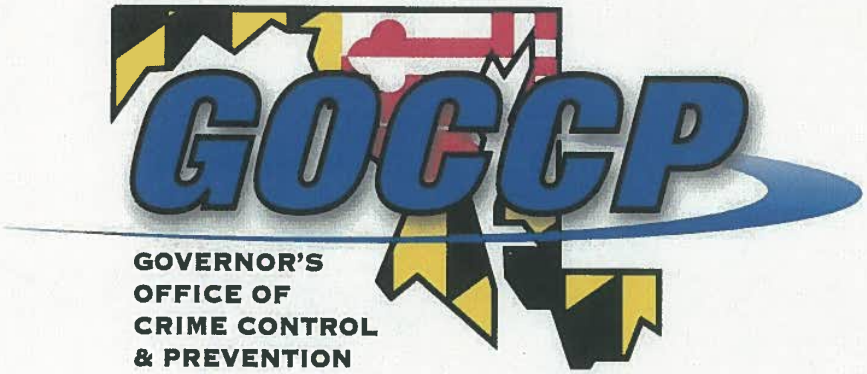

Substance Use and Mental Health Disorder Gaps and Needs Analysis

December 31, 2016

Larry Hogan
Governor

Boyd K. Rutherford
Lt. Governor

V. Glenn Fueston, Jr.
Executive Director
Governor's Office of Crime Control & Prevention

Submitted by: Governor's Office of Crime Control & Prevention
Contact: Donald J. Hogan, Jr.
410.697.9319
donald.hogan@maryland.gov

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Table of Contents

EXECUTIVE SUMMARY 3
INTRODUCTION 4
NATIONAL LANDSCAPE 6
Mental Health Disorder 6
Substance Use Disorder 8
Treatment Barriers 8
MARYLAND'S PUBLIC BEHAVIORAL HEALTH SYSTEM 11
Coverage and Benefits 11
Medicaid Behavioral Health Benefits Package 11
State-Only Funded Services 11
Medicaid Enrollment 12
Overview of Forensically-Involved Individuals Served Annually 12
Current Programs 14
DataLink 14
New Initiatives to Address Coverage Gaps 15
Presumptive Medicaid Eligibility for Justice-Involved Individuals 15
Connecting Criminal Justice with Health Care 16
Medicaid Coverage of Residential Substance Use Treatment 17
Data Driven Justice Initiative 18
FEASIBILITY STUDY 19
Methodology 19
Local Detention Centers 19
Maryland Division of Correction 19
Maryland Division of Parole & Probation 21
Office of Problem Solving Courts 21
Department of Health & Mental Hygiene 21
Findings 21
Local Detention Centers 23
Maryland Division of Correction 25
Maryland Division of Parole & Probation 28
Office of Problem Solving Courts 31

Department of Health & Mental Hygiene 33
SEQUENTIAL INTERCEPT MODEL 36
Intercept 1: Law Enforcement/Emergency Services 37
Crisis Intervention Teams 37
Mobile Crisis Services 37
Stabilization Centers 38
Law Enforcement Assisted Diversion 39
Intercept 2: Post Arrest 39
Rapid Referral Program and Sparrow Program 39
Intercept 3: Post-Initial Hearings 40
Intercept 4: Reentry From Jails, State Prisons, and Forensic Hospitalization 41
Coordination of Services 41
Maryland Community Services Locator 41
Intercept 5: Community Correction and Community Support 42
Day Reporting Center 42
RECOMMENDATIONS 43
CONCLUSION 50
APPENDICES 51
Appendix A: Section 5 of the Justice Reinvestment Act (Chapter 515 of 2016) 51
Appendix B: Local Detention Substance Use Disorder Treatment Survey 52
Appendix C: Local Detention Centers Mental Health Treatment Survey 54
Appendix D: Texas Christian University Drug Screen II 56
Appendix E: SMART TAP Assessment 60
Appendix F: Department of Public Safety and Correctional Services - Aftercare Services Plan 77
Appendix G: Department of Health & Mental Hygiene Behavioral Gap Analysis Survey 78

EXECUTIVE SUMMARY

The Justice Reinvestment Act (Chapter 515 of 2016) requires the Governor's Office of Crime Control & Prevention to report on:

1. A feasibility study of local jail and service providers capacity for substance use and mental health disorder and related treatment; and
2. A plan for how a sequential intercept model could be used to address the gap between offender treatment needs and available treatment services in the State.

As a result of this *Substance Use and Mental Health Disorder Gaps and Needs Analysis* Final Report several recommendations were identified as follows:

1. Encourage compulsory crisis intervention team training for law enforcement officers.
2. Mental health courts should include an active substance use treatment component to target those clients with co-occurring mental health and substance use disorders.
3. Increase the Department of Health and Mental Hygiene and community provider capacity to meet the forensic population needs.
4. Explore and expand opportunities to share data between criminal justice and behavioral health stakeholders.
5. Improve the tracking of referrals and treatment services.
6. Expansion of the sequential intercept model.
7. Report to the Justice Reinvestment Oversight Board on the impact of the move to fee-for-service.
8. Ensure individuals receive the most appropriate treatment and/or treatment level to meet their specific needs at each level of the treatment process.
9. Conduct a survey to determine the needs of each county as it relates to the Justice Reinvestment Act.
10. Expansion of treatment for pretrial inmates and sentenced inmates with a short length of stay.
11. Improved substance use disorder and mental health data entry in the Offender Case Management System.

INTRODUCTION

In 2015, the General Assembly passed, and Governor Hogan signed into law, Senate Bill 602 which established the bipartisan, interbranch Justice Reinvestment Coordinating Council (Council) to develop a statewide framework of sentencing and corrections policies to further reduce the State's incarcerated population, reduce spending on corrections and reinvest in strategies for specified purposes, and report its findings and recommendations on or before December 31, 2015. The Council made the following findings. Through the analysis of Maryland's State prison data, while admissions are down 19% over the last 10 years, 58% are for nonviolent crimes and nearly 60% of prison admissions are failures of probation or post-release supervision. Approximately 43% of probation revocations and over 70% of parole and mandatory supervision returns are for technical violations (i.e., violations that do not involve a new crime). Time served across all offense types has increased by 23% in the last decade, driven by a 25% increase in average sentence length.

From this data, the Council made 19 recommendations and submitted them to Governor Larry Hogan and the Maryland General Assembly. These became the basis for the Justice Reinvestment Act (Chapter 515 of 2016) passed during the legislative session and signed into law on May 19, 2016, by Governor Hogan. The Justice Reinvestment Act represents the most comprehensive criminal justice reform to pass in a generation. It works to hold individual offenders accountable for their actions and the government accountable for its responsibility to spend tax dollars wisely and ensure safe communities. The Act emphasizes treatment for those struggling with addiction, enhances the voice of victims, and strengthens community supervision through evidence-based practices.

Pursuant to Section 5 of the Justice Reinvestment Act, the Governor's Office of Crime Control & Prevention is charged with, in coordination with the Department of Public Safety and Correctional Services, the Department of Health and Mental Hygiene, the Judiciary, public health and treatment professionals, and local corrections authorities, conducting an analysis to determine the gap between offender treatment needs and available treatment services in the State, and report the results of the analysis with recommendations to the Maryland General Assembly on or before December 31, 2016.

Specifically, the analysis shall determine the gap between offender treatment needs and available treatment services in the State to include the following:

1. A feasibility study of local jail and service providers capacity for substance use and mental health disorder and related treatment; and
2. A plan for how a sequential intercept model could be used to address the gap between offender treatment needs and available treatment services in the State.

The Office requested and received data from local detention centers, the Department of Public Safety and Correctional Service (Division of Correction and Division of Parole & Probation) and the Judiciary to answer three research questions:

1. What is the prevalence of substance use disorder/mental illness among offenders involved in the criminal justice system?
2. What is the availability of treatment to this population?

3. What gaps or challenges exist to providing adequate treatment to this population?

Additional information on the methodology used to prepare this report can be found under the **Methodology** subheading of the **FEASIBILITY STUDY** section, on page 20 of this report.

NATIONAL LANDSCAPE

Many individuals who come into contact with law enforcement and the criminal or juvenile justice systems have a mental and/or substance use disorder. According to a 2006 Bureau of Justice Statistics report, approximately 56% of state prisoners, 45% of federal prisoners, and 64% of local jail inmates met the criteria for a mental health disorder.[1] Of those inmates diagnosed with a mental health disorder, an estimated 74% of state prisoners and 76% of local jail inmates met the criteria for both a mental health and substance use disorder, and slightly less than a quarter (24%) of state prisoners and a fifth (19%) of local jail inmates met the criteria for substance dependence or abuse only. Studies have found that for youth in the juvenile justice system, 50% to 70% met criteria for a mental disorder and 60% met criteria for a substance use disorder. Of those youth with co-occurring mental and substance use issues, almost 30% experienced severe disorders that impaired their ability to function.[2]

Mental Health Disorder

The 2006 Bureau of Justice Statistics report also noted that local jail inmates had the highest rate of symptoms of a mental health disorder (64%), followed by state (56%), and federal prisoners (45%).[3] The high rate of symptoms of mental health disorder among jail inmates may reflect the role of local jails in the criminal justice system. Jails are locally operated correctional facilities that receive offenders after an arrest and hold them for a short period of time, pending arraignment, trial, conviction, or sentencing, as well as housing inmates with short sentences. Among other functions, local jails hold mentally ill persons pending their movement to appropriate mental health facilities.

While local jails hold inmates sentenced to short terms (usually less than one year), state and federal prisons hold offenders who typically are convicted and sentenced to serve more than one year. In general, because of the longer period of incarceration, state prisons provide a greater opportunity for inmates to receive a clinical mental health assessment, diagnosis, and treatment by a mental health professional.[4]

Mentally ill persons increasingly receive care provided by correctional agencies.[5] In 1959, nearly 559,000 mentally ill patients were housed in state mental hospitals (Lamb, 1998). A shift to "deinstitutionalize" mentally ill persons had, by the late 1990s, dropped the number of persons housed in public psychiatric hospitals to approximately 70,000 (CorrectCare, 1999). As a result, mentally ill persons are more likely to live in local communities, and some come into contact with the criminal justice system.

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[1] James, D. J., & Glaze, L. E. (2006). Mental health problems of prisons and jail inmates. *U.S. Department of Justice, Office of Justice Program, Bureau of Justice Statistics [NCJ 213600].*

[2] Substance Abuse and Mental Health Services Administration (SAMHSA). (2016). *Criminal and juvenile justice.* Retrieved from http://www.samhsa.gov/criminal-juvenile-justice.

[3] James, D. J., & Glaze, L. E. (2006). Mental health problems of prisons and jail inmates. *U.S. Department of Justice, Office of Justice Program, Bureau of Justice Statistics [NCJ 213600].*

[4] Persons who have been judged by a court to be mentally incompetent to stand trial or not guilty by reason of insanity are not held in these correctional facilities and are not covered by the 2006 Bureau of Justice Statistics report.

[5] National Institute for Corrections (NCIC). *Mentally ill persons in corrections.* Retrieved from http://nicic.gov/mentalillness.

In the 2006 Bureau of Justice Statistics report, it was estimated that 705,600 mentally ill adults were incarcerated in state prisons, 78,800 in federal prisons, and 479,900 in local jails. In addition, research suggests that "people with mental illnesses are overrepresented in probation and parole populations at estimated rates ranging from two to four times the general population" (Prins & Draper, 2009). Growing numbers of mentally ill offenders have strained correctional systems.

According to a 2010 report that was drafted by the National Sheriff's Association, in partnership with the Treatment Advocacy Center, which was based on 2004-2005 data, there are three times more seriously mentally ill persons in jails and prison within the United States, than in hospitals. In fact, this report noted that it is extremely difficult to find a bed for a seriously mentally ill person who needs to be hospitalized. In 1955, there was one psychiatric bed for every 300 Americans. In 2005, there was one psychiatric bed for every 3,000 Americans. In addition, the majority of the existing beds were filled with court-ordered (forensic) cases. Findings also indicated that Maryland ranked sixth on spending the most on state mental health authority (*as illustrated below*).[6]

State	Total number of prisoners in jails and state prisons, June 30, 2005	Estimated number of prisoners seriously mentally ill (16% of total)	Number of patients in state, private, and psychiatric units in general hospitals, 2004	Odds of a seriously mentally ill person being in jail or prison compared to in hospital	State Ranking based on per capita expenditures by state mental health authority, FY 2002 (lowest no. spends most)
Alabama	40,561	6,490	1,609	4.0 to 1	35
Alaska	4,678	748	206	3.6 to 1	20
Arizona	47,974	7,676	827	9.3 to 1	14
Arkansas	18,693	2,991	920	3.3 to 1	50
California	246,317	39,411	10,295	3.8 to 1	13
Colorado	33,955	5,433	1,325	4.1 to 1	31
Connecticut	19,087	3,054	1,571	1.9 to 1	5
Delaware	6,916	1,107	372	3.0 to 1	21
Florida	148,521	23,763	4,826	4.9 to 1	45
Georgia	92,647	14,824	2,921	5.1 to 1	43
Hawaii	5,705	913	311	2.9 to 1	3
Idaho	11,206	1,793	394	4.6 to 1	47
Illinois	64,735	10,358	3,841	2.7 to 1	30
Indiana	39,959	6,393	2,413	2.6 to 1	27
Iowa	12,215	1,954	744	2.6 to 1	39
Kansas	15,972	2,556	732	3.5 to 1	25
Kentucky	30,034	4,805	1,638	2.9 to 1	40
Louisiana	51,458	8,233	1,807	4.6 to 1	42
Maine	3,608	577	463	1.2 to 1	9
Maryland	35,601	5,696	2,211	2.6 to 1	6
Massachusetts	22,778	3,644	2,979	1.2 to 1	12
Michigan	67,132	10,741	2,496	4.3 to 1	16
Minnesota	15,422	2,468	1,982	1.2 to 1	11
Mississippi	27,902	4,464	2,484	1.8 to 1	18
Missouri	41,461	6,634	2,441	2.7 to 1	28
Montana	4,923	788	256	3.1 to 1	7
Nebraska	7,406	1,185	688	1.7 to 1	38
Nevada	18,265	2,922	298	9.8 to 1	37
New Hampshire	4,184	669	337	2.0 to 1	10
New Jersey	46,411	7,426	4,606	1.6 to 1	8
New Mexico	15,081	2,413	732	3.3 to 1	49
New York	92,769	14,843	12,142	1.2 to 1	1
North Carolina	53,854	8,617	2,443	3.5 to 1	41
North Dakota	2,288	366	365	1.0 to 1	23
Ohio	64,123	10,260	2,536	4.0 to 1	34
Oklahoma	32,593	5,215	1,463	3.6 to 1	46
Oregon	19,318	3,091	1,026	3.0 to 1	36
Pennsylvania	75,507	12,081	6,128	2.0 to 1	2
Rhode Island	3,364	538	363	1.5 to 1	19
South Carolina	35,298	5,648	1,113	5.1 to 1	26
South Dakota	4,827	772	319	2.4 to 1	33
Tennessee	43,678	6,988	2,221	3.1 to 1	22
Texas	223,195	35,711	4,579	7.8 to 1	48
Utah	11,514	1,842	462	4.0 to 1	29
Vermont	1,975	316	177	1.8 to 1	4
Virginia	57,444	9,191	2,548	3.6 to 1	32
Washington	29,225	4,676	1,521	3.1 to 1	15
West Virginia	8,043	1,287	609	2.1 to 1	44
Wisconsin	36,154	5,785	1,500	3.9 to 1	17
Wyoming	3,515	562	199	2.8 to 1	24
Total	1,999,491	319,918	100,439	3.2 to 1	

[6] Torrey, E. F., Kennard, A. D., Eslinger, D., Lamb, R., & Pavle, J. (2010). *More mentally ill persons are in jails and prisons than hospitals: A survey of states.* Retrieved from http://www.treatmentadvocacycenter.org/.

Substance Use Disorder

In 2002, in the United States more than two-thirds of jail inmates were found to be dependent on or to abuse alcohol or drugs.[7] Jail inmates who met the criteria for substance dependence or abuse (70%) were more likely than other inmates (46%) to have a prior criminal record. They were nearly twice as likely as other inmates to have been homeless in the year before their offense (16% compared to 9%) or to have grown up with a parent or guardian who abused alcohol or drugs (37% compared to 17%).

Nearly two-thirds of jail inmates who met the criteria for substance dependence or abuse had participated in substance abuse treatment or other alcohol or drug programs in the past. Almost half (47%) of jail inmates who met the criteria for substance dependence or abuse had participated in substance abuse treatment or other programs while under correctional supervision. About a fifth of convicted jail inmates who met the criteria for substance dependence or abuse participated in substance abuse treatment or other programs after the current admission to jail.

According to a 2011 report from the federal Substance Abuse and Mental Health Services Administration's (SAMHSA's) Treatment Episode Data Set (TEDS), the criminal justice system was the major source of referrals to substance use treatment, with probation or parole treatment admissions representing the largest proportion of criminal justice system referrals. Most probation or parole admissions were males between the ages of 18 and 44.[8] Similarly, in SAMHSA's adolescence substance abuse treatment grant programs, juvenile justice is the most frequent referring agency.

