



# BALTIMORE CITY'S BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM

**Plan to Strengthen and Expand the System**

**June 2019**

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## **I. Introduction and Planning Process**

Behavioral Health System Baltimore (BHSB) is a non-profit that serves as the local behavioral health authority for Baltimore City and is responsible for managing the public behavioral health system by:

- Overseeing a provider network that offers a range of mental health and substance use disorder services to residents who have Medicaid, Medicare, or are uninsured/underinsured;
- Directly funding provider organizations to deliver behavioral health care services not covered by insurance; and
- Identifying solutions to address needs, gaps, and barriers to a comprehensive behavioral health system that all Baltimore City residents can easily access.

In the spring of 2018, BHSB engaged stakeholders in a planning process to strengthen the behavioral health crisis response system in Baltimore City. BHSB started this planning process internally to:

1. Outline existing behavioral health crisis services,
2. Identify known service gaps and access barriers, and
3. Make recommendations to improve the behavioral health crisis response system.

BHSB sought stakeholder feedback on the first draft in the summer of 2018. The feedback was reviewed and incorporated into this second draft of the plan document. BHSB is grateful to the many individuals and organizations that participated and offered extremely helpful feedback. An appendix with participating organizations is listed at the end of this document.

Throughout this planning process, BHSB has been working closely with the Baltimore Police Department (BPD) and other Baltimore City representatives regarding the consent decree<sup>1</sup> with the US Department of Justice (DOJ), which has important implications for behavioral health crisis response in Baltimore City. The original intent of this Crisis Response System Plan was to address some of the requirements of the consent decree. However, as that process unfolded, BHSB was asked to complete a much more comprehensive Gap Analysis (or needs assessment) of the public behavioral health system in Baltimore City. As BHSB shifted its focus and priority to the required Gap Analysis, there were questions about whether this plan was still needed as the contents would be incorporated into the Gap Analysis. However, BHSB decided that it was important to finish this effort and have the Crisis Response System Plan be a stand-alone document to reference.

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<sup>1</sup> U.S. Department of Justice v. Police Department of Baltimore City, Consent Decree, <https://consentdecree.baltimorecity.gov>

## **II. Definitions and Principles**

These definitions and principles were used throughout the planning process and apply throughout this document.

### **Definitions**

#### *Behavioral Health*

The term “behavioral health” broadly refers to every individual’s degree of mental (psychological and emotional) well-being and their adjustment to society and the demands of life. It also generally refers to issues related to developmental expectations, life stressors, mental illness, and substance use disorders.

The behavioral health field is an interdisciplinary area of health focused on the prevention, early intervention, treatment, and recovery from mental illness and substance use disorders. There is also a strong emphasis on the promotion of social and emotional health and wellness.

#### *Behavioral Health Crisis*

A behavioral health crisis is a subjective experience that can vary depending on many factors. It is important that individuals be given the autonomy to define crisis for themselves, so they can own the experience, direct the service delivery, and maintain their own recovery.

In general, behavioral health crises include emotional or behavioral distress, potential harm to self or others, significant disorientation or disconnection from reality, a compromised ability to function, or other types of agitation or difficulty calming down. Some specific examples of signs or symptoms include suicidal ideation, self-injury, talking about or exhibiting threatening behavior, risk of or survival from a drug or alcohol overdose, and erratic or unusual behavior.

#### *People with Lived Experience*

People with lived experience, also known as “peers,” have knowledge gained through direct, first-hand experiences and/or identities that are similar to people receiving care. In the context of behavioral health care, the experience is usually with a mental health or substance use disorder, but it may also include other types of relevant experience, such as having prior involvement in the criminal justice system, experiencing homelessness and/or identifying as part of LGBTQ communities. People with lived experience often can quickly develop trusting and meaningful connections with people who have similar experiences, and these connections are critical for behavioral health care to be effective.

## **Principles**

### *Service Values*

BHSB expects that all behavioral health care will be delivered in a way that is trauma-responsive, person-centered and family-centered, culturally and linguistically competent, strengths-based, and recovery-oriented. To be effective, crisis response services must be provided in a way that respects and affirms people's experiences, cultures, and identities. BHSB is committed to working toward health equity and expects that all services within the crisis response system be accessible and responsive to the needs of all individuals and particularly historically marginalized groups.

### *Behavioral Health Integration*

Best outcomes are achieved through the provision of integrated or well-coordinated mental health, substance use, and somatic health care by either the same provider or by a closely coordinated group of providers. This crisis response system plan supports the continued integration of at least mental health and substance use disorder service delivery; therefore, the term "behavioral health" is used throughout this document. Implementation of this plan should continue to advance integration and coordination of services.

### *Crisis Services Across the Lifespan*

This plan intends to address the crisis response needs of people of all ages. Because youth, transition age youth, adults, and older adults sometimes have different needs based on developmental factors and levels of independence, some services should remain separate to allow for specialization. However, wherever possible, BHSB recommends that services for these age groups be equally accessible and available to the extent needed. Recommendations in this plan are intended to address the full developmental lifespan unless otherwise noted.

### ***Substance Use as a Crisis***

While people using substances, including drugs and alcohol, may not identify their use as a crisis, they are included as a priority population in this plan because they may be vulnerable to overdose and other adverse outcomes. Some substance use, particularly opioid use, is highly stigmatized and criminalized, which can make accessing care much more difficult. Although it is a positive step for police to understand behavioral health disorders and have resources to refer people to care, the goal for both BHSB and BPD is to prevent people with behavioral health disorders from having any unnecessary interactions with police whenever possible. To achieve this, crisis services and behavioral health care in general need to be much more accessible to people under the influence of substances and/or diagnosed with substance use disorders.

### *Confidentiality and Privacy*

BHSB takes the rights to privacy and confidentiality of personal health information very seriously, and all recommendations within this report will follow and uphold federal and state laws protecting these rights, such as the Health Insurance Portability and Accountability Act (HIPAA) and the Code of Federal Regulations, Title 42 Part 2 (42 CFR Part 2). There are instances when the sharing of personal health information without consent is allowable and necessary to save lives or prevent significant disruption to care. However, sharing personal health information without consent should be rare and done only in extraordinary cases.

