.
- There are few mental health professionals of diverse ethnicities. Hardest to access are psychiatric services especially those in private practice. Crisis services are temporary interventions involving individuals who will require longer term care. With so few mental health professionals of color, active clinicians will be easily overwhelmed as demand for services continues to increase.
- As stated above, the greatest perceived gaps were lack of Mental Health Urgent Care Centers, lack of 24/7 mobile crisis teams that were within a distance that allowed for more rapid response times, and an absence of emergency detox beds.

- It also should be noted that many families were not aware that MCTs were available in their area, and relied on calling 911 or taking their child to the emergency room. There was much ignorance about what services might be available. There needs to be better publication about the availability of crisis services, and clinicians should inform families about what services exist in their area.
- Trial judges throughout Maryland express frustration with ordering repeated emergency evaluations regarding the same individuals. The "revolving door" is not an academic concept for Maryland judges. Trial judges throughout Maryland note repeated arrests and criminal processing of serious and persistently mentally ill defendants (who frequently also are diagnosed as "co-occurring"- substance abuse). Meaningful civil commitment admissions are perceived as less likely following emergency evaluations while the durability and workability of continuity of care plans following crisis intervention frequently are questioned.
- When an individual with a mental illness is taken to the Emergency Department there is a lack of peer support and family peer support. Further, hospitals and emergency room department staff should have some type of mandatory training to improve the experience of individuals with behavioral health issues and family caregivers.
- The state should implement and fund training programs for family members that include care-givers of a loved one with a mental illness.
- Increase use of technology, such as telehealth, to increase access to crisis services.

3. Please provide any other brief comments regarding clinical crisis walk-in services and mobile crisis team services as they relate to your organization/constituents/colleagues.

- I believe we could do a better job in making the community, families specifically, aware of the existence of crisis services (Ex: Marketing availability of, through wider public dissemination)
- We need to expand the availability and delivering of crisis services beyond the singular focus of clinical. I understand delivering clinical services gets the provider paid, but not every crisis is clinical in nature.
- While crisis interventions are much needed services, the challenge of sustained care will be impacted by issues identified above. Temporary interventions must be followed with continuation of care that may mean in addition to mental and physical health, addressing social determinants such as employment, housing, child or elder care, etc. Challenges met through mobile and crisis oriented clinical services will be that of sustained care.
- Furthermore, an overarching concern "The American Health Care Act", changes proposed by the current administration's as a replacement for the Affordable Care Act "Obamacare". Some reports indicate up to 24 million+ people will lose their health care coverage and that mental health and substance abuse care will not be paid for with federal dollars. Medicaid also is slated to be cut drastically by 2020 with the cost of copays, deductible and medical services increasing substantially. These changes are inhumane and will have far reaching effects on access, cost and ability to pay for the most marginalized communities.

- Regarding substance use – families stressed the importance of using peers in emergency departments. The use of peers in clinical crisis walk-in centers presumably would be helpful as well.
- it is very difficult to generalize as to a statewide trial court perspective as to the status of mobile crisis and walk in crisis services. Judges cite impressive programs and clinicians while uniformly noting gaps of various sorts. The need for realistic and comprehensive continuity of care (aftercare) planning following the crisis event is nearly always noted by trial judges from all jurisdictions.
- Mobile crisis teams should increase the use of peer support and ensure that teams have the ability to refer families of adults, as well as children, to trained peer families and/or orgs. These types of supports should also be provided at in-person walk in crisis centers.
- Increase community education to reduce the stigma associated with mental illness and substance use disorder issues.
- Improve discharge planning from in-patient psychiatric hospitals and step-down services that includes the family and/or caregiver.

Appendix C: Children, Youth & Families Crisis Response Report

MARYLAND CHIPRA QUALITY DEMONSTRATION GRANT

CHILDREN, YOUTH AND FAMILIES' CRISIS RESPONSE AND STABILIZATION REPORT

May 20, 2013

Prepared by: The Institute for Innovation and Implementation
University of Maryland, School of Social Work

Prepared for: The Maryland Department of Health and Mental Hygiene

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APPENDICES:

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INTRODUCTION

The 1999 Surgeon General's report on mental health declared mental health to be a public health issue requiring focus beyond treatment, to prevention and health promotion. It highlighted crisis services as a vital component of a community service array as many youth access behavioral health services for the first time when they are experiencing a crisis.[1] More than a decade later, Maryland Medical Assistance data from State Fiscal Year (FY) 2007 through 2012 clearly demonstrate this public health need. These data show increased numbers of psychiatric emergency department (ED) admissions and inpatient psychiatric hospitalizations for children, youth and young adults, ages 0-21. Total psychiatric ED admissions rose 45% from FY 2007 to FY 2012. After adjusting for inflation, costs for treating youth experiencing crises in hospitals increased 25% from FY 2007 to FY 2012.[2]

There is a growing body of evidence that comprehensive crisis response and stabilization systems help **improve behavioral health outcomes, deter ED and inpatient admissions, reduce out-of-home placements, reduce lengths of stay and costs of inpatient hospitalizations, and improve access to behavioral health services.**[3] Investment in comprehensive crisis response and stabilization systems for children, youth and young adults is a particularly wise public health strategy given that **the risk factors for behavioral health needs are well established with clear windows of opportunity to prevent mental and behavioral health disorders and related problems before they occur.** National research shows that one in five young people has one or more mental, emotional and/or behavioral (MEB) disorders at any given time, with the associated annual cost of treatment, lost productivity and crime estimated to be $247 billion.[4] In their 2009 report, the National Research Council and Institute of Medicine called upon local, state and national leadership to make systemic prevention efforts a high priority in health care, noting that half of all adults with MEB were first diagnosed by age 14 and three-fourths were diagnosed by age 24, with first symptoms typically preceding the disorder by two to four years. Mental health and substance use disorders account for 30% of disability-adjusted life years lost by persons under the age of 25, the highest of any disease category for this age group.[4]

In 2011, the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) awarded a Children's Health Insurance Program Reauthorization Act (CHIPRA) grant to the Maryland Department of Health and Mental Hygiene for its collaborative proposal with the States of Georgia and Wyoming. The Institute for Innovation and Implementation at the University of Maryland, School of Social Work in partnership with the Center for Health Care Strategies[5] provides project management and technical assistance to Maryland, Georgia and Wyoming to support the multi-state collaborative goal of improving quality and better controlling the cost of care using a Care Management Entity[6] structure for children with serious behavioral health disorders enrolled in Medicaid or the Children's Health Insurance Program. This CMS award is distinguished as the only one of the ten CHIPRA grants dedicated to behavioral health issues. While the three participating states, of which Maryland is the lead, represent diverse geographic areas and Medicaid structures, they share common goals,

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[1] U.S. Department of Health and Human Services. (1999). *Mental Health: A report of the Surgeon General.* Available from the National Library of Medicine, National Institutes of Health: http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBHS

[2] The Hilltop Institute, UMBC. (2012). *CHIPRA Year 3, DATA REQUEST #15: ER and Psychiatric Hospitalizations: Maryland Medical Assistance* [Data file.] Provided to The Institute for Innovation & Implementation, University of Maryland School of Social Work under the CHIPRA Quality Demonstration Grant.

[3] Technical Assistance Collaborative (2005). *A community-based comprehensive psychiatric response service: An informational and instructional monograph.* Available from the TAC website: http://www.tacinc.org/media/13106/Crisis%20Manual.pdf.

[4] National Research Council and Institute of Medicine (2009). *Report brief for policymakers. Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities.* Available from the Board of Children, Youth and Families website: http://www.bocyf.org/prevention_policymakers_brief.pdf.

[5] The Center for Health Care Strategies is a national technical assistance center dedicated to improving health care access and quality. See http://www.chcs.org/.