Treatment Barriers

Finding their way to treatment services can be a difficult process for people struggling with addiction, but it is especially difficult for those arrested and entering the criminal justice system. According to the Office of National Drug Control Policy, only four in 10 offenders needing treatment reported receiving treatment services while incarcerated. Among those who do receive treatment, the quality of those services varies from state to state.[9]

Upon release from incarceration, individuals with behavioral health issues face many barriers to successful reentry into the community, such as lack of health care, job skills, education, stable housing, and poor connection with community behavioral health providers, which may jeopardize their recovery and increase their probability of relapse and re-arrest. Individuals leaving correctional facilities often have lengthy waiting periods before attaining benefits and receiving services in the community. Some state correctional systems now suspend rather than terminate benefits such as Medicaid or Social Security, while individuals are incarcerated, and then immediately restart their benefits post-release. However, waiting periods and termination of benefits can have serious effects on the lives of offenders who need to connect with treatment providers to maximize the likelihood of recovery and prevent

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[7] Karberg, J. C., & James, D. J. (2005). Substance dependence, abuse, and treatment of jail inmates, 2002. *U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics [NCJ 209588].*

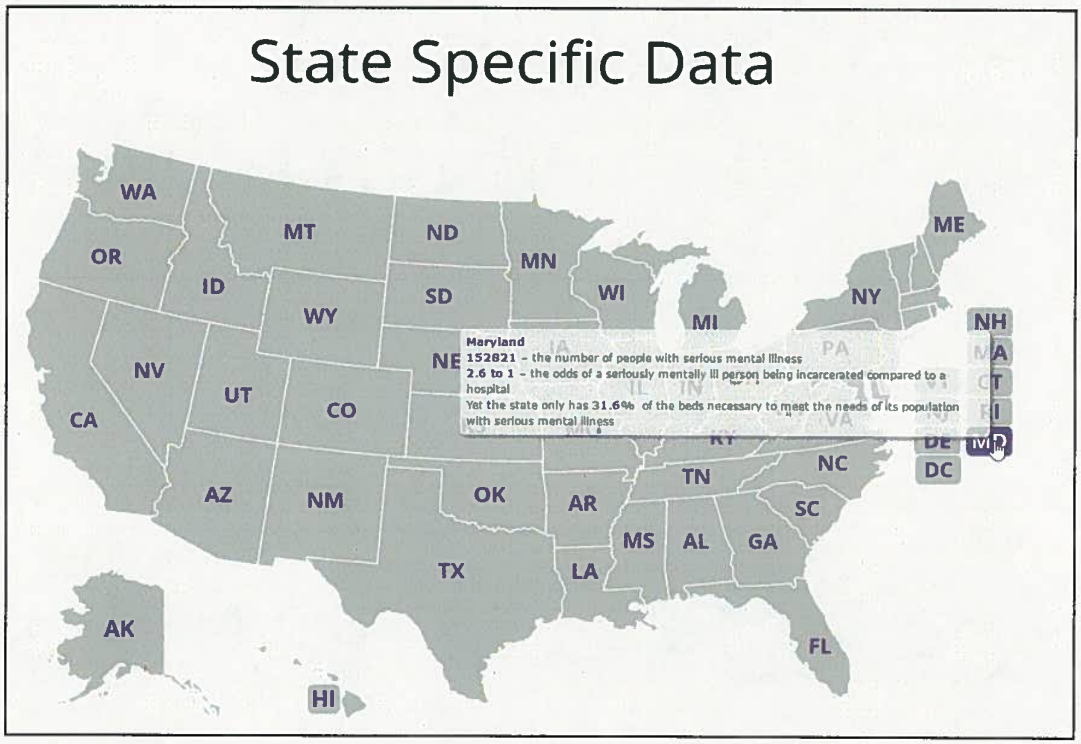
[8] Treatment Episode Data Set (The TEDS Report). (2011). *Characteristics of probation and parole admissions aged 18 or older*. Retrieved from http://archive.samhsa.gov/data/2k10/231Parole2k11Web/231Parole2k11.htm.

[9] Substance Abuse and Mental Health Service Administration. (2016). *Criminal and juvenile justice.* Retrieved from http://www.samhsa.gov/criminal-juvenile-justice.

re-incarceration. These barriers are especially challenging for minority groups, which rank highest among the uninsured and are disproportionately represented in the criminal and juvenile justice systems.

According to a 2016 report that was developed by the County Commissioners Association of Pennsylvania,[10] counties nationwide spend nearly $100 billion annually on health care for inmates and roughly 65% are pretrial detainees. More than 95% of county jail inmates will eventually return to the community, and if mental health and substance abuse issues remain untreated, they are very likely to cycle back into the system through the county jail, again and again.

Within the State of Maryland, based on an interactive map provided by the Treatment Advocacy Center, a national nonprofit organization dedicated to eliminating barriers to the timely and effective treatment of severe mental illness,[11] there are approximately 152,821 individuals with serious mental illness and an odds ratio that 2.6 to 1 individuals with serious mental illness are being incarcerated compared to being hospitalized.



In addition, and in reference to barriers to substance abuse treatment for adults in the criminal justice system, the federal Center for Substance Abuse Treatment under the Department of Health and Human

[10] County Commissioners Association of Pennsylvania. (2016). *Comprehensive behavioral health task force: A guide for counties seeking alternatives to incarcerating mentally ill and substance abusing offenders*. Retrieved from http://www.pacounties.org/GR/Documents/Comprehensive%20Behavioral%20Heatlh%20Task%20Force%20Reform%20Report%20-%20FINAL.pdf.

[11] Treatment Advocacy Center. (2016). *State specific data*. Retrieved from http://www.treatmentadvocacycenter.org/browse-by-state. The Treatment Advocacy Center has documented the laws and standards in each state. State data also includes rankings and grades for certain major issues, including psychiatric bed availability and the number of people with severe mental illness in jails and prisons in each state.

Services indicated in a 2005 report that a number of factors in the jail setting have the potential to interfere with effective treatment, including: lack of funding for services; absence of administrative support for developing comprehensive treatment for programming; tension between substance abuse and criminal justice systems, which have an overlapping but distinctive concerns; physical space and environment that are not conducive to treatment; competing institutional program activities; difficulties in developing mechanisms for sharing information between treatment providers and criminal justice staff's confidentiality issues and the need to share information; lack of case management or continuing care; lack of detoxification services; detoxification symptoms mistaken for mental illness; lack of methadone tapered doses for inmates enrolled in methadone treatment programs prior to relapse; bringing in family members for family reunification or family therapy without careful security screening; HIV/AIDS and sexually transmitted diseases among inmates; inability to provide HIV/AIDS educational materials; institutional restrictions to video equipment; difficulties implementing community in-reach for supplemental as well as basic treatment needs; and treatment providers' reluctance to work in jails.[12]

[12] Center for Substance Abuse Treatment. (2005). *Substance abuse treatment for adults in the criminal justice system: A Treatment Improvement Protocol (TIP) Series 44.* DHHS Publication No. (SMA) 05-4056. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK64137/pdf/Bookshelf_NBK64137.pdf.

MARYLAND'S PUBLIC BEHAVIORAL HEALTH SYSTEM

The Department of Health and Mental Hygiene is actively working to integrate better mental health and substance use disorder services for Medicaid members, as well as the uninsured. Prior to 2015, the public behavioral health system in Maryland operated siloed systems where substance use disorders were included as part of the Medicaid managed care benefit package, while specialty mental health services were administered on a fee-for-service basis by an Administrative Services Organization.

Effective January 2015, both the Medicaid and the majority of state-only funding streams were aligned under the Administrative Services Organization for both mental health and substance use disorder services. In parallel, the Department of Health and Mental Hygiene also merged the former Mental Hygiene Administration and the Alcohol and Drug Abuse Administration to create the Behavioral Health Administration.

This section of this report outlines the coverage, benefits, and available treatment services provided by the Department of Health and Mental Hygiene and the Behavioral Health Administration supporting Medicaid members, the uninsured, and forensically-involved individuals.

Coverage and Benefits

Medicaid Behavioral Health Benefits Package

Although the federal government requires every state Medicaid program to cover a specific set of services, states have some flexibility to design their own benefit packages. Generally, services must be equal in amount, duration, and scope for all participants based on medical necessity criteria - in addition to being available across the state. Maryland has incorporated a wide array of mental health and substance use services into its Medicaid programs. The following mental health services are covered in Maryland: hospitalization; residential treatment for children and adolescent; individual therapy; group therapy; mental health targeted case management; family psychotherapy and psychoeducation; psychiatric rehabilitation; psychological testing; assertive community treatment; mobile treatment; partial hospitalization; intensive outpatient program services; and laboratory services.

In addition, the following substance use services are covered in Maryland: alcohol and/or drug assessment; individual outpatient therapy; group outpatient therapy; partial hospitalization; ambulatory detoxification; opioid maintenance therapy for individuals 18 and over; medically monitored intensive inpatient treatment; medically monitored inpatient detoxification for individuals under 21 years; child and adolescent residential services; and laboratory services.

State-Only Funded Services

Uninsured eligible consumers are individuals for whom the cost of medically necessary and appropriate behavioral health services will be subsidized by the Behavioral Health Administration, using state-only funds, because of the severity of their behavioral health and financial need. Depending on the availability of state funding, services may be provided to consumers who meet specific eligibility guidelines. The uninsured eligibility spans will be for six months for new requests and when spans are

eligible for renewal. Individuals must meet financial need criteria with an income of no more than 200% of federal poverty level and other required conditions.

Uninsured individuals can participate in any eligible ambulatory program they choose as long as they meet the following uninsured eligibility criteria: the individual requires treatment for a behavioral health diagnosis covered by the Public Behavioral Health System; the individual is under 250% of the Federal Poverty Level, and not covered by Medicaid or other insurance; the individual has a verifiable Social Security number; the individual is a Maryland resident; the individual has applied to: Medicaid; the Health Care Exchange; Social Security Income (SSI) or Social Security Disability Income (SSDI), if they have an illness/disability for a period of 12 months or more (or are expected to have an illness/disability for a period of 12 months or more); and the individual meets the U.S. citizenship requirement.

Medicaid Enrollment

Medicaid eligibility is an important factor in the expansion of treatment opportunities for those in the Criminal Justice System. Medicaid eligibility and enrollment can be increased by the use of Certified Application Counselors who are located at local service agencies. In accordance with COMAR 14.35.12, the Maryland Health Benefit Exchange designates community-based organizations, health care providers, units of State or local government, or other entities within specific regions of the State, to perform enrollment activities through Certified Application Counselors. Specifically, Certified Application Counselors are employed or engaged by designated Application Counselor Sponsoring Entities to assist individuals with the application process for determining eligibility for Medicaid, Maryland Children's Health Program, advance premium tax credits and cost-sharing subsidy applications, and may facilitate individuals in enrolling in Qualified Health Plans and Qualified Dental Plans offered through Maryland Health Connection.

Overview of Forensically-Involved Individuals Served Annually

In response to the *Joint Chairmen's Report* in 2014, the Department of Health and Mental Hygiene was required to report on the demand for residential treatment beds generated from drug courts and placements under § 8-507 of the Health-General Article, as well as the average wait time for placement in a treatment slot after the signing of an order under § 8-505 or § 8-507 of the Health-General Article (called § 8-505 or § 8-507 orders or commitments).

A § 8-505 order requires the Department of Health and Mental Hygiene to conduct an evaluation as to a criminal defendant's need for substance use treatment. Between FY 2012 and FY 2014, a total of 3,478 individual § 8-505 orders were issued.

A §8-507 order requires the Department of Health and Mental Hygiene to facilitate the prompt treatment of the defendant following the court's finding that a defendant requires substance use treatment.[13] Between FY 2012 and FY 2014, a total of 1,770 individual § 8-507 orders were issued. There was an

[13] As of October 1, 2017, the Justice Reinvestment Act will require "immediate treatment" unless there are exigent circumstances for a delay.

average wait time of 167 days for recipients of a § 8-507 order, over the same time frame, with a median wait time of 133 days.

Before issuing a court order to commit an individual to the Department of Health and Mental Hygiene for treatment under § 8-507, an evaluation must first occur under § 8-505 or § 8-506. These evaluations are conducted through local health departments to determine what level of care under the American Society of Addiction Medicine's (ASAM) criteria is medically necessary for each individual. During this evaluation, all levels of treatment are considered, including alternatives to residential placement if residential treatment is not medically appropriate.

Following the evaluation ordered under § 8-505 or § 8-506, an appropriate level of care is recommended, based on ASAM criteria. On motion of the defendant, a court may subsequently order treatment at the level of care indicated by the § 8-505 or § 8-506 evaluation, and the Department of Health and Mental Hygiene is unable to place a patient in a lower level of care if their evaluation indicates a residential placement. Therefore, there is generally no flexibility for the Department to consider an alternative treatment option once the evaluation and court order have been issued.

If a residential placement is determined to be medically necessary through the evaluation, individuals are referred to one of the Department of Health and Mental Hygiene's three contractual § 8-507 treatment providers: Gaudenzia, Inc., New Horizons Health Services, or Jude House, Inc., which serve different regions of the state. It should be noted, however, that not everyone who is evaluated as needing residential placement is subsequently ordered into an § 8-507 residential placement. For example, a defendant must accept the recommendation for the level of care and then file a motion for the court to issue the order under § 8-507 before a court can grant the motion for treatment. In addition, if any outstanding warrants or detainers are identified during the clearance process following a court order being issued, this would preclude or delay the order from being implemented.

In FY 2016, the Department of Health and Mental Hygiene was appropriated approximately $6 million in funding, which supported 360 individuals in § 8-507 treatment placements. This included an average daily population of 120 individuals with an average length of stay of four months. While the Department places individuals as court orders are issued, there are many factors that determine the annual census, including: annual budget; daily rate of services, which varies by provider; percentage of cases referred to each provider; and average length of stay

In FY 2017, Governor Hogan appropriated an additional $3 million in funding, bringing the total funding level to approximately $9 million. The Department anticipates placing 540 individuals during the current fiscal year, including a daily census of approximately 180 patients, and admitting approximately 45 patients per month. In addition, there is supplemental grant funding for services in Baltimore City. These residential substance use disorder services are identical to § 8-507 but are funded separately and not included in traditional § 8-507 data collection. A reconciliation of the supplemental grant funds with the § 8-507 program will occur on July 1, 2017, when the Department finalizes the transfer of grant funding for substance use disorder residential services to fee-for-service. Substance use

disorder services provided to forensically-involved individuals by the Behavioral Health Administration include the following (*as illustrated below*).

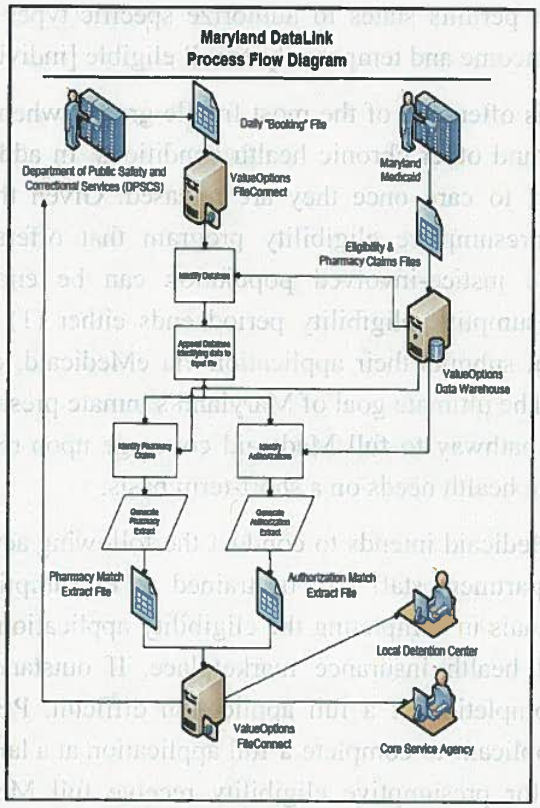
Medicaid Reimbursable	Grant Funded
• **Counseling Programs: Assessment, Outpatient, Partial Hospitalization, and Detox (in residential setting)** • **Opioid Treatment Providers: Methadone (maintenance), and Buprenorphine (induction and maintenance)** • **Physician/Office-based: Vivitrol and Buprenorphine (induction and maintenance)** • **Residential Detox and treatment for adolescents (under 21)** • **Counseling/Detox services in a hospital setting (inpatient and outpatient)**	• **Outpatient, intensive outpatient and opioid treatment services including withdrawal management (for uninsured)** • **Residential Treatment Services** • **Recovery Support Services: Housing, Peer/Recovery Coaching, Care Coordination, Continuing Care, Recovery Community Centers, and Adolescent Club Houses** • **Drug Court/S.T.O.P.**

Current Programs

DataLink

DataLink was developed in partnership between the Department of Health and Mental Hygiene's Behavioral Health Administration, the Department of Health and Mental Hygiene's Office of Health Services, the Department of Public Safety and Correctional Services, the Administrative Services Organization (Beacon Health Options), the Core Services Agencies (Maryland's local mental health authorities), and the local detention centers. The purpose of DataLink is to promote the continuity of treatment for individuals with serious mental illness who are detained in a detention center.

Each day, Beacon Health, receives a file from the Department of Public Safety and Correctional Services that contains all individuals who have been detained and processed at local detention centers in the past 24 hour period; incarcerated at one of the State correctional facilities; or remanded to the Division of Parole & Probation. The data is compared against Medicaid eligibility data, utilizing agreed upon data points to identify a detainee as a match. Once a match is identified, the process looks for mental health authorizations and paid Medicaid pharmacy claims within the past calendar year. This information is then electronically returned to the Department of Public Safety and Correctional Services and uploaded into their Electronic Health Record system where it can be viewed by authorized detention center medical staff.



Detention center medical staff utilize this data to address and track the detainee's medical and mental health needs. Simultaneously, the data is also shared with the local Core Services Agency and may assist in providing coordinated care for the individual while detained and upon release. DataLink is fully operational in 13 jurisdictions (Allegany, Anne Arundel, Baltimore City, Baltimore County, Calvert, Carroll, Charles, Frederick, Harford, Howard, St. Mary's, Washington, and Wicomico), and the Department of Public Safety and Correctional Services.

New Initiatives to Address Coverage Gaps

Presumptive Medicaid Eligibility for Justice-Involved Individuals

With Maryland's Medicaid expansion, many inmates and justice-involved individuals have become eligible for Medicaid. On June 30, 2016, the Department of Health and Mental Hygiene submitted a Section 1115 waiver renewal application for its HealthChoice program - the Maryland's statewide mandatory Medicaid managed care program. On December 27, 2016, the U.S. Centers for Medicare and Medicaid Services (CMS) approved the state's Medicaid Waiver renewal for its HealthChoice program.

In addition to renewing the program, Maryland Medicaid requested federal approval to implement a number of other initiatives that would expand the State's portfolio of services for vulnerable populations. One of these initiatives is Presumptive Eligibility (PE) for inmates. "Presumptive eligibility

is a Medicaid policy option that permits states to authorize specific types of 'qualified entities'…to screen eligibility based on gross income and temporarily enroll eligible [individuals]."[14]

The justice-involved population is often one of the most fragile groups when it comes to substance use disorders, mental health issues, and other chronic health conditions. In addition, it is a very difficult population to reach and connect to care once they are released. Given these challenges, Maryland Medicaid aims to establish a presumptive eligibility program that offers an additional and often simplified avenue in which the justice-involved population can be enrolled in Medicaid, albeit temporarily. A beneficiary's presumptive eligibility period ends either (1) at the end of 30-60 days starting on the day an individual submits their application via eMedicaid, or (2) when full Medicaid eligibility has been determined. The ultimate goal of Maryland's inmate presumptive eligibility program is to provide individuals with a pathway to full Medicaid coverage upon release while also providing access to healthcare for immediate health needs on a short-term basis.

Through the waiver, Maryland Medicaid intends to conduct the following activities under this program. Corrections and local health department staff will be trained as Presumptive Eligibility Determiners (PEDs). PEDs will assist individuals in completing the eligibility application through Maryland Health Connection, Maryland's official health insurance marketplace. If outstanding verification items or connectivity issues make the completion of a full application difficult, PEDs will proceed with the application and encourage the applicant to complete a full application at a later date. While eligibility is temporary, individuals eligible for presumptive eligibility receive full Medicaid benefits under the fee-for-service model during this very finite period. Maryland Medicaid hopes to provide inmates with temporary Medicaid benefits starting July 1, 2017.

Connecting Criminal Justice with Health Care

In spring 2016, Maryland was selected as one of two states to participate in a national initiative called *Connecting Criminal Justice with Health Care* (CCJH). Supported by the U.S. Department of Justice's Bureau of Justice Assistance, the initiative provides technical assistance for state and local entities in their efforts to develop sustainable strategies to enroll effectively justice-involved individuals in health care coverage and connect them to providers and services once they are released. As a part of CCJH, the Department of Health and Mental Hygiene has officially partnered with the Department of Public Safety and Correctional Services, the Maryland Health Benefit Exchange as well as the State's detention centers and local health departments in Harford, Baltimore, and Washington counties.