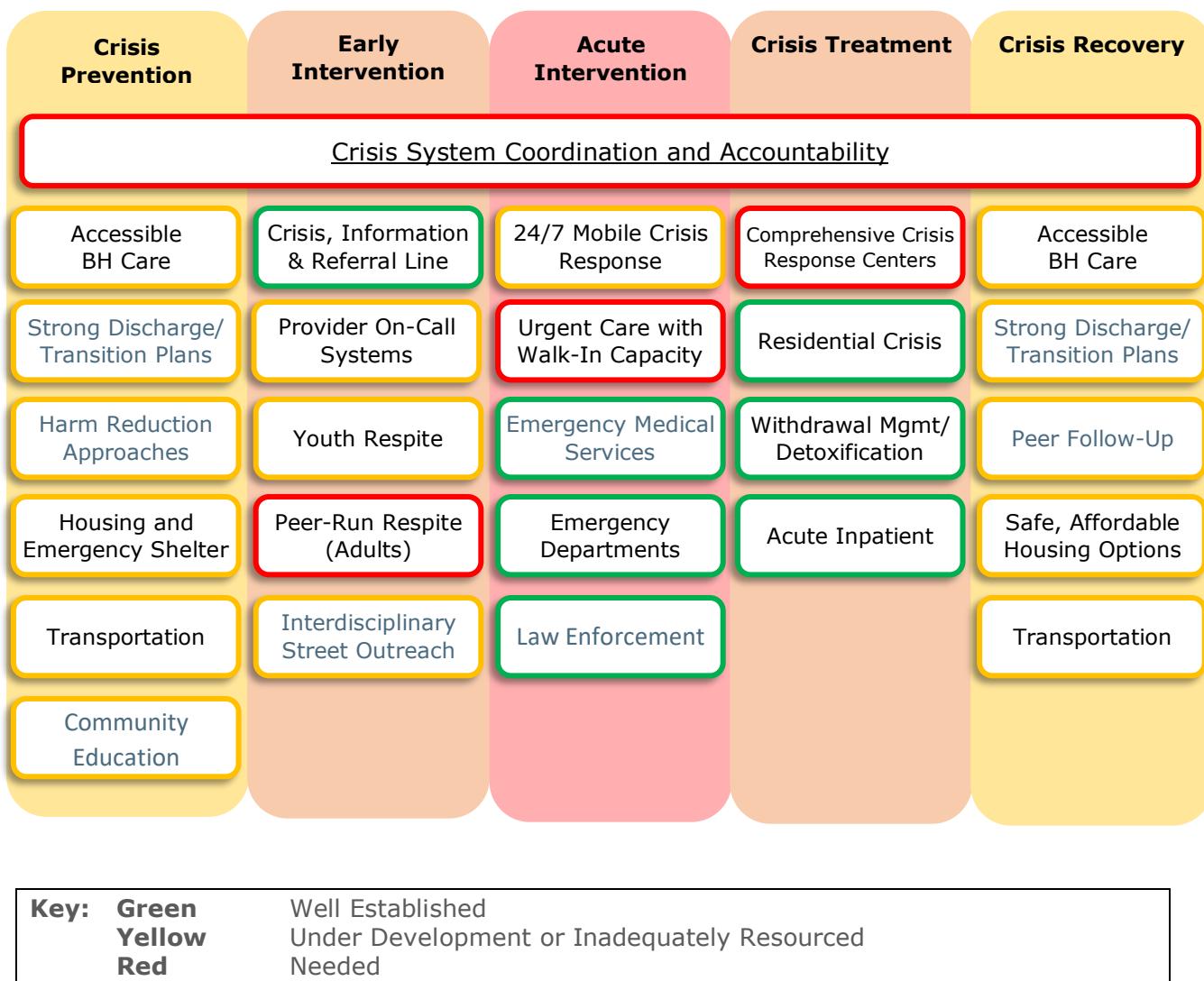
### *Provider Identification*

For the purposes of this planning document, specific behavioral health provider organizations are not identified. Recommendations identified are based on BHSB's understanding of the crisis response needs of Baltimore City residents and not based on any specific provider performance or preference.

### **III. Behavioral Health Crisis Response System Plan Framework<sup>2</sup>**

The diagram below represents phases of behavioral health crisis intervention. Within each phase, existing services and proposed changes are outlined.

BHSB recognizes that this framework simplifies a complex system and that some services could fit into multiple crisis phases. This simplified framework is for planning purposes only. Each of these phases and the services listed within them are described in more detail in the following sections of this plan.



<sup>2</sup> BHSB developed this framework based on a model published by Madenwald & Day, Technical Assistance Collaborative, Inc.

## **IV. Behavioral Health Crisis Response System Plan**

This section of the plan uses the framework presented in the previous section to present existing and proposed crisis response services, strengths and opportunities identified for each service type, and recommendations to improve the overall category and/or each service type. Wherever possible, service descriptions have been quantified with utilization and capacity data.

### **Crisis System Coordination and Accountability**

An effective behavioral health crisis response system ensures that people transition between phases of crisis (or levels of care) with minimal disruption until they reach the crisis resolution phase and are connected to ongoing care and/or other resources to help support their ongoing stability. Additionally, there should be formal processes for continuous quality improvement, incorporating consumer, family member, and system feedback, and ensuring the crisis system is accessible and responsive to all people seeking crisis care.

#### *Description and Data*

Currently, there is no entity in Baltimore City responsible for providing crisis system coordination in a systematic way. BHSB oversees some aspects of the crisis system in Baltimore City, but is not resourced to provide the level of coordination or accountability that would make the behavioral health crisis response system as effective as it could be.

There is no accessible and reliable system to track which providers have immediate openings for relevant services, making coordinating crisis care more difficult. There is also no system to track individuals' progress through crisis services – i.e., whether individuals make it to the next level of service and their crisis resolves effectively.

#### *Strengths and Opportunities*

Baltimore City is fortunate to have a large number of crisis response services available across the crisis phases outlined in this plan document. What it lacks is consistent and systematic crisis care coordination to ensure no one "falls through the cracks." There are several state and local initiatives to build systems that will track provider capacity for various types of services, and BHSB is actively participating in these efforts.

A few other states have implemented projects using software and web-based tools to track individual-level information and to coordinate care. These projects, often referred to as "air traffic controller" models, show real-time provider capacity information to help schedule appointments and use dashboards to track individuals through the continuum of crisis services, use predictive analytics to target interventions to high-risk clients, and display real-time data analysis to highlight

system trends. The primary challenges to this type of project are the development of legally compliant information-sharing agreements across multiple systems of care and the cost of operating a data repository that facilitates timely, continuous integration of datasets from multiple data sources (e.g. different EHRs, case management databases, and public records).

There are also opportunities to develop consistent screening and follow-up protocols across the behavioral health crisis system so that high-risk issues such as suicide and/or overdose are identified and followed up on to ensure these crises are effectively and safely resolved. Although many provider organizations are using evidence-based screening tools and follow-up protocols, there are no standard expectations or requirements in Baltimore City, so it is happening inconsistently.

Because people experiencing behavioral health crises may interact with multiple public systems such as the criminal or juvenile justice systems, social service systems, and other health care systems, BHSB works closely with these systems to ensure people's needs are being met. There are significant opportunities to strengthen coordination between these systems and the behavioral health system as well.

#### *Recommendations*

1. Plan for and implement a data-sharing platform that tracks individuals through the continuum of crisis response services and provides the data needed for partners to more effectively provide care and for the system to monitor outcomes.
2. Develop standard process and outcome measures to determine if the behavioral health crisis system is meeting the needs of residents.
3. Partner with Maryland's Behavioral Health Administrative Services Organization and other stakeholders to ensure transitions occur consistently.
4. Develop standard protocols to ensure consistent screening for risks such as: suicide, overdose, homelessness, violence, and abuse/neglect.
5. Develop standard protocols to follow up with individuals identified as high-risk.
6. Build on existing "familiar faces" projects to improve system level care coordination efforts for individuals utilizing high levels of inpatient care and emergency services.
7. Develop quality standards for case management/care coordination.
8. Support parity in case management/care coordination across the lifespan, provide training and technical assistance, and advocate for funding.
9. Expand the use of peer support services throughout the behavioral health crisis response system.
  - a. Advocate for insurance reimbursement for peer support services.

- b. Work with peer-led organizations to develop standards for peer services and peer supervision in crisis settings and provide technical assistance to crisis providers on these.
10. Work with private insurance companies to ensure they are aware of crisis services that are either grant funded or typically only covered by Medicaid and/or Medicare and to advocate for the inclusion of these less restrictive, less intensive services in their behavioral health care plans.

## Crisis Prevention

Over the last several years, the behavioral health field has been moving toward a framework that prioritizes prevention and health promotion. Recognizing that many external factors contribute to a person's overall behavioral health and wellness, public health systems, including entities like BHSB, are implementing stronger prevention strategies that account for social determinants of health. Issues of unstable housing, food insecurity, lack of access to quality health care, exposure to violence and trauma, racial and social oppression, education inequities, adverse childhood experiences (ACEs), etc. contribute to poorer behavioral health outcomes limit people's access to resources and increase exposure to violence and trauma.

An effective behavioral health crisis response system will include preventive measures as well as advocacy and action to address systemic/structural barriers.

## Accessible Behavioral Health Care

### *Description and Data*

To prevent crises, people must be able to access the behavioral health services they need, when they need them.

### *Strengths and Opportunities*

Approximately 74,000 Baltimore City residents receive behavioral health services through the public behavioral health system each year. This includes a wide range of services that are funded by grants and public insurance (Medicaid/Medicare).

BHSB has many anecdotal reports of long wait times for appointments and lack of capacity for certain levels of care. In its role as the behavioral health authority, BHSB is always trying to assess the needs and capacity of the public behavioral health system. However, BHSB does not have access to the right type of information concerning wait times or capacity to make strong recommendations for improvements at this time. There is an opportunity to build system-level accountability by increasing the type of data that BHSB, as the behavioral health authority, has access to.

Additionally, in a growing nationwide trend, providers have been adopting Open Access models that allow for same-day or next-day appointments in outpatient settings. There are opportunities to work with outpatient mental health and substance use disorder clinics in particular to implement these models to decrease or eliminate wait times and provide immediate access to care.

