



Behavioral Health System
Baltimore

FY 2020 Activities, Data, and Planning

February 2021

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A. Introduction

BHSB is a nonprofit organization that serves as the local behavioral health authority (LBHA) for Baltimore City. In this role, BHSB is tasked by the State of Maryland with a range of activities to plan, manage, and monitor the public behavioral health system at the local level.

BHSB works to build an efficient and responsive system that comprehensively addresses the needs of individuals throughout the lifespan, their families, and communities impacted by mental illness and substance use. We do this by providing local leadership in implementing and overseeing a variety of prevention, early intervention, treatment, and recovery support services as well as developing new and innovative services.

LBHAs operate under the authority of the Secretary of the Maryland Department of Health (MDH), and BHSB has a memorandum of understanding with the MDH Behavioral Health Administration (BHA) that outlines its responsibilities. BHSB has several core functions related to its role and mission:

- Managing public funds and grant awards from multiple sources,
- Building and maintaining relationships with local system partners to advance behavioral health and wellness in Baltimore City,
- Advocating and planning for system changes and improvements,
- Providing public education about behavioral health and how to access the public behavioral health system, and
- Managing a system of care for individuals, families, and communities impacted by mental illness and substance use.

BHSB operates within the context of Maryland's public behavioral health system and is tasked with local oversight and management. In Maryland, most publicly funded behavioral health services are reimbursed through a statewide Administrative Service Organization (ASO), and providers are paid on a fee-for-service basis for services provided to people who have Medicaid or are uninsured.

The MDH also directs grant funds to LBHAs to fund services and initiatives not reimbursable by Medicaid. The state holds the sole authority to regulate the provider network and add services to the Medicaid benefit package, while local authorities identify the unique strengths and needs of their jurisdictions to direct funding where it is most needed.

While service utilization data for Fiscal Year (FY) 2020 is not available due to challenges in the ASO system, Baltimore City is consistently the most represented jurisdiction in the public behavioral health system despite not being the most populous jurisdiction in Maryland. During FY 2019, nearly 78,000 people were served in Baltimore City, with annual expenditures of over \$510 million.

B. New Developments and Challenges

Baltimore City is a large urban jurisdiction with multiple complexities and challenges including a longstanding history of disparities and inequities, a frequently changing political landscape, and several large academic institutions and health systems that have influenced how resources are allocated. BHSB and system stakeholders work closely to address often competing priorities with limited resources. As the LBHA, it is the responsibility of BHSB to be a partner in the work to address the entrenched systemic challenges that have impacted people, their families, and the communities in which they live.

Key Population-Level Indicators

Baltimore City and the State of Maryland have been experiencing a public health emergency with dramatically rising opioid-related fatalities over the past ten years. In response, the Maryland Opioid Operational Command Center was established by the Hogan Administration's 2017 Heroin and Opioid Prevention, Treatment, and Enforcement Initiative. Each jurisdiction is required to establish an Opioid Intervention Team (OIT) to coordinate local opioid response efforts and integrate with statewide efforts. As the city's public health agency, the Baltimore City Health Department (BCHD) leads the overdose response and chairs the OIT. BHSB participates on the OIT, as well as on the city's Opioid Fatality Review team, which is also chaired by BCHD. To facilitate communication and coordination, BCHD staff attends BHSB's internal overdose response work group.

While opioid-related deaths statewide declined by 1.7% percent during 2019 as compared to 2018, the number of deaths in Baltimore City rose by 4.5%. In response to the public health emergency, BHSB collaborates with state and local partners to implement a wide array of strategies. Some of those discussed in other sections of this report include: the Maryland Crisis Stabilization Center; peer-delivered outreach services; the Interdisciplinary Street Outreach project; the Hub and Spokes project; expanding access to buprenorphine in non-traditional, low threshold peer-run settings; offering peer support services to Syringe Services Program customers; the Patient Medical Engagement project; the Maryland Harm Reduction Training Institute; and Bmore POWER.

Baltimore City also continues to experience endemic violence. The homicide rate remains extremely elevated compared to the years leading up to 2015. There was a spike of 342 homicides in 2015, which was exceeded during 2019 with 348 homicides. The total number of homicides in 2020 was 335, with a record number of women and girls killed.¹ In addition to the

¹ Associated Press. (1 Jan 2021). Baltimore Had 335 Homicides in 2020. *US News and World Reports*. *Baltimore Had 335 Homicides in 2020 | Maryland News | US News*.

tragic loss of life, each homicide has a traumatic impact on the individuals, families and communities that survive the loss of a family member, friend, or acquaintance. Such losses can have long-term negative consequences on health and well-being, including mental health conditions, substance use, asthma, autoimmune, cardiac, and other chronic diseases, particularly when compounded by toxic stressors such as systemic racism and other forms of oppression, Adverse Childhood Experiences (ACEs), a lack of affordable and safe housing, food insecurity, food deserts, and limited access to social and economic mobility.

The age-adjusted suicide rate for the United States in 2019 (13.9 per 100,000) was higher than the rate for the state of Maryland (10.3 per 100,000), which in turn was higher than the rate for the city of Baltimore (9.1 per 100,000). Both the United States and Maryland display a significant trend of an increasing suicide rate over the past twenty years. The same pattern is not evident in Baltimore City; however, since suicide is a rare event, changes in rates are difficult to determine over a population as small as a single city. BHSB is working to integrate suicide prevention into its overall prevention strategies.

Systemic Racism

To confront the significant challenges Baltimore City faces, as highlighted by the overdose, homicide, and suicide rates, strategies must be centered on addressing the massive impact of systemic racism. One of the legacies of Baltimore City's explicitly racist housing policies dating back to the early 20th century is a highly segregated city with a poverty rate (21.2%) that is nearly two-and-a-half times that of Baltimore County (9%).² Investment within the city continues to follow the patterns of segregation, with far more investment resources flowing to whiter, wealthier neighborhoods, thus compounding historic disparities.³

The conditions in which people are born, grow, live, work, and age, and which are affected by the distribution of money, power, and resources, are referred to as the social determinants of health. These determinants result in enormous health disparities between communities. As described in the *Baltimore City Demographics and Social Determinants of Health* section of this report, Baltimore City bears a disproportionate burden of conditions that increases the likelihood of chronic behavioral health conditions.

The dominant cultural norms in the United States are based on white supremacy, which is the false belief that White people are superior to other people and that White people should therefore dominate other people. These norms shape our perceptions and behavior and generate structures that ensure disparate access to resources and power, which perpetuates socioeconomic and health inequities.

² American Community Survey, 2019 5-year estimates. <https://data.census.gov>.

³ "The Black Butterfly": Racial Segregation and Investment Patterns in Baltimore. Urban Institute. February 5, 2019, <https://apps.urban.org/features/baltimore-investment-flows/>.

As the local behavioral health authority, it is BHSB's responsibility to work collaboratively with other system partners to analyze institutional power and take action to undo structures that perpetuate racism and other forms of oppression. Importantly, this work resides both at the local level with local system partners and at the state level. Because the public behavioral health system is a state-driven system, BHSB lacks authority over the policies that govern the provider network. The locals and the state need to come together to identify opportunities to engage the resources of the statewide system to dismantle structures that perpetuate racism and other forms of oppression.

The *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* developed by the U.S. Department of Health and Human Services are an important tool to advance this work. However, this framework does not drive the broad systemic change that is essential to build a society in which people can thrive in communities that promote behavioral health and wellness for all.

3 Realms of ACEs⁴

An *Adverse Childhood Experience* (ACE) is a traumatic experience in a person's life occurring before the age of 18. The ACE score is a measure of cumulative exposure to ten specific adverse experiences during childhood. Exposure to any single ACE is counted as one point. With each point, there is increased vulnerability to more adversity.

Maryland began collecting ACEs data through the Centers for Disease Control Behavioral Risk Factor Surveillance System (BRFSS) in 2015. The BRFSS is a statewide survey that collects data on the behaviors and conditions that put individuals at risk for chronic diseases, injuries, and preventable infectious diseases. Over 8,500 Maryland households anonymously participate in this survey each year. Statewide, the prevalence of three or more ACEs was 24%, whereas for Baltimore it was 42%.⁵

Adverse Community Environments are the second realm of traumatic experiences. They include a lack of affordable and safe housing, community violence, structural racism, food insecurity, food deserts, systemic oppression, and limited access to social and economic mobility. Such environments compound ACEs, creating a negative cycle of ever-worsening effects because systemic inequities make it difficult to support thriving communities, which in turn increases the risk of ACEs.

⁴ https://www.acesconnection.com/g/resource-center/fileSendAction/fcType/0/fcOid/489399740685359411/filePointer/504742536782894159/fodoid/504742536782894154/3Realms_092520.pdf

⁵ Maryland Behavioral Risk Factor Surveillance System (2017). "Adverse Childhood Experiences (ACEs) in Maryland: Data from the 2015 Maryland BRFSS Data Tables Only." https://phpa.health.maryland.gov/ccdpc/Reports/Documents/MD-BRFSS/2015_MD_BRFSS_ACEs_Data_Tables.pdf

The third realm of traumatic experiences are environmental. Climate change is contributing to an increase in extreme weather events such as floods, storms, droughts, and heat waves that result in resource scarcity. These conditions, as well as wildfires and pandemics, cause physical and psychological injury.

People who have high exposure to the *3 Realms of ACEs* are more vulnerable to adaptive behaviors such as substance use, binge eating, self-harm, and violence. The prevalence of ACEs in Baltimore City, together with historic and ongoing systemic racism and the disparate rates of poverty, violence, homicide, overdose fatalities, and housing instability, increases the risk of behavioral health disorders.

Dual Pandemics

The COVID-19 pandemic has presented enormous challenges to the behavioral health system, as providers struggled to adapt their operations to rapidly evolving conditions. At the same time, Baltimore City continues to be impacted by an ongoing racial trauma pandemic. Racial trauma, a form of race-based stress, refers to reactions experienced by Black, Indigenous, and people of color to dangerous events and real or perceived experiences of racial discrimination. The intersection of the COVID-19 and racial trauma pandemics with the legacy of structural racism has resulted in a disproportionate impact of harm experienced by Black people in Baltimore City. In 2020, the rate of COVID-19 deaths per 100,000 population was 123.7 for Black Americans, compared with 75.7 for White Americans.⁶ Loss of employment, housing instability, and other socio-economic challenges have also had a disparate impact on Black individuals.

Administrative Service Organization Transition

Maryland's transition to a new Administrative Service Organization (ASO) in January 2020 has been enormously challenging for the public behavioral health system. The ASO manages authorization and claims processing for Medicaid reimbursable services. Claim payments have been inaccurate and delayed, and providers do not have the information they need to determine their financial position. During a time of increased costs, as providers adapt operations to maintain service delivery during the COVID-19 pandemic, this situation is particularly challenging.

Limited Resources Versus Need

BHSB has limited funding and infrastructure relative to the broad scope of its state-delegated responsibilities and a heavy workload due to local needs. State funding for service delivery has remained flat for years. The responsibilities formally delegated by the state to its local

⁶ Egbert, A. & Liao, K. (21 December 2020). The Color of Coronavirus: 2020 Year in Review. APM Research Lab. <https://www.apmresearchlab.org/covid/deaths-2020-review>.

behavioral health authorities continue to grow without a corresponding increase in administrative funding.

The current job market intensifies the fiscal challenges. It is difficult for BHSB to offer competitive salaries for people who have the experience and skill set needed for system management work in a large, complex system like the one in Baltimore City. Large health entities are prevalent in the city, which creates a job market in which both BHSB and community-based service providers find it difficult to compete.

BHSB expends substantial administrative resources writing the program plan that LBHAs are required to submit on an annual basis. Approximately 233 staff hours were spent preparing the program plan section of the FY 2022 Plan and Budget document. Multiplying by BHSB's average salary plus fringe rate of \$41.51 per hour yields a total of approximately \$10,000 of public resources. Extending the program report and plan timeline so that LBHAs are required to submit three or five-year plans instead of annual would reduce the fiscal burden and free up staff resources to move the work forward.

The long-term sustainability of grant-funded programs is unclear. Key services within the system of care rely heavily on grant funds, one example being Peer Recovery Specialists. Peers play an essential role in high-quality, person-centered behavioral health service delivery. However, funding for the development, implementation, and ongoing sustainability of peer-delivered services is limited.

Behavioral health providers that experience ongoing flat funding face the same fiscal and staff recruitment challenges that BHSB does. Many operate on tight budgets with limited cash flow. As funding mechanisms have changed and administrative burdens have increased at both the state and city levels, BHSB's cash flow has tightened, making it more difficult to identify funds to temporarily cover payments to sub-vendors when reimbursement to BHSB is delayed. In addition, providers that operate within very tight budgets are not able to adapt as readily to the changes occurring within the system or make the shift in administrative infrastructure needed to move toward a more value-based payment structure.

An influx of federal and state opioid money in recent years has funded urgently needed services to address the opioid overdose crisis. While these resources have been and continue to be welcome, the challenges in addressing the opioid epidemic are highly complex and require long-term strategies. A plan to sustain these programs is needed. BHSB will need to critically consider the priority needs of the city and prepare to make cuts to ensure that grant funds continue to have maximum impact.

Integrated Service Delivery

Behavioral health system integration is a policy imperative set by the General Assembly in the 2017 Maryland state budget. Across the state, local jurisdictions are in various stages of

integration, and the BHA's goal is to develop infrastructure and processes to support continued integration, using a framework of shared accountability between the BHA and local jurisdictions.

BHSB was created in 2013 through the merger of the city's Core Service Agency (CSA) and Local Addictions Agency (LAA). While the merger allowed BHSB to leverage resources to promote quality and advance public education, advocacy, and data analysis, integration has been an ongoing process.

During the fall of 2020, local jurisdictions were required to complete a tool to self-assess the current level of integration across key system management domains:

- Leadership and Governance
- Budgeting and Operations
- Planning and Data-Driven Decision Making
- Quality
- Public Outreach, Individual and Family Education
- Stakeholder Collaboration
- Workforce

The tool requires jurisdictions to rate themselves for each domain, with the highest being a level three. Based on the criteria in the tool, BHSB assessed itself at level three for each domain except for Quality, which was a level two. Of the seven domains, this is the one that lists the direct client experience in the description of the domain. While BHSB is organizationally structured to perform its training, complaint investigation, and performance improvement activities in an integrated manner, the impact of integration to the individual, family, and/or community in the Quality domain is not fully realized. Consumers continue to experience service delivery that is not integrated. Advancing toward a more integrated experience at the service recipient level is dependent upon factors outside the scope of authority currently granted to the LBHA. Some of the barriers include:

- no reimbursement structure for integrated service delivery,
- no authority at the local level to require specific system-wide programmatic components such as integrated service delivery or evidence-based screening tools or assessments,
- limited access to data beyond the paid claims data from the ASO, and
- limited authority at the local level to enforce quality and provide sanctions for poor service delivery.

Electronic Consent to Share Substance Use Treatment Information

The U.S. Department of Health and Human Services (HHS) implemented changes to Confidentiality of Alcohol and Drug Abuse Patient Records regulations (42 CFR Part 2) in March 2017. These changes were intended to facilitate health integration and information exchange within health care models, while continuing to protect the privacy and confidentiality of patients seeking treatment for substance use disorders (SUD). To date, Maryland has not yet implemented a consent tool that will enable timely access to SUD data for primary care and behavioral health providers, hospitals, and care coordinating entities. This is a significant barrier to integration of care.

Chesapeake Regional Information System for our Patients (CRISP), which is Maryland's statewide health information exchange, is developing a consent tool that will enable SUD consumers to consent to having their SUD data shared with HIE participants, including hospital and ambulatory providers, care coordination entities, and payers. BHSB is monitoring this development and looks forward to the anticipated deployment in June 2021.

State Financing and Regulatory Structure Change

The work of LBHAs has and will continue to undergo significant change as the landscape of behavioral healthcare financing and regulatory structures shifts to promote integration, increased access, and improved outcomes. States are implementing an array of approaches to value-based payment models, all of which require capacity to use data to improve outcomes at the provider level. BHSB is working to develop the internal knowledge of new payment models to help prepare the provider system for these changes through training, technical assistance, and change management support.

The all-payor model of reimbursement for hospitals is complicated, which increases the difficulty in devising meaningful partnership strategies between hospitals and community-based providers. Economic incentives are in many cases not aligned across payment systems, which further complicates such efforts.