In August and September of 2016, Maryland virtually engaged in two learning collaboratives with the second participating state, California, as well as the two technical assistance entities, the Urban Institute and Manatt Health Solutions. In the first two learning collaboratives, Maryland and California shared their priorities and current efforts around enrollment and care coordination for this population. In the third and final learning collaborative, the two states will discuss potential opportunities to sustain these efforts. Elements determined from Maryland and California's experiences will serve as best practices to guide national efforts.

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[14] Health Affairs. (January 9, 2014). *Hospital Presumptive Eligibility*. Retrieved from http://healthaffairs.org/.

Through the collaborative, the Department of Health and Mental Hygiene aims to increase coordination across all relevant health and criminal justice entities, improve data collection and exchange, leverage available workforce, and ensure appropriate resources are available and accessible. The Department of Health and Mental Hygiene and its partners have begun assessing existing resources and designing potential strategies to implement enrollment and care coordination activities. All of its partners continue to make remarkable progress in the establishment of enrollment processes, but there remains a wide variability in terms of where counties are in the development and implementation of their processes.

Medicaid Coverage of Residential Substance Use Treatment

Medicaid, through Beacon Health Options, reimburses providers of substance use disorder treatment for all levels of care outlined by the American Society for Addiction Medicine (ASAM): Level 1 outpatient; Level 2 intensive outpatient and partial hospitalization; and for individuals under the age of 21, Level 3, residential detox and 3.7 treatment. Level 3 residential treatment for adults is currently paid for out of state-only funding due to a federal payment policy, known as the Institutions for Mental Diseases (IMD) exclusion. An IMD is defined as a facility with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases and chemical dependency disorders. The IMD exclusion effectively prohibits states from receiving federal matching dollars for services provided by IMDs for individuals between 21 and 64 years old. The IMD exclusion also limits the number of beds a residential treatment facility may operate in order to receive reimbursement from Medicaid to less than 16.

The effects of the IMD exclusion are significant. The IMD exclusion incentivizes hospitalization in a general acute care hospital over care in a substance use disorder residential treatment program. These hospitalizations typically only treat the medical effects of individuals' illnesses while neglecting the illnesses themselves and the long-term consequences of substance use disorders. The National Council on Alcoholism & Drug Dependence-Maryland noted that the IMD exclusion results in individuals seeking treatment in lower levels of care than what is clinically recommended.

The Department applied for and received authority from the federal Centers for Medicare and Medicaid Services to permit the use of Medicaid funds to reimburse for substance use disorder services in IMDs through its HealthChoice waiver renewal. This waiver will increase reimbursements and allow providers to admit more patients into residential treatment for substance use disorders. The State will implement a similar authorization and payment process for adults that accounts for the array of levels of care under residential treatment (3.7, 3.5, 3.3 and 3.1) phasing in the additional array of services over time.[15]

[15] More specifically, Maryland has applied for expenditure authority for otherwise-covered services provided to Medicaid-eligible individuals aged 21 to 64 who are enrolled in a Medicaid MCO and reside in a non-public IMD for American Society of Addiction Medicine (ASAM) Residential levels 3.1, 3.3, 3.5, 3.7, and 3.7WM. Effective July 1, 2017, Maryland proposes to provide reimbursement for up to two 30-day stays annually for ASAM levels 3.7WM, 3.7, 3.5, and 3.3. Maryland intends to phase in coverage of ASAM level 3.1 beginning on January 1, 2019.

Data Driven Justice Initiative

The Data Driven Justice Initiative, developed by the White House, includes a bipartisan coalition of city, county, and state governments who have committed to using data-driven strategies to divert low-level offenders with mental illness out of the criminal system. The main goal of this project is to have better access to behavioral health data which can be merged with criminal justice data so mentally ill offenders can be diverted from the criminal justice system at various decision points. Data Driven Justice communities commit to:

- Combining data from across criminal justice and health systems to identify the individuals with the highest number of contacts with police, ambulance, emergency departments, and other services, and, leverage existing resources to link them to health, behavioral health, and social services in the community;
- Equipping law enforcement and first responders to enable more rapid deployment of tools, approaches, and other innovations they need to respond safely and more effectively to people in mental health crisis and divert people with high needs to identified service providers instead of arrest; and
- Working towards using objective, data-driven, validated risk assessment tools to inform the safe release of low-risk defendants from jails in order to reduce the jail population held pretrial.

Maryland is one of seven states that officially committed to join the Data Driven Justice Initiative which includes the participation in calls every other week with the White House team and various states and counties around the country to discuss a wide array of data driven topics.

FEASIBILITY STUDY

Section 5(i) of the Justice Reinvestment Act requires "a feasibility study of local jail and service provider capacity for substance use and mental health disorder and related treatment." This section presents the methodology and findings of this study.

Methodology

The Governor's Office of Crime Control & Prevention (Office) requested data primarily from four entities in the State to answer three research questions:

1. What is the prevalence of substance use disorder/mental illness among offenders involved in the criminal justice system?
2. What is the availability of treatment to this population?
3. What gaps or challenges exist to providing adequate treatment to this population?

The Office requested and received information from the following entities:

1. Local Detention Centers
2. The Division of Correction (Department of Public Safety and Correctional Services)
3. The Division of Parole & Probation (Department of Public Safety and Correctional Services)
4. Office of Problem Solving Courts (Judiciary)

Local Detention Centers

Two electronic surveys were disseminated to all 23 local detention centers in the state. The purpose of these surveys was to determine inmates' treatments needs and available treatment services within the local detention centers. One survey addressed substance use disorder and the other addressed mental health. Survey questions sought the following information for each jail. [*Appendix B: Local Detention Substance Use Disorder Treatment Survey and Appendix C: Local Detention Centers Mental Health Treatment Survey*]:

1. The jail's maximum bed capacity and average daily population
2. The number of inmates diagnosed with substance use disorder and mental illness
3. The number of inmates diagnosed with co-occurring disorders
4. The types of substance use disorder and mental health assessments conducted at intake
5. The number of substance use disorder and mental health treatment beds available
6. The types of treatment provided for inmates with substance use disorder and mental illness
7. The steps taken to connect an inmate with a substance use disorder or mental illness to treatment services prior to their release into the community

Maryland Division of Correction

A list of various data elements were sent to the Director of Research & Statistics at the Office of Grants, Policy & Statistics at the Department of Public Safety and Correctional Services, as well as to the Director of Substance Abuse Treatment Services at the Department of Public Safety and Correctional

Services. The following data elements were requested for all State correctional facilities (including the Baltimore City jail which is operated by the State):

- Prison maximum bed space by facility
- Average daily population for each facility
- A copy of any substance use disorder and mental health screening assessments conducted at intake
- Number of inmates suffering from mental illness or serious mental illness by facility
- Number of inmates diagnosed with a substance use disorder by facility
- Number of inmates with co-occurring disorders by facility
- Number of mental health slots by facility
- Number of substance abuse treatment slots by facility
- Number of substance abuse treatment slots filled by facility
- The types of mental health and substance use disorder treatment provided to inmates in Maryland prisons
- Provide a copy of any reentry materials that inmates receive upon release
- Receive a snapshot on the number of inmates on the waiting list to receive treatment

With regards to substance use disorder, mental illness, and serious mental illness, definitions for each are provided below.

Substance Use Disorder: Indicates relatively severe drug related problems. This is calculated by any inmate that scores a three or higher on the Texas Christian University Drug Screen II. [*Appendix D: Texas Christian University Drug Screen II*].

Mental Illness: includes the following:

- Personality Disorders
- Dysthymia Disorder (a chronic depressed mood that occurs most of the day more days than not for at least two years)
- Cyclothymic Disorder (numerous periods of hypomanic symptoms fluctuating with numerous periods of depressive symptoms)
- Seasonal Affective Disorder
- Generalized Anxiety Disorder
- Anxiety Disorder non-specific origin
- Acute Stress Disorder (adjustment disorder)
- Adjustment Disorder with depressed mood
- Attention Deficit / Hyperactivity Disorder
- Social Phobia
- Dissociative Identity Disorder

Serious Mental Illness: As defined by federal regulation, a serious mental illness is a condition that affects "persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of

sufficient duration to meet diagnostic criteria specified within DSM-IV (APA, 1994) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities" such as maintaining interpersonal relationships, activities of daily living, self-care, employment, and recreation. (Substance Abuse and Mental Health Services Administration, 2013, p. 11). Mental disorders typically meeting criteria for serious mental illness include schizophrenia, schizoaffective disorder, psychotic disorders, major depressive disorders, bipolar disorders, and borderline personality disorder. Anxiety disorders (such as obsessive compulsive disorder and panic disorder) or eating disorders (such as anorexia nervosa and bulimia nervosa) can also meet criteria for serious mental illness.

Maryland Division of Parole & Probation

A list of various data elements were sent to the Director of Research & Statistics at the Office of Grants, Policy & Statistics at the Department of Public Safety and Correctional Services, as well as to the Division of Parole & Probation at the Department of Public Safety and Correctional Services. The following data elements were requested:

- Snapshot on the number of offenders under community supervision by supervision type by county
- The number of offenders under supervision by county with a drug special condition
- The number of offenders under supervision by county who are required to attend mental health treatment as a special condition
- The number of offenders under community supervision currently enrolled in substance abuse treatment or mental health treatment by county by supervision type

Office of Problem Solving Courts

A data request was submitted to the Director of the Office of Problem Solving Courts at the Maryland Administrative Office of the Courts regarding various drug court statistics, including:

- Total active clients
- Total clients admitted
- Total clients discharged by discharge type
- Total treatment encounters

Department of Health & Mental Hygiene

The Department of Health & Mental Hygiene recently conducted a jurisdictional needs assessment that was completed in March 2016. The purpose of this need assessment was to determine gaps in treatment at the jurisdictional and service level. More specifically, the Department attempted to identify three types of federal shortage designations in Maryland:

1. Health Professional Shortage Areas;
2. Medically Underserved Areas (MUAs);
3. Medically Underserved Populations (MUPs);

The methodology to identify health professional shortage areas is based on the type of professional discipline (primary, dental, or mental health care), geographic unit (whole county, multiple county, or census tract) and different populations (homeless, low-income, Medicaid etc.). Certain types of facilities may also be eligible as health professional shortage areas such as prisons, mental health hospitals, Federally Qualified Health Centers, or other public or non-profit facilities. These areas are eligible for resources from more than 30 federal programs and other benefits, including federal workforce development programs and enhanced Medicare reimbursement.

Medically underserved areas and medically underserved populations are federally designated locations or population groups that have a shortage of primary care resources. Both are designated based on four criteria: infant mortality rate, poverty rate, percent of the population over the age of 65, and the population to primary care provider ratios. Underserved areas include geographic areas such as counties, census tracts, or minor civil divisions. Underserved populations are for specific population groups, such as low-income individuals, or seasonal or migrant farmworkers.

In order to meet the requirements of the Justice Reinvestment Act, the Department of Health and Mental Hygiene conducted a deeper analysis of participation in the public behavioral health system for five different provider types: (1) Outpatient Mental Health Clinics; (2) Opioid Treatment Programs; (3) Ambulatory Substance Use Disorder Programs; (4) Intermediate Care Facilities for Addiction; and (5) Federally Qualified Health Centers. While there are additional provider types that play a role in the public behavioral health system, the department chose to focus on these five categories given their critical role in the health care safety net.

Through Beacon Health Options, the Department disseminated a survey to providers in the public behavioral health system to assess gaps in mental health & substance use treatment. Survey questions sought the following information from each provider. [*Appendix G: Behavioral Health Gap Analysis Survey*]:

1. The types of services provided
2. The types of insurance accepted
3. The average wait time for treatment
4. A description of service provisions
5. Description of evidence based practices and standardized tools
6. The percentage of service provided to justice-involved populations
7. Any perceived gaps in treatment

Findings

Local Detention Centers

Prevalence of Substance Use Disorder and Mental Illness in the Local Jails

A total of 19 of the 23 local jails responded to the substance use disorder survey while 17 jails responded to the mental health survey. This sample represented jails from rural, suburban, and urban counties alike with jails as small as 50 inmates to over 1,200 inmates. As depicted in Table 1, the prevalence of substance use disorder and mental illness inside local detention centers appears to be a widespread issue. Consider the statistics below:[16]

- 69% of inmates are estimated to be diagnosed with a substance use disorder
- 39% of inmates are estimated to be diagnosed with a mental health disorder, of whom 89% also have a substance use disorder
- 35% of inmates are diagnosed with co-occurring substance abuse and mental health disorders

Table 1. Local Detention Centers Substance Use Disorder and Mental Health Survey Results

Survey Respondents (n = 19)	Total	Average	Range
Bed Capacity	8,954	471	64 - 1,524
Average Daily Population	6,433	339	49 - 1,205
% Capacity	72%	75%	45% - 119%
% Diagnosed with a Substance Use Disorder	69%	67%	9% - 93%
% Diagnosed with a Mental Health Disorder	39%	42%	16% - 96%
% Diagnosed with a Co-occurring Disorder	35%	38%	13% - 81%
% Diagnosed with a Mental Health Disorder also have a Substance Use Disorder	89%	83%	38% - 100%

Substance Use Disorders and Mental Health Screening

Very few local detention centers have a formal screening assessment for substance use disorder. It is most likely determined through an interview with the inmate at intake. On the mental health side, most jails have licensed clinical staff who conduct mental health evaluations of each inmate. This evaluation is conducted to determine the inmate's danger to themselves or others and mentally ill inmates are also at a heightened risk of being victimized by other inmates. One particular detention center uses the Columbia Suicide Severity Scale which is a validated assessment.

Number of Substance Use Disorder and Mental Health Treatment Beds Available

Seven of the 19 jails reported having specific substance use disorder treatment beds totaling over 200 beds. Overall, these treatment beds are at maximum capacity. A few other jurisdictions responded that

[16] No formal definitions of "diagnosed with a substance use disorder" or "diagnosed with a mental health disorder" were provided to the survey respondents which may explain the fluctuation in the range of responses. Some jurisdictions may have determined substance use disorder or mental illness at intake and used that number while others may have included only those formally diagnosed by a licensed psychiatrist.

they do not have specific beds but do have detox units. Five of the 19 jails responded that they have beds for inmates with a mental health disorder totaling over 180 beds and are at about 80% capacity.[17]

Types of Substance Use Disorder and Mental Health Treatment Provided at Local Detention Centers

While not all local detention centers have specific treatment beds available for inmates with substance use or mental health disorders, a variety of treatment is provided to these individuals while in custody. Below are the common survey responses from local detention centers regarding what kind of substance use disorder treatment is available within their facilities.

- Alcoholics Anonymous and Narcotics Anonymous provided through local health departments
- Individual or group counseling
- Medication Assisted Treatment: These programs combine medication assisted treatment with extensive behavioral health counseling. A total of eight current programs are funded by the Governor's Office of Crime Control & Prevention. As of May 31, 2016, approximately 180 inmates have received a Vivitrol injection and 245 injections have been provided in the community. Vivitrol works as a "blocker." It attaches to certain opioid receptors in the brain and blocks the pleasurable feelings associated with taking opioids.
- Peer Recovery Specialist Support: Peer Recovery Specialists are individuals who are in recovery from substance use or co-occurring mental health disorders. Their life experiences and recovery allow them to provide recovery support in such a way that others can benefit from their experiences.
- Gaudenzia Addiction Treatment and Recovery Services: Gaudenzia operates 147 drug and alcohol treatment programs in Pennsylvania, Maryland, and Delaware. Services include specialty programs for pregnant and parenting mothers, adolescents, and people suffering from co-occurring mental illness and substance abuse.
- Trauma, Addictions, Mental Health, and Recovery Program: This program is the State's trauma education project, which has existed for more than 12 years, providing services to individuals age 18 years and older who are detained in participating detention centers. Individuals with a history of abuse, a recent treatment history for a mental health condition or treatment for an alcohol or drug disorder are eligible for participation. This program is State supported with $435,560 allocated to nine detention centers and reaches nearly 500 individuals annually.

Wardens also responded on the common types of treatment for inmates with mental health disorders (*as illustrated below*).

- Individual Counseling: Conducted by psychiatrists who also prescribe medication as needed;
- Group counseling;
- Cognitive Behavioral Therapy: More specifically Dialectical Behavioral Therapy (DBT), a form of Cognitive Behavioral Therapy which tries to identify and change negative thinking patterns

[17] No formal definition was provided for substance use disorder or mental health treatment beds which provided some variation in the results received.

and pushes for positive behavioral changes. DBT is used commonly to treat suicidal and other self-destructive behaviors.

Pre-Release Services for inmates with a substance use disorder or mental illness - Local Jails

It appears that all of the local detention centers surveyed have some sort of process in place to help link inmates to services in the community. Most facilities provide case management services, discharge plans, or individualized treatment plans for the inmates while the individual is incarcerated to facilitate the transition from detention to community. Specific treatment providers are contacted to ensure a smooth transition and continuity of care. Some jails have staff such as reentry coordinators that fill this role. Many jails collaborate with the local health departments and social services agencies to ensure that the individuals obtain access to treatment in the community and receive other services as needed.

The Office currently provides funding for eight medication assisted treatment programs using Vivitrol, which are used for the treatment of persons with a history of opioid use disorders who are being released from local detention facilities. Characteristics of the program include: identification of inmates with a history of opioid addiction; inmate entry into substance use disorder counseling; education related to the medication Vivitrol; inmates beginning the Medicaid enrollment process; and inmates receiving the first shot of Vivitrol approximately two weeks prior to release. Once released, the clients are assigned to intensive counseling.

Additional Survey Comments

The jail wardens were also given the opportunity to provide additional comments regarding the issue of addicted and mentally ill inmates. Comments included:

- There is a lack of community based residential treatment programs.
- Transportation issues limit continuity of treatment outside the jail.
- Not all inmates are formally diagnosed. Many times an individual receives his/her first access to treatment services while incarcerated.
- Due to the short term length of stay, it is more challenging to provide treatment for pretrial inmates and link them to services after they secure release.
- There is a need for increased jail space to provide treatment.

Maryland Division of Correction

Prevalence of Substance Use Disorder and Mental Illness in the State prisons

Data shown in Table 2 (*on the following page*) was provided for 23 State correctional facilities. Information is only provided on prisons that are currently open, only includes those under the correctional authority of the Department of Public Safety and Correctional Services, and excludes federal detainees. As of November 1, 2016, over 6,600 inmates (32%) were characterized with serious drug related problems. Mental health data was only provided in 15 of the 23 State correctional facilities, and in those 15 facilities, 21% (3,787) of State inmates were diagnosed with a mental illness and 7% (1,266) were diagnosed with a serious mental illness. The number of State inmates diagnosed with co-occurring disorders could not be calculated.