[6] A Care Management Entity (CME) operates as the centralized authority for coordinating all care for youth with complex behavioral health challenges and their families. CMEs use the Wraparound service delivery model, which is intensive care coordination premised upon a youth-guided and family- driven, strengths-based approach that is coordinated across agencies and relies upon home- and community-based services and peer supports to avoid residential and hospital care. CMEs fit within the federal definition for a health home provider in the Affordable Care Act (Public Law 111-148, "Patient Protection and Affordable Care Act"). For more information on CMEs as health homes, see Center for Health Care Strategies (2012). *Using care management entities for behavioral health home providers: sample language for state plan amendment development.* Available from the CHCS website: http://www.chcs.org/usr_doc/CMEs_as_Behavioral_Health_Homes_-_SPA_Development.pdf. For more information on the Wraparound model, go to National Wraparound Initiative at http://www.nwi.pdx.edu/.

namely to: (1) improve access to appropriate services; (2) employ health information technology to support data-driven, clinical decision-making; (3) reduce the unnecessary use of restrictive and costly services; (4) improve clinical and functional outcomes for children and youth with serious behavioral health needs; and (5) build resiliency in youth and families, strengthening their involvement both in their own care and in the design and implementation of the behavioral health care delivery system. In particular, one of Maryland's specific goals is to assess existing crisis response services in each of the State's 24 jurisdictions,[7] research best practices, and propose a redesign of Maryland's crisis response and stabilization system for children, youth, young adults and their families. This paper documents findings, to date, with preliminary recommendations and sets forth additional work to be undertaken by the CHIPRA grant to support Maryland in further consideration of these recommendations.

Crisis response and stabilization services provide intervention by trained professionals and support to those experiencing a crisis, allowing for immediate de-escalation of the situation in the least restrictive setting possible, the prevention of the condition from worsening, and the timely stabilization of the crisis. The primary concern is safety of the child, family and community. Diverting children, youth and young adults with serious emotional disturbances from EDs and hospitalization requires comprehensive crisis response services to address immediate crises, as well as stabilization services to prevent repeat crises. Maryland's current behavioral health integration efforts and implementation of the Affordable Care Act (Public Law 111-148, "Patient Protection and Affordable Care Act") provides the opportune time for Maryland to re-evaluate its crisis system and the services currently available to children, youth and families. Further, as mental health and physical health needs are integrated, improvements in Maryland's behavioral health system will have a positive impact on physical health outcomes and spending, as well as on society as a whole. Maryland currently has a patchwork of crisis providers and response services available throughout the state, one which forms a foundation for our children, youth and families, but needs re-evaluation to ensure a well-connected response system exists in every jurisdiction.

> **"Crisis services for mental health should be like a fire department with services available in every neighborhood. Anyone can experience a mental health crisis in their family."**
> *Jane Walker, Executive Director, Maryland Coalition of Families for Children's Mental Health and Parent*

METHODS

CHIPRA Grant project staff established the Crisis Response and Stabilization Redesign Workgroup ("Crisis Workgroup") in December 2011. Members have consistently participated and met ten times in the last year (see p. 3 for a list of Workgroup members). The content of this report is supported by and based upon completion of the following activities by the Crisis Workgroup:

- Conducted national research and site visits to states and communities with successful crisis response and stabilization models, including New Jersey and Milwaukee;
- Analyzed psychiatric ED, hospital utilization, and cost data from FY 2007-2012 by youth's jurisdiction of origin and hospital penetration;
- Developed a continuum of recommended essential core components of a crisis response and stabilization system specific to Maryland, including a review of effective core crisis response and stabilization services within a continuum of care and integration of mental health and substance abuse crisis needs;
- Conducted a gap analysis in partnership with the local Core Service Agencies to determine availability of recommended core services in each of the 24 jurisdictions in Maryland;
- Surveyed Maryland's Psychiatric Residential Treatment Facility (PRTF) Demonstration Waiver[8] Crisis and Stabilization providers to determine service utilization and lessons learned;

[7] Maryland's 24 jurisdictions are comprised of 23 Counties and the City of Baltimore.

[8] In 2007, Maryland was one of ten states awarded the 5-year Community Alternatives to PRTF Demonstration Grant Program, authorized by Section 6063 of the Deficit Reduction Act of 2005 to provide home and community-based services to children as alternatives to PRTFs. These demonstrations tested the cost-effectiveness of providing services in a child's home or community rather than in a PRTF, to determine whether the services provided improve or maintain the child's functioning. In Maryland, this grant is known as the RTC Waiver.

- Partnered with the Alcohol and Drug Abuse Administration to survey Substance Abuse Treatment Coordinators to determine each jurisdiction's capacity to respond to children, youth and young adults in need of substance abuse crisis services; and,
- Cataloged all behavioral health hotlines available in Maryland, including populations and jurisdictions served.

The product of each task is summarized in the text that follows. Further detail is included in the Appendices.

This past fall, the Mental Hygiene Administration (MHA) began holding joint meetings between the CHIPRA Crisis Workgroup and a workgroup charged with assessing the adult crisis system to ensure that the State's crisis response and stabilization system has a full life-span service capacity with specific ability to address the transition aged youth (ages 18-21) population. The two groups are working collaboratively to ensure that redesign resources and efforts from both the children, youth and family (CYF) system and the adult serving system are leveraged together to maximize service capacity and effectiveness. While collaborations between the CYF and adult systems continue, the focus of this report is specific to the findings and recommendations for the design of a crisis system that will reduce Maryland's costly reliance on EDs and hospitalizations and improve CYF outcomes. This may be achieved by addressing service needs and gaps in Maryland's current continuum of care for children, youth, young adults and their families.

PSYCHIATRIC EMERGENCY DEPARTMENT AND INPATIENT ADMISSION DATA

The CHIPRA Grant provides funding to support a contract between The Institute, University of Maryland School of Social Work and The Hilltop Institute at the University of Maryland Baltimore County ("Hilltop Institute). This contract enables The Institute to receive and analyze Medicaid claims data from Maryland's Medicaid Management Information System; to support this particularly effort, the Hilltop Institute provided data for children and youth, ages 0 through 21, with a psychiatric ED admission to a Maryland hospital paid by Maryland Medical Assistance, including both those that did and did not result in an inpatient psychiatric hospitalization for FY2007 through 2012. Hilltop also provided data on inpatient psychiatric hospitalizations during FY 2007 through 2012 that were direct admissions in which youth did not pass through the ED first. Data were provided on the number and costs of admissions for both the county of origin of youth experiencing the crisis and the location of the psychiatric ED admission and/or inpatient psychiatric hospitalization. It is important to note that the data collected are limited to those admissions billed through Maryland Medical Assistance, and does not include admissions paid for through private insurance.

After adjusting for inflation, costs for treating youth experiencing crises in hospitals increased 25% from FY 2007 to FY 2012 (from approximately $52.3 million to about $65.6 million). Additionally, total admissions by the youth's jurisdiction of origin (including psychiatric ED admissions both resulting and not resulting in an inpatient psychiatric hospitalization, as well as non-ED psychiatric hospitalizations) rose 45% from F Y 2007 to FY 2012 (from 7,635 total admissions to 11,078 total admissions). Figure 1 illustrates the changes in psychiatric ED and/or hospitalization admissions from FY 2007 to FY 2012 by county of origin.