Discussion at the state level regarding moving from a Medicaid carve out structure to a carve in is another possible challenge. This change would result in all Medicaid funding being managed by the nine Managed Care Organizations (MCO) in the city, rather than the single Administrative Service Organization (ASO). This change could potentially result in unnecessary complications in the management of state general dollars for services for uninsured individuals or for services that Medicaid does not pay for, both of which are a large component of BHSB's work. Across the country, behavioral health systems that are regarded as the most successful include strong local management. Any change in the system of care should include a well-resourced local system management entity with the proper autonomy and authority to achieve its goals.

Changes in Leadership at State and Local Levels

There have been ongoing changes in leadership at both the state and local levels over recent years, which has made moving the work forward more difficult. The lack of historic knowledge as people change positions results in an increased administrative burden. In addition, the partnerships needed to develop new, innovative, and sustainable service delivery have suffered as key positions at the city and state change.

Role of the LBHA

To maximize impact in local planning and management, LBHAs must have the stature and authority to perform those functions. However, the role that the LBHA plays in the system of care is not always clear. Continued work to develop clarity around roles and authority within the behavioral health system would support LBHAs getting to and being successful at the table with hospitals, physical health care organizations, and other system partners for decision making that impacts people living with mental illness or substance use.

BHSB works on an ongoing basis to build better relationships with the 12 hospitals in the city. This is challenging given the sheer number of hospitals and the size and complexity of each health care system. However, it is essential for hospitals, health care organizations, behavioral health providers, and other system partners to collaborate to ensure that people access effective, high quality, culturally appropriate services through a “no wrong door” model. Because LBHAs hold relationships with the provider network and other system partners, such as the Departments of Social Services and Juvenile Services, judiciary, police, fire, etc., they are well-situated to facilitate cross-system collaboration.

Housing

BHSB regularly receives complaints from consumers, families, and behavioral health providers about housing for individuals who have behavioral health disorders. Some programs that promote themselves as supportive housing or recovery housing do not have State of Maryland certification. Unfortunately, the BHA does not monitor housing that is not certified, and BHSB, as the LBHA, does not have authority to investigate complaints. A comprehensive approach at the state level that creates a mechanism to monitor non-certified programs and far-reaching communication on how concerned citizens can file a complaint is needed.

Additional Challenges

Some of the other barriers to expanding the depth and reach of the public behavioral health system (PBHS) in Baltimore City include:

- Baltimore City mirrors the statewide trend of underutilization of the PBHS by individuals over age 65. Transportation and mobility issues have been identified as key barriers, but there is much to be learned about access to care issues in this population.

- Providers are reluctant to prescribe, and consumers are hesitant to take, medication to assist with substance use disorders.
- Communities are often opposed to having behavioral health services located in their neighborhood, particularly medication assisted treatment services.
- Family-focused interventions are limited in scope and number within the system of care.
- While opioid use and overdose are significant problems and much more is needed to continue addressing the epidemic, reducing the impact of substance misuse cannot be done without acknowledging and making efforts to reduce the impact of alcohol use disorder.
- Implementing, promoting, and holding providers accountable for quality clinical and service delivery standards is difficult when payment is not directly linked to outcomes.
- The current system of care is not designed for a consumer to have a no wrong door experience when requesting help in which the provider either directly serves the consumer or, if unable to fully meet their needs, links them with a warm hand off to a service that would provide the needed services.
- There are not enough bilingual, behavioral health practitioners, and those who exist are in high demand. Salaries that community-based providers can afford are often not competitive.

C. Organizational Structure

As an integrated organization and under the leadership of our Chief Executive Officer (CEO), BHSB’s vision, mission, and values guide the work of building an efficient and responsive system that comprehensively addresses behavioral health across the lifespan.

Vision Statement

We envision a city where people live and thrive in communities that promote and support behavioral health.

Mission Statement

BHSB’s mission is to develop, implement and align resources, programs and policies that support the behavioral health and wellness of individuals, families, and communities.

Statement of Values

BHSB embodies the following values in our work:

- Integrity
- Equity
- Innovation
- Collaboration

- Quality

Organizational Structure

BHSB employs approximately 110 individuals, including public health professionals, licensed behavioral health professionals, and people with lived experience with mental illness and/or substance use disorders. BHSB is led by Crista M. Taylor, a clinical social worker and leader in behavioral health in Maryland with more than 25 years of experience in this field. BHSB is overseen by a Board of Directors, with the Baltimore City Health Commissioner serving as Chair. The Board of Directors serves in a governing role, guiding the strategic vision for the organization and, in addition, serves as the local mental health advisory council and the local drug and alcohol council as defined by the State of Maryland.

BHSB's organizational structure (Addendum A) supports a growing scope of work. It ensures responsiveness to the needs within the changing system, and it establishes the organization as a leader in the new, integrated healthcare landscape. The organizational chart includes staff and represents the reporting structure up to the CEO.

With the retirement of BHSB's Chief Financial Officer effective December 31, 2019, the position was divided into two: Vice President of Finance and Chief Financial Officer, and Vice President of Operations and Chief Operating Officer. This decision was made to support the organization's capacity to be nimble, flexible, and adaptive to change. The environment in which BHSB functions is evolving, and finance and operations, which are at the heart of the work, must remain strong and capable. This meant a structure change for BHSB during 2020 with the creation of an Operations Department.

The six departments within the organization are:

- President's Office
The President's Office is responsible for ensuring the organization is striving to meet its mission, aligning the work with the values of the organization, and effectively and efficiently managing day-to-day programmatic, operational, and fiscal activities. Coordination of Board of Director activities, human resources, and procurement are also managed within the President's office, as well as oversight of select projects that cross all departments.
- Policy and Communications
Policy and Communications uses advocacy and communications strategies to advance evidence-based practices, policy reforms, and mobilize community action. The department manages internal and external communications for BHSB, oversees government and community relations, and implements public education and advocacy campaigns to create positive change. BHSB participates on several coalitions and collaborates with a range of partners to advance policies that support

behavioral health and wellness. The department has a dedicated provider relations contact to assist providers with getting information and support from BHSB.

- Accountability

Accountability works collaboratively with behavioral health provider organizations to support high-quality behavioral health services in Baltimore City. This department provides oversight and support for providers in a variety of ways, including training and technical assistance, compliance audits, and the facilitation of consumer quality activities. The department also manages provider complaints, investigations, and critical incidents.

- Operations

Operations works to increase BHSB's capacity to be nimble, efficient, and adaptive to change. Specifically, the goal of the department is to ensure that BHSB is effectively meeting its mission by strategically implementing and supporting processes that align resources and decision making across the organization. The department facilitates cross-organizational processes, maintains a secure electronic network, facilitates a data-driven approach to BHSB's work with analytics and other data products, advances a harm reduction philosophy and practices, collaborates with community stakeholders to implement activities designed to prevent substance misuse and reduce its health and social consequences, and provides medical consultation to support the clinical work of various teams. In addition, Operations oversees the organization-wide implementation of the strategic plan.

- Programs

Programs works to develop and manage a range of early intervention, treatment, and recovery services for individuals and families with mental illness and/or substance use disorders. The department oversees services within the larger Medicaid fee-for-service system, as well as those directly funded by BHSB through private and public grants, including child and family services, peer support services, medication-assisted treatment, criminal justice diversion, and crisis services for youth and adults. The team collaborates with providers, city and state agencies, and other system partners to implement best practice programming and new or innovative pilots.

- Finance

Finance manages the financial and contracting operations of the organization. The department provides oversight of private and public grant or funding awards, contracts issued to sub-vendors, grants accounting, general accounting, and payroll for organizational-wide work. Activities include contracts issuance, tracking of contract deliverables, payroll processing, tax reporting, managing organizational risk,

preparing organizational and sub-vendor budgets including assurance that all funds are properly utilized and expended, financial statement preparation, and oversight of audits.

Relationships with Other Key Entities

As stated above, the attached organizational chart includes staff only, as BHSB is a nonprofit organization. However, BHSB works closely with the other entities listed in the instructions pertaining to this section of the report. As the city's public health agency, the Baltimore City Health Department (BCHD) leads the overdose response and chairs the Overdose Intervention Team (OIT). BHSB participates on the OIT and the city's Opioid Fatality Review team, which is also chaired by BCHD. To facilitate communication and coordination, BCHD staff participates in BHSB's internal overdose response work group. BHSB's Chief Operating Officer holds an ex officio seat on the Board of Directors for Family League of Baltimore (Family League), which is the city's local management board. BHSB staff participates on the Local Care Team, which is housed within Family League and works with parents, guardians, and other adults on children's behalf to coordinate interagency care. Staff from BHSB's Programs and Accountability Departments work closely with the Administrative Service Organization to oversee the provider network in Baltimore City. As noted above, BHSB's Board of Directors serves as the local mental health advisory council and the local drug and alcohol council as defined by the State of Maryland.

D. FY 2020 Highlights and Achievements

While service utilization data for FY 2020 is not available due to challenges in the ASO system, Baltimore City is consistently the most represented jurisdiction in the public behavioral health system despite not being the most populous jurisdiction in Maryland. According to the National Survey on Drug Use and Health (NSDUH) for 2016-2018, 12.66% of Baltimore City's population received mental health services during each of those three years. Since this rate seems relatively steady for the years referenced, we can assume that approximately 77,000 people received mental health services in Baltimore City in 2019. Estimating based on last year's public behavioral health system numbers, it is likely that an additional 26,000 individuals received substance use disorder services, not including those who are dually diagnosed. While not all of these consumers participated in the public behavioral health system, the numbers point to a large number of individuals receiving behavioral health care services in both the public and private systems.

In FY 2020, BHSB awarded \$45 million in grant funds, with 254 contracts issued to 109 organizations and consultants. Grant funds are used to purchase needed services and supports that are not currently reimbursable by public insurance payers.

Key FY 2020 Highlights

- 39,999 people called the Here2Help Hotline line for assistance.
- 14,244 people were trained on overdose prevention and how to administer naloxone, and 14,068 naloxone kits were distributed.
- Peer specialists in Wellness and Recovery Centers provided 5,705 peer encounters, of which 1,445 were one-on-one support sessions.
- 9,210 children and youth received individual treatment services through the Expanded School Mental Health program.
- 7,804 teacher and parent consultations were provided through the Expanded School Mental Health program.
- 941 children received early childhood mental health services within Head Start centers in Baltimore City.
- BHSB is co-leading the Collaborative Planning and Implementation Committee (CPIC) to meet the behavioral health requirements of the Consent Decree between Baltimore City, the Baltimore Police Department, and the Department of Justice.
- BHSB released nine competitive procurements resulting in 53 contracts with 47 unique organizations, 16 of which were new to BHSB. Total funding awarded is over \$2.6 million.

Anti-racism

One of BHSB's core values is Equity, and our strategic plan includes a goal of increasing health equity in Baltimore City. To build capacity to advance this goal, BHSB is actively engaged in becoming an anti-racist organization.

This work is enormously challenging and can only happen with deep commitment across the organization. The Equity and Inclusion workgroup, which is comprised of BHSB employees representing every department and all levels of the organization, serves as a champion. It functions in the role of change agent to promote a more equitable and inclusive workplace and citywide system of care. Among other activities, this workgroup partnered with BHSB's CEO to conduct an organizational assessment during the fall of 2019 and again during the fall of 2020. While the results showed improvement from 2019 to 2020, there is still much work to be done in advancing BHSB's anti-racist work. Some themes that emerged were a need to better communicate BHSB's anti-racist work across the organization, particularly among supervisors, and a need for additional measurements to track BHSB's anti-racist work.

Building a culture of trust is essential because anti-racism work is hard and can be uncomfortable. Navigating the challenges of COVID-19 helped BHSB evolve a culture that

prioritizes connection. Monthly all staff meetings have become bi-weekly, and the online forum offers a regular opportunity to check in, express appreciation for one another, share information, participate in a wellness activity, and engage in team-building activities.

This past spring and summer, following the high-profile killings of several Black people, BHSB released a public statement declaring its support for the Black Lives Matter movement. A series of facilitated conversations were held so staff had an outlet to talk about their feelings and concerns related to these deaths and the broader landscape of racism and white supremacy in the United States. BHSB also honored Juneteenth by having a presentation and closing operations early.

One important step in dismantling white supremacy culture is to value and practice communication strategies beyond the written word. Bi-weekly all staff meetings provide a consistent and predictable forum to talk about changes that impact BHSB and the system of care.

One of the themes that arose from the 2019 racial justice organizational assessment was staff education, which has been a focus of the Equity and Inclusion workgroup during 2020. It hosted monthly “Lunch & Learns” with relevant topics to share information and engage staff in conversations. It is also developing an Equity Syllabus for the organization and formed a work group focused on human resources to begin reviewing data, policies, and practices.

Several workgroup members partnered with Jo Anne Stanton, who taught *The Psychology of Racism* at Sojourner Douglass College and currently teaches at Morgan State University, to create a training series entitled *Racism Education with Engagement of Leaders into Liberation (REELL) Training*. It has a behavioral health lens and is tailored specifically to BHSB, with the goal of advancing our capacity to become an anti-racist organization. The objectives of the REELL curriculum are that participants will be able to:

1. define systemic racism,
2. acknowledge that systemic racism exists,
3. understand the impact of systemic racism, and
4. advance beyond shame and blame to focus on measurable solutions.

The curriculum includes four sessions, which are scheduled during December 2020 – February 2021. BHSB is closing operations during each session to support staff’s ability to attend.

During the summer of 2020, BHSB applied for and was accepted to participate in the National Child Traumatic Stress Network’s *Being Anti-Racist is Central to Trauma-Informed Care: From Awareness to Action* virtual summit initiative. Its goals include:

1. modeling the nature of the work as an ongoing process rather than a single event,
2. inspiring action at an organizational level, and

3. moving to action.

The initiative includes a continuum of activities, beginning with a competitive application process, periodic assignments, a virtual summit day in September, follow up action-oriented activities, and technical assistance from faculty members. BHSB is using the resources to develop and implement strategies to advance its progress in becoming an anti-racist organization.

Anti-racist activities are beginning to emerge across BHSB's departments and workgroups. To support this movement, the next phase of work is to create an organizational framework that presents the anti-racist actions BHSB commits to take and measures by which we will hold ourselves accountable. A group comprised of a cross-section of staff will begin working to create this framework during the winter of 2021.

Organizational Operations

As described in *Section C. Organizational Structure*, with the retirement of BHSB's Chief Financial Officer effective December 31, 2019, the position was divided into two: Vice President of Finance and Chief Financial Officer and Vice President of Operations and Chief Operating Officer. This decision was made to support the organization's capacity to be nimble, flexible, and adaptive to change. The two positions were filled by internal promotions of BHSB staff, who work collaboratively with each other and the CEO, along with the executive and leadership teams and staff from across the organization, to optimize BHSB's operating capabilities. This meant a structure change for BHSB during 2020 with the creation of an Operations Department and reorganization of other areas of work.

Greater Baltimore Regional Integrated Crisis System (GBRICS) Regional Partnership

As described in *Section E. Planning Process*, BHSB collaborated with 17 hospitals, three other local behavioral health authorities, and leaders in Baltimore City, Baltimore County, Carroll County, and Howard County to develop the Greater Baltimore Regional Integrated Crisis System (GBRICS) Regional Partnership. The overall goal is to reduce unnecessary emergency department use and police interaction for people in behavioral health crisis.

The GBRICS Regional Partnership was awarded funding by the Health Services Cost Review Commission. It will invest \$45 million over five years in behavioral health crisis response infrastructure and services. BHSB will provide overall project management.

Here2HelpHotline

BHSB conducted a re-brand process to identify better messaging and communications strategies to promote the city's 24/7 crisis hotline. Throughout the process, BHSB intentionally sought the voices of community members and people with lived experience in decision-making for the new name of the hotline and design of promotional messaging and materials. The re-

branded Here2Help Hotline helps to strengthen access to care by increasing awareness and understanding of how people can get the behavioral health care and support they need.

COVID-19

In response to the COVID-19 pandemic, BHSB began holding weekly provider check-in calls in to support the provider network in adapting operations to new and ongoing challenges. Since March 2020, BHSB has assisted providers with concerns such as:

- COVID-positive (+) test results among staff and consumers,
- personal protective equipment needs,
- changes in program hours or services,
- storing consumer medication at residential treatment and recovery facilities,
- support for consumers in quarantine, and
- resources, funding opportunities, and other information

Maryland Crisis Stabilization Center

The Maryland Crisis Stabilization Center was moved to its new and permanent location at the Hebrew Orphan Asylum. Its state-of-the-art facilities include 35 beds, although capacity is currently reduced to 17 beds due to COVID-19 protocols.