Many people first access behavioral health care through specialized mental health case management services (referred to as Targeted Case Management), which can assess the person's needs and facilitate connections to behavioral health care services as well as other resources such as housing, benefits, primary care, etc. However, Targeted Case Management is only currently available for people with a mental health diagnosis, even though people who have a substance use disorder (without a mental health diagnosis) would likely benefit from this type of service as well. Expanding the eligibility criteria would involve working closely with the Maryland Department of Health to amend Maryland's Medicaid Plan.

#### *Recommendations*

1. Work with outpatient mental health and substance use disorder programs to implement Open Access models.
2. Collaborate with the Maryland Department of Health to explore expanding Targeted Case Management eligibility criteria to include people with primary substance use disorders (no mental illness).
3. Strengthen BHSB's access to and ability to use data in order to continually assess need within the system of care.

### **Strong Discharge and Transition Plans**

#### *Description and Data*

Transitions between levels of care (services or programs) are a vulnerable time for people with behavioral health disorders. The stress of a change in routine can exacerbate symptoms. Transitions that happen quickly often result in lower-quality discharge plans. As a result, people don't connect with follow-up care and other needed supports. Discharges from intensive or highly structured levels of care such as inpatient or residential care can be especially sensitive to these factors.

Discharges or transitions that do not go well can in and of themselves create a crisis situation for some people. Having thorough discharge practices and robust discharge plans helps prevent behavioral health crises by ensuring people are receiving the care and support they need.

#### *Strengths and Opportunities*

While most discharges/transitions are successful and go smoothly, it can be extremely disruptive when they are not successful, so it is important to give this process attention in this plan.

Very little discharge/transition data are collected systematically, which represents a huge opportunity to understand this process much better.

#### *Recommendations*

1. Develop standards for discharge plan content and discharge processes.
2. Develop standardized outcomes reporting for transitions from one level of care to another.
3. Provide technical assistance to providers with writing and implementing their policies and procedures for discharge plans and discharge processes.

### **Harm Reduction Approaches**

#### *Description and Data*

Harm reduction is a public health approach that seeks to minimize negative social and health consequences associated with a wide range of behaviors. In this document, harm reduction activities generally focus on behaviors associated with drug and alcohol use and mental illness. Harm reduction can both be specific services offered and a philosophy through which behavioral health care is approached. Many organizations in Baltimore City have engaged in harm reduction activities for years, and BHSB has been significantly expanding its activities over the last few years.

Harm reduction activities can help prevent behavioral health crises in many ways, but perhaps most importantly by making meaningful connections with people who are using drugs or alcohol and/or have mental illness. Harm reduction services also usually include opportunities to connect with more formal behavioral health care, making it an important access point for some people.

BHSB currently supports the following harm reduction activities:

- Naloxone training and distribution
- Peer outreach and support
- Syringe exchange services
- Public education and training on safer drug use, especially related to fentanyl
- Advocacy and public education on safe consumption sites (also known as overdose prevention sites)
- Training on harm reduction principles and activities

#### *Strengths and Opportunities*

Harm reduction activities have the potential to reach vulnerable people who may be at risk of negative health and social outcomes. Because harm reduction approaches are so low barrier and person-centered, people are often more likely to make meaningful connections quickly, engage in available support services, and potentially connect to behavioral health care.

Overall, there has been increased acceptance of these types of approaches, allowing for exponential growth over the last few years. However, there are still many opportunities to broaden public support for additional harm reduction activities as well as expand existing activities.

#### *Recommendations*

1. Continue to expand and promote harm reduction approaches within the behavioral health provider network and across Baltimore City as a whole.

### **Housing and Emergency Shelter**

#### *Description and Data*

Inadequate or unstable housing increases a person's risk of experiencing a behavioral health crisis. Nationally recognized best practices, following a Housing First philosophy, emphasize that all people, including people with behavioral health disorders, should be connected to permanent housing as quickly as possible, regardless of the circumstances (i.e., status of recovery, engagement in treatment, etc.).

Two evidence-based practices, Permanent Supportive Housing and Rapid Re-Housing are widely promoted to support people with behavioral health disorders in attaining and maintaining permanent housing.

There are some behavioral health care services that include a residential component (e.g., residential rehabilitation programs, recovery residences, etc.); however, these are not included in this section of the plan because they are considered a health care service that is often only available on a short-term basis to those who meet the medical necessity or eligibility criteria. While these programs provide an important service, they are not meant to address a person's ongoing permanent housing needs.

Safe, affordable, and accessible housing and emergency shelter capacity are widely cited as being inadequate in Baltimore City. One consequence of the lack of accessible independent housing is that people with behavioral health disorders are often referred to behavioral health care services that include a residential component even when they do not necessarily need the treatment aspect of these services, which in turn creates a shortage of those services for people who do need them.

The shortage of housing and shelter also makes discharge and transition planning extremely difficult and time-consuming. Discharge planners often have deadlines outside of their control, and if housing or shelter cannot be secured quickly enough people are often discharged to emergency shelter. This type of discharge plan obviously creates a scenario with an increased risk of crisis occurring.

### *Strengths and Opportunities*

BHSB provides funding to four permanent supportive housing providers, and in FY 20 plans to fund a Rapid Re-housing model. Additionally, BHSB administers HUD Safe Haven and homeless outreach grants.

Although housing and emergency shelter may seem to fall outside of the purview of the behavioral health care system, having safe and affordable housing is an integral part of a person's overall behavioral health, wellness, and stability. As a system partner on Baltimore City's CoC board, BHSB is providing support to planning efforts to redesign the City's homelessness crisis response system, including outreach, sheltering, and a Coordinated Access system to connect people to housing, among other components.

### *Recommendations*

1. Continue to work with system partners and behavioral health providers to promote access to affordable housing and Permanent Supportive Housing and Rapid Re-Housing models.
2. Continue to collaborate with the CoC board to support a redesign of the City's homelessness crisis response system, through activities such as: improving behavioral health competencies and partnerships among shelter providers, improving diversion and eviction prevention strategies, and improving the Coordinated Access system.
3. Explore BHSB's capacity to expand on existing flexible small grants programs that help people pay for things like security deposits, first month's rent, transportation or other needs in order to prevent housing and behavioral health crises.

## **Transportation**

### *Description and Data*

An important part of accessing behavioral health care is being able to get to it efficiently and safely, which many people cite as being a significant barrier. Medicaid and Medicare help pay for some transportation to and from certain appointments, but it can be difficult to arrange and is not available to everyone for all types of appointments.

Baltimore City has public transportation systems operated by the Maryland Department of Transportation that include: one light rail line, one subway line, and an extensive bus system. Baltimore City also operates a free bus, which has very limited bus lines. While there are many more options in Baltimore City than some surrounding counties, the public transit system is often cited as being inefficient, especially as transfers between stations/stops are often required. Additionally, some people do not feel safe or comfortable using public transit for a variety of reasons. Public transportation can also be cost-prohibitive for many people.

There are also several taxicab and ride-sharing companies, but services are often cost prohibitive for people with low incomes, and many funders do not permit vehicles, drivers, or ride-sharing services as an eligible cost.

#### *Strengths and Opportunities*

Transportation needs may seem separate from the behavioral health care system, making it outside of BHSB's sphere of influence. However, it is a critical aspect of people being able to access behavioral health care. There are opportunities for BHSB to work with transportation system partners and develop funding resources for transportation for crisis (non-emergency) situations.

#### *Recommendations*

1. Further develop data and consumer stories about how a lack of transportation options affects access to care.
2. Use data to advocate that funders cover more and different types of transportation costs.

### **Community Education**

#### *Description and Data*

A behavioral health crisis response system can only be effective if people know how or when to access it and are not impacted by the stigma often associated with needing behavioral health care. Many people in the community want to help people with behavioral health disorders, but are unfamiliar with the resources, often resulting in people calling 911 when a behavioral health provider would have been a more effective resource. Several organizations provide community education and awareness campaigns, such as Mental Health First Aid, Children's Mental Health Matters, NAMI Walks, Anti-Stigma Campaign, the New Day Campaign, etc.

#### *Strengths and Opportunities*

Although there are several community education and awareness campaigns already, it is apparent that a deeper reach is needed to ensure all Baltimore City residents know how to access crisis services, similar to using 911, 311, or 211.