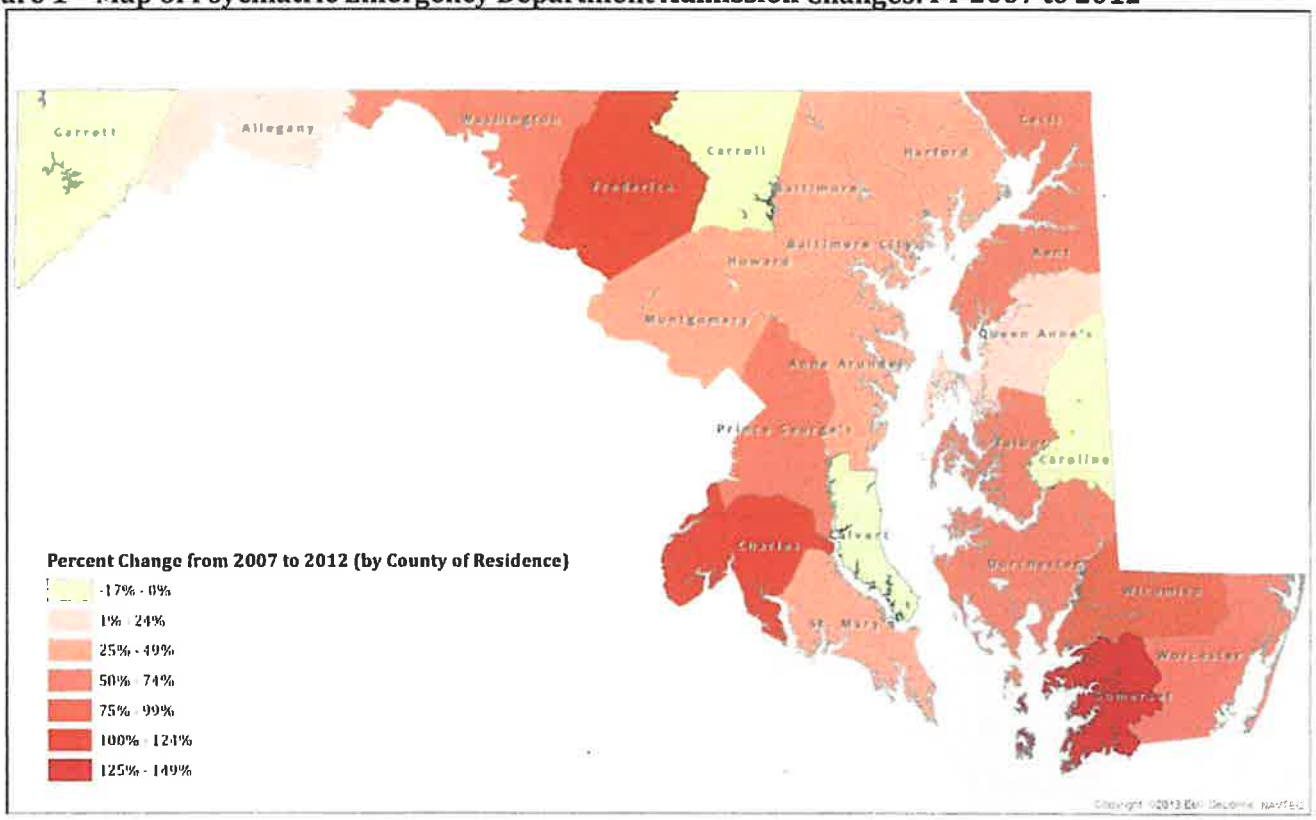
ED admissions for children rose 45% from F Y 2007 to FY 2012, from 7,635 total admissions to 11,078 total admissions.

As illustrated in Figure 1, increases in psychiatric ED and/or hospitalization admissions over the five-year period were not limited to a particular region. Rather, all but four jurisdictions (Calvert, Caroline, Carroll, and Garrett Counties) experienced increases in the number of admissions. Table 1 highlights the jurisdictions that experienced the greatest increases in psychiatric ED and/or hospitalization admissions from FY 2007 to FY 2012.

Table 1. Jurisdictions with the Greatest % Increase in ED Admissions

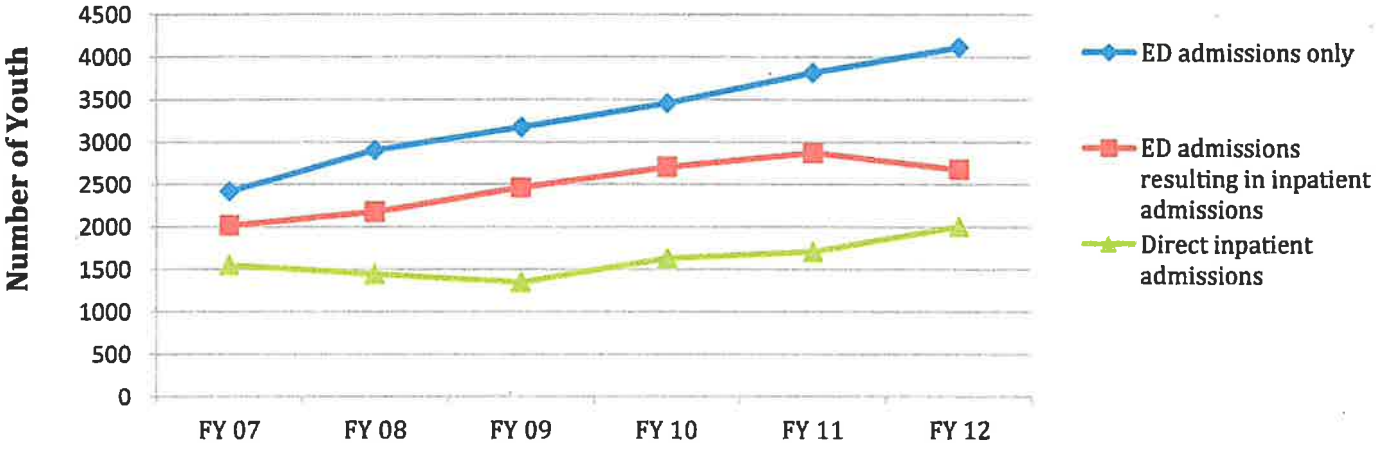
County	2007 - # Youth ED Admissions	2012 - # Youth ED Admissions	% Increase
Somerset	47	117	149%
Charles	71	157	121%
Frederick	189	387	105%
Wicomico	204	374	83%

Figure 1 – Map of Psychiatric Emergency Department Admission Changes: FY 2007 to 2012



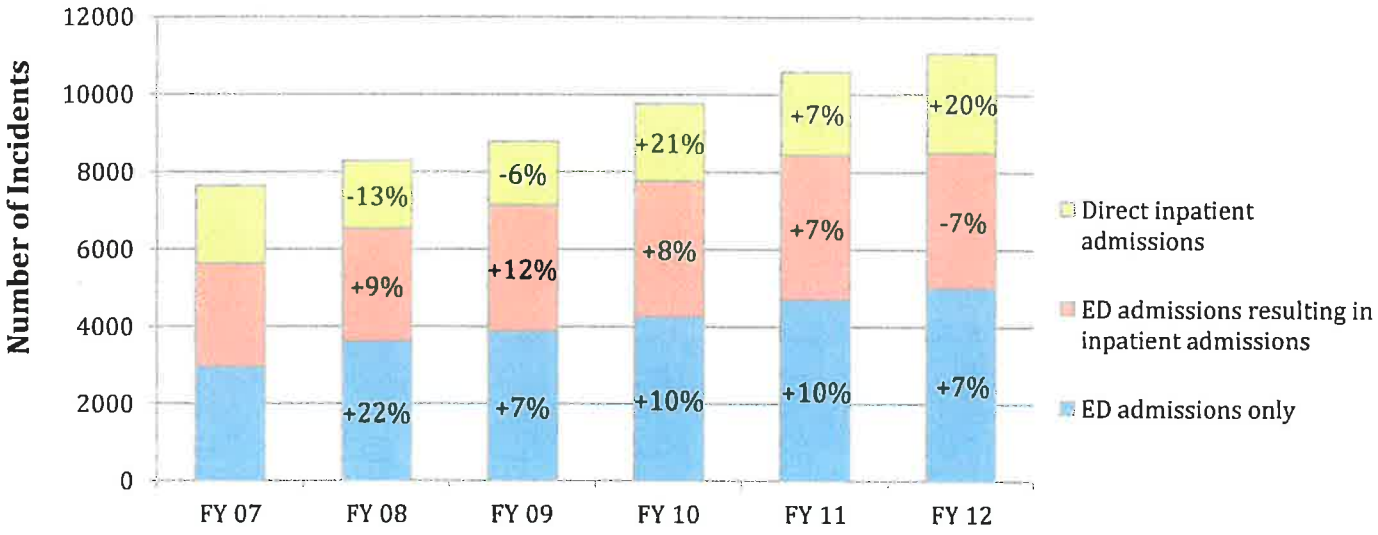
The number of youth with at least one psychiatric ED and/or hospitalization admission escalated from FY 2007 to FY 2012 for all three categories of admissions. For the first category, the number of youth with a psychiatric ED admission that **did not result in an inpatient admission**, the number of youth increased by 70% from 2007 (N=2,418) to 2012 (N=4,115). Second, the number of youth with psychiatric ED admissions **that did result** in an inpatient hospitalization increased by 33% (N for 2007 = 2,018, N for 2,680). Finally, the number of youth with a **direct inpatient admission** increased by 29% from 2007 (N=1,551) to 2012 (N=2,008). See Figure 2 below for trends in the number of youth experiencing admissions and hospitalizations from FY 2007 through FY 2012.