Healing Us Together (HUT) Project

In June 2021 BHSB began collaborating with the Ministers Conference Empowerment Center CDC to plan the HUT (Healing Us Together) project, in which faith-based and community leaders across 14 council districts use the *S.E.L.F. Community Conversations* curriculum to facilitate conversations. The project name (Healing Us Together) represents family and community, and its acronym (HUT) symbolizes the process of recognizing the unique experiences and perspectives of individuals and families.

The goal of HUT is to engage communities that have been adversely affected by COVID-19 and racial trauma and begin a process of self-healing from toxic stress and trauma to wellness and recovery. In partnership with the Ministers' Conference, BHSB developed and trained the first cohort of faith-based and community leaders and continues to provide ongoing coaching.

Bmore POWER

Bmore POWER is a network of people with lived experience related to drug use. It has grown rapidly due to an infusion of state funds in recent years that has had the goal of addressing the continuing high rates of overdose in the Metro Area. With this growth, it was determined that all Bmore POWER members should be formally integrated into BHSB's organizational structure and become BHSB employees with a position title of Bmore POWER Outreach Worker. With this transition in employment classification, BHSB maintained a flexible structure for Bmore POWER Outreach Workers. The change became effective in January 2020, adding 27 new BHSB

employees, which was a 36% increase. It marked an exciting moment in the ongoing evolution of BHSB’s work to advance a harm reduction philosophy.

E. Planning Process

Access to Care

BHSB collaborates with providers and other stakeholders in an array of projects to increase access points to the system of care and create a “no wrong door” experience for city residents. Some of the key projects and programs are described below.

Greater Baltimore Regional Integrated Crisis System (GBRICS) Regional Partnership

The Health Services Cost Review Commission (HSCRC) Regional Partnership Catalyst Grant Program released a Request for Proposals (RFP) to fund behavioral health crisis services in January 2020. The RFP makes a multi-million-dollar investment in system infrastructure that must be sustainable after the five-year grant term. Key RFP requirements include:

- Hospitals must engage in meaningful community partnership and collaboration.
- Partnerships should focus on the nationally recognized, *Crisis Now* model.
- There must be a plan for sustainability.

The Greater Baltimore Regional Integrated Crisis System (GBRICS) Regional Partnership submitted a proposal that was awarded funding by the HSCRC. It will invest \$45 million over five years in behavioral health crisis response infrastructure and services.

GBRICS was developed with the collaboration of 17 hospitals, four local behavioral health authorities, and leaders in Baltimore City, Baltimore County, Carroll County, and Howard County. The overall goal is to reduce unnecessary emergency department use and police interaction for people in behavioral health crisis. It includes five elements:

1. Care Traffic Control System: Create a regional hotline that is supported with infrastructure for real-time capacity and referrals tracking, coordinated dispatching of mobile crisis response, and dashboard reporting.
2. Mobile Crisis Teams: Expand capacity and set regional standards following national best practices.
3. Walk-in/Virtual Crisis Services: Support behavioral health providers to offer same-day access services to address immediate needs.
4. Community Engagement and Outreach: Support culture change to increase awareness and use of the hotline as an alternative to calling 911 or using the emergency department.
5. Non-profit Multi-Stakeholder Oversight: Drive regional activity and shared accountability.

BHSB will provide overall project management for the GBRICS Regional Partnership. This includes being fiscally accountable for the funding, issuing competitive procurements for the project components, managing day-to-day activities, and supporting collaboration among stakeholders.

Collaborative Planning & Implementation Committee (CPIC)

BHSB continues to work closely with the City of Baltimore, the Baltimore Police Department (BPD), the U.S. Department of Justice (DOJ), and members of the Consent Decree Monitoring Team to address the behavioral health requirements in the City's 2017 Consent Decree with the U.S. Department of Justice. BHSB co-chairs the Collaborative Planning and Implementation Committee (CPIC) and its four sub-committees, which are made of various stakeholders who inform the work: advocacy groups, provider organizations, juvenile/criminal justice partners, Baltimore City representatives, consumers, and family members. The central aim of work is to decrease interactions between people with behavioral health disorders and police.

The subcommittees are responsible for:

- reviewing policies related to BPD's interactions with city residents who may have behavioral health conditions and recommending changes that will lead to modifications in police operations,
- developing new and revising existing behavioral health and related training for police and first responders.
- developing a data dashboard with relevant behavioral health and law enforcement data for the group to review progress, and
- implementing the recommendations from the *Baltimore Public Behavioral Health System Gap Analysis*⁷ report to make improvements to the behavioral health system that will lead to minimizing or eliminating police responding to behavioral health crises.

Interdisciplinary Street Outreach

Street outreach is a critical component of BHSB's crisis response system and recovery-oriented system of care. Whereas other service providers are designed to serve clients who initiate care on their own behalf or to intervene at the time of a crisis, street outreach is designed to proactively canvass communities and develop trusting relationships. This enables outreach workers to identify persons with unmet behavioral health needs early and begin an intervention before the person experiences a crisis.

Following a competitive RFP in FY 2019, FY 2020 was the first implementation year of the Interdisciplinary Street Outreach project. The team leverages local, state, and federal funds to provide integrated, street-based services to people who are not otherwise able to access care.

⁷ <https://www.baltimorepolice.org/baltimore-public-health-system-gap-analysis>

Services include peer support, crisis de-escalation, harm reduction interventions, buprenorphine prescriptions, clinical mental health and addiction assessments and counseling, and expert housing and benefits systems navigation.

In FY 2020, the team played a critical role in ensuring access and continuity to essential services and supplies, particularly buprenorphine, amidst the chaos of COVID-19. Many of the people served were abruptly disconnected from shelter or other living arrangements as they or living companions needed to isolate or socially distance. Many also experienced interruptions or barriers to accessing behavioral health care as health care facilities suspended or altered their service offerings. The team has also been working closely with Emergency Medical Services to increase the number of referrals and develop a real-time referral mechanism for overdose survivors who refuse transportation to a hospital.

During FY 2020, the team achieved the following deliverables:

- Number of persons served: 1,303
 - Of this group, at the time of enrollment:
 - 905 (69%) had a known mental health condition,
 - 647 (50%) had a known “drug abuse” or “alcohol abuse”⁸ condition,
 - 742 (57%) had two or more chronic conditions (defined as a chronic mental health, addiction, developmental disability, or health condition), and
 - 996 (76%) were living in a place not meant for human habitation.
 - Of the persons whose enrollment ended during FY 2020 (970):
 - 280 (29%) exited to “positive” (non-street) destinations and
 - 86 (9.4%) gained or increased their income between start and exit.

Bmore POWER

Bmore POWER (Peers Offering Wellness Education and Resources) is a network of people with lived experience related to drug use. It was started in 2016 by two individuals who participated in BHSB’s Harm Reduction Training (HaRT) Program and has grown rapidly due to an infusion of state funds in recent years that has had the goal of addressing the continuing high rates of overdose. Bmore POWER outreach workers conduct street outreach, educate community members and elected officials about harm reduction, and participate in coalitions that advocate for policies that reduce harm and promote health and wellbeing for people who use drugs. Bmore POWER outreach workers were formally integrated into BHSB’s organizational structure and became BHSB employees in January 2020.

During FY 2020, Bmore POWER:

- trained 10,582 people to prevent overdoses and administer naloxone and

⁸ Language in data collection tool mandated by federal standards.

- distributed 23,347 doses of naloxone.

Critical Incident and Complaint Investigations

As the LBHA for Baltimore City, BHSB has authority designated by the state to provide local oversight of programs and services within the public behavioral health system (PBHS) and to investigate Critical Incidents and Complaints. BHSB partners with the BHA to manage investigations, utilizing a collaborative and consultative approach.

A Critical Incident is an unexpected occurrence involving death, serious physical or psychological injury, or the risk of serious adverse outcome. Critical Incidents offer an opportunity to educate the provider about the latest research and encourage implementation of evidence-based practices and protocols, with the goal of focusing the provider's attention on changing the contributing factors to reduce the probability of such an event recurring in the future.

A Complaint is an expression of verbal or written dissatisfaction that can include, but is not limited to, services, manner of treatment, outcomes, or experiences. Complaints may be submitted by anyone, including program participants, family members, behavioral health professionals, behavioral health program staff, community members, and other stakeholders. As the entity responsible for investigating Complaints, BHSB serves as the voice of consumers, family members, and program staff. Complainants are educated about standards of care, and information regarding services available in the PBHS is shared with stakeholders.

The investigation of a Critical Incident or Complaint addresses (as applicable) clinical services, quality of care, regulations, rights of consumers, and consumer satisfaction. Strong collaborative relationships are built with programs to facilitate the provision of technical assistance. Program staff is educated on ways to operationalize regulations and standards, best practices, trends, and strategies that BHSB is implementing.

BHSB collaborates with providers that require immediate support to achieve compliance. Providers who have had a recent site visit from an accrediting organization or Maryland Medicaid may be required to quickly come into compliance and will be given immediate support. Resolution of a Critical Incident or Complaint could involve addressing consumer satisfaction, revising policies and procedures, complying with regulations, and adopting best practices. The goal of the process is quality behavioral health care that promotes healthy communities and healthy workplaces within the PBHS.

During FY 2020, there were:

- 57 Critical Incidents, all of which have been closed, and
- 119 Complaints, all of which have been resolved and closed.

Enhancements to Sub-vendor Monitoring Functions

BHSB utilizes a team-based approach to contract development and management. A Contract Team, comprised of four members, is responsible for collaborating to develop, monitor, and audit contracts. During FY 2020, BHSB advanced the capacity of the teams to perform these functions by clarifying the various tasks assigned to each of the four members.

During the winter of 2020, BHSB created and implemented an electronic workflow process to streamline BHSB's contracting processes and facilitate internal communication amongst the Contract Team members. The goals were to provide real-time data at the individual user and organizational levels to support informed decision making and increase accuracy, timeliness, and customer service.

The electronic workflow system was implemented for FY 2021 contracting but did not fully support all required functions due to unanticipated limitations in the application software. To prepare for FY 2022 contracting, BHSB developed a list of system requirements and evaluated the cost and functionality of various contract management applications, including BHSB's existing Contract Management System (CMS), which is a web-based, electronic application for contract management and reporting. The decision that resulted from this process was to retain CMS and work with the vendor to develop it to meet BHSB's requirements for FY 2022 contracting.

BHSB issues grants to sub-vendors by executing legally binding contracts. To increase customer service and transparency, BHSB hosted meetings for sub-vendors during the spring of 2020. Key information regarding BHSB's contracting processes was posted on BHSB's website and presented during the meetings, with the goal of supporting sub-vendors in preparing for and successfully fulfilling the requirements of FY 2021 contracts.

BHSB employs various processes to monitor administrative, fiscal, and programmatic contractual performance, one of which is periodic program reports. To standardize procedures for monitoring program reports, BHSB implemented the *Program Report Monitoring Policy* during the summer of 2020.

To inform planning for FY 2022 contracting, BHSB conducted a customer satisfaction survey to collect feedback from sub-vendors regarding their experiences with BHSB's contracting processes. The survey was distributed to 153 sub-vendors, and 32 individuals responded. The key theme that emerged was the importance of proactive and frequent communication. To further enhance customer service efforts, BHSB is implementing six targeted recommendations that emerged from the survey data. A customer service survey will be included as a part of the overall contracting process moving forward.

During FY 2021, BHSB has begun planning the creation of a contract compliance policy. The policy will detail the three key elements of contract compliance at BHSB, which include 1)

program monitoring and reporting, 2) financial monitoring and reporting, and 3) auditing for adherence to contract terms and deliverables. The projected date for implementation is the spring of FY 2022.

More detailed information regarding BHSB's processes to monitor administrative, fiscal, and programmatic contractual performance are described in *Section F: Service Delivery and Recovery Supports*.

Unmet Needs and Gaps

As described earlier in this section of the report (*Section E. Planning Process*), BHSB works closely with the City of Baltimore, the Baltimore Police Department (BPD), the U.S. Department of Justice (DOJ), and members of the Consent Decree Monitoring Team to address the behavioral health requirements in the City's 2017 Consent Decree with the U.S. Department of Justice. This includes implementing the recommendations from the *Baltimore Public Behavioral Health System Gap Analysis* report, which analyzed existing public behavioral health service systems to identify unmet need, service gaps, barriers to accessing care, opportunities for better collaboration, and other recommended system improvements, particularly as they pertain to decreasing or improving interactions with police.

Community and Stakeholder Engagement

Authentic engagement with communities requires systems to share power. Historically, this is not something that systems were built to do and is a massive – yet fundamentally critical - undertaking. One of the legacies of systemic racism in Baltimore City is an earned distrust of large institutions and systems. Building trust with communities will be an ongoing process, and it will require BHSB to continue to evolve an anti-racist organizational culture and operational processes that:

- ensure feedback that is offered is recorded, analyzed, and thoughtfully utilized to inform system planning and resource management decisions;
- create transparency in decision making and resource allocation; and
- develop equitable opportunities for small, community-based organizations that have been historically marginalized to compete for grant funding.

To advance community engagement, BHSB has a dedicated Community Engagement Coordinator who works to build relationships between BHSB and community members. An internal workgroup supports communication and coordinates activities across teams.

Due to historic mistrust and the stigma associated with substance use treatment, many providers, particularly Outpatient Treatment Programs (OTPs), experience challenges connecting with the community members of the neighborhoods in which they are located. Often OTPs looking to operate in a particular community experience significant push back. It

can be very difficult for them to build relationships with community members. BHSB brings together the provider and the surrounding community members to foster relationship building through conversation. When concerns are reported by community leaders or elected officials, BHSB responds by facilitating constructive conversations between community members and the behavioral health provider. These forums provide opportunities for significant stakeholder feedback regarding the availability, accessibility, and quality of services in the system of care.

In addition, at the request of a community and provider, BHSB facilitates the creation of a *Good Neighbor Agreement*. This process includes facilitated discussions aimed at developing partnerships. The goal is to address issues and conditions in the neighborhood that may have a negative impact on consumer safety, treatment outcomes, provider staff, and the quality of life enjoyed by community residents and business owners. During FY 2020, BHSB facilitated four meetings between community leaders and new providers and attended 31 community meetings as behavioral health experts.

As described in *Section F. Service Delivery and Recovery Supports*, BHSB conducted a re-brand process during FY 2020 to identify better messaging and communications strategies to promote the city's 24/7 crisis hotline. Throughout the process, BHSB intentionally sought the voices of community members and people with lived experience in decision-making for the new name of the hotline and design of promotional messaging and materials. Promoting a citywide hotline, re-branded as the Here2Help Hotline, that reflects the voice and perceptions of our community, helps to strengthen access to care by increasing awareness and understanding of how people can access the behavioral health care and support they need.

Another significant process that involved stakeholder input is the *Baltimore Public Behavioral Health System Gap Analysis (Gap Analysis)* report. Key informant interviews or focus groups included 166 individuals, of whom at least 48 were consumers or family members. The development of the Gap Analysis report was overseen by the Collaborative Planning and Implementation Committee (CPIC), which was formed to oversee the behavioral health components of the Consent Decree and includes representation from more than 65 entities, including community-based and hospital providers, city and state agencies, philanthropists, advocates, people with lived experience, their families, and other stakeholders.

Local and State Behavioral Health Advisory Councils

The BHSB Board of Directors serves as both the local mental health advisory council and the local drug and alcohol council. The Maryland Behavioral Health Advisory Council is a statewide council that promotes a coordinated, high-quality, and culturally competent system of care. BHSB participates in the Planning Committee, which engages in a year-long planning process to develop the Maryland Behavioral Health Plan and Federal Mental Health Block Grant Application.

Behavioral Health Disaster Plan Activities

BHSB coordinates with the Baltimore City Health Department (BCHD) and the City of Baltimore in the event of a public emergency. In this role, BHSB is responsible for the following functions:

1. Before emergency situations, BHSB:
 - a. Reviews and updates the Baltimore City Behavioral Health Disaster Preparedness Plan.
 - b. Identifies and trains BHSB's response team.
2. During emergency situations, BHSB:
 - a. Coordinates with BCHD to determine the types of behavioral health resources required, ensures adequate behavioral health services are available, and ensures accurate information on mental health resources is disseminated to the public.
 - b. Collaborates with crisis service providers to deliver emergency behavioral health professionals at programs, emergency shelters, and other locations as needed.
 - c. Monitors operational status of behavioral health providers and assists to overcome barriers faced by providers, consumers, and communities.
3. After emergency situations, BHSB:
 - a. Assesses community needs for ongoing and/or long-term disaster recovery services and identifies resources to provide those services.
 - b. Participates in debriefing sessions with emergency responders.
 - c. Completes a report of the emergency response, including number of people served, types of services provided and recommendations to improve planning, response, and recovery activities in the future.