#### *Recommendations*

1. Source feedback from consumers on how to market alternatives to 911 services.
2. Explore expansions of existing community education and awareness campaigns.

## **Early Intervention**

Early intervention refers to an intervention (i.e., service, contact point, etc.) that happens at the first sign of potential crisis and can either prevent a full crisis from occurring or minimize the disruption and trauma of a full crisis.

One of the main goals of a well-functioning behavioral health crisis response system is to support people in the least restrictive settings by intervening as early as possible to prevent the negative outcomes associated with behavioral health crises, such as arrest, unnecessary hospitalization, homelessness, overdose, suicide, and other poor health outcomes.

## **Behavioral Health Crisis, Information, and Referral (CI&R) Hotline**

### *Description and Data*

Baltimore City has an integrated (mental health and substance use disorder) behavioral health Crisis, Information, and Referral (CI&R) Line that is available to the public 24 hours per day, 7 days per week, 365 days per year (referred to as 24/7). This hotline, 410-433-5175, is a part of the state's Maryland Crisis Hotline system and the National Lifeline Service. The CI&R Line provides crisis counseling and suicide risk assessment, information on behavioral health services and other community resources, and linkage to services by scheduling appointments with behavioral health providers with the caller on the phone. The CI&R Line can also connect the caller to a mobile crisis team, police, or EMS if emergency services are indicated.

### In Fiscal Year 2018 (FY 18)

- The CI&R Line received over 42,000 calls
- 7,667 (18 percent) of those calls were related to a behavioral health crisis
- The remaining 82 percent of calls were for information and referral

### In Fiscal Year 2017 (FY 17)<sup>3</sup>

- The CI&R Line received over 45,000 calls
- 8,345 (19 percent) of those calls were related to a behavioral health crisis
- The remaining 81 percent of calls were for information and referral

### *Strengths and Opportunities*

Baltimore City's CI&R Line is well established, particularly among mental health providers and individuals enrolled in behavioral health treatment. Over the past couple of years, BHSB has increased the marketing of the hotline to ensure more people in Baltimore City know what it is and how to access it; however, BHSB is aware that more marketing of the hotline is needed to ensure broader awareness and increased utilization, particularly among groups not accustomed to calling it

<sup>3</sup> BHSB operates on the State of Maryland's fiscal year, July 1 – June 30.

such as people with substance use disorders. Despite increased marketing, the number of calls received by the hotline slightly decreased from FY 17 to FY 18; the reason for this is not known and should be explored more.

A significant number of calls that come into 911 are considered non-acute. The Baltimore City Fire Department Emergency Medical Services reports that approximately 32 percent of the more than 150,000 calls they respond to are considered low acuity and could be treated by alternative non-emergency services. These calls are primarily for people who have little access to primary care and transportation and/or are not conducting adequate self-care and include a large number of people with behavioral health concerns. Many of these calls could potentially be diverted to the CI&R Line, which would increase the likelihood of a mobile crisis team intervening instead of first responders. There is a significant opportunity to explore a more formal connection with the Baltimore City Fire and Police Departments and the CI&R Line.

The CI&R Line providers have limited information about appointment availability and treatment capacity of community providers, making it difficult to assist callers in accessing appropriate care quickly. Additionally, even when appointments are made, it can be difficult for the staff to stay in touch with people to track the outcomes of appointments and ensure crises have adequately been stabilized.

Presently calls from or on behalf of youth are transferred directly to the youth-serving crisis response provider. Although this allows for specialization of services, it also creates separate processes for callers. BHSB is currently working with the CI&R Hotline partner agencies to configure the call referral system to ensure youth needs are met while ensuring alignment between youth and adult CI&R processes.

#### *Recommendations*

1. Work with system partners to assess the capacity to redirect non-acute calls that come in through 911 to the CI&R Line.
2. Increase marketing for the CI&R Line and evaluate impact of marketing efforts.
  - a. Target marketing to populations that underutilize the hotline: people using drugs, substance use disorder service providers, and youth and families.
3. Work with system stakeholders and providers to develop and implement a real-time capacity tracking tool for treatment services so that the CI&R Line can facilitate more effective linkage to care.
4. Employ peers to work the CI&R Line so that peer support is readily available to callers.
5. Continue to participate on Maryland's Crisis Hotline workgroup, which is developing recommendations to improve crisis hotline services across the

- state. Recommendations from that workgroup will be implemented in Baltimore City to the extent they are relevant and needed.
6. Continue to coordinate with other similar phone lines, including 211 and 311 to ensure referral processes are clear and community resources are kept up to date.
  7. Implement best practices for calls related to youth and families to ensure the needs of callers are met.

## **Provider On-Call Systems**

### *Description and Data*

Many types of outpatient behavioral health programs have an on-call system that connects people who are enrolled in their services to crisis support. Requirements differ depending on the type of service, with higher levels of care having increased requirements. For example, Assertive Community Treatment providers are expected to have staff on call and available by phone 24/7; whereas outpatient behavioral health clinics may only be required to have an after-hours crisis plan, which can be individualized to meet the needs of each provider organization. As such, practices among service providers vary greatly, even among the same level of care.

It is important to note that while on-call crisis services play a critical role in the behavioral health crisis response system, they are generally only available to individuals already enrolled in services with those providers. Most providers do not offer immediate unscheduled intake services for new consumers.

### *Strengths and Opportunities*

Baltimore City is fortunate to have a large number and variety of behavioral health providers, and in general, most programs do have an on-call, after-hours crises response system to support individuals already enrolled in their services in the event of a crisis. Additionally, there are benefits to working with a known clinician or peer during a crisis, which is another strength of these kinds of crisis services. However, the degree of variability in on-call, after-hours crisis services may leave some people vulnerable.

Additionally, there are Medicaid billing codes that outpatient behavioral health providers (e.g., outpatient mental health centers, etc.) could use to access reimbursement for providing crisis services. However, BHSB's review of claims data shows that very few providers bill for these types of services, which could be for several reasons, such as: billing or practice requirements that make the services unappealing to providers (i.e., too high burden or not worth the cost), lack of understanding or awareness of billing feasibility of these services, and billing/service protocols that are too restrictive to be useful. There is an opportunity for BHSB to understand why these services are not being used and potentially

advocate for changes to make them more useful and/or provide technical assistance, so provider organizations understand how to use them.

#### *Recommendations*

1. Assess the effectiveness of existing on-call after-hours crisis availability among behavioral health providers; identify opportunities for improvement; develop standards for best practices; and create an implementation plan with provider organizations.
2. Ensure that providers are effectively utilizing current reimbursement structures for urgent care services for enrolled clients and that administrative barriers to full utilization are addressed.

### **Respite Services – Youth**

#### *Description and Data*

Respite services for youth under the age of 18 are often considered a service for their caregiver, rather than for the young person directly. There are both in-home and out-of-home respite services available for youth. For in-home respite services, a provider from an approved program comes into the home or takes the youth out into the community for a few hours to give the family a needed break. The number of hours and frequency of the visits vary depending on each situation. Out-of-home respite is an overnight service. It can be provided by a residential respite program or a treatment foster care home. Typically, out-of-home respite is provided for one or two nights at a time, with varying frequency. Respite services can de-escalate crises, prevent crises, or operate as a support following step-down from inpatient or residential care to help youth transition more smoothly back to a home environment.

According to data from Beacon Health Options, in FY 17:

- 42 youth in Baltimore City received respite services.

#### *Strengths and Opportunities*

Respite services are enormously helpful to caregivers, but many sources report a lack of capacity in Baltimore City. Anecdotal reports state that many providers, especially those providing out-of-home community-based respite care, have difficulty providing these services due to the needs of the youth being greater than what the providers can support, particularly on an unplanned basis. For many years, BHSB has provided grant funding to support the sustainability of these services and offset administrative costs associated with the respite model. This includes supporting administrative staffing, outreach and marketing efforts, as well as other non-Medicaid reimbursable activities.

### *Recommendations*

1. Evaluate the needs and solutions for respite care services, including in-home, out-of-home, and facility-based settings for youth.
2. Explore ways to improve stakeholder partnerships which may impact access to respite care services.
3. Advocate for an evaluation of the rate structure for Medicaid reimbursement for respite care in collaboration with the Maryland Department of Health.