Figure 2 – FY 2007 to FY 2012 Trends in Youth with ED Admissions and/or Inpatient Hospitalizations



The total number of incidents in each category of psychiatric ED and/or hospitalization admissions also grew from FY 2007 to FY 2012. First, The number of psychiatric admissions that **did not result in an inpatient admission** increased by 70% (N for 2007 = 2,958, N for 2012=5,016). Incidents of psychiatric ED admissions **that did result in an inpatient hospitalization** climbed as well, with the total number of admissions increasing by 31% (N for 2007 = 2,670, N for 3,489). Lastly, the total number of **direct inpatient admissions** increased by 28% (N for 2007 = 2,007, N for 2012 = 2,573). Overall, admissions increased by 45% (N for 2007 = 7,635, N for 2012 = 2,573). See Figure 3 below for admission and hospitalization trends from FY 2007 through FY 2012.

Figure 3 – FY 2007 to FY 2012 Trends in Number of ED Admissions and/or Inpatient Hospitalizations



The percentage in each stacked bar represents the change from the previous fiscal year for that particular type of admission/hospitalization.

Figure 4 displays the number of admissions in FY 2012 per 1,000 Medicaid enrollees (ages 0 through 21) in each Maryland jurisdiction, including psychiatric ED admissions that did and did not result in an inpatient hospitalization, and non-ED psychiatric inpatient hospitalizations. The average psychiatric ED/inpatient hospitalization admission rate in FY 2012 was 18.7 admissions per 1,000 enrollees. The admission rate in FY 2012 was particularly high in the Eastern Shore region, the Western Maryland region, and Baltimore City. Dorchester County was the highest, with a rate of 43.2 admissions per 1,000 enrollees, followed by Washington County (29.7 admissions per 1,000 enrollees), Somerset County (29.6 admissions per 1,000 enrollees), Baltimore City (25.3 admissions per 1,000 enrollees), and Allegany County (25.1 admissions per 1,000 enrollees).

Figure 4 – Map of the Rate of Psychiatric Emergency Department Admissions, FY 2012, per 1,000 Medicaid Enrollees (Ages 0 through 21), and the Locations of Admissions by Hospital in FY2012

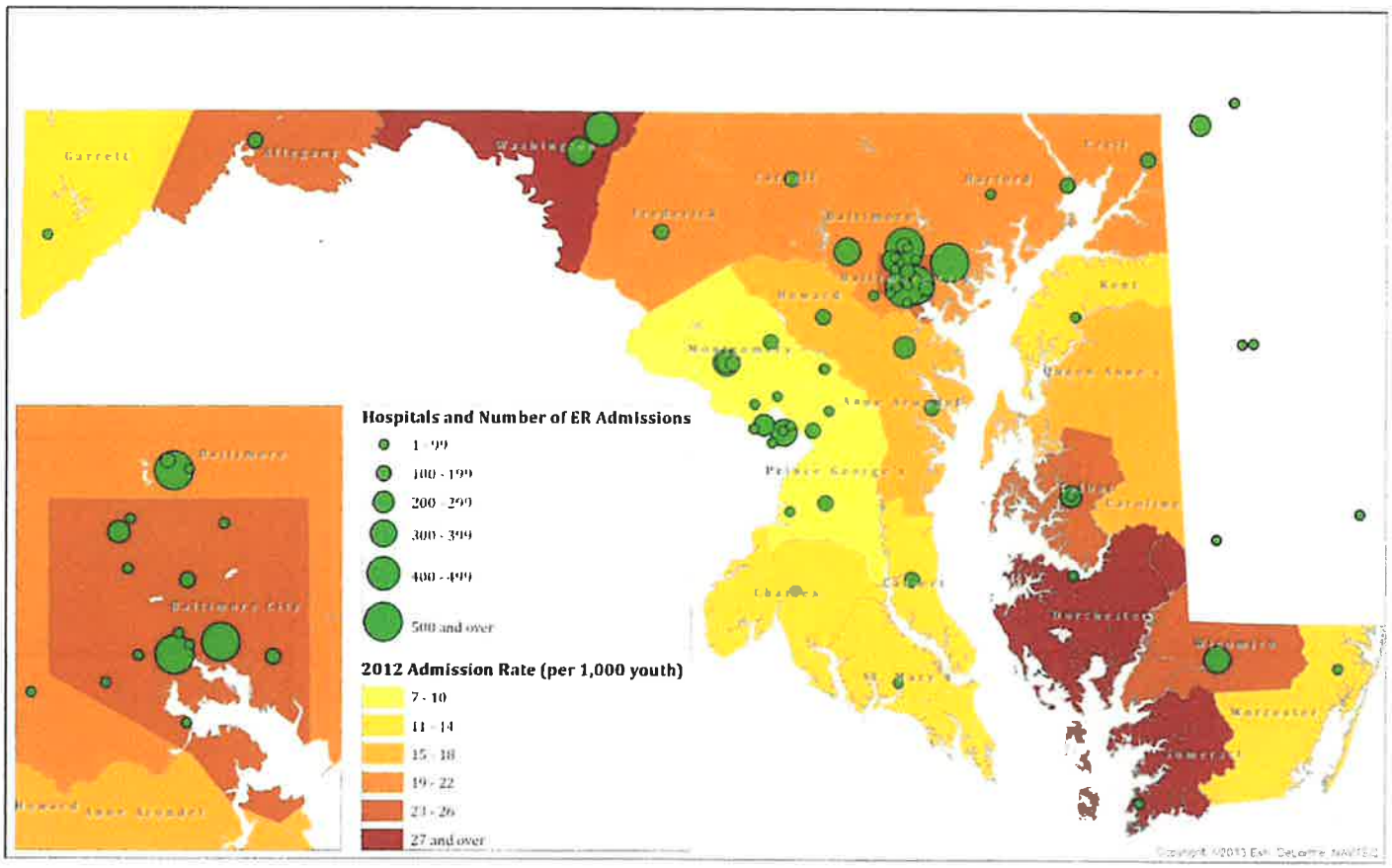


Figure 4 also displays the number of psychiatric emergency department admissions among hospitals in the Maryland region. Of the 65 hospitals that admitted youth in FY 2012, the greatest number of admissions occurred at Sheppard Pratt Health System (1,932), Johns Hopkins Hospital (1,015), and University of Maryland Medical System (960).