Beginning in March 2020, BHSB performed new emergency response activities related to COVID-19. Activities such as surveying providers on operational needs, linking providers experiencing COVID-19 outbreaks at their programs to BCHD medical and contract tracing resources, and conducting regular online provider update calls will be incorporated into the next revision of the Behavioral Health Disaster Preparedness Plan.

F. Service Delivery and Recovery Supports

Services Across the Lifespan

The behavioral health system of care in Baltimore City is large and complex with multiple funding mechanisms and a diverse spectrum of stakeholders. BHSB manages a full range of services across the life span from prevention and early intervention to treatment and recovery.

Most public behavioral health system (PBHS) services are reimbursed through a statewide fee-for-service system. In addition to overseeing these services, BHSB secures and directly awards public and private funds to support the development of innovative programs and the ongoing operations of behavioral health services not reimbursable by the fee-for-service system.

Services within the fee-for-service system include:

- outpatient mental health and substance use disorder treatment,
- medication assisted treatment for substance use disorder,
- intensive outpatient and partial hospitalization,
- inpatient treatment,
- psychiatric and residential rehabilitation,
- residential substance use disorder treatment,
- respite care,
- residential crisis,
- targeted case management,
- mobile treatment,
- assertive community treatment, and
- supported employment.

Services directly funded by BHSB include, but are not limited to:

- assertive outreach,
- court-based assessments,
- mobile crisis response,
- methadone home delivery,
- housing supports,
- school-based services,
- wellness and recovery centers,
- harm reduction training,
- harm reduction outreach and naloxone distribution,
- peer support,
- prevention,
- early childhood services, and
- specialty services tailored to meet the unique needs of special populations such as older adults, people experiencing homelessness, women with children, and individuals involved in the criminal justice system.

Special Population Groups

The BHA identifies special population groups that are prioritized for substance-related and mental health disorders service delivery:

- Substance-related Disorders (SRD) Services and Other Addiction Services
 - Individuals at risk for relapse due to an unstable recovery/living environment, including individuals experiencing homelessness
 - Individuals with opioid-related disorders engaged in Medication Assisted Treatment (MAT)
 - Individuals identified as intravenous drug users
 - Individuals transitioning from incarceration to the community
 - Individuals who are HIV positive
 - Individuals with co-occurring disorders
 - Individuals with other addiction disorders such as gambling and tobacco use
 - Pregnant women and women with children
- Mental Health (MH) Services
 - Individuals with serious and persistent mental illness and co-existing conditions, including, but not limited to, individuals: with court and criminal justice involvement, with traumatic brain injury (TBI), experiencing homelessness, with co-occurring disorders, who are victims of trauma, and who are deaf and hard of hearing
 - Individuals transitioning from more intensive level residential rehabilitation program (RRP) services to supportive housing
 - Individuals transitioning from RRP to independent living
 - Individuals who may have forensic involvement and are ready for discharge from a state hospital
 - Transitional aged youth (TAY) transitioning from residential treatment centers, state hospital, group homes, therapeutic group homes, or community into other MH services

While there is some overlap, the special population groups are not integrated across behavioral health, with separate lists maintained for substance-related and mental health disorders. BHSB oversees a wide array of programs across Baltimore City's PBHS that addresses the needs of BHA's designated groups. Although funding streams are separate, BHSB works with providers to integrate service delivery when possible. These programs are discussed in more detail below.

Here2Help Hotline

Baltimore City has one number, the Here2Help Hotline, to call for confidential advice, counseling, emotional support, suicide prevention, crisis intervention, and help accessing mental health and substance use disorder services. Services also include general resource

information, telephone outreach to individuals for whom an intake appointment was scheduled, and assistance with obtaining health insurance if needed. The Here2Help Hotline operates 24 hours per day, seven days per week, and is staffed by behavioral health professionals qualified to respond to a crisis or suicidal emergency.

Over the fifteen years that the hotline has been in operation, there has been an increase in calls, from a total of 26,833 calls in FY 2006 to 39,999 in FY 2020.

Crisis Services for Adults

Crisis services available to adults in Baltimore City include mobile crisis services, a 21-bed residential crisis program, targeted case management services, and an 18-bed residential withdrawal management program for adults. In FY 2020, Baltimore City expanded mobile crisis services to include the hours of midnight to 7am, bringing the city to 24-hour mobile crisis services availability.

In FY 2020, crisis services:

- responded to 33,097 hotline calls,
- provided mobile crisis response to 2,452 individuals,
- successfully diverted 892 of 1,316 (68%) emergency department referrals from inpatient hospitalization,
- completed 659 admissions to residential crisis services, with 68% of those served having a co-occurring substance use disorder, and
- maintained an occupancy rate of 90% for the residential crisis beds.

Crisis Services for Children and Families

Baltimore Child and Adolescent Response System (BCARS) is the youth crisis services provider for Baltimore City. BCARS' youth community stabilization program offers urgent care appointments and intensive community-based services and supports to promote family preservation and/or stabilize a child's placement. It also provides limited mobile crisis response services to the Baltimore City Public School system and youth in foster care. BCARS currently operates Monday - Friday from 8:30 am to 7:00 pm, but 24/7 telephonic support for youth and families in crisis is provided through the Here2Help Hotline. Baltimore City's youth crisis response system also includes respite care services.

In FY 2020, BCARS responded to 1,223 Here2Help Hotline calls. Of those calls, 481 youth received triage services and linkage to community resources, 190 received a formal assessment, and 165 were admitted to individualized BCARS services.

Maryland Crisis Stabilization Center

The Maryland Crisis Stabilization Center (Center) provides safe, short-term sobering services for adults under the influence of drugs and/or alcohol or who were recently revived from an overdose. The Center's innovative model supports recovery in communities, as it helps to link people with substance use disorders to treatment and recovery support services that will help them in overcoming their addiction.

The Center is specifically designed to serve adults under the influence of substances (or recently revived) in Baltimore City who meet the Maryland Institute for Emergency Medical Services Systems (MIEMSS) approved medical criteria for safe transport to the Center, and who can be safely served in a community setting. BHSB worked closely with the Baltimore City Fire Department (BCFD), Baltimore City Health Department (BCHD), and MIEMSS in developing the medical criteria for Center eligibility.

The Center operates 24 hours a day, seven days a week, 365 days a year, and is staffed with a combination of a nurse practitioner, licensed practical nurse, certified nursing assistants, peer recovery specialists, and intake staff. A licensed social worker is on-site 16 hours a day, and staff conducts follow-up outreach for up to 30 days post-discharge.

The Center opened in a temporary location on April 2, 2018 with a capacity of 15 beds (ten beds and five recliners). In October 2020 it moved to a new and permanent location at the Hebrew Orphan Asylum. This state-of-the-art facility has 35-bed capacity, although it is currently reduced to 17 beds due to COVID-19 protocols.

Currently, BCFD Emergency Medical Services (EMS), mobile crisis teams, hospital emergency department referrals, referrals from other community-based treatment providers, and walk-ins serve as the modes of access to the Center. When individuals are ready to leave the Center, staff assists them in connecting with transportation to return to their home, treatment services, or another destination.

Significantly, this project creates a non-traditional access point within the crisis services continuum for individuals with behavioral health disorders who engage in high-risk substance use and related behaviors. Traditionally, crisis services are accessed by calling the 24/7 Here2Help Hotline. This mode of access is dependent upon the individual, concerned family member, or other community member calling the hotline for help, and the individual in crisis agreeing to be visited by the team. Sometimes in the middle of a crisis, an individual may not see the need to call a hotline for behavioral health support, instead ending up in contact with EMS, mobile crisis teams, hospital emergency departments, and other outreach providers. The incorporation of direct referral protocol and training for EMS (and other organizations) supports the integration of emergency and other personnel into the behavioral health crisis response system.

An eleven-member Implementation Board for the Center ensures oversight and accountability of all project partners and oversees a financial sustainability plan. The Implementation Board is chaired by the Behavioral Health Administration's Deputy Secretary and includes the Baltimore City Health Commissioner. Other Board members were nominated by the State of Maryland governor and Baltimore City mayor.

In conjunction with other Center stakeholders, BHSB utilizes an action research paradigm to learn from experiences during both the development and implementation phases of this project to ensure high-quality sobering and crisis stabilization services. A self-adjusting evaluation model assesses the effectiveness of the proposed interventions. Both process and outcomes data are collected and will be used to achieve the following outcomes:

- decrease drug and alcohol-related emergency department visits and
- increase the number of individuals discharged from the Center who are linked to community-based behavioral health services and recovery supports upon discharge or within 30 days.

Key data points include:

- FY 2020: 1,645 admissions with 1,232 unduplicated consumers
- Since the inception of the project in April 2018 through October 2020, 58% of individuals have been linked to community-based behavioral health services upon discharge.

Greater Baltimore Regional Integrated Crisis System (GBRICS)

Beginning in January 2021, the Greater Baltimore Regional Integrated Crisis System (GBRICS) Regional Partnership will invest \$45 million over five years in behavioral health crisis response infrastructure and services. GBRICS was developed with the collaboration of 17 hospitals, four local behavioral health authorities, and leaders in Baltimore City, Baltimore County, Carroll County, and Howard County. BHSB will provide overall project management for the GBRICS Regional Partnership. This includes being fiscally accountable for the funding, issuing competitive procurements for the project components, managing day-to-day activities, and supporting collaboration among stakeholders.

The goals of the five-year project are:

1. Hospitals will experience a reduction in the number of repeat emergency department cases for behavioral health.
2. Minimize encounters with law enforcement or police for people experiencing a behavioral health crisis.

Opioid Crisis Unit

The Opioid Crisis Unit (OCU) offers 12 beds that can serve individuals for up to 96 hours before transitioning to another level of care. Walk-in intake and assessment are available seven days a week, 24 hours a day. In May 2019, it transitioned to the same provider that operates the Maryland Crisis Stabilization Center, which co-located Baltimore City's substance use crisis services.

A consumer experiencing an opioid-related crisis may walk in or be referred by a hospital emergency department, family members, service providers, or emergency personnel such as EMS and police. A multidisciplinary team develops a client-centered recovery care plan with each consumer served in the crisis unit. The recovery care plan is a roadmap for that individual's treatment, as well as being an agreement between the consumer and provider. It identifies the consumer's goals and objectives during the treatment episode and offers relapse prevention education, such as identifying support networks and triggers to support recovery efforts after the consumer transitions from the OCU.

Peer support specialists and care coordinators work in collaboration with the consumer and treatment team to facilitate linkage to the agreed-upon services upon discharge and assure a warm handoff to the next level of care. The services provided at the OCU include:

- urgent/walk-in screening and referral crisis services 24 hours a day,
- clinical crisis stabilization services, such as counseling, de-escalation, treatment, and safety planning,
- nursing/medical assessment for medical clearance by a licensed nurse on site upon arrival,
- monitoring of medical needs throughout the stay,
- evaluation for medication assisted treatment (MAT) and either induction of buprenorphine or linkage to an opioid treatment program (OTP) for methadone maintenance,
- comprehensive biopsychosocial assessment to determine treatment needs,
- American Society of Addiction Medicine (ASAM) assessment by licensed staff to determine the appropriate level of care,
- linkage with a peer support specialist,
- residential stay for up to 96 hours with referral to another level of care as appropriate based on medical necessity,
- care coordination to assist with linkage for ongoing care and warm handoff to the next level of care, and
- up to 30 days post-discharge intensive care coordination targeted to individuals who are deemed at high risk of opioid overdose due to either 1) being discharged from the

Opioid Crisis Unit with no linkage to treatment services or 2) having been readmitted to the center.

During FY 2020, 937 consumers were referred to the OCU, of whom 912 met criteria and were admitted. Of consumers admitted, 643 (71%) were linked to another level of care upon discharge, 95 (10%) left before completing services, 47 (5%) completed services with no further treatment needed, and 127 (14%) were discharged with no services. In April 2020, intensive care coordination was implemented to provide care coordination services up to 30 days post-discharge from the OCU for consumers who were either discharged with no services or readmitted to the OCU, with 137 unique individuals receiving this service. These individuals were linked to resources such as treatment, recovery support/self-help services, housing, entitlements, transportation assistance, and other services and resources.

Early Childhood Services

Early Childhood Mental Health (ECMH) services supported by BHSB were provided in three of the four Head Start centers in Baltimore City, serving 941 children during FY 2020. ECMH ensures that children who are enrolled in Head Start Centers and their families have access to high-quality mental health services that promote optimal social-emotional health and academic success. To be effective, behavioral health service providers in early childhood centers collaborate with teachers, administrators, families, and clinicians to employ sound behavioral health service integration that leads to academic success and is essential to overall health. A special emphasis is placed on ensuring support for children and families during the critical transition from pre-school settings to school settings.

Judy Center Partnership

A partnership between the DRU Judy Center and BHSB affords a mental health consultant who provides the following services to families: Chicago Parent Program, Second Step, mental health workshops, social skills groups, individual and family therapy, consultation with teachers and caregivers and home visits. During FY 2020, 184 youth were served through this partnership.

Behavioral Health Services in Schools

Mental illness and substance use among youth significantly impact youth, families, and communities and contribute to significant challenges in schools, such as chronic absence, low achievement, disruptive behavior, and dropping out. Schools can provide stability, important educational and social supports, and the opportunity to link youth to behavioral health services to which they might not otherwise have access.

BHSB partners with Baltimore City Public Schools (City Schools) to ensure that youth have access to high-quality behavioral health care that promotes social-emotional health and

academic success. BHSB plays a critical role in funding, coordinating, and overseeing a range of behavioral health services for youth and families through the schools.

The Expanded School Mental Health (ESMH) program provided prevention and mental health treatment services in 126 out of 166 (76%) schools to 9,210 youth during the 2019-2020 school year. Annual funding of \$2.7 million for the ESMH program is provided through a long-standing collaboration between BHSB, City Schools, and several private foundations. This funding supports licensed mental health professionals who provide a range of services, including screenings and evaluations, parent and teacher consultations, individual and group treatment, and prevention services to youth at schools. Costs of some mental health treatment services are covered by Medicaid.

Substance use disorder (SUD) prevention, early intervention, and treatment services were provided to students in 15 schools and two school-based sites in Baltimore City. BHSB provides \$525,000 annually to support licensed behavioral health professionals with skills in addictions treatment who provide a range of services, including screenings and evaluations, individual treatment, early intervention services, parent and teacher consultations, and group prevention activities for youth and families. Licensed behavioral health professionals also coordinate closely with School-Based Health Centers and health suites to address students' health care needs and refer for HIV or TB testing.

Transitional Age Youth (TAY)

BHSB oversees three funding resources for transitional age youth (TAY). This funding supports enhancement of Residential Rehabilitation Program (RRP) services for TAY in two Baltimore City RRs and embeds a clinician in a Baltimore City housing program to support the behavioral health assessment and linkage needs for TAY.

BHSB continued its support and close coordination with the new RRP provider selected through a competitive procurement that took place in FY 2019. These efforts were successful in assisting the program with facilitating its first admissions of TAY in May 2020. BHSB is continuing to provide intensive support as the program fully implements these services.

In addition to funding this specific work, BHSB works to ensure TAY are identified as a special population in the larger system of care, providing outreach and education regarding the unique needs of TAY, and identifying opportunities for the system of care to be more responsive.

U-TURNS

U-TURNS (Trauma, Unity, Recovery, Navigation and Safety) launched in February 2017. It utilizes a trauma-informed approach, with the goal of creating a safe space where young people who have been exposed to violence, chronic stress, and trauma can be supported to fulfill their positive potential. It is funded under the National Child Traumatic Stress Initiative by a five-year

award from the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services.

Peer navigators engage youth through street outreach and support them in reaching their goals through peer support, yoga, tai chi, acupuncture, and *S.E.L.F. Community Conversations*, which is a model that uses structured dialogue and culturally appropriate exercises to address the learning points that accompany exposure to trauma, abuses, and other forms of adverse conditions. S.E.L.F. is an acronym (Safety, Emotions, Loss, and Future) that identifies these four facets of universal human responses to complex and potentially dangerous life circumstances. The goal is to focus on the effects of exposure to trauma, which include loss of safety, inability to manage emotions, overwhelming losses, and a paralyzed ability to plan for or even imagine a different future.

Program implementation was significantly altered in March 2020 in response to the COVID-19 crisis. U-TURNS uses an in-person service delivery model, and the model has required continuous adjustment to adapt to remote operations online to comply with state and federal guidance that requires social distancing during the COVID-19 public health emergency.