## **Peer-Run Respite Services – Adults**

### *Description and Data*

Peer-run respite offers adults with behavioral health disorders who are experiencing increased stress or symptoms to receive help in a peer-supported environment, often in home-like settings. The connections and relationships that peers offer can provide enough support to either prevent or de-escalate a crisis. Many people experience peer-run services as more empowering and enriching than traditional clinical and medical services, making them especially appropriate during a crisis.

There are currently no formal peer-run respite services available in Baltimore City.

### *Strengths and Opportunities*

There is an opportunity to develop peer-run respite services for adults in Baltimore City, particularly since there are so many strong existing peer-run organizations in the Baltimore area.

### *Recommendations*

1. Partner with peer-led organizations to develop respite care services for adults in Baltimore City.

## **Interdisciplinary Street Outreach**

### *Description and Data*

Street outreach teams engage individuals with behavioral health disorders who are not well engaged in traditional services. Outreach teams are flexible and assertive in their approach and work well with individuals experiencing or at risk of homelessness. Teams frequently have peer recovery specialists on staff with relevant lived experience that helps people trust and connect better with them.

For many years, BHSB has funded several outreach programs to respond to individuals with behavioral health disorders and people experiencing or at risk of homelessness. Whereas other services typically intervene at the time of a crisis, street outreach workers proactively canvass and develop trusting relationships that help identify and intervene early with vulnerable people who have unmet behavioral health needs.

Due to their close relationships with individuals and community members, outreach workers can sometimes be the first responders to a developing crisis. Outreach is typically the only non-police service that assertively maintains efforts to engage a person who declines to enroll in behavioral health care. Additionally, outreach teams play a critical role in supporting crisis services during disaster or severe weather responses.

#### *Strengths and Opportunities*

In July 2018, BHSB initiated a competitive process to identify a provider to receive braided outreach funding from multiple sources that had historically been awarded separately. Implementation efforts, continuing through 2020, are expected to: ensure more comprehensive geographic coverage, expand eligibility, reduce response times to outreach requests, reduce duplication of services, and improve care coordination for individuals with complex comorbidities.

#### *Recommendations*

1. Continue implementation of the Interdisciplinary Outreach model described above.
2. Collaborate with the CoC board to support a redesign of the City's homelessness crisis response system that includes a strategic plan for citywide street outreach.

### **Acute Intervention**

Acute intervention refers to an intervention (i.e., service, contact point, etc.) that happens once a crisis is occurring. This intervention should happen quickly and focus on immediate stabilization of symptoms and stressors to minimize potential harm to the person.

A well-functioning crisis system will have a robust range of acute crisis interventions that can respond quickly depending on the severity of crisis, with the goal of intervening at the lowest appropriate level of care possible.

### **Mobile Crisis Response**

#### *Description and Data*

Mobile crisis teams provide in-person, community-based behavioral health crisis assessment, brief intervention services, and referral to treatment and other resources for adults. They are a voluntary service and respond to people in their homes, on the street, or other community locations convenient to the person in need. Although mobile crisis teams respond as quickly as possible, there are times when all the teams are responding to calls or are not operating, creating wait times.

Mobile crisis teams serving adults currently operate from 7 am to midnight, 7 days per week. In FY 17, the adult mobile crisis team provider:

- Responded to approximately 2,500 calls
- More than half of those (53 percent) were to hospital emergency departments for diversion from inpatient admission to community-based care
- When a mobile crisis team was called to an emergency department for evaluation for diversion, 76 percent of the individuals were diverted to a community-based service

The youth community stabilization provider offers two to four weeks of in-home/community/school crisis stabilization services, depending on program eligibility, for youth and families. These services are accessed through mobile crisis response which is available to students in the public school system and youth in foster care as well as through urgent care appointments to the general public.

The community stabilization provider for youth currently operates Monday- Friday from 8:30 am to 7:00 pm. In FY 17, the youth community stabilization provider:

- Received 1,024 calls
- Served over 500 Baltimore City youth

#### *Strengths and Opportunities*

Mobile crisis and community stabilization services are a critical role in the behavioral health crisis response system by stabilizing crises in the community instead of emergency departments, inpatient hospitals, or even police responders.

However, these teams are not available 24/7 and have limited staffing to respond to the volume of crisis calls in the city, which means the teams are not always able to respond immediately. Additionally, except for in schools and for youth in foster care, there are no mobile crisis teams that serve youth in the community. When these services are not available, people must rely on higher levels of care or other options such as police or emergency medical services, which are readily available and have the capacity to respond quickly.

#### *Recommendations*

1. Expand mobile crisis teams for adults to 24/7 coverage and build sufficient capacity to have the ability to respond to most crises within one hour or less.
2. Assess the need to expand mobile crisis teams and/or community/in-home stabilization for youth to ensure adequate coverage to meet the needs, including for youth with autistic and autism spectrum disorders and other developmental disabilities.
3. Ensure all mobile crisis teams receive ongoing training on developmentally appropriate intervention for people across the lifespan and population-specific responses and resources (e.g., LGBTQ, immigrant or refugee

populations, other marginalized groups, etc.), and ongoing cultural competence to ensure the most effective responses.

4. Employ peers on mobile crisis teams
5. Facilitate coordination between mobile crisis team services and hospital emergency departments to increase opportunities to divert people to community-based care whenever appropriate.

## **Urgent Behavioral Health Care with Walk-In Capacity**

### *Description and Data*

Urgent behavioral health care with walk-in capacity would operate much like urgent care clinics for somatic health services. People could walk in when a need arose and receive assessment, triage, short-term targeted intervention services, prescriptions, and referrals for ongoing care. Urgent behavioral health clinics can operate as standalone community-based facilities or be integrated within existing outpatient behavioral health clinic settings that also provide ongoing care. The goals of urgent behavioral health care clinics are to resolve immediate short-term needs and prevent further escalation or the need for more intensive care.

Urgent behavioral health clinics are not typically open 24/7 and intervene at lower levels of acuity than comprehensive crisis response centers (described below). However, urgent behavioral health care clinics would still serve as a less costly and intensive alternative to emergency departments, inpatient hospitalization, or alternative responses like police.

Currently the only dedicated outpatient urgent care clinic available in Baltimore City is the youth-serving community stabilization provider mentioned in the previous section. Additionally, some outpatient behavioral health care providers have urgent care capacity for individuals already enrolled in their services.

### *Strengths and Opportunities*

There are extremely limited walk-in urgent behavioral health care services available in Baltimore City for individuals not already enrolled in care. There is an opportunity to explore the need, identify service delivery models, plan funding strategies, and establish this service in convenient locations throughout the city.

As mentioned elsewhere, there is an opportunity to implement Open Access or same-day scheduling models in existing outpatient clinic settings that could restructure intake processes with the goal to reduce wait times for treatment appointments. This type of scheduling model has been implemented in a wide variety of settings across the country and has shown to significantly increase access to care. While not necessarily designed as an urgent care model, having same-day access to clinical staff, including prescribers, may provide enough access to care for new people seeking help as well as clients already enrolled in services to decrease the need for more intensive care.

## *Recommendations*

1. Expand existing urgent care and community stabilization services available through the youth community stabilization provider.
2. Implement Open Access scheduling models among interested outpatient behavioral health providers that would allow individuals not already enrolled in services to receive treatment appointments more quickly.
3. Assess the need for and implement as indicated outpatient behavioral health urgent care clinics with walk-in capacity for people across the lifespan throughout Baltimore City.
4. Ensure that peers are an essential component of service delivery in urgent care service delivery into the staffing models of urgent care clinics.

## **Emergency Medical Services (EMS)**

### *Description and Data*

When calls made to 911 are screened as a medical emergency, they are dispatched through Emergency Medical Services (EMS), operated by the Baltimore City Fire Department. EMS responds to calls related to behavioral health crises including overdose, suicidal ideation, severe intoxication, delirium, and behavior that is often secondary to a behavioral health disorder or exacerbation of symptoms, such as significant lack of self-care, etc. EMS responds by administering naloxone to reverse opioid overdoses; providing treatment for insufficient self-care resulting in medical issues such as dehydration, injury, or infection; and transporting people to emergency departments for further assessment and/or treatment, including for emergency petitions.