Table 2. Maryland State Prison Inmates with Substance Use and Mental Health Disorders								
Facility	Total Bed Space	Average Daily Population	Substance Use Disorder	Serious Mental Illness	Mental Illness	Substance Use Disorder %	Serious Mental Illness %	Mental Illness %
Baltimore City Detention Center	996	292	16	8	46	5.5%	2.7%	15.8%
Baltimore Central Booking Intake Center	948	729	10	95	370	1.4%	13.0%	50.8%
Dorsey Run Correctional Facility	1,098	542	273			50.4%		
Eastern Correctional Institution-Annex	608	596	276			46.3%		
Eastern Correctional Institution (East & West)	2,719	2,616	979			37.4%		
Poplar Hill Pre-Release Unit	192	173	76			43.9%		
Eastern Correctional Institution Total	***3,519***	***3,385***	***1331***	***235***	***627***	***39.3%***	***6.9%***	***18.5%***
Jessup Correctional Institution	1,971	1,731	426	25	341	24.6%	1.4%	19.7%
Maryland Correctional Institution - Hagerstown	2,044	1,860	679	223	542	36.5%	12.0%	29.1%
Maryland Correctional Institution - Jessup	1,068	1,034	309	14	152	29.9%	1.4%	14.7%
Maryland Correctional Institution for Women	849	783	372	121	493	47.5%	15.5%	63.0%
Brockbridge Correctional Facility	651	580	209			36.0%		
Central Maryland Correctional Facility	516	490	219			44.7%		
Eastern Pre-Release Unit	180	173	71			41.0%		
Southern Maryland Pre-Release Unit	180	170	64			37.6%		
Maryland Correctional Pre-Release System	***1,527***	***1,413***	***563***	***10***	***284***	***39.8%***	***0.7%***	***20.1%***
Maryland Correctional Training Center	2,848	2,467	975	76	464	39.5%	3.1%	18.8%
Baltimore City Correctional Center	508	500	142			28.4%	N/A	N/A
Maryland Reception, Diagnostic and Classification Center	808	339	81			23.9%	N/A	N/A
Maryland Reception, Diagnostic and Classification Center	***1,316***	***839***	***223***	***35***	***243***	***26.6%***	***4.2%***	***29.0%***
Metropolitan Transition Center	594	366	19	2	97	5.2%	0.5%	26.5%
North Branch Correctional Institution	1,487	1,289	136	86	368	10.6%	6.7%	28.5%
Patuxent Institution	869	559	283	152	249	50.6%	27.2%	44.5%
Roxbury Correctional Institution	1,804	1,739	611	117	567	35.1%	6.7%	32.6%
Threshold	32	28	12		0	42.9%	N/A	N/A
Western Correctional Institution	1,715	1,607	375	67	210	23.3%	4.2%	13.1%
Total	**24,685**	**20,663**	**6,613**	**1,266**	**5,053**	**32.0%**	**6.1%**	**24.5%**

*Total bed space as of October 21, 2016.
Average Daily Population for FY 2016.
Substance Use Disorder Data Stock Population as of November 1, 2016.
Nine month Stock Population average from January 2016 – September 2016 for serious mental illness and mental illness.

Substance Use Disorders and Mental Health Screening

As previously mentioned, the Department of Public Safety and Correctional Services uses the Texas Christian University Drug Screen II to screen all inmates for substance use disorder at the Maryland Reception Diagnostic, and Classification Center as well as the Maryland Correctional Institute for Women. This screener consists of 15 questions with many of them relating to drug use in the past 12 months. Those inmates who score a three or higher are referred for further addictions assessment using the Treatment Assignment Protocol (TAP) Assessment [*Appendix E: SMART TAP Assessment*]. Those offenders within the standing population at all other institutions receive these screening assessments if applicable while they are incarcerated. Any inmate who scores a one or higher on the TAP Assessment is referred for treatment once the inmate is within two years of an anticipated release date.

After sentencing, an inmate will be screened for mental health disorders and will be sent to the Patuxent Institution if the inmate is found to meet certain mental health criteria. The Patuxent Institution has a correctional mental health unit at Jessup.

Types of Substance Use Disorder and Mental Health Treatment Provided at State Prisons

- *Methadone Maintenance*: Offenders are screened to determine if they participated in methadone maintenance treatment prior to incarceration. If so, then methadone maintenance therapy will be provided in the prison. These sentenced offenders receive a 21-day detoxification regime.
- *Segregation Addictions Program*: This is provided for inmates found guilty of failing a drug test, possession of alcohol, drugs, paraphernalia or refusing a drug test while in custody. The program lasts for three months and consists of two group therapy sessions as well as one individual therapy session per week. The curriculum is based upon Education Motivational Enhancement Therapy and Cognitive Behavioral Therapy. A total of 22 slots are available for this treatment. Upon completion of the program, inmates are referred for a follow up assessment and given additional treatment as needed.
- *Addiction Treatment Protocol*: This is designated for any inmates that score a one, two, or three on the TAP Assessment. The program lasts for six months and consists of two group therapy sessions as well as one individual therapy session per week. The curriculum is based upon Rational Emotive Behavioral Therapy and Cognitive Behavioral Therapy. A total of 560 slots are available for this treatment. The Maryland Correctional Institution for Women has a similar but shorter (three month) program due to the shorter sentences of females.
- *Therapeutic Community*: This is designated for any inmates that score a three or four on the TAP Assessment. This includes an intensive six month program with individual and group counseling, educational seminars, and self help programming. The program addresses education on addiction including how to identify triggers, developing skills for addressing cravings, and learning how to respond to relapses. These offenders also receive sessions around criminal thinking, criminal networks, and criminal lifestyle as well as right living skills with the intent to change the offender's lifestyle. A total of 606 slots are available for this intensive treatment.
- *Aftercare*: This is available for inmates who complete the Addiction Treatment Protocol. This includes one weekly group session as well as individual counseling sessions as needed for up to a year. This is also supported for Narcotics Anonymous and Alcoholics Anonymous meetings. A total of 240 slots are available for Aftercare.

The type of mental health treatment provided within Maryland state correctional facilities is provided below:

- *Baltimore City Pretrial*: The Division of Pretrial and Detention Services in Baltimore City has a 32 bed licensed mental health unit for men to treat the acute mental health patients. The services on the unit include 24-hour nursing care, psychiatric evaluations and psycho-educational groups. This unit helps to stabilize the pretrial mental health population. Men detainees receive outpatient supportive therapy and medication management. Women detainees receive outpatient supportive therapy and medication management. Since the closing of the women's detention center, the women detainees who are in need of acute care are sent to the licensed mental health unit located at the Maryland Correctional Institution for Women, which can hold 13 females for stabilization. There is also a Special Needs Unit, which is a voluntary program that can house 40

male detainees. This unit is for the seriously mentally ill, and services received are medication management, individual therapy, group therapy, and art groups.

- *Corrections*: There are two licensed mental health units in the Division of Correction. There are 190 licensed mental health beds located at Patuxent Institution and 13 licensed beds at the Maryland Correctional Institution for Women. These units are for stabilization and for intensive therapy for the more seriously mentally ill inmates who cannot function within general population at a maintaining institution. Services offered include psychiatric services, 24 hour nursing, activities therapy, group therapy, and individual therapy. Each correctional institution has psychology staff and psychiatric services for inmates. These services are considered to be outpatient, because the inmates are housed in general population or restrictive housing. Psychological services available at each institution are crisis management, suicide assessments, short term therapy, supportive therapy, and some group therapy. All institutions have psychiatric services that offer medication management. The Division of Correction has three Special Needs Units, which function as a general population tier, but offer more intensive mental health services. One unit is located at the Maryland Correctional Institution for Women, which has four beds. North Branch Correctional Institution has 56 beds, and the Roxbury Correctional Institution has 32 beds. These units offer individual therapy every other week, group therapy, psycho-educational groups, medication management, and a multi-disciplinary treatment team (includes mental health staff, case management, social work, and custody).

Pre-Release Services for inmates with a substance use disorder or mental illness - State Prisons

Correctional staff work with inmates to develop an aftercare services plan [*Appendix F: Department of Public Safety and Correctional Services - Aftercare Services Plan*]. The Department of Public Safety and Correctional Services has a Reentry and Transition Services Unit which employs Transition Coordinators within each facility. These Coordinators help to assign discharge plans for the offenders so they can find resources in the community upon release.

Maryland Division of Parole & Probation

The number of offenders under supervision with a drug special condition

Table 3 (*illustrated on the following page*) shows the percentage of offenders assigned a drug special condition by county by supervision type. A drug special condition could be a condition for drug testing or for drug treatment. The current records keeping system does not provide a way to differentiate between the two. As of November 1, 2016, there were 52,835 offenders under community supervision in Maryland. Over 23% of offenders were assigned a drug special condition while under supervision. Overall drug special conditions were highest for offenders in the Drinking Driver Monitor Program (41.3%) followed by pretrial (26.1%), probation before judgment (20.4%), probation (19.6%), parole (15.3%), and mandatory release (7.0%).

There was large fluctuation in percentages by counties of offenders assigned a drug special condition. Here are some of the trends:

Top Five Counties:	Bottom Five Counties:
Carroll - 57.3% Frederick - 50.6% Harford- 46.6% Washington - 41.5% Wicomico - 40.5%	Prince George's - 9.5% Howard - 9.9% Baltimore City - 10.9% Queen Anne's - 12.5% Kent - 13.6%

The opinion of the Department of Public Safety and Correctional Services is that the number of offenders with a drug special condition is higher than what the data indicates. While the data received is most likely an accurate reflection of what was extracted from the Offender Case Management System, it is not an accurate reflection of the number of offenders with a testing/treatment condition. This is mostly due to data entry variations throughout the state. For various reasons, special conditions are not entered into the Offender Case Management System or they are entered as "other" (and the condition written exactly how it appears on the probation or parole order). As a result, this data would not show up in the report that was generated for this request. This is an ongoing training issue that has been addressed with intake units across the state.

Table 3. Maryland Offenders under Community Supervision with a Drug Special Condition by County by Supervision Type							
County	Parole	Mandatory Supervision	Probation	Probation Before Judgment	Pretrial	Drinking Driver Monitor Program	Total
Allegany	10 21.3%	3 7.1%	90 22.1%	0 0.0%	6 20.0%	151 58.8%	260 32.7%
Anne Arundel	29 16.2%	14 9.5%	751 35.2%	178 29.8%	2 13.3%	97 9.6%	1,073 26.2%
Baltimore City	168 11.7%	48 3.5%	518 7.7%	63 4.6%	5 13.9%	500 50.0%	1,302 10.9%
Baltimore County	87 16.1%	29 6.2%	585 17.3%	114 16.2%	3 42.9%	730 37.1%	1,548 21.9%
Calvert	2 3.0%	3 9.4%	67 15.8%	6 46.2%	0 0.0%	62 18.0%	140 15.9%
Caroline	10 13.7%	1 3.1%	116 32.4%	11 26.2%	0 0.0%	N/A	138 27.2%
Carroll	19 29.2%	11 26.2%	339 52.2%	90 43.9%	3 50.0%	400 74.6%	862 57.3%
Cecil	6 7.1%	3 5.8%	122 15.6%	23 17.8%	0 0.0%	N/A	154 14.7%
Charles	22 16.9%	11 15.1%	115 16.0%	2 7.1%	0 0.0%	N/A	150 15.7%
Dorchester	4 5.9%	2 6.5%	154 39.4%	10 28.6%	8 80.0%	N/A	178 33.1%
Frederick	32 28.3%	9 23.1%	349 38.2%	84 45.2%	21 25.6%	602 72.5%	1,097 50.6%
Garrett	1 6.7%	0 0.0%	46 37.7%	5 35.7%	1 25.0%	N/A	53 32.3%
Harford	48 27.3%	31 31.6%	533 36.8%	117 40.3%	6 21.4%	689 67.7%	1,424 46.6%
Howard	10 13.9%	1 2.4%	58 10.1%	16 7.7%	0 0.0%	62 11.0%	147 9.9%
Kent	2 6.9%	0 0.0%	22 17.7%	0 0.0%	0 0.0%	N/A	24 22.9%
Montgomery	11 8.3%	8 8.0%	391 17.0%	41 16.8%	3 33.3%	548 34.1%	1,002 22.9%
Prince George's	62 11.8%	16 4.2%	269 6.8%	30 12.0%	0 0.0%	178 25.0%	555 9.5%
Queen Anne's	11 25.0%	0 0.0%	34 10.9%	5 20.8%	0 0.0%	N/A	50 12.5%
Somerset	16 18.6%	4 12.1%	45 28.5%	14 48.3%	0 0.0%	N/A	79 17.8%
St. Mary's	5 5.3%	0 0.0%	110 22.3%	3 23.1%	1 10.0%	N/A	119 25.6%
Talbot	11 25.6%	1 2.5%	99 36.8%	10 27.8%	0 0.0%	197 30.3%	318 30.6%
Washington	60 28.4%	28 17.9%	391 46.8%	58 52.7%	24 61.5%	N/A	561 41.5%
Wicomico	57 21.7%	14 11.5%	312 35.5%	56 52.3%	1 50.0%	353 60.9%	793 40.5%
Worcester	13 16.0%	4 16.7%	100 33.3%	25 55.6%	0 0.0%	N/A	142 31.5%
Interstate	3 18.8%	1 7.7%	13 19.7%	0 0.0%	0 0.0%	N/A	17 13.6%
Total	699 15.3%	242 7.0%	5,629 19.6%	961 20.4%	84 26.1%	4,569 41.3%	12,186 23.1%

Data was limited regarding the number of offenders who are required to receive mental health treatment as a special condition of supervision. There is a special condition in the Offender Case Management System module Intake Classification named "Obtain mental health evaluation and participate in mental health treatment as directed." The total for the active parole and probation population was 2,059 but it appears that not all agents are entering this information.

Offenders under community supervision enrolled in substance abuse or mental health treatment

The number of offenders under community supervision enrolled in substance abuse or mental health treatment is not known. This data was not able to be obtained as there are no data fields within the Offender Case Management System to track substance abuse or mental health enrollment. Since this data was not available, the Division of Parole & Probation was contacted regarding barriers to offenders receiving treatment under supervision and any other potential reason why these offenders decline treatment. Among the many internal barriers that can inhibit treatment success for offender-clients are:

- A history of failure
- Alienation from and cynicism about the social structures and governmental agencies that typically have had a major impact on them
- A sense of hopelessness that anything can make a difference in their lives
- A culturally supported belief that treatment is for weak people
- The perception that treatment is further punishment
- Lack of transportation to get to a treatment provider
- Lack of family support
- They don't have health insurance
- They have no money to pay for treatment
- They are not ready for treatment and would rather continue using
- They don't think they need it

Office of Problem Solving Courts

Various drug court data were obtained for FY 2015 as depicted in Table 4 with 2,154 active drug court clients including 687 new admissions and 794 discharges. Of drug court participants assigned to treatment, 59% had at least one treatment encounter in FY 2015. Over 90% of all treatments are attended by clients and unexcused absences occur only 4% of the time. The average numbers per client are inflated due to a few outliers.

Table 4. FY 2015 Drug Court Statistics	
FY 2015 Drug Court Statistics	**Number**
Total Active Clients	2,154
Total Clients Admitted	687
Total Clients Discharged	794

FY 2015 Drug Court Treatment Encounters	Number	Percent	Average Per Client	Range
Total Active Clients Assigned to Treatment	1,770	100.0%	-	-
Total Clients with at least one Treatment Encounter	1,045	59.0%	-	-
Total Treatments Scheduled	33,624	100.0%	32.18	1 - 274
Attended	30,431	90.6%	29.12	1 - 267
Excused	1,869	5.6%	1.79	1 - 278
FTA or no Meeting (Unexcused)	1,324	3.9%	1.27	1 - 43

Table 5 displays drug court discharge statistics by various demographic variables including race, ethnicity, gender, and age. Reasons for being terminated from the program include failing to appear for court, failing to comply with the treatment plan, failing to comply with the drug courts rules and receiving a new arrest or conviction. The neutral category also has several examples including the death of the client, the client timed out of probation, or they were unable to comply with drug court requirements due to a severe medical or mental health issues.

Overall African Americans achieved a higher completion rate (68.2%) than Caucasians (50.6%) statewide. There was no significant difference in completion rates among Hispanics (60.0%) versus non-Hispanics (60.2%) or males (61.5%) versus females (55.6%). The successful completion of a drug court is positively correlated to age. Those clients 40+ had the highest completion rate (72.4%), followed by those 30-39 (64.6%), 21-29 (45.3%), and 18-20 (37.5%).

Table 5. FY 2015 Maryland Drug Court Discharge Statistics				
Race	**Completed**	**Terminated**	**Neutral**	**Total Discharges**
American Indian	1 100.0%	0 0.0%	0 0.0%	1 0.1%
Asian/Pacific Islander	2 66.7%	1 33.3%	0 0.0%	3 0.4%
African American	290 68.2%	93 21.9%	42 9.9%	425 53.6%
Caucasion	176 50.6%	157 45.1%	15 4.3%	348 43.9%
Other	8 50.0%	7 43.8%	1 6.3%	16 2.0%
Total	**477 60.1%**	**259 32.6%**	**58 7.3%**	**794 100.0%**
Ethnicity	**Completed**	**Terminated**	**Neutral**	**Total Discharges**
Hispanic	12 60.0%	6 30.0%	2 10.0%	20 2.5%
Not Hispanic	465 60.2%	252 32.6%	56 7.2%	773 97.5%
Total	**477 60.1%**	**259 32.6%**	**58 7.3%**	**794 100.0%**
Gender	**Completed**	**Terminated**	**Neutral**	**Total Discharges**
Female	104 55.6%	69 36.9%	14 7.5%	187 23.6%
Male	373 61.5%	190 31.3%	44 7.3%	706 76.5%
Total	**477 60.1%**	**259 32.6%**	**58 7.3%**	**794 100.0%**
Age	**Completed**	**Terminated**	**Neutral**	**Total Discharges**
18-20	9 37.5%	14 58.3%	1 4.2%	24 3.0%
21-29	124 45.3%	124 45.3%	26 9.5%	26 9.5%
30-39	126 64.6%	57 29.2%	12 6.2%	195 24.6%
40+	218 72.4%	64 21.3%	19 6.3%	301 37.9%
Total	**477 60.1%**	**259 32.6%**	**58 7.3%**	**794 100.0%**

Department of Health and Mental Hygiene

Needs Assessment

Health Professional Shortage Areas

In 2015, 23% of the state's population resided in the mental health health professional shortage areas (35 areas total 1,333,806 residents). Jurisdictions with 100% of their resident population residing in mental health shortage areas include Calvert, Caroline, Cecil, Charles, Garrett, Harford, Kent, Queen Anne's, St. Mary's, Somerset, Washington, Wicomico, and Worcester counties. With the exception of Talbot County, the entire Eastern Shore is considered a mental health shortage area. When compared to the statewide percentage, Allegany and Dorchester counties had a higher percentage of people residing in a mental health care shortage area. The percent of population in Baltimore City residing in a mental health care shortage area was very similar to the statewide percentage of 25%.