U-TURNS serves a vulnerable population that includes transitional age youth (TAY) experiencing homelessness and their families. All TAY are vulnerable during the COVID-19 crisis, but homeless TAY are at an even higher risk. According to the Centers for Disease Control and Prevention (CDC) COVID Data Tracker (December 2020), homeless youth are disproportionately African American and are largely unsheltered with an increased propensity of poor underlying health. The COVID-19 crisis disproportionately raises barriers for homeless TAY, as these underserved families lack economic resources to access services remotely independent of supports from programs like U-TURNS.

During U-TURNS 2020 grant year (October – September 2020), peer navigators made a total of 2,186 street outreach encounters. Outreach efforts have shifted from in-person, street outreach to virtual online methods since March. Peer navigators formally enrolled 41 young people into U-TURNS, with 55% of the young people enrolled choosing to meet with mental health therapists to benefit from deeper clinical interventions. Participants attended at least one *S.E.L.F. Community Conversation* peer-led group each week. Participants also attended at least one acupuncture, yoga, and/or mindfulness session during the grant's 2020 fiscal year.

Family Peer Support

Parents, caregivers, and family members of children with emotional and behavioral health challenges need significant support and education resources. BHSB supports a statewide network of parent-peer supports through funding and technical assistance provided to Maryland Coalition of Families (MCF). MCF utilizes a Family Peer Support Specialist (FPSS) model. This model pairs individuals with lived experience as caregivers for a child with mental

health, substance use, and/or other behavioral health conditions, to provide support to parents in similar caregiver roles. These supports can include helping families navigate services and systems, attending meetings with families, explaining rights and responsibilities, and providing opportunities to meet with individuals in similar, stressful roles. There is no cost to parents/caregivers for services, which reduces barriers to engagement and support. Expansion of these services to support loved ones of all ages who are impacted by individuals with a Gambling Disorder began during FY 2018 and has continued through FY 2020. BHSB has also utilized funding from the Maryland Department of Human Services to expand the work of MCF to support families served by the Baltimore City Department of Social Services.

MCF provides webinars and family trainings on behavioral health topics and coordinates the Family Leadership Institute, which provides education and resources to parents, caregivers, and family members of children with emotional and behavioral health challenges. It is also an active partner in the *Children's Mental Health Matters!* campaign with the Mental Health Association of Maryland.

Medication Assisted Treatment (MAT)

In January 2017, BHSB released a report that quantified a significant unmet need for medication assisted treatment (MAT) services in the city. The estimated number of opioid users was 24,887, which represented the number of individuals potentially in need of MAT. The MAT treatment capacity in Baltimore City was calculated to be 17,587, which was based on opioid treatment program (OTP) and buprenorphine providers' self-report of capacity. These numbers yielded an estimated capacity deficit of 7,300.

To address this need, BHSB collaborates with state and local partners to expand access to MAT through the Buprenorphine Initiative, which has the goal of expanding uninsured individuals' access to buprenorphine within traditional treatment and non-traditional settings. Office Based Opioid Treatment (OBOT) provides services in six traditional substance use treatment programs. During FY 2020, 76 uninsured individuals were served. Another project, which focuses on non-traditional settings, locates services in low-threshold, peer-run settings and in the Project Connections at Re-Entry (PCARES) Re-Entry van that serves individuals recently released from the Baltimore City jail. During FY 2020, over 80 uninsured individuals were served in two peer-run locations. The COVID-19 pandemic has impacted the service delivery of these projects. Operations have been adjusted to preserve staff and consumer safety, while ensuring no interruption in access to medication and services.

Another MAT expansion project is the continuation of the *Hub and Spokes* project. The goal of the project is to expand buprenorphine medication-assisted treatment by:

- 1) offering treatment on demand by minimizing barriers to treatment, such as limited induction times and transportation,

- 2) subscribing to an individualized and whole person approach to opioid use disorder treatment that includes health integration, case management, counseling, and peer services, and
- 3) increasing the participation of community-based *Spoke* providers in managing and monitoring buprenorphine for ongoing maintenance.

The *Hub* site is located at the University of Maryland Opioid Treatment Program. It offers low-threshold, intensive, and on-demand buprenorphine induction and stabilization. It also offers peer support services for treatment engagement, counseling, and health integration. Once individuals are deemed stable, they can be referred to a *Spoke* provider. The *Spoke* providers are community care providers that are willing to manage and monitor individuals' buprenorphine treatment. A community care provider can be a primary care or infectious disease practice, psychiatrist, or outpatient SUD provider that is waived to prescribe buprenorphine, knowledgeable of the disease model of addiction, and willing to work within this integrative model of care. In FY 2020, the *Hub and Spokes* project served 87 unique individuals and developed five *Spoke* providers.

BHSB has also implemented the Patient Medical Engagement project. Individuals who inject opioids and other substances often require hospitalization for serious medical complications of their drug use, including infections of bones (osteomyelitis), heart valves (endocarditis), and severe abscesses of the skin and spine (epidural abscess). Acute medical hospitalization presents a key opportunity to engage patients in effective treatment for opioid use disorder. Unfortunately, because of their medical conditions, these patients often require prolonged sub-acute medical rehabilitation after the acute hospital stay. In these settings, treatment for opioid use disorder, including medications such as methadone or buprenorphine, is often not continued due to administrative and logistical barriers. Without effective treatment, these patients are at extremely high risk of relapse and overdose after discharge from the sub-acute medical rehabilitation facility.

The Patient Medical Engagement project aims to overcome administrative and logistical barriers to effective opioid addiction treatment and connect patients with effective care prior to their discharge from the acute hospital. Project partners during the first year of the project include Johns Hopkins Bayview Medical Center, Bayview Addiction Treatment Services (ATS) Opioid Treatment Program, IBR Reach, and two skilled nursing facilities. During FY 2020, 23 individuals were served.

BHSB also continues to fund the methadone home delivery project. This project ensures that consumers who receive methadone medication experience no interruption to their medication regimen when admitted into skilled nursing facilities or upon becoming homebound. During FY 2020, this project served 218 consumers.

Older Adults

Since FY 2017, BHSB has employed one of the six Older Adult Behavioral Health Pre-Admission Screening and Resident Review (PASRR) specialists in Maryland (“OA Specialist”). This staff person works in close collaboration with the Baltimore City Health Department (which serves as the Area Agency on Aging) as a behavioral health consultant and liaison to systems that serve older adults, such as long-term care facilities, senior buildings, and hospitals. The OA Specialist:

- Conducts follow-up visits with individuals placed in Baltimore-area nursing facilities through the PASRR process, which ensures individuals are appropriately placed in Medicaid-certified nursing facilities in the least restrictive setting possible. Fifteen visits were conducted during FY 2020.
- Provides consultation to assist hospitals working with older adults who need placement and services in the community. Eighteen consultations for nursing home placements, assisted living facilities placements, and linkages to community support services for older adults were provided in FY 2020.
- Conducts presentations and trainings. In FY 2020, the OA specialist conducted eight PASRR presentations, including seven at nursing facilities and one with the Baltimore City Interagency Committee.
- Maintains a list of assisted living facilities that are known by BHSB to have a high level of behavioral health competency. In FY 2020, 11 facilities were on the list.

In FY 2020, as part of the COVID response, the OA specialist additionally:

- Provided supportive contacts to long-term care providers that were under extremely high stress due to COVID.
- Participated in the Baltimore Neighbors Network initiative to reach older adults isolated in their homes.

Additionally, two BHSB-funded older adult outreach teams provided in-home mental health services to 67 older adults who were disconnected from care. Both teams are staffed by a psychiatric nurse, and one of the teams uses telehealth to connect older adults to a geriatric psychiatrist. Both teams have experienced a reduction in staffing over the last ten years as their flat-funded grants have declined in value. During FY 2021, BHSB and BHA are exploring ways to enhance the staffing model. This includes partnering with a Johns Hopkins project funded by the National Institutes of Health that offers older adults peer support. Data about enrolled individuals’ health benefits is also being collected with the goal of better understanding their eligibility for billable services.

While three of the 67 older adults receiving in-home outreach were transitioned to lower levels of care, the remainder continued to need in-home services as of the end of FY 2020. This points

to a gap in PBHS services that is evident in FY 2019 utilization data. Baltimore City mirrors the statewide trend of underutilization of the PBHS by individuals over age 65. The OA Specialist and OA outreach teams have been working to better understand the challenges experienced by this population in accessing care. While transportation and mobility issues have emerged as primary barriers, efforts to explore this issue continue.

In FY 2020, as part of the COVID-19 response, older adult outreach teams adjusted their outreach strategies to include regular telephone check-ins and telehealth visits. However, the teams have been challenged conducting video telehealth visits due to some consumers' lack of access to technology. This has exacerbated the existing gap in access to services for this population.

State Hospital Transitions

BHSB partners with a Forensic Assertive Community Treatment Team (FACTT) to serve individuals with serious and persistent mental illness who are involved with the criminal justice system. Nine individuals were assisted in transitioning out of state hospitals during FY 2020.

In addition, BHSB partners with an Assertive Community Treatment (ACT) team to support people experiencing homelessness to acquire and maintain housing. The team provides in-reach, engagement, and transition planning services to individuals residing in state psychiatric hospitals with complex mental health and other secondary diagnoses who require additional support for discharge readiness. Funding is available for subsidies to help make housing affordable, and the ACT team provides follow-up services after discharge from the hospital for ten individuals. In FY 2020, this project successfully maintained six individuals in the community with safe and affordable housing.

Housing First Pilot is another project that provides increased support to individuals in Baltimore City, Prince George's County, and Montgomery County who are experiencing homelessness. The project assisted 72 individuals with the goal of obtaining and maintaining timely, safe, and affordable independent housing.

Residential Rehabilitation Program (RRP) and Capitation Project

Residential Rehabilitation Program (RRP) programs in Baltimore City have a total of 357 beds serving city residents. There are eight RRP providers located throughout Baltimore City, two of which are programs dedicated to serving the transitional age youth (TAY) population. In addition, there are two providers that participate in the Capitation Project, which has a total of 354 slots that serve city residents and those willing to reside in Baltimore City. For both service lines, BHSB serves as the point of contact for all referrals, which originate from state hospitals or from the community. State hospital referrals are prioritized.

For RRP referrals, BHSB's clinical staff determines the applicant's eligibility and identifies the appropriate level of care (intensive or general). When there are no RRP vacancies, the applicant is assigned to a waiting list. The waiting list is maintained and reviewed on a regular basis to ensure system capacity is fully utilized. Referrals are forwarded to programs when a vacancy becomes available. BHSB clinical staff ensures that individuals who are on the RRP waiting list are connected with other resources. During FY 2020, 308 RRP referrals were received on behalf of individuals seeking RRP services within Baltimore City.

Baltimore City is the site of the state's only Capitation Program. It is offered by two providers to individuals who have a high level of behavioral health needs that are often complicated by somatic health issues. Capitation serves the individuals by providing coordinated services including case management, psychiatric services, employment services, peer support, support groups, medication management and monitoring, and assistance with housing. During FY 2020, 128 referrals were received, and a total of 376 individuals participated in the program.

BHSB continues to work to streamline and structure the referral processes to increase efficiency and support quality of care transitions. Additional goals include tracking demographic data, assisting in increasing capacity, providing an understanding of the needs of the population served, and identifying gaps in services.

Recovery Housing and Rapid Re-housing

The Women with Children Recovery Housing Program provides services for adults who identify as women and have at least one child under the age of 18 in their custody. Recovery housing provides a substance-free living environment for up to one year while connecting consumers to care coordination services. The grant that funds recovery housing requires a fee-for-service reimbursement model to pay for housing, and a separate grant pays for care coordination services.

During FY 2020, 17 unduplicated families were served in the program. Of the ten families who left the program over the year, seven exited to permanent housing. At any given point, about half of all heads of households were either employed or in school, while all consumers were involved in a recovery-oriented service such as outpatient treatment, 12-step support groups, and/or individual counseling.

BHSB identified a significant unmet need to support transitional services into independent housing. Rapid re-housing, which has a strong evidence base for being highly effective in terms of housing retention and cost efficiency, was identified as the best-suited model to address this unmet need in Baltimore City. A portion of the funds that supports recovery housing was allocated to support rapid re-housing, and BHSB released an RFP in the fall of 2018 seeking applicants to provide recovery housing and/or rapid re-housing. Two organizations were selected to provide recovery housing, and one to provide rapid re-housing.

The recovery housing services have been implemented, but rapid re-housing is on hold due to a funding issue that led the selected provider to decline the award. Together with the selected provider, BHSB and BHA have learned that the originally proposed funding amount and funding structure are incompatible with the rapid re-housing model. BHSB is collaborating with BHA to revise and re-release the rapid re-housing component of this RFP.

Outpatient Civil Commitment

There are some Baltimore City residents with serious mental illness that the PBHS has not engaged well in treatment. These individuals may end up involuntarily hospitalized or unnecessarily involved in the criminal justice system, resulting in poor overall health outcomes. The Outpatient Civil Commitment (OCC) program was created to address this need.

The OC program serves Baltimore City residents with a serious mental illness. Access to the program is available if the following three conditions are met:

1. The patient:
 - is currently retained following a hearing at an inpatient psychiatric hospital unit and has been retained during at least one other psychiatric hospitalization within the past 12 months. (This process requires approval from an Administrative Law Judge and can be approved voluntarily or involuntarily.)
OR
 - had two inpatient psychiatric hospitalizations within the past 12 months and would like to enter the program voluntarily.
2. The patient has a demonstrated history of not engaging in available community treatment.
3. The patient is unlikely to seek and/or participate in community treatment upon discharge.

BHSB received federal funding from SAMHSA to implement a pilot OCC program in Baltimore City and subsequently secured funding through the BHA to continue the pilot once federal funding ended. Legislation was passed during the 2017 legislative session to support implementation of the project, and regulations that grant the legal authority to operate the program were promulgated on October 27, 2017.

The program offers intensive outreach and engagement by peer specialists, with the goal of building trusting relationships and connecting people to ongoing treatment to reduce the incidence and duration of psychiatric hospitalization, homelessness, incarceration, and interaction with the criminal justice system, while improving the health and social outcomes of individuals with a serious mental illness. The pilot is being implemented in partnership with the BHA, National Alliance on Mental Illness (NAMI), the Mental Health Association of Maryland (MHAMD), and other stakeholders.

Peer specialists work with the individual, family members, hospital treatment team, and a community treatment provider of the individual's choice to develop a consumer-centered service plan based on the individual's wants and needs. Individuals receive help connecting to behavioral health services, primary and/or specialty care providers, housing support, employment services, entitlements, and benefits.

BHSB is responsible for the full implementation of the OCC project, including reviewing all referrals to ensure that the eligibility criteria are documented sufficiently and that providers are serving individuals in a client-centered manner. The Consumer Quality Team at the MHAMD conducts regular qualitative interviews with participants and relays feedback to project partners. A stakeholder group oversees project design and implementation, monitors project impact, and gathers lessons learned to inform how the pilot might best be expanded statewide in the future. In FY2 2020 a total of seven individuals were referred, of whom four were enrolled in the program. All enrollments were voluntary.

OCC staff continues to build relationships with local hospitals that can refer individuals to the project. Additionally, due to the regulation changes addressing voluntary hospitalization, BHSB has increased marketing of the program to include patients themselves and their loved ones.

Traumatic Brain Injury

BHSB contracts with Mary T Maryland to provide neuro-rehabilitative services for individuals with acquired brain injuries. Services include residential supports that meet COMAR 10.21.05; behavioral management and consultation; cognitive rehabilitation; case management that assists with access to entitlements; coordination of rehabilitation, behavioral health and/or somatic care; habilitation/employment services and assistance that meets COMAR 10.09.46; and individual support services that meet COMAR 10.09.46. During FY 2020, five consumers were served.

Law Enforcement and Behavioral Health

Public safety officials often find themselves on the front lines of responding to behavioral health crises but have few resources available to address the needs of people with serious behavioral health conditions. Meanwhile, people with behavioral health conditions are over-represented in jails and prisons: 65% of inmates meet the criteria for a substance use disorder, and more than half have a mental illness.⁹

Baltimore City has implemented several initiatives to address the criminalization of individuals with behavioral health disorders and increase access points within the system. BHSB works closely with the Baltimore Police Department (BPD) to provide leadership and oversight of

⁹ The National Center on Addiction and Substance Abuse at Columbia University, Behind Bars II: Substance Abuse and America's Prison Population (February 2010).

specific projects, as well as to more generally inform and coordinate efforts within each other's systems.