According to EMS data, in FY 17:

- EMS responded to 154,000 calls in Baltimore City, which is a 20 percent increase over the past two years
- EMS responds to an average of 17 non-fatal overdoses each day, and 1-3 additional fatal overdoses

### *Strengths and Opportunities*

911 and EMS are well established and highly effective emergency response systems that are easily accessible to the public. EMS already responds to behavioral health emergencies rapidly and consistently.

When EMS responds to a non-fatal overdose, over 12 percent of people in Baltimore City decline transport to an emergency department for follow-up care. BHSB is currently working with EMS to better understand the reasons people decline transport and what their needs are in that moment. Preliminary activities have been focused on ensuring people have the CI&R Line number, giving people naloxone,

having a peer recovery specialist conduct outreach to connect with them, and giving them other resource information.

#### *Recommendations*

1. Continue to work with EMS and the Baltimore City Health Department (BCHD) to address the needs of individuals who experience a non-fatal overdose who decline transport to an emergency department.

### **Hospital Emergency Departments**

#### *Description and Data*

Hospital Emergency Departments (EDs) play a critical role in assessing behavioral health crises, providing immediate brief intervention, admitting individuals into inpatient care when necessary, and referring for follow-up care. EDs are currently the only locations allowed to accept Emergency Petitions for involuntary psychiatric assessment filed on behalf of people who are at risk of harming themselves or others due to a mental illness.

Baltimore City has 11 hospitals with emergency departments within the city limits, and additional hospitals outside the city limits also serve a high number of Baltimore City residents. The Veteran's Administration (VA) in downtown Baltimore also has an emergency department accessible to veterans. Eight of the 11 hospitals in Baltimore City are designated by the Maryland Department of Health as emergency psychiatric facilities and are required to accept Emergency Petitions. Seven of these hospitals also have psychiatric inpatient units for adults, and two have psychiatric inpatient units for youth.

According to the latest data from the Maryland Hospital Association, in 2015<sup>4</sup>:

- There were 26,025 behavioral health visits (including all payer sources) in emergency departments in Baltimore City

In Baltimore City, the primary behavioral health diagnoses for ED visits were:

- alcohol-related disorders (29 percent),
- mood disorders (24 percent),
- other substance-related disorders (13 percent),
- anxiety disorders (10 percent),
- schizophrenia and other psychotic disorders (9 percent),
- suicidal ideation or self-injury (4 percent), and
- "other" behavioral health issues (11 percent).

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<sup>4</sup> Maryland Hospital Association, Behavioral Health Task Force Environmental Scan:  
[https://www.mhaonline.org/docs/default-source/publications/bhtf-environmental-scan\\_sept-2016-release-with-jan-2017-revisions.pdf?sfvrsn=2](https://www.mhaonline.org/docs/default-source/publications/bhtf-environmental-scan_sept-2016-release-with-jan-2017-revisions.pdf?sfvrsn=2)

According to data from Beacon Health Options, in Baltimore City during FY 16:

- 66 percent of people with Medicaid who presented in the ED for a mental health condition were then admitted for inpatient psychiatric treatment

There are several special initiatives related to behavioral health being implemented in Baltimore City EDs, many in collaboration with BHSB.

#### Screening, Brief Intervention, Referral to Treatment (SBIRT)

SBIRT is a national best practice that recommends that all individuals in a health care setting, regardless of their presenting problem, be screened for high-risk situations such as substance use, violence/abuse, or suicide. BHSB, as a partner in the Maryland SBIRT project, supported implementation of SBIRT for substance use in health care settings in Baltimore City.

Following this model, when a person screens high for substance misuse, someone will talk to them about the potential negative consequences of their substance use and whether they are motivated to change behavior related to their use (i.e., brief intervention). Individuals may also be referred to treatment. Most hospitals have implemented a universal SUD screening tool in their EDs.

#### Buprenorphine Induction

Buprenorphine is a medication used to treat opioid addiction, and most EDs in Baltimore City are providing the first dose (called induction) while people are still in the ED, with a next-day appointment for follow-up care and ongoing buprenorphine treatment in the community. Providing buprenorphine induction immediately greatly improves many people's ability to follow up with treatment because their withdrawal symptoms are being managed.

#### Peer Support

All of Baltimore City's hospital systems have begun implementing peer support in the ED and other hospital settings. In most Baltimore City EDs, people who screen positive for substance use issues, or who have recently survived an overdose will receive a brief intervention and follow-up contact from a peer. Additionally, some hospitals refer overdose survivors to a peer who will continue to make follow-up visits with the person after they are discharged from the hospital.

#### *Strengths and Opportunities*

Emergency Departments play a critical role in the behavioral health crisis response system, and Baltimore is in a unique position with a high concentration of nationally recognized hospital EDs. Most of the EDs in Baltimore City are partnering with BHSB and the Baltimore City Health Department to implement specific interventions aimed at improving behavioral health outcomes.

Many people who seek care in EDs have experienced high-risk incidents such as overdose, suicidal ideation or attempts, violence, abuse, traumatic stress, and homelessness. While EDs often refer individuals who are not admitted for inpatient care to ongoing community-based outpatient care, little is known broadly about the outcomes of those referrals. People may seek care in an ED because they are not well connected to community-based care. In a well-functioning behavioral health crisis response system, there would be a high degree of confidence that vulnerable individuals are seamlessly getting connected to community-based care, but without outcomes data, it is difficult to know whether individuals are receiving needed follow-up care upon discharge.

Although EDs provide a critical service for people experiencing behavioral health emergencies, many people experiencing a behavioral health crisis do not require the intensity of services that an ED provides. Many people would be able to stabilize and/or resolve crises in community outpatient settings if more immediate services were available. There is also an opportunity to develop more ED diversion opportunities for people who go to the ED, but do not require such a high-level intervention.

#### *Recommendations*

1. Partner with hospital EDs and community-based behavioral health care providers to establish processes and practices for seamless diversion and/or discharge.
2. Expand and standardize the use of evidence-based screening and assessment tools such as SBIRT, suicide risk assessment, etc.
3. Develop measures to track outcomes of ED visits, particularly for people who use the ED for “high risk incidents” such as overdose or suicide.
4. Expand programs for people who have experienced high-risk incidents to ensure a rapid and meaningful connection is made to follow-up care.
5. Expand buprenorphine induction in EDs.
6. Increase the use of peers in hospital EDs.

## **Law Enforcement**

#### *Description and Data*

When calls made to 911 are screened as non-medical incidents requiring follow up, they are dispatched through the Baltimore Police Department (BPD). BPD is the eighth largest municipal police force in the nation, staffed by nearly 3,100 civilian and sworn personnel. BPD officers respond to a wide variety of calls directly or indirectly related to behavioral health crises, including altercations, loitering, and erratic or concerning behavior.

Officers are also involved in the execution of Petitions for Emergency Evaluation (also known as Emergency Petitions), which involve taking people with mental

illness to an emergency department for involuntary mental health assessment when there is good reason to believe they may present a danger to themselves or others. Officers may be the petitioner and provide transportation or solely provide transportation for petitions written by other eligible petitioners.

BHSB works closely with BPD to provide leadership and oversight of specific projects as well as to more generally inform and coordinate efforts within each other's systems. A major shared goal is to significantly decrease the number of people with behavioral health disorders who encounter the criminal justice system, including police, through prevention and diversion efforts. Some of those efforts have already begun and others are still being developed, as noted below.

#### Crisis Intervention Team (CIT) Model<sup>5</sup>

In Baltimore City, police officers receive intensive training on behavioral health and crisis de-escalation, known as the Crisis Intervention Team (CIT) model. Tests administered at the beginning and end of every training consistently show a gain in knowledge and change in attitudes. Evaluations also consistently demonstrate satisfaction with the training, and preliminary analysis shows that CIT-trained officers are more likely to use verbal-only de-escalation techniques. When available, CIT-designated officers (those who have completed 40 hours of training and agreed to serve in that role) are dispatched to calls related to behavioral health.

All new police recruits receive 16 hours of behavioral health awareness training as part of the Police Academy's curriculum, and experienced patrol officers, including supervisors, Police Training Academy (PTA) staff, and Sheriff's deputies are offered an additional 40 hours of behavioral health training.