Medically Underserved Areas

As of 2015, there were 46 Medically Underserved Areas in Maryland, encompassing more than 974,000 Maryland residents. Calvert, Caroline, Garrett, Kent, Somerset, and Worcester counties each have 100 percent of their populations residing in underserved area designations. Howard County is the only jurisdiction that does not have a medically underserved designation. Baltimore City had the largest number of shortage area designations at 15, with 77% of its population residing in an underserved area.

Medically Underserved Populations

There are 13 medically underserved populations in Maryland covering more than 142,000 residents. A total of 10 of Maryland's 24 jurisdictions have an underserved population designation. Prince George's County has three underserved populations and Anne Arundel County has two. The jurisdictions with the largest percentages of population covered by underserved population designations are Dorchester, Wicomico, and Carroll county (37.3%, 18.5%, and 14.0% respectively).

Outpatient Mental Health Clinics

Outpatient Mental Health Clinics provide a range of mental health services to meet an individual's needs in order to promote recovery and resiliency including family and group therapy; co-occurring substance use treatment; medication services; and on-call and crisis intervention services. All jurisdictions except Queen Anne's County have at least one Outpatient Mental Health Clinic that participates in the public behavioral health system. On average, Maryland has 10 clinics per jurisdiction with a median of five. These clinics provide 100% of treatment for mentally ill persons within 13 jurisdictions (primarily the Eastern Shore and Southern Counties).

Ambulatory Substance Use Disorder Programs

Ambulatory Substance Use Disorder Programs offer American Society of Addiction Medicine outpatient counseling, intensive outpatient treatment, partial hospitalization, and ambulatory withdrawal management. There are roughly 225 of these programs throughout the state with at least one in every jurisdiction. On average, each jurisdiction has nine programs, with a median of five. Over half (117) of

the State's Ambulatory Substance Use Disorder programs are concentrated in the Central Maryland region (including 62 programs from Baltimore City alone). Approximately 15% of Ambulatory Substance Use Disorder programs are located on the Eastern Shore and nearly 12% of are located in Western Maryland.

Opioid Treatment Programs (OTP)

Opioid Treatment Programs are certified to provide medication assisted treatment including methadone and buprenorphine. There are over 29,000 individuals in need of Opioid Treatment Programs service over and above the capacity of 32,422 treatment slots. Proportionally Prince George's County and Baltimore County have a significantly higher need over capacity than all other jurisdictions. An analysis of providers enrolled in the public behavioral health system reveals there are significantly less OTPs statewide, namely on the Eastern Shore, in comparison to other Ambulatory Substance Use Disorder programs. Seven counties do not have an Opioid Treatment Program that participates in the public behavioral health system. With the exception of Garrett County, all of these jurisdictions are on the Eastern Shore. When assessing coverage at a regional rather than jurisdictional level, it is clear that Maryland has more robust treatment access in the Central Maryland region. Only one opioid treatment program covers the lower eastern shore.

Intermediate Care Facilities for Addiction

Intermediate Care Facilities for Addiction provide intensive (24-hour staffing) substance use disorder treatment in a residential setting. Due to federal payment policy, the funding of these facilities is limited within the public behavioral health system. Principally, Medicaid only reimburses for services provided to youth under the age of 21 years in these facilities. For adults 21 years or older, these services are available through a fixed amount of state-only funding. Since Medicaid is the primary payor of behavioral health services nationally, this has likely impacted the expansion of these services in other jurisdictions in the state.

There are a total of 21 Intermediate Care Facilities for Addiction in Maryland and approximately 50% of counties have one with over 20% located in Baltimore City. There is one each located on the lower shore, mid shore, and upper shore. Governor Hogan has made access to these services a top priority. Specifically, the A.F. Whittsitt Center has been restored to 40-bed capacity resulting in greater access on the Upper Shore.

Federally Qualified Health Centers

Federally Qualified Health Centers are community-based health care providers funded by the federal government to provide low-cost care to underserved populations. These centers provide a comprehensive array of health care and supportive services. In many instances, they offer integrated mental health and/or substance use disorder services, including medication assisted treatment, traditional medical care and preventive health service, family planning, and HIV/AIDS services.

There are a total of 135 service site locations for Federal Qualified Health Centers in Maryland of which 36 are located in Baltimore City. The next highest concentrations of locations are in Montgomery

County (17), Caroline County (15), Prince George's County (10), Talbot and Wicomico Counties with 8 each, followed by Anne Arundel and Washington counties with 6 each. Only Calvert and Carroll Counties have no sites. Fifty-three satellite sites with headquarters in Washington D.C. are included in the total number.

Provider Survey

Survey Sample

A total of 110 treatment providers completed the Behavioral Health Gap Analysis survey. Nearly half of the respondents (46.4%) indicated that they provided both mental health and substance use services. The remainder identified as providing mental health services only (39.1%), or substance use services only (11.8%). The majority served the Central Maryland region (52.7%), followed by the the DC Capital region (22.7%), Western Maryland (20.0%), Lower Shore (19.1%), Southern Maryland (12.7%), the Mid Shore (12.7%) and the Upper Shore (9.1%).

Types of Service Provided

With regards to service provision, the respondents indicated that they provided outpatient mental health services (71.7%), psychiatric rehabilitation services (35.8%), mental health case management (19.8%) and mental health crisis services (19.8%). For substance use disorder treatment, the respondents noted that they provided ASAM level one counseling (41.5%), ASAM Level 2.1 intensive outpatient counseling (33.0%), buprenorphine treatment (29.2%), and other medication assisted treatment, such as naltrexone (17%). A small group of providers noted that they provided residential substance use treatment.

The Average Wait Time for Treatment

Notably, 70.6% of respondents indicated that they did not have a waitlist for new patients. Of the providers that did report a wait list, wait times reported ranged from less than one week (21.9%) to more than one month (28.1%). Furthermore, 34.4% of respondents reported wait times in the two-to-three week range.

Justice Involved Populations

The majority of respondents noted that they are already serving justice involved populations (86.1%). with approximately 64% noting that it made up a small portion of their patient mix (0 - 25 % of their patients). A small subset (5.5%) noted 76 - 100% of their patients were justice-involved.

Any Perceived Gaps In Treatment

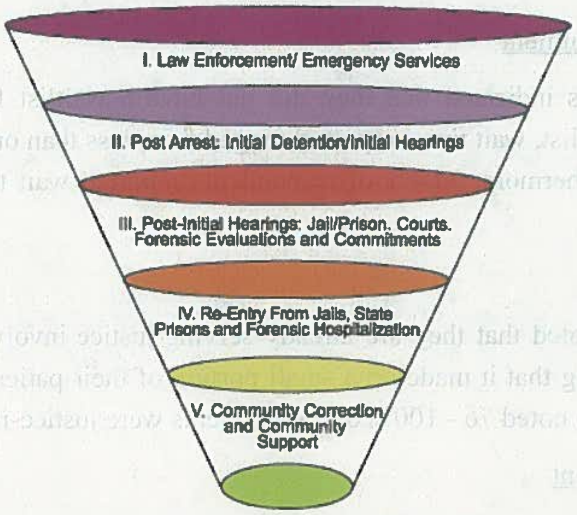
Issues impacting social determinants of health, as well as clinical services were the most commonly cited gap in the treatment system. Roughly 25% of providers noted housing (13%) or transportation (12%) were lacking in the area they serve. With regards to clinical services, the most frequently cited gaps in care were psychiatric services (12%); a lack of prescribers (10%), whether for psychiatric medications or medication assisted treatment such as buprenorphine; and children's services (10%). An additional 10% noted a lack of provider choice/provider shortages in general.

SEQUENTIAL INTERCEPT MODEL

Section 5(1)(ii) of the Justice Reinvestment Act requires "a plan for how a sequential intercept model could be used to address the gap between offender treatment needs and available treatment services in the State."

The Sequential Intercept Model – developed by Mark R. Munetz, MD, and Patricia A. Griffin, PhD, in conjunction with the GAINS Center - provides useful framework for organizing and conceptualizing the range of community-based alternatives to standard prosecution. The Sequential Intercept Model describes five points at which the standard criminal justice process of arrest, conviction, and incarceration can be interrupted (or intercepted), which results in a dramatically different procedure for the individual: (1) law enforcement and emergency services; (2) post-arrest: initial detention or initial hearing and pretrial services; (3) post-initial hearings: jails/prisons, courts, forensic evaluations, and commitments; (4) re-entry from jails, prison, and forensic hospitalization; and (5) community corrections and community support.[18]

The Sequential Intercept Model itself is a model, not a specific intervention, and therefore generally not appropriate for empirical research on effectiveness. However, when a specific jurisdiction uses the Sequential Intercept Model for planning – using "systems mapping" to identify gaps and opportunities in a collective attempt to revise current policy and practice involving interventions with justice-involved individuals with behavioral health problems – this can be considered an intervention. Accordingly, systems-level research might investigate the impact of systems-mapping upon outcomes relevant to justice involvement for those with behavioral health problems.



Within the State of Maryland, the Department of Health and Mental Hygiene's Behavioral Health Administration Forensic Services Program utilizes the Sequential Intercept Model as its organizational framework for deploying staff and resources at multiple entry points to the criminal justice system to

[18] DeMatteo, D., LaDuke, C., Locklair, B. R., & Heilbrum, K. (2012). Community-based alternatives for justice-involved individuals with severe mental illness: Diversion, problem-solving courts, and reentry. *Journal of Criminal Justice, 41*, 64-71.

screen and link individuals with mental health concerns. This section shows the various services that are provided to individuals at each interception point in the State of Maryland as well as a few national programs which could be replicated in Maryland.

Intercept 1: Law Enforcement/Emergency Services

The first intercept refers to the initial contact between the individual and police officers or other first responders.

Crisis Intervention Teams

Crisis Intervention Teams (CIT) provide police officers with mental health training and community partnerships for dealing with situations involving behavioral health disorders, such as drug use and/or mental health problems. The Mental Health Association of Maryland (MHAMD) states, "CIT is a partnership between law enforcement, behavioral health providers, and advocates to assist and divert individuals in crisis, resulting in less lethal interventions, better outcomes, and increased safety for all involved."[19] Police training in mental health concepts differs from state to state as well as at the local level for some specifics of training. However, CIT is more than simply Law Enforcement training, it is an evolving partnership between law enforcement, behavioral health, self advocates and the community. Expanding the crisis system of services is integral to increasing the effectiveness of intervening with those experiencing a behavioral health crisis.

In 2014, the State of Maryland held three forums on CIT in the eastern, central and western regions, focusing on the CIT Planning and Implementation for each region The forum was designed to help Maryland create standards for CIT across the State. In November, 2015, a three day seminar was held for Maryland CIT groups to advance the Community aspects of the teams and to provide "train the trainer" workshops. Maryland's first Annual CIT Conference will be held on January 26, 2017.

Of Maryland's 24 jurisdictions, 12 have implemented CIT and five are in progress. Anne Arundel, Frederick, Harford, Howard, and Montgomery counties have CIT-trained officers on all shifts, and Howard County has committed to train all officers. One of the core elements of CIT is "to help communities develop more responsive access to behavioral health services, increase collaboration between police and crisis behavioral health clinicians, and provide structured training for police agencies that increases understanding of behavioral health issues and provides skills that are effective in intervening in the field."[20]

Mobile Crisis Services

Community-based mobile crisis services provide 24/7 availability of face-to-face professional and peer intervention. The teams are deployed 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 healthcare facility. A multi-disciplinary team, including peer support workers, works to

[19] Crisis Intervention Training. Mental Health Association of Maryland. Retrieved from https://www.mhamd.org/crisis-intervention-training/.
[20] CIT Core Elements Form. Retrieved from www.citinternational.org/.

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 may continue past the crisis period. There are currently 13 mobile crisis team programs in Maryland, with two of these programs covering multiple counties.

Stabilization Centers

Stabilization (Sobering) centers are facilities that provide a safe, supportive, environment for mostly uninsured, homeless or marginally housed publicly intoxicated individuals to become sober. Sobering centers provide services for alcohol-dependent individuals that may have secondary problems such as drug abuse/dependence, mental illness and/or medical issues. Stated goals for sobering centers include:

- Provide better care for homeless alcohol-dependent persons and improve health outcomes
- Decrease the number of inappropriate ambulance trips to the emergency department for homeless alcohol-dependent individuals
- Decrease the number of inappropriate emergency department visits for homeless alcohol-dependent individuals
- Create an alternative to booking individuals arrested for public inebriation

More generally, short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery. Core attributes of residential crisis services include providing housing during a crisis with services that are short term, serving individuals or small groups of clients, and are used to avoid hospitalization. Current literature generally supports that crisis residential care is as effective as other longer psychiatric inpatient care at improving symptoms and functioning. It also demonstrates that the satisfaction of these services is strong, and the overall costs for residential crisis services are less than traditional inpatient care.

In the fall of 2015, the Episcopal Housing Center partnered with Behavioral Health System Baltimore to begin work on a Stabilization Center in Brooklyn, Maryland.[21] The proposed services for the Baltimore Stabilization Center would provide voluntary care for adults who are intoxicated and will operate 24 hours a day, seven days a week. It would be able to serve 30 to 35 people at a time, with stays, on average, lasting between six and 10 hours.

Planned services include:

- Medical screening and examination
- Basic first aid
- A bed
- Medical monitoring (including withdrawal scores and vital signs)
- Hydration and electrolyte replacement
- Food, clothing and showers

[21] Behavioral Health System Baltimore - Stabilization Center. Episcopal Housing Corporation. http://www.episcopalhousing.org/projects/current-projects/the-stabilization-center/.

- Screening, brief intervention and referral to treatment for substance use, mental health and physical health disorders
- Case management for up to 30 days after a visit to ensure linkage to needed services, including behavioral health treatment, shelter assistance and health care

Law Enforcement Assisted Diversion

Law Enforcement Assisted Diversion (LEAD) began in Seattle in 2011. Under the LEAD program, "eligible low-level drug and prostitution offenders are diverted to community-based treatment and support services at the time of arrest, thereby avoiding prosecution and incarceration."[22] This process gives trained officers the discretion to make a referral to a designated caseworker in lieu of arresting and booking the individual into jail. The caseworker then conducts an assessment and connects the individual with resources tailored to their needs. The Seattle program has reduced re-arrest rates among participants by almost 60%.[23]

The LEAD program in Baltimore, with grant support from Open Society Institute-Baltimore and the Governor's Office of Crime Control & Prevention, will focus on a portion of the City which contains a combination of high rates of drug-related crime and a recent increase in investment. The Baltimore Police Department and Behavioral Health Systems of Baltimore are implementing this program and a full time Director has been hired. With a start up date in January 2017 it is anticipated that LEAD will serve at least 60 clients in the first year. LEAD is a promising program which will address persistent crime and public safety concerns related to illegal drug use, through the implementation of a pre-booking diversion program that enables law enforcement to immediately connect eligible individuals to evidence-based services.

Intercept 2: Post Arrest: Initial Detention/Initial Hearings

The second intercept focuses on interventions that occur after the offender has been arrested, but before he or she enters a plea or goes to trial. Those at this intercept have obviously penetrated the criminal justice system, but there are several options for jurisdictions that wish to divert these individuals from standard prosecution and prevent further penetration into the criminal justice system.

Rapid Referral Program and Sparrow Program

The Rapid Referral Program and the Sparrow Program in Vermont help to connect individuals facing nonviolent criminal charges with resources to help address mental health and substance abuse issues. At arraignment, the judge has the discretion to set a condition of release for the individual to attend a substance abuse assessment and assign counseling if needed. If the client does not attend mandated initial assessment, the judge will issue a summons for the client to appear in court and make a decision about which steps will be taken next. Successful completion of these programs may be factored into the resolution of the criminal case by the Judge. The charges may even get dropped.

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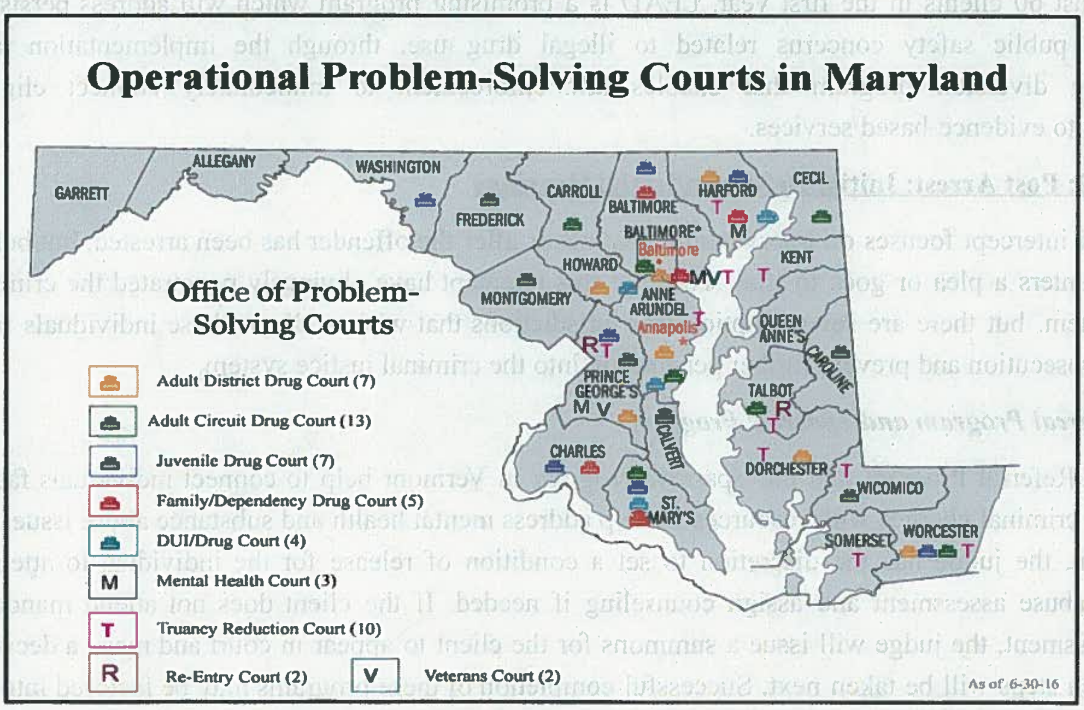
[22] Bernstein, G (2015). Pre-booking diversion: an alternative to conviction and incarceration. The Baltimore Sun. http://www.baltimoresun.com/news/opinion/oped/bs-ed-bernstein-0301-20150228-story.html.
[23] Ibid.

An example of a county's approach to pre-trial diversion in Maryland is provided by the Montgomery County Department of Corrections and Rehabilitation. They have a therapist on site to meet with individuals to assess and refer out to substance abuse and mental health services and also have a psychiatrist on site once a week for medication maintenance until individuals are connected to those services in the community.

Intercept 3: Post-Initial Hearings: Jail/Prison, Courts, Forensic Evaluations, and Commitments

The third intercept occurs after the initial court hearing, and there are a range of community-based alternatives at this stage. Diversion from standard prosecution to problem-solving courts, such as drug courts, mental health courts, or veterans' courts, occurs at intercept three. Problem-solving courts are the most well-researched intervention for offenders with special needs, although some of the newer types of problem-solving courts do not yet have a strong empirical base.