BHSB, the BPD, National Alliance on Mental Illness Metropolitan Baltimore (NAMI Metro) and the city's two crisis providers, BCRI and BCARS, partnered in 2004 to create a program to train patrol officers to better respond to behavioral health crises. The five partners have maintained a strong collaboration that has supported changes to the approach over time to integrate ongoing learning and quality improvement.

These five partners, in conjunction with the Collaborative Planning and Implementation Committee (CPIC), work together to sustain the Crisis Intervention Team (CIT) program, which is a nationally recognized model for community policing that has proven to keep individuals experiencing mental illness out of jails and improve public safety. CIT helps to improve officers' ability to identify and address behavioral health crises and ensure the safety of officers, individuals in crisis, and bystanders. The collaboration between officers and behavioral health providers assists individuals experiencing the crisis and their families, identifies resources, and ensures officers get the training and support needed to respond. BHSB employs a full-time program coordinator who is a clinician and works out of the police training academy. The coordinator works to fully integrate the training into the police department, facilitate improved provider and police relationships, and implement components of the CIT model.

The CIT program provides all new city officers with 24 hours of Behavioral Health Awareness (BHA) training and selected experienced officers with 40 hours. Officers who complete the 40-hour training are designated as CIT officers and have a primary role to respond to behavioral health crisis calls. This training is currently being revamped and will resume once it has gone through the approval process described below. CIT training results in officers having the knowledge and ability to:

- reduce stigmatization of persons with mental illness;
- prevent unnecessary restraint, incarceration, and hospitalization;
- help prevent injury to officers, family members, and individuals in crisis; and
- link individuals with behavioral health disabilities to treatment and resources in the community.

In FY 2020, eight training classes were held for police recruits at the BPD Academy, totaling 235 trainees.

The Training and Implementation Subcommittee (TIC) of the CPIC continues to meet bi-weekly. Its mission is to create the four trainings required by the Consent Decree:

- Behavioral Health Awareness (Academy training),

- In-Service training (minimum of 8 hours of behavioral health training for all sworn officers in 2020),
- training for 911 and BPD Dispatch, and
- revision of the 40-hour advanced CIT training.

This mission includes developing the training goals, schedules, lesson plans, and subject matter experts to work with the BPD (particularly police instructors), as well as collaboration with the U.S. Department of Justice (DOJ) and Consent Decree Monitoring Team. The first live Behavioral Health Awareness training was held January 22-24, 2020. Due to the COVID-19 pandemic, subsequent Behavioral Health Awareness Academy trainings have had a hybrid approach: trainees are in classrooms in the BPD Academy with subject matter experts brought in virtually. Behavioral health In-Service training for 2020 was intended to consist of Mental Health First Aid, in partnership with the Mental Health Association of Maryland, with an additional two hours for BPD policy related to crisis intervention. Due to the COVID-19 pandemic, the training was revised to be an 8-hour training that was delivered virtually. The content was developed by BPD and consists of modified lessons from the Behavioral Health Awareness Academy training and BPD policies and includes BPD body-worn camera footage for scenario discussions. The In-Service training began in September 2020 and is scheduled to be completed in March of 2021.

A curriculum was developed during FY 2020 to train 911 and Dispatch operators in behavioral health. Several pilots were held in the fall of 2020, and the CPIC and TIC worked with BPD and Baltimore City Fire Department (BCFD), which oversees 911, to create a new diversion protocol. The training is in the pilot phase and will be implemented once that is complete. It is co-facilitated by a behavioral health subject matter expert and trainers from both 911 and BPD Dispatch.

In the latter part of 2020, development of the 40-hour CIT certification training also began. The TIC worked with subject matter experts, the DOJ, and the Consent Decree Monitoring Team to develop an advanced training for CIT officers, who will apply and be selected to participate. This curriculum is currently in the public comment phase, after which it will move into the pilot phase. Because this training cannot be implemented remotely, the delivery will be dependent on COVID-19 restrictions in Baltimore City.

An outgrowth of the CIT program, the Crisis Response Team (CRT), also continued to operate during FY 2020. The CRT is a behavioral health unit within the BPD that consists of a specially trained CIT officer paired with a licensed behavioral health clinician to respond to 911 and other dispatch calls believed to be related to behavioral health crises. The team also provides support to officers responding to behavioral health-related calls across the city and provides outreach and follow-up support to individuals who have had prior contact with the police department and/or the behavioral health system.

After two years of funding from the Morton K. and Jane Blaustein and the Leonard and Helen R. Stulman Foundations to support the start-up and establishment of the CRT, ongoing funding has been secured from the BHA that will allow for the continued sustainability of this initiative. A preliminary analysis completed by the Johns Hopkins School of Public Health concluded that CIT was responsible for a 37.6% reduction in use of force in the Central district compared to the other districts. Furthermore, CIT was responsible for a 9.2% reduction in citizen complaints against officers in the Central district compared to the other districts. Ongoing data collection continues to indicate a higher usage of de-escalation techniques and diversion to community-based resources by the team, as compared to other behavioral health calls for service in the Central District. In addition, surveys and focus groups that were conducted reflected an increased level of confidence among officers in responding to behavioral health calls and an overall positive impact on the culture and attitudes toward behavioral health.

Another initiative that addresses the criminalization of individuals with behavioral health disorders is Law Enforcement Assisted Diversion (LEAD). LEAD is a diversionary pilot program that was launched on February 21, 2017. It provides public safety officials with an alternative to incarceration by diverting people with low-level drug offenses to treatment and support services. Care is provided through intensive interventions such as assertive community treatment, residential substance use disorder services, comprehensive case management, medication assisted treatment, peer support, and other services. LEAD has demonstrated that treatment and recovery support services improve health and reduce recidivism.

LEAD was first implemented in Seattle, WA in 2011. A 2015 study found the following positive outcomes:

- Participants are 58% less likely to be arrested than individuals arrested for similar offenses but not enrolled in LEAD.
- Participants have lower recidivism rates than individuals in the normal criminal justice system, including those in therapeutic or problem-solving courts.
- Criminal justice costs declined by \$2,100 for participants, while control group participants' costs increased by \$5,961.

In addition, an unplanned, but welcomed, effect of LEAD in other states has been the reconciliation and healing brought to police-community relations. LEAD has helped facilitate positive relationships between police officers and residents and strong alliances between police and the behavioral health provider community. Baltimore City has experienced a similar effect within the pilot zone where LEAD is operating.

Initial funding was secured from Open Society Institute; Governor's Office of Crime, Control and Prevention; Abell Foundation; and Morton K. and Jane Blaustein Foundation. Baltimore City

provided one additional year of funding through FY 2019, and state funding has been secured to continue support of the project.

Through the end of FY 2020, LEAD received 329 referrals and served 131 participants.

Individuals who are deaf or hard of hearing

For consumers who are deaf or hard of hearing and meet criteria for public behavioral health services, BHSB provides communication assistance by clinicians and interpreters who are fluent in American Signed Language (ASL) and trained to provide signing communication as part of clinical and rehabilitation services. ASL services are available within the following levels of care: outpatient mental health treatment, residential and psychiatric rehabilitation programs (RRP, PRP), and supported employment program (SEP). During FY 2020, 44 unique consumers were served in outpatient mental health treatment, 46 in PRP, 46 in RRP, and 3 in SEP.

Pregnant women and women with children

BHSB is a partner in the Substance Exposed Newborn (SEN) Learning Collaborative, which is led by Baltimore City Department of Social Services. The purpose of the SEN Collaborative is to support and sustain cross-system collaboration to ensure the safety and wellbeing of substance-exposed newborns and their families. BHSB's role in the Collaborative is to:

- educate behavioral health providers on the substance exposed newborn statute § 5-704.2 Family Law Article;
- serve as a liaison between child welfare, Collaborative members, and substance use treatment providers;
- educate the Collaborative on the system of care to promote access to services;
- educate the Collaborative on relevant issues regarding behavioral health services for parents and family members;
- provide outreach and education to community residents, providers, child welfare agencies, and medical providers related to behavioral health services;
- serve as an expert on current and potential resources and best practices related to behavioral health services and building an effective local system of care; and
- provide non-identifying behavioral health data to the Collaborative as needed to advance its work.

System Partnerships to Advance Integrated Behavioral Health Services

BHSB works to strengthen the continuum of integrated behavioral health services and ensure access to these services through a broad range of collaborative partnerships, including state and city agencies, hospitals, behavioral health providers, people with lived experience and their families, the community, and other system stakeholders and advocates. It is through

partnerships that BHSB will continue to expand access to high-quality care for residents of Baltimore City regardless of which door they enter for services.

Key State and City Partners

Some of BHSB's key state and city partners include: MDH, Department of Juvenile Services, Department of Public Safety and Correctional Systems, Health Services Cost Review Commission, Baltimore City Mayor's Office, Baltimore City Health Department (BCHD), Baltimore City Department of Social Services, Baltimore City Public Schools, Baltimore Police and Fire Departments, and the District and Circuit Courts of Baltimore City. Examples of these partnerships are described throughout this report.

It is important to note the close collaboration between BHSB and the BCHD on a broad range of projects and initiatives. BCHD staff participates in internal collaborative work groups at BHSB to ensure overlapping bodies of work are coordinated and impact is maximized, particularly in the priority work of overdose response. The Baltimore City Health Commissioner serves as the Chair of BHSB's Board of Directors.

Coalitions and Associations

BHSB also works closely with system partners to advance policies that support the behavioral health and wellness of Baltimore City residents. This is accomplished through legislative advocacy and active participation in multiple coalitions and statewide committees including, but not limited to the:

- Baltimore City Substance Abuse Directorate,
- BRIDGES Coalition,
- Maryland Behavioral Health Coalition,
- Marylanders Against Poverty,
- Maryland Association for the Treatment of Opioid Dependence (MATOD),
- Mental Health Association of Maryland (MHAMD) Mental Health and Criminal Justice Partnership,
- Maryland Parity @10 Coalition,
- Baltimore Harm Reduction Coalition,
- Maryland Essentials for Childhood Coalition
- Maryland State Council on Child Abuse and Neglect, and
- MDH's Behavioral Health Advisory Council and its committees.

BHSB is an active member of the Maryland Association of Behavioral Health Authorities (MABHA), which is the association that supports all LBHAs. MABHA meets monthly with MDH leadership, and BHSB's CEO serves on the Executive Committee. Furthermore, BHSB participates with the Maryland Philanthropy Network (MPN), attending meetings regularly, engaging in discussions regarding system needs, and helping MPN plan for educational opportunities for

the Health Funders committee to ensure that the voice of behavioral health and the importance of behavioral health integration is incorporated into its work. BHSB also attends Optum Provider Council and Behavioral Health Advisory Council meetings.

Policy and Advocacy

BHSB works closely with the Baltimore City Council and the Baltimore City state delegation to reform the behavioral health system and support behavioral health and wellness in Baltimore City. Through a collaborative stakeholder-informed process, BHSB develops bi-annual policy priorities that outline the policy efforts for which BHSB will be advocating in the coming year. BHSB has a dedicated staff person who proactively and systemically addresses the growing need to promote positive relationships between providers and communities. BHSB meets with community members, their elected representatives, and providers to facilitate constructive conversations and establish good neighbor agreements.

BHSB is also actively involved in the state's planning efforts to restructure the system of care. This process involves a 12-member work group, of which BHSB's CEO is a member representing MABHA, and multiple stakeholder collaborative discussion groups in which BHSB regularly participates.

Provider Engagement

BHSB is responsible for overseeing hundreds of providers within Baltimore City's public behavioral health system (PBHS) and has a dedicated Provider Relations Manager who serves as the main point of contact for providers and works closely with them to understand and resolve community challenges, many of which impact the consumers they serve. The Provider Relations Manager assists with addressing questions, troubleshooting concerns, and responding to issues that arise. Other functions include answering questions about accreditation, licensure, and Code of Maryland Regulations (COMAR) and completing Agreements to Cooperate.

BHSB reaches out to new providers with an invitation to schedule a meet and greet visit and hosts orientation sessions to welcome new and prospective providers into the system, introduce them to BHSB, begin building collaborative relationships, and offer suggestions on how to engage with the local community, broader system of care, and BHSB. BHSB also manages provider closures in collaboration with the BHA, providers, stakeholders, and the Administrative Service Organization (ASO), including the transition of consumers.

In addition, service line meetings are held with the following groupings of providers: psychiatric rehabilitation programs (PRP), residential rehabilitation programs (RRP), opioid treatment programs, mobile treatment and assertive community treatment, targeted case management, residential SUD, buprenorphine, school-based, supported employment, Capitation Project, housing first, outpatient clinics, and veteran-serving providers. Meetings are generally held quarterly to educate providers on happenings within the system and engage them in dialogue

about how to best support and enhance service delivery, including ways to promote behavioral health integration. In response to the COVID-19 pandemic, BHSB began holding weekly Provider Check-in calls in March 2020 to support the provider network in adapting operations to new and ongoing challenges.

In FY 2020, BHSB issued 280 Agreements to Cooperate to new and renewing programs requesting to operate in Baltimore City's PBHS. A significant number of agreements have been for PRP and SUD residential care, in addition to one new RRP program.

Syringe Services Program

BHSB continues to partner with the Syringe Services Program (formerly the Baltimore City Needle Exchange Van) to offer peer support services to van consumers. Peer Support Specialists employ evidence-based and evidence-informed practices to initiate and maintain relationships with consumers who utilize services from the Syringe Services Program. Practices include motivational interviewing and a harm reduction model that includes drug education, a non-confrontational and non-judgmental approach, and education concerning the benefits of medication assisted treatment. Peer support specialists work on the van 10 to 15 hours per week and supported over 300 individuals during FY 2020. The services were suspended mid-year due to the pandemic.

Maryland Harm Reduction Training Institute

The Maryland Harm Reduction Training Institute (MaHRTI) at BHSB aims to develop the Maryland harm reduction workforce and support Maryland programs in providing optimal services to people who use drugs. MaHRTI provides training and technical assistance to the following audiences:

- peers and people who use drugs,
- Maryland Department of Health ACCESS Harm Reduction grantees,
- syringe services programs, and
- overdose response programs.

During FY 2020, MaHRTI provided 13 in-person training sessions to 224 people. Training topics included:

- Harm Reduction 101,
- Stigma, Trauma, and People Who Use Drugs,
- A Harm Reduction Approach to Motivational Interviewing,
- Safer Injection,
- De-escalation, and
- Core training for Syringe Services Programs.

MaHRTI also provided technical assistance to harm reduction programs by request.

Sexual Health in Recovery

In FY 2018, BHSB received its first funding and technical support from the Maryland Prevention and Health Promotion Administration (PHPA) to train and implement the Sexual Health in Recovery (SHIR) curriculum at four substance use disorder treatment programs. In FY 2020, BHSB received a \$65,000 award from BHA for SHIR. BHSB contracted with four organizations to provide SHIR groups in FY 2020. Due to contracting delays and the COVID-19 pandemic, the contracted providers did not offer SHIR groups in FY 2020.

System Capacity Tracking Projects

One of the pressing needs in Baltimore City and other jurisdictions across Maryland is a centralized mechanism to access real-time information regarding the capacity of behavioral health treatment programs to admit new consumers into various levels of care. BHSB is collaborating with state and local partners to develop systemic strategies to address this need.

After piloting a Real Time Capacity Tool (RTCT) using Google apps from September 2017 to May 2019, BHSB supported BCHD's launch of www.CHARMCare.org in May 2019. Like the RTCT, but more comprehensive, CHARMCare.org provides a no-cost platform for all types of health and human services providers to provide detailed information on their locations and services offered, as well as real-time capacity data. The publicly accessible platform also allows users to filter by different treatment preferences and eligibility criteria, such as: type of insurance accepted, levels of care offered, populations served, and specialty services available. BHSB continues to partner with BCHD to plan improvements to CHARMCare.org, update provider information, and organize provider trainings. In FY 2020, BCHD devoted additional staff time to calling providers to ensure the database's accuracy and added a section specifically related to changes in services related to COVID-19. BHSB continues to provide consultation and support.

Behavioral Health Service Needs

As described in *Section E. Planning Process*, the *Baltimore Public Behavioral Health System Gap Analysis*¹⁰ report was finalized in December 2019. It analyzed the existing public behavioral health service system to identify unmet needs, service gaps, barriers to accessing care, opportunities for better collaboration, and other recommended system improvements, particularly as they pertain to decreasing or improving interactions with police. BHSB's activities to address system gaps are described throughout this report.