Further, 87% (46 out of 53) of Maryland's hospitals that reported youth psychiatric admissions in FY 2012 experienced an increase in the number of admissions from FY 2007 to FY 2012. In general, based on Medical Assistance data, Maryland has experienced a climb in both the number of psychiatric admissions and the costs of serving youth with crises in hospitals. See Appendix 1 for the complete set of ED and psychiatric hospitalization data for FY 2007-FY 2012.

87% of the Maryland hospitals that reported youth psychiatric admissions experienced an increase in the number of admissions from FY 2007 to FY2012.

RECOMMENDED CRISIS SYSTEM CORE COMPONENTS

In redesigning the CYF crisis system, the overarching goals are to keep children and their families safe and to strengthen service capacity and access to a comprehensive crisis system. Building a statewide comprehensive crisis system is expected to ultimately reduce: (1) utilization of EDs; (2) unnecessary inpatient psychiatric hospitalizations; (3) disruption of a youth's home placements (i.e., family homes, foster homes, group homes); and (4) response required by law enforcement. The language and services used in describing the recommended essential components are intended to encompass both mental health and substance abuse treatment in keeping with Maryland's movement toward full behavioral health integration.

The Crisis Workgroup discussed and developed a set of recommended essential core components within a continuum of care deemed to be essential to meet the needs and reach all children, youth, young adults and their families in Maryland. Specific attention was paid to the design of Wraparound Milwaukee's system in Wisconsin, as well as New Jersey's statewide system with care coordination and stabilization services. Through the CHIPRA grant, site visits were conducted in both Milwaukee and New Jersey to allow for in-depth, in-person discussions with state and local officials detailing successes and lessons learned. Particularly noteworthy is Milwaukee's system requirement that all psychiatric inpatient admissions first be assessed by a crisis response and stabilization team. This practice results in significant inpatient diversion. In the wake of the recent tragedy at Sandy Hook Elementary School in Connecticut, Wraparound Milwaukee's Mobile Urgent Treatment Team (MUTT) was highlighted as a crisis response system that intervenes effectively in the lives of children, youth, and young adults to avert tragedy.[9] See Appendix 2 for more information about the Milwaukee and New Jersey programs.

Maryland's Mental Hygiene Administration is piloting a similar innovative program in Baltimore City using redirected residential treatment center (RTC) funds.[10] This project provides an intensive set of services to children and youth who enter the ED at both Johns Hopkins and University of Maryland hospitals due to a psychiatric emergency. An onsite crisis clinician facilitates emergency case planning and referral to a variety of services including urgent care, crisis respite care, and ongoing stabilization services for up to eight weeks after the crisis. These services are projected to reduce overcrowding at EDs, prevent hospitalizations, and divert youth from RTC placements.

The CHIPRA Crisis Workgroup's recommendation for a crisis response and stabilization system is organized into three broad components with seven services or functions organized within the three components. The seven services are most effective when interwoven as functions within an entire continuum of care and are not likely to be as effective when implemented as stand-alone programs.

Component #1 - Immediate Triage and Crisis Response Information: The goal of the first component is for immediate triage and crisis response information to be the first available resource within a continuum of care to an individual accessing behavioral help, whether for the first time or for someone familiar to crisis services. This component provides preventative and initial crisis response resources, as well as triaging to determine if the individual is currently safe or whether further intervention is required. This component also includes technology services (i.e. online chat and support groups). The hotlines' access points should be well known and available to all children, youth and families across Maryland.

Core Service #1 – Hotlines and Online Resources

Component #2 – Community-Based Crisis Response Services: Community-based crisis response services, the second component, encompasses services that involve a face-to-face intervention in the community. A coordinated bridge between Components 1 and 2 should be designed and implemented for individuals who need to transition

[9]Cherkis, J. (2012, December 19). Sandy Hook Mental Health: Program gaps may be easier to fix than gun laws. *The Huffington Post.* Retrieved from http://www.huffingtonpost.com.

[10] Budget Amendment M00L01.03 Community Services for Medicaid Recipients added the following language to the general fund appropriation: "provided that $3,000,000 in general funds appropriated for the provision of private institutional care to youth may not be used for that purpose and instead may be used only to support community-based residential treatment diversion programming." Chairmen of the Senate Budget and Taxation Committee and House Appropriations Committee (2011). Report on the State Operating Budget (HB 70) and the State Capital Budget (HB 71) and Related Recommendations by the Joint Chairmen. Available from the Maryland General Assembly's website: http://167.102.242.144/smb/mgaleg.maryland.gov/google_docs$/pubs/budgetfiscal/2011rs-budget-docs-jcr.pdf).

to a higher intensity of service. Component #2 includes crisis and behavioral health assessments, including establishment of crisis and safety plans and initial stabilization for the youth. Depending upon the projected population density and need, adjoining jurisdictions could share providers for one or more of these services. The following core services are all intended to provide an immediate response to de-escalate the crisis, providing initial assessments, and begin the stabilization process.

Core Service #2 - Mobile Crisis Response (a Team of behavioral health qualified and trained clinicians that intervenes at the time of the crisis where the consumer is located (i.e. the youth's home or school)

Core Service #3 - Urgent Care Services (a non-hospital based walk-in location where rapid access to licensed behavioral health clinicians is available)

Core Service #4 - Emergency Respite (a safe environment (i.e. residential or group home) designed to provide a temporary break for caregivers of youth with serious behavioral health needs for up to two weeks)

Core Service #5 - Crisis Beds (Hospital-based 23-hour observation beds or non-hospital based overnight beds available to stabilize acute crises and prevent inpatient hospitalizations)

Core Service #6 - Emergency Department and Detention Center Diversion Programs (clinic or facility-based interventions that divert youth from accessing the ED or detention center for de-escalation or initial services)

Component #3- Longer Term Crisis/Stabilization Services: Longer-term crisis/stabilization services, the third component, encompass services required either after a crisis is medically stabilized or to prevent a crisis when high-risk behavioral health factors are indicated. Care coordination services are essential to help a family work through major issues that can lead to crises. This component can improve quality of care and have a tremendous impact on addressing the cycle of repeat crises, which often lead to lost school days (and a parent's missed work days) and increased health care costs. Similar to the first component, this component should include mechanisms for referrals and linkages to required services and resources within the public and private behavioral health system to treat ongoing behavioral health needs. Examples of such services include individual or group therapy, medication management, psychiatric rehabilitation services, alcohol anonymous, utility assistance and social services.

Core Service #7 – Care Coordination and Stabilization (longer-term, community-based interventions intended to provide stabilization support and to prevent future crises)

See Appendix 3 for a chart detailing the recommended components and services within a full continuum of care approach. When developing a crisis response and stabilization system, *the availability of transportation and the intended population's ability to physically access the services should be factored into the service array design.*

In addition to the recommended crisis service components, extensive coaching/training and social marketing should be designed and delivered to local schools, law enforcement, and hospitals to establish practices and policies that promote the use of crisis system resources and breaks the trend of reliance on EDs, arrests, and hospitalizations. Tracking the reduction of ED and inpatient utilization along with other positive outcomes (such as reduction in juvenile arrests) resulting from new crisis services will be critical to show the impact a deep and broad crisis system can have in Maryland.

Finally, implementation science should be employed to ensure successful implementation of programs and practices in human service environments. Implementing a program or intervention is considerably more challenging than designing a program. Therefore, proven and systematic implementation practices should be put in place when rolling out a new or enhanced crisis response and stabilization model. Close attention should be paid to the degrees of implementation, which include: 1) *Paper Implementation* (establishing policies), 2: *Process Implementation* (training and supervising), and 3) *Performance Implementation* (ensuring benefits to the target audience) when implementing any new program.[11]

The availability of transportation and the intended population's ability to physically access the services should be factored into the service array design.