The Office of Problem-Solving Courts for the Administrative Office of the Courts is responsible for assisting Maryland's problem-solving courts in development, maintenance, and advancement of a collaborative therapeutic system. The Office of Problem-Solving Courts has overseen the creation of problem-solving programs in 21 of the 24 jurisdictions in Maryland and works with public and private stakeholders to develop and establish best practices in problem-solving courts. At the present time, there are 53 Operational Problem-Solving Courts in Maryland (*as illustrated below*).



A Mental Health Court is a specialized court docket established for defendants with mental illness that substitutes a problem-solving approach for the traditional adversarial criminal court processing. There are three Mental Health Courts in the State in Baltimore City, Harford County, and Prince George's County. Participants are identified through mental health screening and assessments and voluntarily

participate in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals. The overarching goal of the Mental Health Court is to decrease the frequency of participants contacts with the criminal justice system by providing participants with judicial leadership to improve the social functioning, employment linkage, housing needs, treatment, and support services of participants.

Mental Health Courts rely on individualized treatment plans and ongoing judicial monitoring to address both the mental health needs of offenders and public safety concerns of communities. These courts also seek to address the underlying problems that contribute to criminal behavior, and to assist with the avoidance of recurring correctional visits, as well as to overall lower the recidivism of this population.

Intercept 4: Reentry From Jails, State Prisons, and Forensic Hospitalization

The fourth intercept focuses on the application of community-based interventions to facilitate successful reentry into the community following release from incarceration following a conviction, or release from secure forensic hospitalization following a finding of not criminally responsible.

Coordination of Services

This involves connecting individuals reentering their communities with key community resources. These resources can include enrollment in Medicaid, scheduling of medical appointments, referral and introduction to mental health service providers, referrals to health care, supportive housing, and other support services before release. Dedicated staff or mental health and social work professionals in the correctional facility assist individuals in identifying the services for which they are eligible and assist them in enrolling in these services. For justice-involved individuals with mental health and substance use disorders, facilitating access to health care and coordinating treatment and support services prior to release from jails and prisons improves the likelihood of a successful return and tenure in the community. When individuals return to their communities, they should have access to the medication, treatment, and services they need to maintain a stable and healthy life. An effective pre-release coordination plan will coordinate an individual's discharge from jail or prison to a community-based service provider or case manager. Both correctional and community provider staff facilitate the individual's transition.[24]

Maryland Community Services Locator

The Maryland Community Service Locator is a free online statewide directory of information developed to assist professionals in referring clients to criminal justice, health and social services. This system is also available for use by inmates "behind the walls" of approximately 20 Maryland facilities. This system empowers inmates to be able to independently access program information regarding their reentry needs prior to their release.

Treatment services pertaining to mental illness and/or substance use disorders is available in one or more of the search criteria, to include: Buprenorphine Certified Physicians and Treatment Providers, Mental

[24] Data Driven Justice Playbook: How to Develop a System of Diversion (2016). Retrieved from http://www.naco.org.

Health Services, Substance Abuse Prevention/Recovery Programs, Substance Abuse Treatment Programs (Certified), and more.

Intercept 5: Community Correction and Community Support

Finally, the fifth intercept describes how community corrections, such as specialized probation or parole, can be used with individuals with severe mental illness.

Day Reporting Center

The Washington County Sheriff's Office received $540,000 from the Office to provide personnel, operating expenses, contractual services and equipment for a Day Reporting Center in the county. The program provides community-based services and treatment to offenders under probation, pretrial supervision, and those sentenced directly to the Day Reporting Center, in order to reduce recidivism, jail population and corrections related costs. This new center will provide non-violent offenders who have substance abuse disorders with effective supervision and proven treatment programs that include therapy, life skills, and education. Offenders who are sent to the day reporting center will be required to be employed or actively searching for employment. They will go through a controlled, step-by-step process to help them become productive citizens.

This Day Reporting Center is supported by a partnership of criminal justice, behavioral health, and educational entities, including the Courts, Parole and Probation, the Washington County State's Attorney's Office, the Maryland Office of the Public Defender, the Washington County Bar Association, and the Washington County Health Department. Offenders who enter the program are expected to make their way through a four-phase protocol that includes an initial behavioral health and criminogenic risk assessment, daily classes, urinalysis testing, curfews, and levels of supervision by the Division of Parole & Probation that advance from intensive to intermediate to aftercare. Offenders are expected to participate in the Day Reporting Center's activities for a minimum of 92 days within a six-month period. Those who do not meet the criteria of the program will either be sent back to an earlier phase, or incarcerated.

RECOMMENDATIONS

In response to the various efforts that have occurred within the State of Maryland as they pertain to, or provide guidance for, available treatment services to offenders – behind the bars and in the community – and based on prior research findings, several recommendations have been identified to include the following:

Recommendation #1: Encourage compulsory crisis intervention team training for law enforcement officers.

According to research, crisis intervention team training has been associated with an increase in the number and proportion of calls involving possible mental illness, and an increase in the rate of voluntary transport of individuals experiencing a psychiatric crisis to treatment facilities by crisis intervention team officers.[25] It has also been suggested that crisis intervention team training is an effective model to reduce response time to psychiatric crises, reduce costs incurred by specialized police responses (e.g., tactical intervention units), and reduce injury rates for officers.[26]

Recommended Charge: All law enforcement officers should receive entry level training on mental health issues. Also, the primary law enforcement agency in each county should be encouraged have 24/7 coverage by a Crisis Intervention Team (CIT). The primary goals of CIT are to increase the knowledge and skill of law enforcement to increase their effectiveness and to continually partner with behavioral health agencies to increase the effectiveness of the teams.

Lead Agency: Department of Health and Mental Hygiene; Police Training Commission

Recommendation #2: Mental health courts should include an active substance use treatment component to target those clients with co-occurring mental health and substance use disorders.

Given the high rates of co-occurring mental health and substance use disorders among those involved in the criminal justice system, it is not surprising that a sizeable portion of mental health court clients are dually diagnosed.[27]

Recommended Charge: The Office of Problem Solving Courts should incorporate case management plans to address substance abuse, mental health, or co-occurring mental health and substance use disorders. As previously mentioned, and based on the findings of this feasibility study, 89% of the inmates who are diagnosed with a mental health disorder also have a substance use disorder which supports the notion that mental health courts should also include a substance use disorder component.

Lead Agency: Office of Problem Solving Courts

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[25] DeMatteo, D., LaDuke, C., Locklair, B. R., & Heilbrun, K. (2012). Community-based alternatives for justice-involved individuals with severe mental illness: Diversion, problem-solving courts, and reentry. *Journal of Criminal Justice*, citing Teller, Munetz, Gil, and Ritter (2006). Retrieved from http://www.drexel.edu/.

[26] Dupont, R., & Cochran, S. (2000). Police respond to mental health emergences: Barriers to change. *The Journal of the American Academy of Psychiatry and the Law, 28*, 338-344.

[27] DeMatteo, D., LaDuke, C., Locklair, B. R., & Heilbrun, K. (2012). Community-based alternatives for justice-involved individuals with severe mental illness: Diversion, problem-solving courts, and reentry. *Journal of Criminal Justice*. Retrieved from http://www.drexel.edu/.

Recommendation #3: Increase the Department of Health and Mental Hygiene and community provider capacity to meet the forensic population needs.

The *2014 Joint Chairmen's Report*, in an effort to address stakeholder concerns regarding delays associated with court involved individuals navigating through the Behavioral Health Administration's forensic system of care, recommended a 10% increase in the number of beds available for substance use disorder treatments, either through partnering with the private sector, reducing decreasing length of stay in state hospitals by having more funding for housing and wrap around services, or adding 100 more State beds.

The Forensic Services Advisory Council, which first met in December 2016, is an ongoing council that provides advice to the Executive Director of the Behavioral Health Administration regarding potential strategies for addressing the six recommendations presented to the Secretary of Health and Mental Hygiene in August 2016 by the Forensic Services Work Group. It will track the progress made on each recommendation and based upon assessment data presented, offer specific recommendations regarding the midcourse corrections that could be made to improve the effectiveness of the strategies and approaches implemented.

The Secure Evaluation and Therapeutic Treatment Program relocated from Perkins to Springfield in November freeing up space at Perkins to increase bed capacity. Renovation is complete and the Department is currently securing the positions needed for staff to open 16 additional beds at Perkins. It is important to note that forensic bed capacity challenges at Behavioral Health Administration Facilities cannot be solved by simply adding additional beds. The Forensic Services Advisory Council will consider additional strategies like increasing diversion services, including crisis services; improving the discharge planning process and care coordination/case management designed to connect individuals to the services they need; and expand the array of services available in the community tailored to meet the needs of forensically-involved people.

Recommended Charge: Increase the bed capacity within the Department of Health and Mental Hygiene, based on the following recommended items, listed in the *Forensic Services Work Group: Report of Recommendations*:

- Immediate opening of 24 inpatient hospital beds (one unit), initially on a temporary basis, to address current backlog of court committed individuals. As stated above, the Department is preparing to open 16 more beds at the Clifton T. Perkins Institution. The Forensics Advisory Group is currently considering ways to add eight more beds for committed in-patient individuals as well as the 24 step-down beds referred to in the next item.
- Rapid creation of the 24 "Step-down" beds within existing Department of Health and Mental Hygiene infrastructure thus allowing for the transfer of appropriate patients from the inpatient level of care.
- Expedited contracting with community-based hospitals/systems to use private sector psychiatric beds.
- Expedited re-assessment of actual bed needs.

Lead Agency: Department of Health and Mental Hygiene, Forensic Services Advisory Council

Recommendation #4: Explore and expand opportunities to share data between criminal justice and behavioral health stakeholders.

The findings from this report clearly show the direct link between substance use disorder, mental illness and the increased likelihood of being involved in the criminal justice system. DataLink, the data sharing initiative with the Department of Public Safety & Correctional Services, Local Detention Centers, Beacon Health Options at the Department of Health and Mental Hygiene, and the State's Core Service Agencies, is a prime example of how different stakeholders in the mental health and criminal justice systems share information to improve outcomes for mentally ill inmates. Currently 13 jurisdictions in Maryland are signed onto Datalink while most other jurisdictions have begun the process of signing on.

This is a strong start to an effective standardized form of data sharing, but there are several other potential data sharing partnerships to explore including hospital data from Chesapeake Regional Information Systems for Patients (CRISP), prescription data from Maryland Prescription Drug Monitoring Program, various substance abuse data from the Washington/Baltimore High Intensity Drug Trafficking Area, emergency medical services data from the Maryland Institute for Emergency Medical Services Systems, supervision and detention data from the Department of Public Safety & Correctional Services, booking data from the local detention centers, and arrest data from law enforcement agencies.

Recommended Charge: The Governor's Office of Crime Control & Prevention will work with Beacon Health Options to ensure that all Maryland counties sign up for Datalink. This relationship can be enhanced through quarterly Mental Health and Criminal Justice Partnership DataLink Subcommittee meetings. Expanding this partnership statewide will help mentally ill inmates be provided access to appropriate treatment.

While abiding the legal restrictions of sharing personally identifiable protected health information, various criminal justice and public health agencies should have open discussions about data sharing. This includes organizing facilitated discussions with the various agencies mentioned above. Data is crucial in implementing effective policy, and some of the hindrances could be resolved by creating more channels for effective communication between departments.

Lead Agency: Governor's Office of Crime Control & Prevention, Mental Health & Criminal Justice Partnership

Recommendation #5: Develop outcome based performance measures to track the impact of referrals and treatment services.

Currently, the data collection between the tracking of referrals and treatment services between the Division of Parole & Probation, the Department of Health and Mental Hygiene, the Office of Problem Solving Courts, and local treatment providers is paper based. This makes it difficult to track the performance and progress of treatment providers. Currently the Division of Parole & Probation does not

have any data available on the number of offenders receiving treatment while on supervision or their outcomes in treatment.

Recommended Charge: Use an automated form of data sharing for referral and treatment service information to better track outcomes of patient treatment visits and the quality of treatment.

Lead Agency: Office of Problem Solving Courts, Department of Public Safety and Correctional Services, Department of Health and Mental Hygiene, Governor's Office of Crime Control & Prevention

Recommendation #6: Expansion of the sequential intercept model.

The Sequential Intercept Model is an effective way to determine various diversion points for mentally ill and drug addicted individuals that come into contact with the criminal justice system and prevent them from penetrating deeper into the system. Research shows that incarceration is an ineffective way to rehabilitate those individuals who are incarcerated with a mental illness and/or substance use disorder and reduces their ability to return to the community as a law abiding citizen. This model provides an organizing tool for diversion and linkage alternatives while addressing criminalization. Using this model, a community can develop targeted strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community treatment.

Recommended Charge: Once identified as having mental illness or substance use disorder, individuals should be diverted from the criminal justice system, at the earliest possible decision point while considering public safety risk. Not only does criminal justice diversion improve the outcomes for this at-risk population, it also frees up State and local jail beds for the most violent offenders.

Lead Agency: State and local law enforcement, Judiciary, Problem Solving Courts, State and local corrections, Division of Parole & Probation, treatment/reentry programs, and core service agencies.

Recommendation #7: Report to the Justice Reinvestment Oversight Board on the impact of the move to fee-for-service for substance use disorder services.

As noted earlier, effective January 2015, both the Medicaid and the majority of state-only funding streams were aligned under the Administrative Services Organization (ASO) for both mental health and substance use disorder services.

In addition, the Department of Health and Mental Hygiene is now actively aligning state-only grant funds under the ASO. In January 2017 all ambulatory state-only services for the treatment of substance use disorder services will move to a fee-for-service structure managed by the State's ASO. Eight jurisdictions opted to transfer their substance use disorder operations to fee-for-service early and have moved grant funds. In those jurisdictions, all providers were able to bill for state-only services through the ASO on July 1, 2016. This phase of the integration will provide for reimbursement for ambulatory services through the ASO, regardless of whether the person is enrolled in Medicaid or is uninsured. State-only funds for grant funded residential substance use services will move to a fee-for-service structure July 1, 2017.

In June 2016 the Behavioral Health Administration began hosting monthly transfer of grant meetings for local jurisdictions, who agreed to move their ambulatory services to fee for service in July 2016, to share

transition plans and challenges. All jurisdictions are required to move these services to the claims based billing platform in January 2017. Starting in January 2017 all jurisdictions will meet together monthly to plan for the movement of residential substance use services to fee for service beginning in July 2017.

In its 1115 waiver renewal with the Centers for Medicare and Medicaid Services, the Department is required to work on integrating physical health and behavioral health in the State with the goal of implementing new recommendations no later than January 2019.

Recommended Charge: Agencies will report to the Justice Reinvestment Oversight Board on the impact of the move to fee-for-service for substance use disorder services so as to determine how this will affect the system including both availability and quality of treatment.

Lead Agency: Justice Reinvestment Oversight Board & Agencies

Recommendation #8: Ensure individuals receive the most appropriate treatment and/or treatment level to meet their specific needs at each level of the treatment process.

An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets changing needs. Through Beacon Health Options, the Department of Health and Mental Hygiene employs medical necessity criteria to ensure individuals are placed in the appropriate service. Medical necessity criteria is considered at admission, exclusion, continued stay, and discharge criteria. Psychosocial, occupational, and cultural and linguistic factors are also considered. It is important to note this criteria varies for each service.

Diagnosis alone does not determine the necessity of treatment at a given level or intensity or service. Individuals with the same diagnosis or one individual over time may exhibit a wide range of severity of signs and symptoms of illness or psychosocial needs. Continual assessment assures that the most appropriate plan is being implemented and that multiple issues are being addressed. A varying combination of services and treatment components maybe implemented during the course of treatment and recovery. This also ensures that a person is not stagnant in one treatment level which also does not allow for that treatment slot to be used for a more appropriate patient.

Lead Agency: Department of Health and Mental Hygiene

Recommendation #9: Assess the needs of each county relating to substance use and mental health disorders.

The Department of Health and Mental Hygiene recently performed a jurisdictional needs assessment for the State. This analysis demonstrated the largest gap in substance use disorder and mental health provider participation is in areas designated as Mental Health Professional Shortage Areas (primarily the Eastern Shore and Western Maryland). Further, based on responses from the Department of Health and Mental Hygiene, the Department of Public Safety & Correctional Services, and the Office of Problem Solving Courts, it is clear that other factors such as lack of transportation and an unstable housing situation affect the ability to participate in treatment.

Among the entities created by the Justice Reinvestment Act is the Local Government Justice Reinvestment Commission. The purpose of this Commission is to advise the Justice Reinvestment

Oversight Board on how the Justice Reinvestment Act is impacting local governments, make recommendations regarding grants to local governments, and create performance measures to assess the effectiveness of grants. In order to fulfill these duties it is essential that the Commission have an understanding of each county's needs regarding how substance use and mental health disorders will be impacted by the Justice Reinvestment Act.

Recommended Charge: The Local Government Justice Reinvestment Commission should assess the needs of each county and make recommendations on how to address these needs. The commission should consider the needs of each county when making recommendations for grants to the Justice Reinvestment Oversight Board.

Lead Agency: Local Government Justice Reinvestment Commission

Recommendation #10: Expansion of treatment for pretrial inmates and sentenced inmates with a short length of stay.

As stated by multiple jail wardens who responded to the detention center surveys, due to the short term length of stay, it is more challenging to provide treatment for pretrial inmates and link them to services after they secure release. Research shows that being detained two or more days prior to trial increases an individual's likelihood of either failing to appear for court or committing a new offense while on pretrial supervision.[28] One could assume that this statistic would have more of an impact on arrestees with substance use disorder or those diagnosed with a mental illness. Overall, two-thirds of the jail population in the state are pretrial inmates.

In addition, with the implementation of the Justice Reinvestment Act, most drug offenders will receive an additional five days good conduct credit per month. If they attain a job in the facility, they will gain an additional five days. Furthermore, offenders convicted of various offenses including CDS and theft offenses will start receiving reductions in sentences. This causes a problem on the treatment side as many of these offenders will be released without having the opportunity to enter into or complete a substance abuse program within the facility.

Recommended Charge: Adoption of validated mental health and substance use disorder screening instruments to be conducted at intake. Using validated instruments would better detect drug addiction and also help to identify symptoms of mental illness keeping in mind that many arrestees may not have ever been formally diagnosed. Having individuals evaluated promptly and placed into the appropriate facility (in custody or in the community) is key to assuring they receive the proper care and treatment. The pretrial services officers (in those counties that have pretrial services agencies) can then refer this information to the district court judges during bail review hearings and also help to link the offenders to services in the community on while on pretrial supervision.