Workforce development

One of the critical needs of the behavioral health system is workforce development. It is essential that the behavioral health field prepare leaders with the change management skills that are needed to successfully facilitate behavioral health integration at the staff, provider,

¹⁰ <https://www.baltimorepolice.org/baltimore-public-health-system-gap-analysis>

community, and system levels. Overall, the behavioral health workforce is too few, inadequately supported and trained, and faces significant changes that impact practice, credentialing, funding, and ability to keep up with changes in practice models driven by changing science, technologies, and systems. To address these needs, BHSB sponsored an array of free professional development opportunities during FY 2020 to increase capacity across the network to provide high quality, evidence-based, and evidence-informed services.

A total of 1,570 individuals participated in 48 trainings and conferences. In April 2020, in response to COVID-19 restrictions, BHSB shifted from providing in-person trainings to online trainings. Of the 48 trainings, 34 were held online. Training topics included:

- certified peer recovery specialist – various trainings
- clinical supervision
- conscious discipline
- cultural humility
- Expanded School Behavioral Health Learning Institute
- mindfulness
- motivational interviewing
- online training methods
- self-care for behavioral health professionals
- sexuality & gender training program
- telehealth services
- treatment planning
- urban trauma
- writing effective progress notes

To help prepare future behavioral health leaders, BHSB has become a field placement site for students, with five students interning during the 2019/2020 school year. Students have come from the University of Maryland and Morgan State University Schools of Social Work and the University of Baltimore School of Human Service Administration. As of January 2021, BHSB has hosted three students during the 2020/2021 school year.

During FY 2020 BHSB collaborated with the Johns Hopkins Bloomberg School of Public Health, to implement the East Baltimore Community Trauma Response initiative to promote healing in East Baltimore for survivors of violence. Through this collaboration, BHSB had an opportunity to facilitate a process group for the Johns Hopkins Department of Medicine, Fellowship Program for Child Psychiatry, to mitigate the stressors inherent in the program, as well as build supportive connections among the first-year fellows. The structure of the process group includes key aspects of the *S.E.L.F. Community Conversations* model. Feedback from the first

cohort of fellows was extremely positive, and the department faculty requested that BHSB continue it during FY 2021. It is now formalized as a part of the fellowship training schedule.

High Intensity Utilization

Frequent use of acute behavioral health care services is referred to as high intensity utilization (HIU). Individuals with HIU are often highly vulnerable and have co-morbid or tri-morbid conditions. BHSB previously received on a regular basis lists from the ASO of adults (age 18 and older) who met an agreed-upon criteria for HIU. Although this practice has been discontinued, BHSB's clinical team continues to work to meet the needs of individuals with HIU by developing direct relationships with the local hospitals and other community providers to serve as a resource for guidance and coordination for individuals who are not responding well to traditional interventions. A higher level of care management is provided to assess what services would be most beneficial and to increase the likelihood of maintaining stability in the community, with the goal of decreasing hospitalizations. This also occasionally includes working in collaboration with the ASO's clinical staff. Presentations to hospital social work staff have done a great deal to establish working relationships and partnerships in developing discharge plans for those that meet HIU criteria. In FY 2021 BHSB will be partnering with the ASO to re-initiate the establishment of consistent reports of individuals with HIU.

During FY 2020, BHSB coordinated care for 23 individuals with high needs, many of whom met the criteria for HIU.

ASAM Patient Placement Criteria Training

The BHA, in partnership with the American Society of Addiction Medicine (ASAM), offered free ASAM regional training in Maryland during FY 2019. The training included activities that support the development of the knowledge and skills required to implement the ASAM criteria. BHSB staff attended this training, and providers were encouraged to attend as well. BHSB assessed that this training sufficiently addressed the needs of the city's provider community.

Safe, Stable and Affordable Housing

Safe, stable, and affordable housing in a healthy neighborhood is a social determinant of behavioral health. Among unsheltered persons surveyed in Baltimore City, 41% self-reported a mental illness, and 46% self-reported substance use issues.¹¹ BHSB works with partners to strengthen a range of housing interventions, including:

- providing supports people need to live independently in their homes through services such as older adults outreach and assertive community treatment;

¹¹ Baltimore City 2020 Point in Time Count Report.

[https://homeless.baltimorecity.gov/sites/default/files/Full_Preliminary%20Report\[1\].pdf](https://homeless.baltimorecity.gov/sites/default/files/Full_Preliminary%20Report[1].pdf)

- improving habitability and affordability of the city’s housing stock through advocacy and by administering grants and partnering and writing letters of support on grant applications, including several MDH community bond applications;
- strengthening healthy, resilient neighborhoods through prevention activities;
- preventing people from entering homelessness through crisis intervention and effective discharge planning; and
- making homelessness rare and brief.

The U.S. Department of Housing and Urban Development (HUD) competitively awards homeless services funding to local jurisdictions through the Continuum of Care (CoC) Program, which is designed to promote community-wide commitment to the goal of ending homelessness. In FY 2020, BHSB provided leadership and support to the CoC board and Executive Committee and chaired the CoC’s Homeless Response System Workgroup, which provides oversight to the homeless services system’s access points and screening, assessment, and intake processes (collectively known as “Coordinated Access”). In FY 2020, these groups helped ensure stability and community input throughout leadership changes at the city as well as the city’s COVID-19 response.

BHSB directly administers two CoC grants, Safe Haven and Street Outreach, and provides technical assistance to ensure these projects are accessible, low-barrier services. The goal for both projects is to transition people into permanent housing as quickly as possible. In addition, through state funds, BHSB provides matching grants to three permanent supportive housing projects that serve people experiencing homelessness, which helps the city leverage additional federal funding for this purpose.

Office-Based Buprenorphine

The *Medication Assisted Treatment (MAT)* subsection of *Section F. Service Delivery and Recovery Supports* provides detailed information about BHSB’s initiatives to expand access to buprenorphine.

Co-occurring Disorders

BHSB’s organizational structure supports a fully integrated approach to its role of system oversight. Staff at all levels and across all departments are expected to make decisions that support integration within the scope of their role and assigned areas of responsibility. While separate funding streams for mental health and substance use disorders at the federal and state levels make it difficult to fully integrate service delivery at the consumer and community level, BHSB uses its role to advance an integrated approach to the work.

For example, Maryland’s Administrative Service Organization (ASO) is responsible for collecting behavioral health services utilization for Maryland’s fee-for-service PBHS. The data for mental

health and substance use disorders has historically been collected and reported separately. BHSB's data team built the capacity to analyze the claims data to identify unduplicated individuals served by both systems and analyze expenditures accordingly.

In addition, as discussed in multiple sections of this report, BHSB expends significant staff resources overseeing the existing crisis response system. While funding for specific crisis services is generally specific to mental health or substance use disorders, BHSB works with providers to ensure that the full range of consumers' needs are met.

As described in *Section E. Planning Process*, the *Baltimore Public Behavioral Health System Gap Analysis*¹² report was finalized in December 2019. It analyzes the public behavioral health system (PBHS) to identify unmet needs, service gaps, barriers to accessing care, opportunities for better collaboration, and other recommended system improvements. The analysis is integrated across mental health and substance use disorders. The Greater Baltimore Regional Integrated Crisis System (GBRICS) Regional Partnership, also described in *Section E. Planning Process*, will invest \$45 million over five years in integrated behavioral health crisis response infrastructure and services.

It is also important to note that BHSB convenes regular service line meetings with providers in which mental health and substance use disorder programs are grouped together when possible. Meetings are generally held quarterly to educate providers on happenings within the system and engage them in dialogue about how to best support and enhance service delivery, including ways to promote behavioral health integration.

Crisis Response and Diversion Activities

BHSB expends significant staff resources to oversee the existing crisis response system, identify gaps, and collaborate with state and local partners to develop innovative strategies to increase access. This work is described in detail throughout this document.

Pathological Gambling Addiction

The Here2Help Hotline connects individuals with problem gambling to services. In addition, Maryland Coalition of Families (MCF) operates a "warm line" in partnership with the Maryland Center for Excellence on Problem Gambling to assist in connecting individuals and loved ones impacted by problem gambling with services. MCF also provides one-to-one support through a family peer support specialist. Family peer support specialists are spouses, siblings, parents, or other loved ones of someone with gambling issues who have been trained to help other families and can help them access services. In FY 2020 new pilot strategies were implemented to support families with youth and young adults to educate them on online gaming at home.

¹² <https://www.baltimorepolice.org/baltimore-public-health-system-gap-analysis>

During FY 2020, 33 individuals received support, and 161 problem gambling outreach activities were provided.

Tobacco and Nicotine Cessation

BHSB believes that health and wellness are vital components of the recovery process for individuals with behavioral health disorders. To assist individuals with achieving health and wellness, BHSB promotes cessation of tobacco and nicotine use by actively participating on the state's MDQUIT Advisory Board, disseminating MDQUIT resources to providers and consumers, and facilitating discussions and presentations in provider meetings. BHSB also requires contracted providers to implement approaches to reduce tobacco and nicotine use, including vaping.

Peer Recovery Specialists and Certified Peer Recovery Specialists

Peer Recovery Specialists (“peers”) use their personal experiences of recovery from trauma, substance use, or mental illness to help others make their own journey to recovery. Peers’ personal experiences make them uniquely capable of authentically engaging with people, building trust, and instilling a sense of hope that treatment works, and recovery is possible. State-credentialed Certified Peer Recovery Specialists have received training and passed an exam on ethics, advocacy, self-care, mentoring, and other topics.

Providers and other partners throughout Baltimore City’s system of care employ peers in various roles and settings, including:

- assertive community treatment,
- Capitation Project,
- Maryland Crisis Stabilization Center
- Opioid Crisis Unit,
- housing first projects,
- Hub and Spokes project,
- Drug Treatment Court,
- family navigation services,
- harm reduction outreach and naloxone distribution,
- Interdisciplinary Street Outreach project,
- anti-stigma trainings and group support around mental health disorders, substance use, and medication assisted treatment,
- recovery coaching in outpatient treatment settings,
- case management support for consumers in the Law Enforcement Assisted Diversion and Outpatient Civil Commitment programs, and
- emergency department SBIRT (Screening, Brief Intervention, and Referral to Treatment).

Through a competitive RFP process initiated in FY 2020, two new Wellness and Recovery Centers¹³ were awarded funding starting in FY 2021. Baltimore’s six Wellness and Recovery Centers provide consumer-centered peer support services, including anti-stigma workshops, Wellness Recovery Action Planning (WRAP), educational sessions such as parenting and GED classes, one-on-one peer support, peer-led groups (e.g., SMART Recovery®, Alcoholics Anonymous, and Narcotics Anonymous), acupuncture, tai chi, and other activities that reduce isolation and promote family and social support. One of these centers focuses on LGBTQ persons, while another center focuses on harm reduction services. Two of the centers provide nearly 24/7 availability of drop-in recovery support, which helps bridge the time when traditional services are not available.

One center is unique in that it follows a clubhouse model and serves adolescents ages 13-17 who are at risk for behavioral health issues. The Adolescent Clubhouse receives an average of 111 visits per month. In FY 2020, while Baltimore City was under the restrictions of social distancing and a shelter-at-home order due to the COVID-19 pandemic, the clubhouse limited services but was still able to provide a culturally centered and spiritually based Afrocentric therapeutic approach called NTU Psychotherapy, with a focus on harm reduction and reducing high-risk behaviors such as alcohol and drug use and unsafe sex.

In FY 2020, Baltimore City residents visited Wellness and Recovery Centers 78,127 times. The Centers provided 1,297 one-on-one peer support sessions, over 3,216 group support sessions, and placed 96 persons in jobs. In addition, over 217 persons were confirmed to have entered a treatment program as a result of a referral from a Wellness and Recovery Center. In response to COVID-19 restrictions, adjustments were made by Wellness and Recovery Centers to ensure peer services were available. All centers have offered virtual and telephonic support since March 2020. One of the centers subsequently fully reopened, while two others have increased street outreach efforts.

Public Awareness Education

BHSB uses communications strategies to advance best practices and policy reforms, promote access to the system of care, and mobilize community action, all while solidifying BHSB as a leader in the system of care by adhering to consistently branded communications. BHSB has built strong relationships with media outlets and communities using traditional, social, and earned media and paid advertising, and has developed targeted campaigns to educate the public on service availability and the impact of stigma.

¹³ In this document and in public materials, BHSB uses the term “Wellness and Recovery Centers” to include Recovery Community Centers in an effort to promote integration. We note this here to prevent confusion because BHA uses the term “Recovery Community Centers” to distinguish those that are supported with SUD funds.

BHSB regularly promotes the city's 24/7 crisis hotline. In November 2019, BHSB began a re-brand process to identify better messaging and communications strategies for promoting the hotline in Baltimore City. Throughout the re-branding, BHSB intentionally sought the voices of community members and people with lived experience in decision-making for the new name of the hotline and design of promotional messaging and materials. Promoting a citywide hotline that reflects the voices and perceptions of our community helps to strengthen access to care by increasing awareness and understanding of how people can get the behavioral health care and support they need.

In July 2020, BHSB announced the Here2Help Hotline, with a new name and look for Baltimore City's behavioral health hotline. BHSB disseminates information about the hotline using our communications platforms, including our website and social media accounts, and with print materials. BHSB also used earned media opportunities to promote the hotline through various local media outlets in Baltimore City. In addition, BHSB relies heavily on our partners to help promote the hotline in the community. As such, we distribute print materials to providers, city agencies, and local businesses. BHSB also partners with the Greater Baltimore Committee to promote the hotline through its virtual communications platforms.

To reduce stigma associated with behavioral health conditions, BHSB organized a virtual community art project, *Your Path is Your Own*, in recognition of recovery month. BHSB maintains the virtual art gallery on our website: <https://www.bhsbaltimore.org/get-involved/virtual-art-gallery/>. All communications for this effort were done virtually, using BHSB's existing communications platforms, such as Constant Contact, our website, and our social media accounts. BHSB also created a social media toolkit with pre-developed messages that partner organizations could use to help promote the project.

BHSB participated in several community-wide events during FY 2020 that raised awareness of behavioral health issues and addressed stigma. Specific activities include:

- *Stoop Storytelling* event in which BHSB partnered with NAMI Metro to organize a storytelling event with seven storytellers who each had seven minutes to share their personal stories of recovery and resilience.
- In September 2020, BHSB hosted a virtual community storytelling event in recognition of National Recovery Month. During the event people shared their stories with peers and advocates for behavioral health and wellness.
- In December 2020, BHSB's Annual Gathering, *Our Humanity: Supporting Communities with Equity and Intention*, featured a panel discussion with local community leaders discussing how to promote resilience and recovery.
- BHSB continues to create new content for the "Journey to Wellness" page of its website to share stories of people, providers, families, and communities that are helped by the

system of care in Baltimore City: <https://www.bhsbaltimore.org/news/journey-to-wellness/>.

In addition to the public education activities conducted by staff, BHSB funds organizations to provide public education and support activities for individuals, families, and communities in Baltimore City, including:

- Mental Health Association of Maryland provides children’s mental health information and campaign materials for the *Children’s Mental Health Matters* campaign, participates in health fairs, conducts older adult mental health and advanced directive trainings, collaborates with BHSB to disseminate Mental Health First Aid throughout the city, and oversees a public education project to address the behavioral health needs of new mothers.
- National Alliance on Mental Illness (local and state chapters) provides family support trainings and workshops on mental health topics and coordinates the annual NAMI Walk, a public education event that promotes awareness of mental illness.
- Maryland Coalition of Families provides webinars and family trainings on mental health topics and coordinates the Family Leadership Institute, which provides education and resources to parents, caregivers, and family members of children with behavioral health challenges. It also participates in health fairs and provides education to families on the Good Samaritan Law and children’s mental health information, as well as campaign materials for Children’s Mental Health Matters.
- On Our Own of Maryland provides presentations on the stigma of mental illness, partners with local consumer-run organizations in various educational events, and provides assistance and referrals to consumers via telephone and in person.
- Bmore POWER developed the *Go Slow* campaign to educate people who use drugs about fentanyl. This campaign utilizes a harm reduction approach to inform people that fentanyl is likely to be in their drugs and that using more slowly could save their life. The website is www.GoSlow.org.

Engaging Culturally and Linguistically Diverse Individuals

The U.S. Department of Health and Human Services developed the National Culturally and Linguistically Appropriate Services (CLAS) Standards to advance health equity, improve quality, and help eliminate health care disparities. By tailoring services to an individual's culture and language preferences, health professionals can help bring about positive health outcomes for diverse populations.

To advance organizational and system-level capacity to provide culturally and linguistically appropriate services, BHSB completed a CLAS Standards Self-Assessment during FY 2020 which

informed the development of strategies to advance this work during FY 2021. An update on the implementation of the identified strategies is attached as Addendum C.