[11] Fixsen, D., Naoom, S., K. Blase, R. Friedman, and F. Wallace (2005). Implementation research: a synthesis of the literature. Tampa, FL: University of Southern Florida.

GAP ANALYSIS - JURISDICTIONS WITH THE GREATEST NEED FOR CRISIS RESPONSE SERVICES

In September 2012, the CHIPRA Crisis Workgroup issued a survey to Maryland's nineteen Core Service Agencies (CSAs) to determine the availability of the recommended crisis system components and services in each jurisdiction. In addition, the survey collected details about existing providers and programs serving children, youth, young adults and their families. Results from the survey along with data provided by the Hilltop Institute were used to conduct a preliminary statewide gap analysis.

All CSAs in Maryland responded to the survey. For a complete summary of the survey responses, see Appendix 4. Results indicated that an average of three out of the recommended seven essential services were available in each jurisdiction and to children and youth of all ages. Availability was defined as having a provider that serves but is not necessarily located in the jurisdiction. CSAs reported that access to several core crisis services for children and youth is critically low across the State, as evidenced by the fact that crisis care coordination and stabilization is available to only four jurisdictions, emergency respite is available to a mere seven jurisdictions, emergency department diversion is available to 13 jurisdictions, and urgent care is available to 14 jurisdictions. All crisis bed providers identified by the CSAs are limited to serving individuals that are 18 years or older.

> An average of three out of the seven essential crisis services were available in each jurisdiction.

Access to essential services was reported to be particularly low in Carroll, Cecil, Garrett, Harford, and St. Mary's Counties, where CSAs reported their jurisdictions had access to two or fewer of the seven essential components. Figure 5 displays known locations of providers of any crisis service type that at a minimum serve children and youth ages 0 to 17. While crisis response coverage is low throughout the State, there is **a particular dearth of services in parts of Western Maryland** in contrast to other regions in Maryland. Carroll and Garrett Counties do not have any crisis service providers for children and youth located in their jurisdictions. Garrett County does not have access to mobile crisis services, and mobile crisis service coverage across the Western region is low, with only one provider available to Allegany, Carroll, Frederick, and Washington Counties. Urgent care provider coverage is also particularly low in Western Maryland, where respondents indicated a lack of urgent care services for children and youth in Allegany, Carroll, Frederick, Garrett, and Washington counties.

Results from the CSA survey indicate that **Maryland is critically lacking a coordinated, stable crisis response service array, and instead hosts a patchwork of crisis providers dispersed unevenly throughout the State**. Further, many programs (i.e. Baltimore City's ED Diversion program) lack secure funding sources and are at-risk of terminating essential crisis response services in the event that their funding is no longer available.

In order to determine which Maryland regions demonstrate higher need for crisis response services relative to other regions, a gap analysis was conducted using Medicaid claims data and the results from the CSA survey. The following measures were included in the gap analysis for each Maryland jurisdiction:

- Rate of crisis episodes by county of origin in FY 2012: Measured as the number of youth ages 0 through 21 with a psychiatric admission (both resulted in and did not result in an inpatient hospitalization) per total number of Medicaid enrollees, ages 0 through 21;
- Rate of crisis episodes by location of psychiatric admission in FY 2012: Measured as the total number of psychiatric admissions among all hospitals for a given jurisdiction per total number of Medicaid enrollees, ages 0 through 21;
- Number of essential crisis system components available: Measured as the total number (range of 0 to 7) of essential crisis system services serving the jurisdiction; and
- Ratio of providers of essential crisis services to crisis episodes: Measured as the number of providers serving the jurisdiction to the number of crisis episodes occurring in that jurisdiction (by county of origin of the children and youth).

In order to represent the cumulative need for crisis services for each jurisdiction, composite scores that encapsulate all measures indicated above were calculated for each jurisdiction. The initial step in calculating scores was standardizing measures. Because each factor was measured differently, converting measures to the

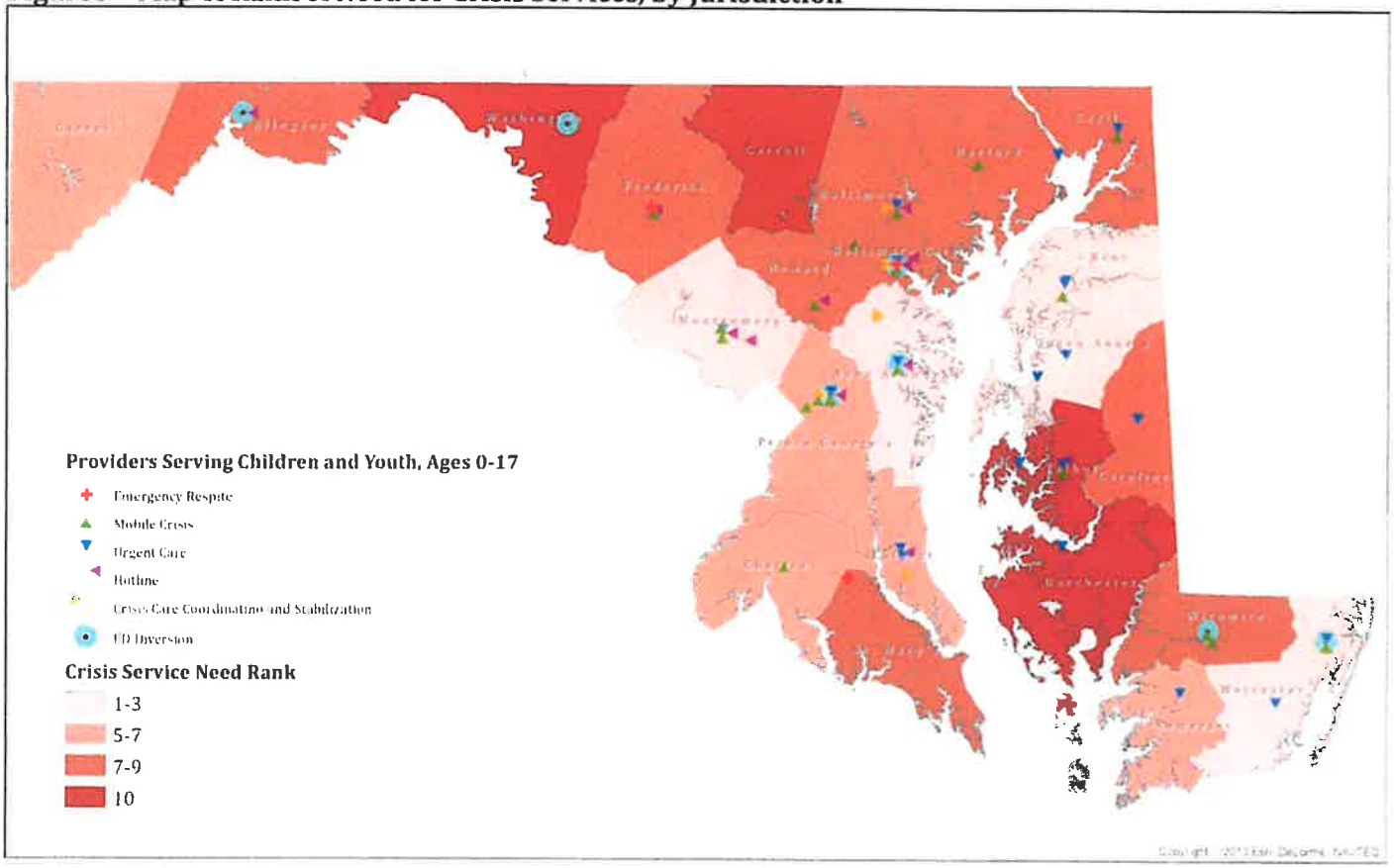
same metric was necessary. This was accomplished by calculating a "Z score" for each county. The following equation was used for each jurisdiction along each measure:

$$Z = \frac{(\text{Jurisdiction Value} - \text{Average of Jurisdictions in State})}{\text{Standard Deviation of Jurisdictions in State}}$$

By incorporating standard deviations in the calculation, each Z-score is relative to other Maryland jurisdictions and not compared to an absolute standard. After Z-scores were calculated for every jurisdiction along each measure, summary scores were calculated for each jurisdiction. Z-scores for each measure were summed to reveal each jurisdiction's cumulative needs score. After a composite score was calculated for every jurisdiction, the jurisdictions were ranked by sorting the scores from highest to lowest. The jurisdiction with the highest composite score is at the greatest need for crisis services, and the jurisdiction with the lowest score is at the lowest need for crisis services, based on relative need according to the metrics outlined above.