Based on data collected by BHSB in FY 17, the following law enforcement staff received 40 hours of training:

- 109 experienced officers, (this includes Patrol, supervisors, PTA staff, and Sheriff's deputies)
- 90 new recruits, and
- 3 dispatch operators

BHSB has an employee embedded within the Police Training Academy, who has significantly strengthened the partnership between BHSB and BPD. In addition to providing training, this staff person supports individual officers through day-to-day problem solving and case conferencing.

#### Crisis Response Teams (CRT)

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<sup>5</sup> This training program was previously referred to as the Behavioral Emergency Services Team (BEST), but changed its name to be consistent with the national model on which it is based.

CRT is a project based on national CIT best practices and is being piloted in the Central District as of June 2017. This co-responder team consists of CIT-trained officers and licensed behavioral health clinicians, who respond exclusively to situations related to behavioral health crises. This team is currently available Sunday – Saturday, 11 am – 7 pm.

As of December 31, 2018, the team:

- Responded to 1,022 calls for services
- Conducted 3,631 follow-up visits

#### Law Enforcement Assisted Diversion (LEAD)

LEAD is another national best practice being piloted in the Central District as of February 2017. It is a pre-booking diversion program where law enforcement officers can divert eligible individuals to intensive case management in lieu of arrest. Interested and eligible individuals who have committed misdemeanor drug or prostitution-related offenses can also be referred through a social referral which means an officer can refer an individual without an imminent arrest. LEAD operates Monday – Friday, 10 am – 6 pm.

As of April 1, 2019, LEAD:

- Enrolled 109 individuals in services
  - 71 of those were social referrals
  - 38 were arrest referrals
- Attempted to engage over 250 referrals

#### Community Planning and Implementation Committee (CPIC)

The CPIC is a group of stakeholders co-facilitated by BHSB, the Mayor's Office of Human Services, and BPD that provides community oversight to the behavioral health strategies intended to reduce and improve interactions with law enforcement. CPIC was originally formed to guide the implementation of CIT in the city, and has been expanded to oversee the implementation of the behavioral health requirements of BPD's consent decree.

#### *Strengths and Opportunities*

BPD has shown investment in working effectively with individuals with behavioral health disorders by verbally de-escalating crises (minimizing uses of force), diverting individuals from arrest, and connecting them to behavioral health care. BPD has a strong collaborative relationship with BHSB and an active goal to expand these types of partnerships and ultimately decrease people's involvement with criminal justice systems. In addition, Baltimore City signed on to participate in the national Data Driven Justice initiative which demonstrates the City's commitment to

developing a smarter, more data-informed criminal justice system that promotes opportunities for diversion.<sup>6</sup>

BPD officers play a critical role in safely and effectively executing Petitions for Emergency Evaluation when individuals are unwilling or unable to seek evaluation on their own. However, many officers report that because each emergency department has different policies and practices related to accepting Emergency Petitions, officers sometimes experience significant time away from their regular duties to stay with someone in an emergency department until they can safely be assessed. There are additional burdens on emergency responders and delays in access to care related to the fact that not all emergency departments are designated as psychiatric emergency facilities.

DOJ's investigation into BPD and their resulting report and consent decree described earlier outlines several opportunities for stronger collaboration between the criminal justice and behavioral health care systems, and BPD and BHSB are committed to using the momentum of the consent decree to enact meaningful change in Baltimore City.

Further, a well-functioning crisis system would ideally significantly decrease the need for police to respond to behavioral health crises because other behavioral health care would be accessible and could intervene instead. This idea is the explicit vision of CPIC, with consensus from BPD, the Mayor's Office of Human Services, and BHSB.

#### *Recommendations*

1. Continue providing training to BPD officers on behavioral health and de-escalation techniques to ensure a sufficient number of officers are available in all districts, throughout the day, to respond to calls related to behavioral health. This will minimize arrests, improve the safety of officers and residents, divert people to the behavioral health crisis response system, and reduce the unnecessary involvement of the criminal justice system.
2. Ensure that police receive training specifically for youth and young adults.
3. Identify funding to sustain and expand the CRT and LEAD projects to better address behavioral health crises and divert people from the criminal justice system.
4. Increase the use of peers in all police-related projects.
5. Work with BPD to identify additional projects or processes that will incorporate non-police interventions to divert people experiencing behavioral health crises from police interactions wherever possible.

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<sup>6</sup> For more information on the Data Driven Justice Initiative click this link  
<http://www.naco.org/resources/programs-and-services/data-driven-justice>

6. Work with BPD, hospitals, the judiciary, and other stakeholders to review the Emergency Petition process and data, identify opportunities to improve processes and strengthen data collection, and advocate for system changes to implement recommendations.
7. Explore options with city and state partners to consider diverting funding from BPD to the behavioral health system to better respond to crises where a police response is not required, potentially through social compacts or justice reinvestment.

## Crisis Treatment

Crisis Treatment refers to an intervention (i.e., service, contact point, etc.) that happens once a crisis is occurring. This intervention should happen quickly and focus on resolution of symptoms and stressors to minimize potential harm to the person and establish ongoing support upon discharge. Crisis treatment services are short-term and intensive interventions, such as crisis counseling, individual and group therapy, medication evaluation and management, etc.

A well-functioning crisis system will have a robust range of crisis treatment that can intervene quickly depending on the severity of crisis, with the goal of intervening at the lowest appropriate level of care possible, resolving the immediate crisis, and developing a plan for future stability.

## Comprehensive Crisis Response Centers

### *Description and Data*

Comprehensive Crisis Response Centers operate 24/7 and provide triage, assessment and evaluation, extended evaluation, treatment initiation including buprenorphine induction, and peer support. The centers offer a less costly alternative to emergency departments while also offering real-time connection to ongoing treatment, case management, and peer support services. The centers can also offer an alternative destination for EMS transport as well as serve as a receiving center for emergency petition evaluation. The over-arching goal of a comprehensive crisis response center is to serve as a direct alternative to a hospital emergency department by providing the specialized emergency care needed for individuals with mental illness and/or substance use disorder. These centers do not currently exist in Baltimore City as described here.

### Maryland Crisis Stabilization Center (Stabilization Center)

The Stabilization Center is a new program model in Maryland being developed as a pilot in Baltimore City. It offers a safe place for individuals who are under the influence of drugs or alcohol to sober and receive short-term interventions, such as buprenorphine induction and medical screening and monitoring. Individuals are also

offered the opportunity to connect with ongoing behavioral health treatment, peer and recovery support services, and case management. The Stabilization Center has been approved to serve as an alternative destination site for EMS, meaning individuals can be transported directly there instead of an emergency department. Mobile crisis teams can also refer and transport individuals. The feasibility of expanding referral sources and offering walk-in capability at this site is still being assessed.

### 24/7 Urgent Opioid Use Disorder Crisis Services

In September 2017, BHSB received grant funding through the Maryland Opioid Rapid Response initiative to fund a new service that provides 24/7 crisis services operated within a residential substance use disorder setting. These services are available for adults with an opioid use disorder on a walk-in basis. The project began operations on November 13, 2017 and has 12 beds that can serve individuals for up to 96 hours before being transitioned to another level of care. Walk-in intake and assessment are available seven days a week, 24 hours a day.

#### *Strengths and Opportunities*

As stated above, many people using the emergency department for behavioral health care do not need the intensity of services offered by the ED and could be better served in a community-based setting. There is significant opportunity to plan for, develop, and implement alternatives to the emergency department to ensure that individuals receive recovery-oriented crisis care in a community-based setting that includes a real-time connection to ongoing behavioral health care.

Two strengths in this area are that the State of Maryland Behavioral Health Administration Advisory Council issued a report in November 2017 which called for the establishment of crisis centers, and the Maryland Crisis Stabilization Center has an Implementation Board comprised of high-level state and local officials who are dedicated to ensuring the success of this project. Although neither of the two projects mentioned here are operating fully as comprehensive crisis response centers, they both contain several elements and move Baltimore City closer to developing this capacity.

#### *Recommendations*

1. Implement the Maryland Crisis Stabilization Center pilot project, assess the impact of this new service, and expand as appropriate
2. Plan for, implement, and assess the effectiveness of alternative locations beyond emergency departments to accept and process Emergency Petitions
3. Include peers in all staffing models developed
4. Incorporate capacity to serve youth through existing or new projects

## **Residential Crisis Services**

### *Description and Data*

Baltimore City has one 21-bed community-based residential crisis unit that provides an alternative to or step-down from hospital-based mental health crisis services for adults. Residential crisis services include intensive behavioral health assessment and observation, medication management, intensive short-term intervention services, and discharge planning. Individuals must voluntarily consent to services.