It would be highly beneficial to have intensive treatment programs that could start shortly after a person enters the jail prior to going to trial, perhaps within 7-10 days once they have cleared the withdrawal

[28] Lowenkamp, C., VanNostrand, M., & Holsinger, A. (2013). *The Hidden Costs of Pretrial Detention.* The Laura and John Arnold Foundation.

process. These programs may exist in some jurisdictions around the State, but it is far more difficult in rural areas. This presents an important opportunity to intervene with those inmates with a drug addiction who cycle through the criminal justice system with short lengths of stay.

Lead Agency: Local Detention Centers, Local Pretrial Services Agencies, Department of Health and Mental Hygiene

Recommendation #11: Improved substance use disorder and mental health data entry in the Offender Case Management System

Based on data received by the Department of Public Safety and Correctional Services, the State of Maryland has a much lower percentage of mentally ill inmates (28% Division of Correction, 39% local jails) compared to national estimates collected by the Bureau of Justice Statistics (49%). A question remains if this lower statistic is more attributable to data entry or the state having a fewer number of mentally ill inmates. Mentally illness data is tracked manually on spreadsheets from the psychology department at the Department of Public Safety & Correctional Services. This data is not interfaced with the Department's Offender Case Management System.

The available drug and mental health data on the parole and probation population is also very limited and based on information provided by the Division of Parole and Probation which provided the number of offenders with a drug special condition. This special condition cannot tell you whether an offender is required to enroll in drug treatment or take a drug test. This data comes from the Offender Case Management System (OCMS) but it does not appear to be entered uniformly in this system. While the data received is most likely an accurate reflection of what is in OCMS, it does not appear to be an accurate reflection of the number of offenders with a testing/treatment condition. According to the Department, this is most likely due to data entry variations throughout the state. This information can be entered in as case notes which will not populate in any OCMS report.

Recommended Charge: State inmate mental health data should be collected in the Department's OCMS. This will allow a more accurate account of state inmates with mental health issues so they can be referred for appropriate treatment. Parole and probation agents should be trained on the proper data entry of drug and health information into OCMS to track better the treatment of offenders out in the community.

Lead Agency: Department of Public Safety and Correctional Services

CONCLUSION

Individuals with substance use disorders and mental illnesses are overrepresented in the criminal justice system. The data collected from the local jails and State prisons shows that 69% of jail inmates and 32% of prison inmates have a substance use disorder in Maryland. Furthermore, 39% of jail inmates and 28% of prison inmates have been diagnosed with a mental health disorder. In addition, 89% of those diagnosed with a mental health disorder also have a co-occurring substance use disorder. While State prisons and local detention centers in collaboration with the Department of Health and Mental Hygiene are dedicating substantial resources to provide adequate treatment for these inmates inside their facilities, incarceration should not be the first option for these individuals.

The Sequential Intercept Model helps the State to consider alternatives to traditional criminal justice processing in a collective attempt to revise current policy and practice involving interventions with justice-involved individuals with behavioral health problems. The State of Maryland has adopted various diversion programs and should continue to expand the use of such alternatives as well as adopting additional evidence-based programs from other states, while using the Sequential Intercept model as a guide.

Based on findings from this feasibility study and research on the sequential intercept model implementation in Maryland, various recommendations have been provided. Taken together, these recommendations will move Maryland toward safer communities and a criminal justice system more accountable to individuals with mental health and/or substance use disorders. Interagency cooperation and information sharing will not only play a large role, but will be vital, to these endeavors.

APPENDICES

Appendix A: Section 5 of the Justice Reinvestment Act (Chapter 515 of 2016)

SECTION 5. AND BE IT FURTHER ENACTED, That the Governor's Office of Crime Control and Prevention shall: (1) in coordination with the Department of Public Safety and Correctional Services, the Department of Health and Mental Hygiene, the Judiciary, public health and treatment professionals, and local corrections authorities, conduct an analysis to determine the gap between offender treatment needs and available treatment services in the State, including: (i) a feasibility study of local jail and service provider capacity for substance use and mental health disorder and related treatment; and (ii) a plan for how a sequential intercept model could be used to address the gap between offender treatment needs and available treatment services in the State; and (2) report the results of the analysis with recommendations to the General Assembly, in accordance with § 2–1246 of the State Government Article, on or before December 31, 2016.

Appendix B: Local Detention Substance Use Disorder Treatment Survey

1. Please provide your contact information:

Name

Organization

Email Address

Phone Number

2. What is your jail's maximum bed capacity?

3. What was your average daily population over the past year?

4. Please estimate the number of inmates in your facility diagnosed with aSubstance Use Disorder

5. Is a Substance Use Disorder assessment conducted at intake?

- Yes
- No

6. What is the name of the assessment your jail is using? Is this assessment validated?

7. Does your jail have Substance Use Disorder treatment beds?

- Yes
- No
- Other (please specify)

8. How many Substance Use Disorder treatment beds does your jail have?

9. On average, how many Substance Use Disorder treatment beds are filled at given time?

10. Other than the treatment beds, on average how many inmates are receiving some type of Substance Use Disorder treatment in your jail?

11. What treatment services are provided by your jail to inmates with Substance Use Disorders? Who provides these services?

12. What steps are taken to connect an inmate to Substance Use Disorder treatment services prior to their release into the community?

13. Please estimate the number of inmates in your facility diagnosed with a co-occuring Mental Health/Substance use Disorder

14. Do you have any additional comments?

Appendix C: Local Detention Centers Mental Health Treatment Survey

1. Please provide your contact information:

Name

Organization

Email Address

Phone Number

2. What is your jail's maximum bed capacity?

3. What was your average daily population over the past year?

4. Please estimate the number of inmates in your facility diagnosed with a**Mental Health Disorder**

5. Is a Mental Health Assessment conducted at intake?

- Yes
- No

6. What is the name of the assessment your jail is using? Is this assessment validated?

7. Does your jail have Mental Health treatment beds?

- Yes
- No
- Other (please specify)

8. How many Mental Health treatment beds does your jail have?

9. On average, how many Mental Health treatment beds are filled at given time?

10. Other than the treatment beds, on average how many inmates are receiving some type of Mental Health treatment in your jail?

11. What treatment services are provided by your jail to inmates with Mental Health Disorders? Who provides these services?

12. What steps are taken to connect an inmate to Mental Health treatment services prior to their release into the community?

13. Please estimate the number of inmates in your facility diagnosed with a co-occuring Mental Health/Substance use Disorder

14. Do you have any additional comments?

Appendix D: Texas Christian University Drug Screen II

TCU Drug Screen II

Instruction Page

The following questions ask about your drug use (including alcohol) in the past 12 months. Please answer them by marking only one circle for each question. If you do not feel comfortable giving an answer to a particular question, you may skip it and move on to the next question.

If you are an inmate, please refer to the 12-month period immediately before you were locked up; that is, the last time you were in the "free world."

Also, alcohol is a drug. Your answers to questions about drug use need to include alcohol use, such as drinking beer.

The example below shows how to mark the circles --

	Yes	*No*
1. I like ice cream.	O	●

TCU DRUG SCREEN II

During the last 12 months (before being locked up, if applicable) –

	Yes	No
1. Did you use larger amounts of drugs or use them for a longer time than you planned or intended?	O	O
2. Did you try to cut down on your drug use but were unable to do it?	O	O
3. Did you spend a lot of time getting drugs, using them, or recovering from their use?	O	O
4. Did you get so high or sick from drugs that it –		
a. kept you from doing work, going to school, or caring for children?	O	O
b. caused an accident or put you or others in danger?	O	O
5. Did you spend less time at work, school, or with friends so that you could use drugs?	O	O
6. Did your drug use cause –		
a. emotional or psychological problems?	O	O
b. problems with family, friends, work, or police?	O	O
c. physical health or medical problems?	O	O
7. Did you increase the amount of a drug you were taking so that you could get the same effects as before?	O	O
8. Did you ever keep taking a drug to avoid withdrawal symptoms or keep from getting sick?	O	O
9. Did you get sick or have withdrawal symptoms when you quit or missed taking a drug?	O	O

10. Which drug caused the most serious problem? [CHOOSE ONE]

O *None*
O *Alcohol*
O *Marijuana/Hashish*
O *Hallucinogens/LSD/PCP/Psychedelics/Mushrooms*
O *Inhalants*
O *Crack/Freebase*
O *Heroin and Cocaine (mixed together as Speedball)*
O *Cocaine (by itself)*
O *Heroin (by itself)*
O *Street Methadone (non-prescription)*
O *Other Opiates/Opium/Morphine/Demerol*
O *Methamphetamines*
O *Amphetamines (other uppers)*
O *Tranquilizers/Barbiturates/Sedatives (downers)*

11. How often did you use each type of drug during the last 12 months?

	DRUG USE IN LAST 12 MONTHS				
	NEVER	ONLY A FEW TIMES	1-3 TIMES A MONTH	1-5 TIMES A WEEK	ABOUT EVERY DAY
a. Alcohol	O	O	O	O	O
b. Marijuana/Hashish	O	O	O	O	O
c. Hallucinogens/LSD/PCP/ Psychedelics/Mushrooms	O	O	O	O	O
d. Inhalants	O	O	O	O	O
e. Crack/Freebase	O	O	O	O	O
f. Heroin and Cocaine (mixed together as Speedball)	O	O	O	O	O
g. Cocaine (by itself)	O	O	O	O	O
h. Heroin (by itself)	O	O	O	O	O
i. Street Methadone (non-prescription)	O	O	O	O	O
j. Other Opiates/Opium/Morphine/Demerol	O	O	O	O	O
k. Methamphetamines	O	O	O	O	O
l. Amphetamines (other uppers)	O	O	O	O	O
m. Tranquilizers/Barbiturates/Sedatives (downers)	O	O	O	O	O
n. Other *(specify)* _____	O	O	O	O	O

12. During the last 12 months, how often did you inject drugs with a needle?

O *Never* O *Only a few times* O *1-3 times per month* O *1-5 times per week* O *Daily*

13. How serious do you think your drug problems are?

O *Not at all* O *Slightly* O *Moderately* O *Considerably* O *Extremely*

14. How many times before now have you ever been in a drug treatment program?
[DO NOT INCLUDE AA/NA/CA MEETINGS]

O *Never* O *1 time* O *2 times* O *3 times* O *4 or more times*

15. How important is it for you to get drug treatment now?

O *Not at all* O *Slightly* O *Moderately* O *Considerably* O *Extremely*

Scoring for the TCU Drug Screen II

Page 1 of the TCU Drug Screen is scored as follows:

1. Give 1-point to each "yes" response to 1-9 (Questions 4 and 6 are worth one point each if a respondent answers "yes" to any portion).

2. The total score can range from 0 to 9; score values of 3 or greater indicate relatively severe drug-related problems, and correspond approximately to DSM drug dependence diagnosis.

3. Responses to Question 10 indicate which drug (or drugs) the respondent feels is primarily responsible for his or her drug-related problems.

The TCU Drug Screen II was developed as part of NIJ Grant 1999-MU-MU-K008, *Assessment of a Drug Screening Instrument*.

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For more information on the TCU Drug Screen II, please contact:

Institute of Behavioral Research
Texas Christian University
TCU Box 298740
Fort Worth, TX 76129
(817) 257-7226
(817) 257-7290 FAX
Email: ibr@tcu.edu
Web site: www.ibr.tcu.edu

Appendix E: SMART TAP Assessment

SMART TAP Assessment

Client Profile

Client's First Name:_____ **Last Name:** _____**DOC #:**_____

SSN#_____ **DOB**_____ **Gender:** ☐ **Male** ☐ **Female**

Zip Code_____

Race: ☐ White ☐ Alaskan Native
☐ Black ☐ American Indian
☐ Asian or Pacific Islander
☐ Other

Ethnicity: ☐ Puerto Rican ☐ Hispanic
☐ Mexican ☐ Not Hispanic
☐ Cuban ☐ Other

Highest Grade Completed _____
☐ **For grades 1-11 enter the number**
☐ **12/High School Diploma/GED**
☐ College Casework
☐ College AA/Associates
☐ BA/BS Degree
☐ Post College/Graduate School Degree

H.S. Diploma:
☐ Earned GED
☐ Earned HS Diploma
☐ No GED, No HS Diploma

Veterans Status
☐ Never in Military
☐ On Active Duty
☐ Veteran
☐ Veteran – **In Combat 0-6 months ago**
☐ Veteran – **In Combat 6-12 months ago**
☐ Veteran – **In Combat more than 12 months ago.**

Explanation for Veterans Status.
When asking about a client's veterans status please select from the list documented here on the form only.

INTAKE

County of Residence:_____ ***Injection Drug User:*** ☐ Yes ☐ No ☐ Denies

Currently Pregnant: ☐ Yes ☐ No ☐ **Unknown (If Yes enter Due Date** ____/____/_____**) Intake Date**___/___/___

Presenting Problem (In Client's own words) _____

_____

Source of Referral:

- ☐ Aids Administration
- ☐ Alcohol and Drug Abuse Admin
- ☐ Alcohol/Drug Abuse Care Provider
- ☐ Defense Attorney
- ☐ Drug Court
- ☐ DSS/TCA (Temporary Cash Asst.)
- ☐ DWI/DUI Referral
- ☐ Employer/EAP
- ☐ Individual/Self Referral
- ☐ Juvenile Justice
- ☐ Local Detention
- ☐ Other Attorney
- ☐ Other Community Referral
- ☐ Other Criminal Justice
- ☐ Other Health Care Provider
- ☐ Parent/Guardian/Family
- ☐ Parole
- ☐ Poison Control Agency
- ☐ Pre-Trial Services Agency
- ☐ Probation
- ☐ School
- ☐ State Prison
- ☐ Student Assistant Program
- ☐ TASC-Other Diversionary programs
- ☐ DHMH (HG-8505)
- ☐ DHMH (HG-507)

TREATMENT ASSIGNMENT PROTOCOL (TAP) ASSESSMENT

Class: ☐ Intake ☐ Follow-up How Long at Current Address: _____Yrs _____Mos

Is the Residence Owned by You or Family? ☐ Yes ☐ No

Primary Payment Source

- ☐ Primary Adult Care (PAC)
- ☐ ADAA (State Funding)
- ☐ DHMH Managed Care/Health Choice
- ☐ Medicaid Other than Health Choice
- ☐ Medicare
- ☐ Non-Managed Private Insurance
- ☐ Private Managed Care/HMO
- ☐ Out of Pocket Payment
- ☐ Other Public Funds
- ☐ Other

Interviewed By:_____

Special Code: ☐ N/A, Interview Completed ☐ Patient Refused
☐ Patient Terminated ☐ Patient Unable to Respond

Religious Preference? ☐ Baptist ☐ Methodist ☐ Non-denominational ☐ Protestant
☐ Catholic ☐ Jewish ☐ Islamic ☐ Other ☐ None

Controlled Environment past 30 days
☐ No ☐ Jail ☐ Alcohol/Drug Treatment ☐ Medical Treatment ☐ Psychiatric Treatment

If in a controlled environment how many days did you spend there?_____

Days Attended AA/NA/Similar Meetings in Last 30 Days_____ Days on Wait List_____

Is this TAP for Concerned Person: ☐ Yes ☐ No Months Since DC From Last Admission_____

Event Type: ☐ Admission ☐ Crisis Intervention ☐ Placement Screening Event Type Date_____

Alcohol/Drug Usage

For Questions 1-5 complete the Substance Matrix Chart on the following page

1. Which substance/s is considered the client's Primary, Secondary, Tertiary
2. Was the substance prescribed to the client?
3. What was the age of first use?
4. What is the Severity of use?
5. What is the frequency of use?
6. What are the methods of use?

7. Have you ever tried to reduce or control your use of this substance?

a. Primary ☐ Yes ☐ No b. Secondary ☐ Yes ☐ No c. Tertiary ☐ Yes ☐ No

8. Has anyone ever asked you to stop using these substances?

a. Primary ☐ Yes ☐ No b. Secondary ☐ Yes ☐ No c. Tertiary ☐ Yes ☐ No

9. What was the date of last use?

a. Primary _____ b. Secondary _____ c. Tertiary _____

Other Addictions: ☐ Eating Disorder ☐ Gambling ☐ Sex ☐ Tobacco

10. Is Methadone Maintenance Planned ☐ Yes ☐ No

11. Have you ever attended a self-help/support group (AA/NA, R/R, church, etc.)? ☐ Yes ☐ No

12. Last substance admission environment in the last 10 years

☐ Extended Outpatient
☐ Intensive Outpatient
☐ Medically monitored intensive res
☐ Outpatient Detox
☐ PMIC
☐ No Previous Admission
☐ Not Applicable
☐ Medically managed Detox
☐ Medically monitored Detox
☐ Medically managed intensive inpt.
☐ Clinically managed high intensity Res.
☐ Clinically managed medium intensity Res.
☐ Day Treatment partial Hospitalization
☐ Clinically managed low intensity Res.
☐ Continuing Care

13. Number of prior substance abuse admissions during the last 10 years _____

Interview Rating:

14. How would you rate the client's potential for continued use?
☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes:

Notes: (How severe was the usage?)