Figure 5 displays the scores for each jurisdiction, illustrating the need for crisis response services for each jurisdiction based on the rate of psychiatric admissions by jurisdiction of origin, rate of psychiatric admissions by hospital location, ratio of crisis service providers to the number of psychiatric admissions, and number of essential crisis components available. Figure 5 demonstrates that **need is greatest (relative to other regions) in portions of the Eastern Shore and Western Maryland.** Results of the gap analysis reveal that, in order of highest to lowest, the cumulative need scores for crisis response services is greatest for Talbot County, Washington County, Dorchester County, Carroll County, and Allegany County. While a statewide need for a comprehensive crisis response system is evident, this gap analysis reveals that there are particular regions in Maryland with relatively greater need than others.

Figure5—Map of Rank of Need for Crisis Services, by Jurisdiction



LESSONS LEARNED FROM PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) WAIVER PROGRAM

PRTF Waiver Crisis and Stabilization providers were surveyed to determine the impact and utilization of the Waiver Crisis and Stabilization service. This service is only available to youth enrolled in the PRTF Waiver Program, which is a federal demonstration program serving youth in the community whose psychiatric needs meet the medical necessity criteria for residential treatment centers. The impact of deescalating crises and preventing future incidents was assessed, specifically in relation to this program. Data were collected from September 2011 to April 2012. During that time period, crisis and stabilization providers indicated that they responded to 56 incidents. Of those 56 incidents, 89% (50) did not result in an ED visit, and 93% (52) did not result in an inpatient psychiatric hospitalization. Participants in the PRTF Waiver who receive this service are enrolled in a Care Management Entity (CME) and have an assigned Wraparound care coordinator and the support of a Child and Family Team (CFT). Crisis response and stabilization services are authorized by the Administrative Service Organization (ASO) in three-day increments for up to nine days at a time.

Crisis services provided through the PRTF Waiver Program are reported to lack preliminary linkages between the youth/family and the provider before an actual crisis occurred. **Crisis services could be more effectively delivered by providing both preventative engagement and backend stabilization and education after a crisis is stabilized.** In this way, families who are at-risk for crises can meet with providers face-to-face, develop enhanced crisis plans at the start of services, and receive crisis support well before a mobile crisis response is required. It is anticipated that by employing such an approach, providers will be more successful in preventing behavioral health crises.

The following components of crisis services are recommended within the CME and Wraparound model:

1. Assessment: Conducted prior to a crisis, in coordination with the Wraparound care coordinator (and together, where possible) to develop an initial crisis plan within the first week of enrollment in care coordination.
2. Crisis Response: An in-person response to the location where a crisis is occurring to assess, de-escalate, and provide initial stabilization.
3. Stabilization: In-person support for up to two weeks following a crisis response to support revisions to the crisis plan and provide education and training on preventing and responding to crises. Stabilization may also be provided at the recommendation of the Wraparound CFT to prevent a crisis, and must be authorized separately by the ASO.

This proposed crisis service design would allow for increased engagement with families and greater availability to assist both before and after a crisis occurs, resulting in better support for families and projected cost savings. While the PRTF Waiver was not reauthorized by Congress and new enrollment ended in September 2012, CMS has approved the use of a limited amount of remaining funds to further support Maryland's residential treatment diversion efforts.

SURVEY OF ALCOHOL AND DRUG ABUSE CRISIS SERVICES

To support behavioral health integration efforts, the CHIPRA Crisis Workgroup partnered with the Alcohol and Drug Abuse Administration to better understand existing crisis services for children, youth, young adults and families related to alcohol and drug use and abuse. To assess the availability and breadth of these services, the Workgroup issued a survey to the Substance Abuse Treatment Coordinators across the state, inquiring about: (1) their current process for responding to children, youth and young adults in alcohol and/or drug abuse related crises; (2) whether jurisdictions refer persons in crisis to the ED, hotlines, etc.; (3) the jurisdiction's urgent care capacity; (4) the availability of detox units and/or damp shelters (i.e., places where individuals can go while intoxicated); and (5) the availability of care coordination services. For some of these questions, jurisdictions were asked whether processes differed when addressing various populations: children and youth aged 0-17 years, 18-21 year olds, and individuals 22 years old and over. Twenty out of 24 jurisdictions responded. Responses clearly indicated that **Maryland lacks comprehensive alcohol and drug abuse services across the state, particularly for younger populations**. All of the responses received are synthesized in Appendix 5.

CRISIS RESPONSE HOTLINES IN MARYLAND

Maryland has a fair number of available youth and family crisis hotlines that respond to calls relating to suicide, domestic violence, and/or sexual assault. The cataloging of available hotlines by jurisdictions demonstrated gaps in coverage as well as inefficiencies in some jurisdictions. A list of Maryland's hotlines is set forth in Appendix 6. Although Maryland has several hotlines (state, national, and local) that individuals in crisis can call, the current configuration of call centers does not allow for a coordinated statewide response system for screening, triaging and dispatching crisis teams. Such a coordinated response would be needed if Maryland were to adopt Milwaukee's ED diversion model requiring that all psychiatric inpatient admissions be first assessed by a crisis response and stabilization team. With the launch of Maryland's Health Insurance Exchange,[12] Maryland could benefit by exploring options for re-configuring call centers to assure consistent and comprehensive coverage across the state and alignment with other health reform implementation efforts.

RECOMMENDATIONS

Recommendation #1: Expansion of Community Crisis Response and Stabilization Services

- ED Diversion Programs:
  - Continue evaluation of the two existing ED Diversion Sites (University of Maryland and John Hopkins) and explore program sustainability options.
  - Maintain and expand current ED Diversion model by creating a direct relationship between mobile crisis response system assessments and authorization/payment for inpatient psychiatric hospitalization admissions (Milwaukee ED diversion model). See also Recommendation #3.
  - Utilize mobile technology to expand crisis service assessments capabilities via existing ED Diversion Program.
- Develop policy guidance to increase mobile crisis services in the school systems to reduce the use of Emergency Petitions and police involvement.
- Expand the availability of care coordination via the Care Management Entity model to provide preventative and post-crisis stabilization services.
- Identify specific areas in need of urgent care appointments and increase this capacity.