According to data submitted to BHSB by the residential crisis provider, in FY 17:

- There were 734 admissions with an average length of stay of 10 days
- Over half of people admitted had co-occurring mental health and substance use disorders
- The residential crisis unit operated at 93 percent occupancy

### *Strengths and Opportunities*

Residential crisis services provide a critical alternative to hospital-based crisis care and as step-down from hospital-based care to ensure a smoother transition back to the community. These services are often less disruptive to people's lives than hospital-based services due to being voluntary and community-based. They are also capable of providing a high level of clinical and medical support in a community setting at a much lower cost than hospital-based services.

Currently community-based residential crisis services are only available to adults, and the unit operates at near capacity, so there may be opportunities to expand this service type.

### *Recommendations*

1. Assess the effectiveness of and need for community-based residential crisis services for youth, and expand as indicated
2. Assess the need for additional adult community-based residential crisis capacity and expand as needed

## **Withdrawal Management**

### *Description and Data*

Withdrawal Management (WM)<sup>7</sup> refers to assessment and intervention services meant to assist a person who has been actively using drugs and/or alcohol manage symptoms of withdrawal when they stop using these substances. Some substances, particularly alcohol and benzodiazepines, may require medical intervention to safely

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<sup>7</sup> Withdrawal management services used to be referred to as detoxification or "detox" services. However, the term "withdrawal management" more accurately describes the services being provided and has a less stigmatizing connotation.

withdraw. Withdrawal management is often a first step when a person enters treatment, rather than it being a complete treatment on its own.

In Baltimore City, there are three levels of withdrawal management (WM) services offered: hospital-based, community residential, and outpatient withdrawal management. There are 48 hospital-based withdrawal management beds available, and approximately 58 non-hospital community residential withdrawal management beds available. Recent changes in the reimbursement of residential treatment for substance use disorder has allowed for an expansion of residential WM capacity in the city. The capacity of outpatient WM services is more difficult to track because it is not based on beds and can fluctuate based on need.

#### *Strengths and Opportunities*

Withdrawal management services are critically important to helping people with substance-related disorders transition from active substance use to ongoing treatment by managing symptoms related to withdrawal.

Although hospital-based and community residential WM services play an important role in the behavioral health crisis system, particularly for individuals who use alcohol which has dangerous withdrawal symptoms, there is unknown capacity for providing WM services on an outpatient basis. Some providers have reported a reluctance to provide this type of service due to risk associated with managing withdrawal symptoms. Providers have also reported challenges in meeting the needs of individuals with serious mental illness also in need of WM services.

#### *Recommendations*

1. Assess the current capacity, utilization rates, and effectiveness of hospital-based and community residential WM services to determine if additional capacity is needed.
2. Examine the barriers to implementing outpatient WM services; identify opportunities for system enhancements; and develop a plan for increasing this level of care.
3. Assess the capacity of existing WM programs to effectively serve people with serious mental illness. As indicated, provide technical assistance to ensure this group of people have access to clinically appropriate care.

## **Acute Psychiatric Inpatient Care**

#### *Description and Data*

Psychiatric inpatient care is an intensive level of behavioral health crisis care provided in a hospital setting on a voluntary or involuntary basis. Seven hospitals in Baltimore City have psychiatric inpatient units, six of which accept people admitted on an involuntary basis. Psychiatric inpatient care includes evaluation and treatment, medical and nursing monitoring and intervention, diagnostic testing,

medical consultation, medication management, some counseling services, and case management to coordinate discharge planning. Most people access inpatient care through hospital emergency departments and have been evaluated as needing inpatient care.

According to data from Beacon Health Options, in Baltimore City in FY 18:

- 4,587 unique individuals received inpatient psychiatric care (8 percent of the total number of people utilizing mental health services in the public behavioral health system)
- Because this level of care is so intensive, the cost of care represented a disproportionate 23 percent of total expenditures for mental health services
- In FY 16, the average length of stay was seven days, and 20 percent of people discharged were re-admitted within 30 days

### *Strengths and Opportunities*

As noted elsewhere, Baltimore is in a fortunate position to have so many strong hospital systems within the city limits, which is a strength in itself and creates many opportunities for partnerships.

With 20 percent of people discharged being re-admitted within 30 days, there is an opportunity to explore the outcomes of discharges from inpatient units more closely.

There is also an opportunity to evaluate the capacity of inpatient units compared to the need, particularly for youth. Anecdotal reports show that youth and adults sometimes wait so long for a bed in an inpatient unit that they end up receiving their full course of care in the Emergency Department instead.

### *Recommendations*

1. In partnership with area hospitals and the Maryland Hospital Association, assess the precipitating factors for re-admission, determine what the target re-admission rate should be for Baltimore City, and develop an intervention to support people in preventing readmission
2. In partnership with the Maryland Hospital Association, implement best practices for discharge in all inpatient psychiatric units
3. Evaluate inpatient treatment capacity to determine whether more inpatient care is needed, particularly for youth.

### **Crisis Recovery**

Individuals who have experienced a crisis may be vulnerable to the recurrence of a crisis if the factors that led to the original crisis have not been addressed adequately. Additionally, many people may feel heightened stress or fear after experiencing a crisis, which can exacerbate underlying symptoms and lead to another crisis.

A well-functioning crisis system will ensure that people who have recently experienced a crisis receive adequate support following the crisis.

Several services noted in this section overlap with the Crisis Prevention section and will only be covered in this section as they relate to Crisis Recovery. It is easy to recognize the connection between Crisis Prevention and Crisis Recovery, but the emphasis on what is needed and why varies slightly and is important to note.

### **Strong Discharge and Transition Plans**

*(Addressed in Crisis Prevention Section above.)*

### **Accessible Behavioral Health Care**

*(Addressed in Crisis Prevention Section above.)*

### **Peer Follow Up**

#### *Description and Data*

Peers play a critical role throughout the continuum of crisis response services and can be especially helpful in helping people navigate and trust the behavioral health system following a crisis.

#### *Strengths and Opportunities*

There are some existing peer outreach and follow-up services already noted throughout this document, and there is an opportunity to develop much more capacity and infrastructure to provide follow up for more people. A pilot program between NAMI and two psychiatric inpatient hospitals is underway to explore the outcome of on-site connections to peer support services that patients and their families can continue to engage with after discharge.

#### *Recommendations*

1. Work with NAMI to learn from the current pilot program.
2. Seek funding for and provide technical support to initiatives that formalize referral processes and provide warm/hot handoffs from crisis services to peer services.

## **Appendix**

### **Stakeholders That Offered Feedback**

BHSB would like to thank the stakeholders who took the time and effort to provide thoughtful feedback on our first draft of this plan. The feedback received was extremely helpful and significantly changed the structure and content of this document.

- Associated Catholic Charities
  - Baltimore Child & Adolescent Response System (BCARS)
- Baltimore City Department of Social Services
- Baltimore City Department of Juvenile Services
- Baltimore City Public Schools
- Baltimore Crisis Response, Inc. (BCRI)
- Baltimore Harm Reduction Coalition
- Bmore POWER
- Bmore Clubhouse
- Department of Justice Crisis Experts
- Disability Rights Maryland
- Healthcare Access Maryland
- Health Care for the Homeless
- HOPE Wellness & Recovery Center
- Johns Hopkins Bloomberg School of Public Health
- Maryland Coalition of Families
- Mental Health Association of Maryland
- Mercy Medical Center
- National Alliance on Mental Illness (NAMI) – Baltimore Metro Chapter
- On Our Own, Inc. Wellness & Recovery Center
- People Encouraging People
- Baltimore City Office of the Public Defender
- St. Agnes Hospital
- Tuerk House
- Valley/Bridge House
- Youth Empowered Society (YES) Drop-In Center

BHSB also received a letter from Disability Rights Maryland, urging BHSB to expand behavioral health crisis services, but not expand or increase funding for specialty Baltimore Police Department programs aimed at people with behavioral health disorders. This letter was signed on by 40 organizations or individuals. BHSB greatly appreciates this feedback and has incorporated it into this document and planning efforts.