Withdrawal

1. What is the longest # of days in a row that you have gone without using alcohol and/or drugs:

   a. In the last 30 days?_____ b. In the last 6 months?_____ c. 30 days prior to incarceration _____

2. Is the client reporting or exhibiting any of the following symptoms:

- ☐ Abdominal cramps/diarrhea
- ☐ Agitation
- ☐ Anxiety
- ☐ Back spasms
- ☐ Depression
- ☐ Excessive or periodic sweating
- ☐ Excessive Sleeping
- ☐ Excessive Yawning
- ☐ Hallucination
- ☐ Headaches
- ☐ Increased pulse rate
- ☐ Insomnia, Sleep Disturbance
- ☐ Muscle Aches, bone pain
- ☐ Nausea, vomiting
- ☐ Runny Nose
- ☐ Seizures
- ☐ Tremors
- ☐ Watery eyes

3. How many times in your life have you been treated for:

   a. Alcohol abuse?_____ b. Drug abuse?____

4. How many of these were for:

   a. Alcohol detox only?_____ b. Drug detox only?_____

5. How many days in the last 30 have you been treated for alcohol and/or drugs as an:

   a. In-patient?_____ b. Out-patient?____

6. How many times in the last 30 days have you used:

   a. Alcohol?_____ (30 days prior to incarceration) b. Drugs?_____ (30 days prior to incarceration)

   1. 1-2 times per week
   2. 1-3 times per month
   3. 2-3 times daily
   4. 3-6 times per week
   5. Daily
   6. More than 3 times daily
   7. No use in past month
   8. Unknown

7. How many days in the last 30 have you experienced:

a. Alcohol problems? (30 days prior to incarceration)_____ b. Drug problems? (30 days prior to incarceration)_____

8. How many times have you had:

a. Alcohol DTs? _____b. A drug overdose?_____

9. Do you sometimes use prescription, over the counter medication, alcohol, or an illicit drug to relieve withdrawal symptoms? ☐ Yes ☐ No

10. Have you noticed the need to increase the amount you use to achieve the same effect or high, Yes or sometimes feel less effect or high, after using your usual amount? ☐ Yes ☐ No

11. Would you say that you often use more than you initially intended to over a longer period of time? ☐ Yes ☐ No

12. Have you ever had blackouts while drinking or using; drank or used enough that you could not remember what you said or did the next day? ☐ Yes ☐ No

13. When you were using, would you say that you spent a great deal of time obtaining the substance(s) you used, using them, and/or recovering from their effects? ☐ Yes ☐ No

14. IV drug use in the past? ☐ Yes ☐ No

15. Do you currently use tobacco?
☐ No Tobacco Use ☐ Cigarettes ☐ Cigars and Pipes ☐ Smokeless Tobacco ☐ Combo/more than 1

16. If yes, indicate daily amount? ☐ 1/2 Pack ☐ 2 Packs ☐ 1-2 Packs ☐ ½-1 Pack ☐ No tobacco use

17. Would there be adequate support at home for you if you needed help while detoxing? ☐ Yes ☐ No

18. Do you have significant problems with other possible addictions such as sex, eating disorders, or gambling? ☐ Yes ☐ No

Interviewer Rating:

19. How would you rate the client's need for detox treatment?

☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes:

Medical

1. How many times in your life have you been hospitalized for medical treatment? _____

2. How long ago was your last hospitalization for a physical problem? Yrs_____ Mo_____

3. Do you have a history of or current diagnosis of any of the following:
(Select all that apply)

- ☐ Abscess
- ☐ Arthritis
- ☐ Cirrhosis or liver problems
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fractures
- ☐ Gastrointestinal bleeding
- ☐ Hearing Problems
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Kidney Problems
- ☐ Lung/breathing problems
- ☐ Pancreatitis
- ☐ Seizures
- ☐ Sexually transmitted disease
- ☐ Vision

4. Do you have chronic medical problems which continue to interfere with your life? ☐ Yes ☐ No

5. Are you taking any prescribed medication on a regular basis for a physical problem? ☐ Yes ☐ No

If yes please list:

6. How many days in the last 30 have you experienced medical problems? _____
(If answer is greater than 0 proceed to #7. If not proceed to #8)

7. How troubled have you been in the last 30 days by these medical problems?
☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

8. How many times in the last 30 days have you visited an ER?_____ (prior to incarceration)

9. Have you ever been diagnosed with TB? ☐ Yes ☐ No

10. Are you currently using birth control? ☐ Yes ☐ No (prior to incarceration)

11. What is your weight? _____ lbs.

12. Have you noticed a recent weight loss? ☐ Yes ☐ No

13. How many times in the last 6 months have you been hospitalized due to a non-Tx drug and/or alcohol related problem? _____

Interview Rating:

14. How would you rate the client's need for medical treatment?
☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes:

Motivation

1 Is the client motivated to change his/her alcohol/drug use? ☐ Yes ☐ No

2.Are there any medical conditions which interfere with the client's treatment needs? ☐ Yes ☐ No

If yes please specify:

3. How important now to the client is treatment for these medical problems?
☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

4. Are there any psychological conditions which interfere with the client's treatment needs? ☐ Yes ☐ No

5. How important now to the client is treatment for these psychological problems?
☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

Interview Rating:

6. How would you rate the client's readiness to change?
☐ Action ☐ Contemplation ☐ Determination ☐ Maintenance ☐ Pre-contemplation ☐ Relapse

Notes:

Co-occurring

1, How many times have you been treated for any psychological or emotional problems in a hospital or in-patient setting? _____

Questions 2-9
Have you had a significant period, that was not a direct result of alcohol/drug use, in which you have:

	(The questions requires a Yes/No response for all three columns.)	Past 30 Day	Lifetime	30 days prior
2	Experienced serious depression, sadness, hopelessness, lack of interest?			
3	Experienced serious anxiety, tension, inability to relax, unreasonable worry?			
4	Experienced hallucinations or saw/heard things that did not exist?			
5	Experienced trouble understanding, concentrating, remembering?			
6	Experienced trouble controlling violent behavior including rage or violence?			
7	Experienced serious thoughts of suicide?			
8	Attempted suicide?			
9	Been prescribed meds for psychological or emotional problems?			

Do you have access to these medications now? (If # 9 is yes for 30 days or lifetime please specify medications)

10. How many days in the last 30 have you experienced psychological or emotional problems?_____
(If answer is greater than 0 proceed to #11. If not proceed to #12)

11. How troubled have you been in the last 30 days by these emotional problems?
☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

12. Psychiatric problem in addition to alcohol/drug problem? ☐ Yes ☐ No

Interview Rating:

At the time of the interview was the client:

13. Obviously withdrawn/depressed? ☐ Yes ☐ No
14. Obviously hostile? ☐ Yes ☐ No
15. Obviously anxious/nervous? ☐ Yes ☐ No
16. Having trouble with reality testing, thought disorders, paranoid thinking? ☐ Yes ☐ No
17. Having trouble comprehending, concentrating, remembering? ☐ Yes ☐ No
18. Having suicidal thoughts? ☐ Yes ☐ No
19. How would you rate the client's need for treatment for emotional problems?
☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

Notes:

Employment

1. Education completed? _____

2. Training or technical education? Yrs___ Mo_____

3. Do you have a profession, trade, or skill? ☐ Yes ☐ No

If yes please specify:

4. Do you have a valid driver's license? ☐ Yes ☐ No

5. Do you have an automobile available for use? ☐ Yes ☐ No

6. Longest full time job? Yrs____Mo____

7. Usual or last occupation?

☐ Farming, Forestry and Fishing occupations
☐ Homemaker
☐ Management and Professional Specialty
☐ Occupation not reported
☐ Operators, Fabricators, and Laborers
☐ Precision Production Craft and Repair Occupations
☐ Refused to answer
☐ Service Occupations
☐ Technical, Sales and Administrative

8. Does someone contribute to your support in any way? ☐ Yes ☐ No *(if yes answer #9. If no cont. to #10)*

9. If yes, does this constitute the majority of your support? ☐ Yes ☐ No

10. Employment Status

☐ Employed Full Time (35 hours or more per week)
☐ Self-Employed
☐ Unemployed
☐ Unemployed, seeking work
☐ Unemployed, note seeking work
☐ Employed Part Time in Steady Job
☐ Disabled (cannot work)
☐ Incarcerated (cannot work)
☐ Homemaker Full Time
☐ Attending School Full Time-Not Working
☐ In Skills Development, Training or School full time
☐ Retired/Permanently Out of Work Force
☐ Other, Out of Work Force
☐ Unemployed, not seeking work

11. Employer_____

12. How many days in the last 30 were you paid for work? (Include under the table) _____

How much money did you receive from the following resources in the last 30 days:

13. Employment (gross)? $_____

14. Unemployment comp? $_____

15. Welfare? $_____

16. Pension, SS, benefits? $_____

17. Mate, family, friends? $_____

18. Illegal? $_____

Current Gross/Taxable
Individual monthly income $_____

19. What is your primary source of income? (Prior to incarceration)

☐ Disability ☐ Self-employment
☐ Other ☐ Unemployment compensation
☐ Public Assistance/TCA ☐ Unknown
☐ Retirement/pension ☐ Wages/Salary

19a Other Income Sources

☐ Disability ☐ Self-employment
☐ Other ☐ Unemployment compensation
☐ Public Assistance/TCA ☐ Unknown
☐ Retirement/pension ☐ Wages/Salary

20. How many months have you been employed during the last 6 months? _____

21. How many days in the last 30 have you experienced employment problems? _____

22. How many days of work and/or school have you missed in the last 6 months due to substance abuse related problems? _____

23. Do you have current health insurance?

☐ DHMH Medicaid Managed Care ☐ No Health Insurance
☐ Medicaid (Other than Health Choice) ☐ Non-Managed Private Insurance
☐ Medicare ☐ Other Public Funds
☐ PAC (Primary Adult Care) ☐ Private Managed Care (HMO)

24. If yes, does it cover substance abuse treatment? ☐ Yes ☐ No

Interview Rating:

25. How would you rate the client's need for employment services?
☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes:

Family/Social Relationships

1. What is your current relationship status?

☐ Common Law/Domestic Partner ☐ Unknown
☐ Divorced ☐ Separated
☐ Married ☐ Widowed
☐ Never Married

2. Are you satisfied with this situation? ☐ Yes ☐ No ☐ Indifferent

If no please specify:

3. What has been your usual living arrangement? (prior to incarceration)

☐ Child/Adolescent Foster Care ☐ Private Residence (apartment, home)
☐ Group Home ☐ Residential Substance Abuse Treatment
☐ Halfway House, Transitional Housing ☐ Shelter
☐ Hospital, Nursing Home ☐ Sober Living Facility
☐ Independent Living ☐ Street/Outdoors (sidewalk, abandon buildings)
☐ Jail/Prison/Detention Facility ☐ Dependent Living

4. How long have you lived in these arrangements? Yrs___ Mo___

5. Are you satisfied with these arrangements? ☐ Yes ☐ No ☐ Indifferent

6. Do you live with anyone who:

a. Has a current alcohol problem? ☐ Yes ☐ No

b. Uses non-prescribed drugs? ☐ Yes ☐ No

7. With whom do you spend most of your free time? ☐ Alone ☐ Family ☐ Friends

8. Are you satisfied spending your free time this way? ☐ Yes ☐ No ☐ Indifferent

9. How many close friends do you have? _____

10. Select the people with whom you have had a close, long lasting relationship:
☐ Mother ☐ Father ☐ Sister/Brother ☐ Children ☐ Friends

11. Have you had significant periods in the last 30 days or in your lifetime in which you have experienced serious problems getting along with your:

(*The questions require a Yes/No response for both columns.*)	Past 30 Day	Lifetime
Mother?		
Father?		
Brother/sister?		
Sexual partner/spouse?		
Children?		
Other significant family?		
Close friends?		
Neighbors?		
Co-workers?		

12. Have any of these people abused you? If so, how and when?
(*The questions require a Yes/No response for all columns.*)

	Past 30 Days			Lifetime		
	Emotionally	Physically	Sexually	Emotionally	Physically	Sexually
Mother						
Father						
Brother/sister						
Sexual Partner/spouse						
Children						
Other Significant Family						
Close friend						
Neighbor						
Co-worker						
Other/Specify						

13. How many children do you have age 17 or less (birth, adopted, or stepchildren) whether they live with you or not? _____ *(If answer is greater than 0 proceed to # 14 & 15. If not proceed to #16)*

14. How many of these children spent the last 6 months (prior to incarceration) living with you?_____

15. Are any of your children living with someone else because of a child protection order? ☐ Yes ☐ No

16. Has your substance use caused problems at home with your partner, kids, or home obligations?
☐ Yes ☐ No

17. Do you have a DSS case worker? ☐ Yes ☐ No

18. How troubled have you been in the last 30 days prior to incarceration by:

a. Family problems? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

b. Social problems? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

19. How troubled have you been in the last 30 days by:

a. Family problems? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

b. Social problems? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

20. Have you given up or reduced your involvement in important social or recreational activities that did NOT include drinking or using? ☐ Yes ☐ No

21. Is there a family history of substance abuse or dependency? ☐ Yes ☐ No

Interview Rating:

22. How would you rate the client's need for family or social counseling?
☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes

Legal

1. Was this admission prompted by the criminal justice system? ☐ Yes ☐ No

2. Are you on parole or probation? ☐ Yes ☐ No

How many times have you been arrested and/or charged and/or convicted for the following:
Leave gray areas blank

	Arrested	Charged	Convicted
3. Shoplifting/vandalism?			
4. Parole/probation violation?			
5. Drug charges?			
6. Forgery?			
7. Weapons offense?			
8. Burglary, larceny, B & E?			
9. Robbery?			
10. Assault?			
11. Arson?			
12. Rape?			
13. Homicide/manslaughter?			
14. Prostitution?			
15. Contempt of court?			
16. Driving While Intoxicated past 12 months?			
17. Non-drug or alcohol-related crime while under the influence in the last 12 months?			
18. Non-drug or alcohol-related crime while not under the influence in the last 12 months?			
19. Drug or alcohol-related crime in the last 12 months?			
20. Other?			

21. How many times have you been arrested in the past 12 months (prior to incarceration and include this one)? _____

22. How many times have you been arrested in the past 30 days? _____ 30 days prior to incarceration?_____

23. How many months were you incarcerated in your life? Yrs_____Mos_____Days_____

24. How long was your last incarceration? Yrs_____Mos_____Days_____

25. What was it for?

26. Are you presently awaiting charges, trial, or sentence? ☐ Yes ☐ No

27. If yes, what for?

28. How many days in the last 30 were you detained or incarcerated? _____30 days prior to incarceration?_____

29. How many days in the last 30 have you engaged in illegal activities for profit? _____

30. How serious do you feel your current legal problems are?
☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

Interview Rating:

31. How would you rate the client's need for legal services?
☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Not at all

Notes:

ASAM - PPC2R *(Recommended but not required)*

Dimension	Level of Risk	Level of Care
1. Acute Intoxication and/or Withdrawal Potential Comments:	_____	_____
2. Biomedical Conditions and Complications Comments:	_____	_____
3. Emotional, Behavioral, or Cognitive Conditions and Complications Comments:	_____	_____
4. Readiness to Change Comments:	_____	_____
5. Relapse, Continued Use, or Continued Problem Potential Comments:	_____	_____
6. Recovery/Living Environment Comments:	_____	_____

For Level of Risk

0 – Not at all
1 – Slightly
2 – Moderately
3- Considerably
4 - Extremely

For Level of Care enter the corresponding number

0.5 Early Intervention
I Outpatient
I .D Outpatient Ambulatory Detox.
I OMT Opiod Maintenance Therapy
II.1 Intensive Outpatient Treatment
II.D Intensive Outpatient Detox
II.5 Partial Hospitalization
III. 1 Clinically Managed – Low Intensity
III. 3 Clinically Managed – Medium Intensity
III. 5 Clinically Managed – High Intensity
III. 7 Medically Monitored Intensive Inpatient
III.7-D Medically Monitored Intensive Inpatient Detox.
IV Medically Managed Intensive Inpatient
IV.D Medically Managed Intensive Inpatient Detox
OMT.D Opioid Maintenance Thearpy-Detox

Environments

☐ Counseling
☐ Mental Health
☐ Substance Abuse
☐ Substance Abuse/Mental Health

Clinical Override:

- ☐ Clinical Judgment
- ☐ Lack of Insurance
- ☐ Legal Issues
- ☐ Level of Care Not Available
- ☐ Managed Care Refusal
- ☐ N/A
- ☐ Other
- ☐ Patient Opinion

Recommended Level of Care _____

Recommended Environment _____

Actual Level of Care _____

Actual Environment _____

Comments:

Summary

Interviewer Confidence Rating:

1. In your opinion, is the information in this assessment significantly distorted due to client's misrepresentation?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

2. In your opinion, is the information in this assessment significantly distorted due to client's ability to understand?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Considerably ☐ Extremely

Comments

Assessment Duration

Interview: Start Date_____ **End Date**_____ **Total Interview Time**_____

Appendix F: Department of Public Safety and Correctional Services - Aftercare Services Plan

Department of Public Safety and Correctional Services
AFTERCARE SERVICES PLAN

Client Name _____ DOC/SID # _____

Admission Date _____ Discharge Date _____

The client has successfully completed treatment. The Provider, having consulted with the client, have agreed on the following aftercare plan:

- ☐ Substance Abuse Treatment: (Specify. e.g. IOP Intensive Out-Patient)
- ☐ Peer Support Group: (Specify how often client will attend. e.g. NA, AA)
- ☐ Family and Support System: (Specify: for example Sharing a Relapse Prevention Plan or counseling)
- ☐ Vocational Services: (Career Counseling, Job Development, Life Skills)
- ☐ Education: (Seeking GED Courses, Associates Degree, Bachelors Degree, Masters Degree)
- ☐ Medical/ Mental Health Services: (Dental, Optical, Physical)
- ☐ Other:(Specify.)

I have reviewed this aftercare service plan and I agree with the goals stated above.

_____ _____
Client's Signature Date

_____ _____
Counselor's Signature Date

_____ _____
Clinical Supervisor's Signature Date

Appendix G: Department of Health and Mental Hygiene Behavioral Health Gap Analysis Survey

Behavioral Health Gaps Analysis

The Department of Health and Mental Hygiene is surveying providers to collect information on gaps in community behavioral health services at the local level. The information provided in this survey will assist the Department in responding to numerous legislative reports.

Email address *

Valid email address

This form is collecting email addresses. Change settings

What region of the state do you serve? If serving multiple areas, please check all that apply.

- [ ] Western Maryland (Allegany, Carroll, Frederick, Garrett, and Washington Counties)
- [ ] DC Capital Region (Montgomery and Prince George's Counties)
- [ ] Central Maryland (Anne Arundel, Baltimore, Carroll, Howard, and Harford Counties, and Baltimore City)
- [ ] Southern Maryland (Calvert, Charles, and Saint Mary's counties)
- [ ] Upper Shore (Cecil, Kent and Queen Anne's Counties)
- [ ] Mid Shore (Caroline, Dorchester, and Talbot Counties)
- [ ] Lower Shore (Somerset, Wicomico and Worcester Counties)

What type of services do you provide

- ( ) mental health
- ( ) substance use
- ( ) both mental health and substance use
- ( ) neither

What types of insurance do you accept? Please check all that apply.

- [ ] Medicaid
- [ ] Medicare
- [ ] Blue Cross Blue Shield
- [ ] self-pay
- [ ] other third party payors
- [ ] grant funds

Do you have a wait list for new patients?

- ○ Yes
- ○ No

If Yes, how long are wait times:

- ○ less than one week;
- ○ two to three weeks;
- ○ one month;
- ○ more than one month.

Type of service provision. Check all that apply.

- [ ] outpatient mental health
- [ ] mental health supported employment
- [ ] psychiatric rehabilitation
- [ ] mobile treatment or Assertive Community Treatment
- [ ] mental health case management
- [ ] mental health crisis services
- [ ] mental health partial hospitalization
- [ ] outpatient counseling services (ASAM 1)
- [ ] methadone maintenance treatment
- [ ] buprenorphine treatment
- [ ] other Medication Assisted Treatment therapies (ie, naltrexone)
- [ ] intensive outpatient counseling (ASAM 2.1)
- [ ] partial hospitalization (ASAM 2.5)
- [ ] recovery housing
- [ ] low intensity halfway house (ASAM 3.1)
- [ ] medium intensity residential SUD (ASAM 3.3 or 3.5)
- [ ] high intensity residential SUD (ASAM 3.7)
- [ ] high intensity residential SUD Detox (ASAM 3.7D)

Does your organization utilize evidenced-based practices?

- Yes
- No

Please describe the evidenced-based practices your organization employs.

Long answer text

What standardized tools are you utilizing within your facility to track the progress of your patients (ex- BDI, SF-12, PHQ-9 etc)?

Long answer text

Do you serve the justice-involved population (this includes any individual who receives mental health or substance use treatment under a court order)?

- Yes
- No

Approximately what percent of your patient population is justice-involved:

- 0 - 25%
- 26 - 50%
- 51 - 75%
- 76 - 100%

What is the biggest gap in mental health and/or substance use treatment in the area you serve?

Long answer text