Ongoing CHIPRA Crisis Workgroup Action Items to Support Recommendation #1:

- Collaborate with CSAs to identify hospitals for two additional ED Diversion sites using the allocated PRTF Waiver funds approved by CMS. Priority will be placed on hospitals willing to pilot the Milwaukee ED diversion model.
- Explore partnership with schools systems, beginning with the Eastern Shore, to explore expansion of community crisis services in the school system.
- Under CHIPRA funding, design a detailed evaluation project with School of Social Work faculty researchers to evaluate patterns and specifics of children and youth who are over-utilizing EDs and hospitals.
- Partner with the Maryland Coalition of Families for Children's Mental Health to facilitate focus groups and administer a survey to gain family and youth community voice and input on how the crisis system can be improved.
- Determine the foster care population's ED and inpatient impact on the behavioral health system and engage in further conversations with the Department of Human Resources to ensure that youth involved in the child welfare system have clear access to crisis services to minimize placement disruptions.
- Explore use of ED and inpatient hospitalization by Department of Juvenile Services (DJS) populations and engage in further conversations with DJS to ensure clear access to crisis services.
- Assemble a crisis service provider directory and develop a recommended plan for provider recruitment to expand the crisis services workforce.
- Investigate the most effective means to expand urgent care capacity.
- Explore options for incorporating crisis response systems into the Medicaid State Plan, as a service under a 1915(i) State Plan Amendment or as a stand-alone service, with recommendations for making crisis response services universally available.

[12] See http://marylandhbe.com/

Recommendation #2: Statewide Promotion, Training and Quality Assurance of Crisis Programs

- Design and execute a statewide crisis response training and coaching model.
- Develop and implement a training and coaching program for all system partners to include law enforcement, schools, and hospitals to promote the use of crisis system resources to reduce reliance on EDs, arrests, and hospitalizations.
- Implement a continuous quality improvement program which ensures the collection, analysis, and dissemination of key data elements that are utilized to measure successful program implementation.

Ongoing CHIPRA Crisis Workgroup Action Items to Support Recommendation #2:

- Research national human service quality assurance models and programs along with implementation science research to develop a recommended quality improvement program.

Recommendation #3: Streamline Behavioral Health Crisis Triage Response in Maryland

- Using existing or reconfigured hotline call centers, develop a coordinated statewide response system for screening, triaging and dispatching crisis response teams and align with other health reform and behavioral health integration efforts. Consideration should be given to assessing all insurance carriers a set per member/per month amount to ensure a robust statewide crisis response system.
- Test and explore the statewide adoption of the Milwaukee ED diversion model requiring that all psychiatric inpatient admissions be first assessed by a mobile crisis response team and linking payment/authorization to crisis response team assessments.
- Work with local jurisdictions to ensure that hotline call centers are able to provide a bridge between triage response and services available in each local community.

Ongoing CHIPRA Crisis Workgroup Action Items to Support Recommendation #3:

- Further research the current behavioral health hotlines in Maryland, including analysis of financing sources, penetration rates, multi-system reliance and connectivity, and ability to provide a bridge between triage response and available services.

CONCLUSION

From a public health perspective, it is essential for states to have a comprehensive crisis response and stabilization system that is coordinated, integrated, and contained within the broader behavioral health system to meet the needs of children, youth, and young adults with behavioral health needs and their families. Most recently, the nation witnessed the effects of a tragically missed opportunity to intervene in the life of a young adult in the horrific shootings in Newtown, Connecticut. **The value that results from investing in early prevention, intervention, and health promotion, inclusive of crisis support and stabilization, as a vital component of a community service array cannot be overstated.**

Tragedies of this magnitude foster momentum for systemic change at the local, state and federal levels. Prior to this tragedy, Maryland was poised with data on increased psychiatric use and costs of ED and inpatient hospitalization, as well as gaps and inefficiencies in Maryland's current ability to respond to children, youth and young adults experiencing behavioral health crises. With the continued support of the CHIPRA grant along with current behavioral health integration and the Affordable Care Act implementation efforts, Maryland is well postured to seize the current momentum and re-design its crisis system. This will also position the State to further leverage potential federal opportunities directed towards promoting mental health wellness, improving outcomes for children, youth and youth adults with behavioral health needs and their families, and strengthening overall community well-being.

Appendix D: BHAC Membership List

Maryland Behavioral Health Advisory Council

Barbara L. Allen, Co-Chair
Community Advocate

Dan Martin, Co-Chair
Mental Health Association of Maryland

Makeitha Abdulbarr
Maryland County Behavioral Health Advisory Councils

Barbara J. Bazron
Office of the Deputy Secretary, Maryland Department of Health

Dori S. Bishop
Family Member

Karyn M. Black
Maryland Association of Behavioral Health Authorities (MABHA)

Lori Brewster
Maryland Association of County Health Officers

*Kelby Brick
Governor's Office of Deaf and Hard of Hearing

Mary Bunch
Family Member (Child)

*Laura Cain
Disability Rights Maryland
(Formerly the Maryland Disability Law Center)

*Sara Cherico-Hsii
Office of the Secretary, Maryland Department of Health

Kenneth Collins
Maryland County Behavioral Health Advisory Councils

Marian Currens
Maryland Association for the Treatment of Opioid Dependence

Jan A. Desper Peters
Black Mental Health Alliance, Inc.

Allysa Dittmar
Governor's Office of Deaf and Hard of Hearing

Catherine Drake
Maryland Division Of Rehabilitation Services

The Hon. Adelaide Eckardt
Maryland State Senate

Stevanne Ellis
Maryland Department Of Aging

Kate Farinholt
National Alliance on Mental Illness of Maryland

Robert L. Findling
Academic/Research Professional

Ann Geddes
Maryland Coalition of Families for Children's Mental Health

Lauren Grimes
On Our Own of Maryland, Inc.

Elaine Hall
Maryland Health Care Financing, MDH

Shannon Hall
Community Behavioral Health Association of Maryland

Christina Halpin
Consumer (Youth/Young Adult)

Carlos Hardy
Maryland Recovery Organization Connecting Communities

Dayna Harris
Maryland Department of Housing & Community Development

Virginia Harrison
Maryland Association of Boards of Education

Maryland Behavioral Health Advisory Council

The Hon. Antonio Hayes
Maryland House of Delegates

Jim Hedrick
Governor's Office of Crime Control and Prevention

*Joel E. Klein
Medical Professional

Sylvia Lawson
Maryland State Department of Education

Sharon M. Lipford
Community Advocate

Theresa Lord
Family Member (Child)

Dennis L. McDowell
Family Member

The Hon. Dana Moylan Wright
Maryland Judiciary Circuit Court

Yngvild Olsen
Maryland Association for the Treatment of Opioid Dependence

Mary Pizzo
Office of the Public Defender

Keith Richardson
National Council on Alcoholism and Drug Dependence of Maryland

Catherine Simmons-Jones
Medical Professional

Jeffrey P. Sternlict
Medical Professional

Tracey Webb
Governor's Office for Children

Anita Wells
Academic/Research Professional

Albert Zachik
Maryland Behavioral Health Administration

Japp Haynes, IV
Consumer

Michael Ito
Maryland Department of Juvenile Services

Jonathan Kromm
Maryland Health Benefit Exchange

*Susan C. Lichtfuss
Maryland County Behavioral Health Advisory Councils

The Hon. George Lipman
Maryland Judiciary District Court

Jonathan Martin
Maryland Department of Budget and Management

Stephen T. Moyer
Maryland Department of Public Safety and Correctional Services

Kathleen O'Brien
Maryland Addiction Director's Council

Luciene Parsley
Disability Rights Maryland

Charles Reifsnider
Consumer

Linnette Rivera
Maryland Department Of Disabilities

Clay Stamp
Office of the Secretary, Maryland Department of Health

Brandi Stocksdale
Maryland Department of Human Resources

*Ellen M. Weber
Drug Policy and Public Health Strategies Clinic, University of Maryland Carey School of Law

John Winslow
Maryland County Behavioral Health Advisory Councils

*Individuals who are no longer members and, in most cases, have been replaced

BHA Staff Support: Cynthia Petion, Deputy Director, Systems Management; Hilary Phillips, Director of Planning, Sarah Reiman, Judith Leiman, Tsegereda Assebe and Greta Carter, Office of Planning; Larry Dawson, Office of Prevention and Wellness for Public Health; Deirdre Davis, Office of Treatment and Recovery Services; Thomas Merrick, Office of Children's Services