BHSB participates in the Language Access Task Force, collaborating with other stakeholders to address the barriers for individuals with limited English proficiency (LEP) to receive equitable services in the city. Together with Legal Aid, the Maryland Department of Human Services, the Maryland Department of Health, the Mayor's Office for Immigrant Affairs, and many service providers, BHSB works to increase the prevalence and accessibility of culturally and linguistically competent behavioral health services for the growing population of consumers with LEP.

In addition, BHSB sponsored a *Sexuality and Gender Training Program* during FY 2020. This program began in FY 2018, when BHSB received funding from the BCHD's Sexually Transmitted Diseases (STD)/HIV Prevention Program to train and provide technical assistance to eight behavioral health programs to build capacity to engage and serve people of all genders and sexual orientations in a culturally competent and affirming manner. The FY 2018 providers successfully revised organizational policies, refreshed program environments, and enhanced clinical services to be more inclusive and welcoming. BCHD awarded FY 2020 funding to BHSB to sponsor training and technical assistance for eight additional providers, who participated in a kick-off training in January 2020, followed by several months of technical assistance.

During FY 2021, BHSB will partner with Native American Lifelines-Baltimore to create marketing and other outreach materials that integrate indigenous culture and values with information on opioids, medication-assisted treatment (MAT), harm reduction strategies, and risk factors related to opioid use disorder. Native American Lifelines-Baltimore will also facilitate culturally informed interventions that support recovery.

Promotion of Evidence-Based Practices

A high-quality behavioral health system is one in which the ever-expanding knowledge base derived from research is rapidly integrated into practice. In a city such as Baltimore, in which health indicators suggest that residents experience a significantly greater burden of illness, behavioral health conditions, disabilities, and mortality than other jurisdictions, this is an urgent need. It is also important to understand and address the racial disparities that exist in establishing an evidence base for effective treatment approaches.

Research specific to effective mental health treatment for Blacks is severely lacking. Most prevention and treatment interventions have been tested in majority White populations and have either not included an adequate sample of Blacks to develop evidence for this population or have not analyzed outcomes across racial groups.¹⁴ Studies proposed by Black scientists are

¹⁴ *The Crisis of Black Youth Suicide in America*. A Report to Congress from The Congressional Black Caucus Emergency Task Force on Black Youth Suicide and Mental Health, p. 20-21.
https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf

less likely to be funded than those proposed by White researchers, and health disparities research projects, which are more often proposed by Black scientists, are among those least frequently funded.¹⁵ In addition, mistrust of health care providers and stigma regarding mental health conditions among Blacks are significant barriers to accessing behavioral health services. Evidence-based practices that have been tested in majority White populations may not be effective in addressing these barriers.

Baltimore City's population is 62% Black, which means that a substantive evidence base establishing effective treatment approaches does not exist for the majority of its residents. Embedding a racial and ethnic equity lens into how research is conducted and integrated into practice requires authentic partnerships with community-based organizations that facilitate collaborative exchange and ongoing learning. Such partnerships open up opportunities to conduct research that aligns with guiding principles such as those put forth by Child Trends¹⁶:

1. Examine backgrounds and biases.
2. Commit to dig deeper into the data.
3. Recognize that the research process itself has an impact on communities, and researchers have a role in ensuring research benefits communities.
4. Engage communities as partners in research.
5. Guard against the implied or explicit assumption that White is the normative, standard, or default position.

To begin addressing these racial disparities, BHSB has begun planning for community listening sessions to obtain feedback from Baltimore City residents and community stakeholders. The feedback will inform BHSB's next steps to ensure decisions are made through an equity lens that ameliorates racial disparities and improves collaboration with Black, Indigenous, and People of Color (BIPOC).

BHSB has also developed a survey for providers to obtain feedback on evidence-based practices utilized within their organization. The survey solicits feedback on challenges with evidence-based practices in relation to consumers who identify as BIPOC.

Evidence-informed Practices

BHSB supports the integration of a broad array of evidence-informed practices across the PBHS in Baltimore City. Some of these are described in the following sections.

¹⁵ *The Crisis of Black Youth Suicide in America*. A Report to Congress from The Congressional Black Caucus Emergency Task Force on Black Youth Suicide and Mental Health, p. 6.

https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf

¹⁶ Kristine Andrews, Jenita Parekh, and Shantai Peckoo, *How to Embed a Racial and Ethnic Equity Perspective in Research*, A Child Trends Working Paper (2019). https://www.childtrends.org/wp-content/uploads/2019/09/RacialEthnicEquityPerspective_ChildTrends_October2019.pdf

Children and Adolescents

Various behavioral health providers in Baltimore City serving children, adolescents, young adults, and families utilize evidence-based and evidence-informed practices during their daily interactions. BHSB also supports the integration of such practices through various contracts.

Among some of the practices utilized by contracted sub-vendors are the following:

- Botvin LifeSkills Training (School-Based SUD and MH)
- Chicago Parent Program (CPP) (School-Based MH)
- Circle of Security (Various Providers)
- Conscious Discipline (Early Childhood Mental Health Program)
- Facilitating Attuned Interactions (FAN) (Kennedy Krieger Institute, PACT)
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT) (School-Based MH)
- Maryland TAY Model (Harbor City Unlimited/Empowering Minds Resource Center)
- Mental Health First Aid (Various Providers)
- Mindful Awareness Play (Kennedy Krieger Institute, PACT)
- Motivational Interviewing (Various Providers)
- Roberts' Seven Stage Crisis Intervention Model (BCARS)

Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) is a multi-disciplinary intensive, integrated approach to community mental health service delivery. Mental health services are provided to the individual in the community and address an array of issues, including homelessness and reducing unnecessary hospital stays. The mission of ACT is to help people become independent and integrate into their community as they experience recovery. ACT team members work together to provide mental health, substance use, housing, supported employment, medical, and legal support. There are currently seven ACT teams in Baltimore City that serve an average of 100 consumers each.

Forensic Assertive Community Treatment Team (FACTT)

Forensic Assertive Community Treatment Team (FACT) builds on the Assertive Community Treatment (ACT) model by making adaptations to serve individuals with serious and persistent mental illness who are involved with the criminal justice system. A FACT team assisted nine individuals in transitioning out of state hospitals during FY 2020.

Hub and Spokes

The *Hub and Spokes* model was developed in Vermont based on chronic disease management principles. Individuals with opioid use disorders can initiate treatment at the *Hub*, which then collaborates with other providers and systems (the *Spokes*) to coordinate care, particularly for

people at high risk of negative outcomes including overdose. There are two *Hubs* operating in Baltimore City.

Crisis Now

Crisis Now is a model to provide to safe, effective crisis care that diverts people in distress from emergency department and jail by developing a continuum of crisis care services that matches people's clinical needs. This reduces and prevents suicides while providing more immediate and targeted help for a person in distress. It also cuts the costs of services by reducing the need for psychiatric hospital beds, emergency department visits, and law enforcement response.

The model identifies core elements of crisis care, which include:

- regional or statewide crisis call centers coordinating in real time,
- centrally deployed, 24/7 mobile crisis,
- short-term, "sub-acute" residential crisis stabilization programs and
- essential crisis care principles and practices.

The *Crisis Now* model will be implemented by the Greater Baltimore Regional Integrated Crisis System (GBRICS) Regional Partnership.

National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit

The Substance Abuse and Mental Health Services Administration (SAMHSA) published the *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit* to establish national guidelines for crisis care and support program design, development, implementation, and continuous quality improvement in systems of care.

The GBRICS Regional Partnership will implement these best practice guidelines.

Motivational Interviewing

From April 2019 - September 2019, BHSB collaborated with the Danya Institute to hold six motivational interviewing (MI) trainings for 169 behavioral health practitioners and peer specialists. There were three levels of training, including three introductory MI trainings, two intermediate MI trainings, and one advanced MI training. Post-training evaluations showed 98% of attendees "strongly agreed" or "agreed" that training objectives were met, training was relevant and useful, and the presenter was knowledgeable and well-prepared.

S.E.L.F. Community Conversations

S.E.L.F. Community Conversations evolved from The Sanctuary Model®. It is an evidence-supported model of culturally appropriate exercises and templates for facilitating conversations among small groups or in larger community contexts. The goal of S.E.L.F. (Safety, Emotions, Loss, and Future) is to focus on the effects of exposure to trauma, which include loss of safety, inability to manage emotions, overwhelming losses, and a paralyzed ability to plan for or even

imagine a different future. The model posits that safe spaces and specific, structured conversations enhance capacity for self-regulation and healthy coping strategies.

The *S.E.L.F. Community Conversations* model recognizes that most of the restorative powers needed to promote the growth and wellness of participants and communities resides in the collective wisdom and strength of community members. It is not intended to replace other behavioral health interventions that promote healing in specific cases where trauma or abuse responses have become more severe.

During FY 2020, BHSB provided regular *S.E.L.F. Community Conversations* coaching for five community-based groups that are implementing the model to promote resilience and recovery. BHSB also collaborated with the East Baltimore Community Trauma Response initiative to facilitate a process group for fellows in the Johns Hopkins Hospital Fellowship Program for Child Psychiatry. It uses the *S.E.L.F. Community Conversations* model to facilitate conversations that mitigate the stressors inherent in the program as well as build supportive connections among the fellows.

In June 2021, BHSB began collaborating with the Minister's Conference of Baltimore and Vicinity to plan the HUT (Healing Us Together) Project, which uses the *S.E.L.F. Community Conversations* curriculum to support conversations in community that are intended to move people from injury to healing and recovery. The goal of HUT is to engage communities that have been adversely affected by COVID-19 and racial trauma and begin a process of self-healing. In partnership with the Ministers' Conference, BHSB developed and trained the first cohort of faith-based and community leaders and continues to provide ongoing coaching.

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

Screening, Brief Intervention and Referral to Treatment (SBIRT) is a practice that works to integrate behavioral health into the somatic health care system. SBIRT provides prevention and early intervention using validated screening tools and evidence-based interventions to identify individuals at risk of substance use disorders and those in need of behavioral health services and to refer them to treatment.

In FY 2020, BHSB funded peer recovery specialists to deliver SBIRT services at four hospital emergency departments in Baltimore City: Grace Medical Center, Mercy Medical Center, Medstar Harbor Hospital, and University of Maryland Medical Center.

Project Towards No Drug Abuse

Project Towards No Drug Abuse (Project TND) is implemented as one of BHSB's prevention strategies. It is a substance use prevention program that targets high school-aged youth and can be implemented in classrooms or community settings. Project TND is designed to stop or reduce the use of cigarettes, alcohol, marijuana, and other drugs. It teaches behavioral and

coping skills and provides the student with accurate information about environmental, social, psychological, and emotional consequences of drug use and misuse.

During FY 2020 five providers implemented Project TND as part of their programming. They served a total of 430 youth.

Communities That Care

Communities That Care (CTC) is implemented as another of BHSB's prevention strategies. It is a prevention system grounded in science that gives communities the tools to address their adolescent health and behavior problems through a focus on risk and protective factors. CTC provides a structure to engage community stakeholders, a process to establish a shared community vision, tools to assess levels of risk and protective factors, and a process to set specific, measurable community goals.

FY 2020 marked the planning stages of implementing CTC in Baltimore City. BHSB worked closely with the CTC technical support team for guidance and technical assistance, and seven providers began implementing CTC as part of their programming and served approximately 500 youth.

Prevention Promotion and Awareness

Most of the prevention funding allocated to Baltimore City is focused on preventing substance use disorders. While BHSB adheres to the requirements of each funding source, it also works to align strategies to promote an integrated behavioral health and wellness prevention strategy that prevents and mitigates the impact of ACEs, trauma, systemic racism, violence, and other adverse community events.

During FY 2019, MDH reassigned oversight of multiple prevention and health promotion programs to the Office of Population Health Improvement (OPHI) in MDH's Public Health Services (PHS) division. To streamline administrative processes, OPHI merged the previously separate annual funding processes for the Prevention Services, Opioid Misuse Prevention Program (OMPP), and Strategic Prevention Framework Partnerships for Success (SPF-PFS) programs into a single application process.

Prevention Services

In FY 2018, BHSB engaged in a planning process using SAMHSA's *Strategic Prevention Framework* (SPF) and developed a comprehensive and holistic strategy to prevent substance use, misuse, and related behavioral health problems among young people in Baltimore City. This process started with a community needs assessment to understand how community members view behavioral health concerns and what they identify as solutions. Involving and

including communities impacted by substance use in identifying, developing, and implementing solutions is a critical component of the SPF process in which BHSB continues to engage.

The focus population is youth and young adults ages 12-24 years old and opportunity youth (defined as people between the ages of 16 and 24 who are not in school and not employed) who may have experienced some adverse childhood experiences (ACEs). Two prevention interventions were identified that are built on community-defined evidence and evidence-based practice. These interventions address the factors known to contribute to substance use, particularly the three categories of substances identified as priority targets: marijuana, alcohol, and non-medical use of prescription drugs (NMUPD).

There are two main strategies to connect with young people: 1) School-Based Approach and 2) Community-Based Approach.

1. School-Based Approach

The intervention identified for implementation in school settings is *Project Towards No Drug Abuse (Project TND)*. It is a substance use prevention program that targets high school-aged youth and can be implemented in classrooms or community settings. *Project TND* is designed to stop or reduce the use of cigarettes, alcohol, marijuana, and other drugs. It teaches behavioral and coping skills and enables the student to state accurate information about environmental, social, psychological, and emotional consequences of drug use and misuse. In addition to *Project TND*, providers are required to implement job readiness, mentoring, workforce development, and/or other substance use prevention opportunities for participating youth. The goal of this strategy is to enhance soft skills, academic aspirations, social engagement, and school attendance. This work is done in collaboration with Baltimore City Public Schools (City Schools), and through this partnership, City Schools selects the specific schools to participate in the project.

2. Community-Based Approach

The intervention identified for implementation in community settings is *Communities That Care (CTC)*, a prevention system grounded in science that gives communities the tools to address their adolescent health and behavior problems through a focus on risk and protective factors. *CTC* provides a structure to engage community stakeholders, a process to establish a shared community vision, tools to assess levels of risk and protective factors, and a process to set specific, measurable community goals.

The community-based strategy offers a unique opportunity for innovative practices. Providers offer a range of activities, such as arts and cultural enrichment, sports and fitness, mentorship, mindfulness, college and career readiness, and life skills that foster

positive youth engagement and promote optimal behavioral health and well-being for youth and their families.

BHSB released a competitive procurement during FY 2019 that resulted in the selection of three community-based organizations to provide services. These selected providers implemented Project TND in nine schools and CTC in six communities. In June 2019, another competitive procurement was released seeking additional service providers to embed these two interventions into the places where young people naturally congregate, including schools and educational settings, extra-curricular and workforce readiness programs, summer camps, and other youth development opportunities. The scope of services changed to reflect ongoing learning from the initial implementation.

During the first half of FY 2020, BHSB staff began engaging with community leaders and stakeholders, neighborhood associations, youth-serving organizations, community members and youth to build capacity for implementing CTC in five neighborhoods: Shipley Hill/Mill Hill, Edmondson Village, Irvington, Poplar Grove, and Cherry Hill. Outreach to engage youth was conducted in a broad array of settings, including seven City Schools, the University of Maryland, youth townhall meetings, Baltimore City Recreation and Parks activities, and BHSB-sponsored community conversations and focus groups.

Beginning in January 2020, an additional 15 community-based organizations were selected to implement the revised scope of services. These organizations began introducing the strategies to schools and communities and holding kick off events to enroll participants.

The Center for Communities that Care, which is located at the University of Washington, supports local implementation providing training materials, facilitating some CTC trainings, and helping to guide implementation in the selected neighborhoods. BHSB participates in monthly coaching calls to discuss the implementation of the five phases of CTC:

1. getting started,
2. getting organized,
3. developing a community profile,
4. creating a profile, and
5. implementation and evaluation.

BHSB is currently in phase two and has held two social development strategy trainings, which were attended by 14 members of the community board. The community board is made up of sub-vendors who have implemented successful programs in the selected neighborhoods, developed strong relationships with youth and families, and gained the trust of local community leaders. BHSB also reached out to potential key leaders who can influence policies and help fundraise, which is an important component of the CTC process. The community

board will be reaching out to other key leaders as it works toward creating a shared vision and work plan.

There have been community board orientations in two of the neighborhoods in which CTC will be implemented. The meetings were led by the sub-vendors selected by BHSB to implement CTC. They provided an overview of the five-phased process, identified the five selected neighborhoods in which CTC will be implemented, discussed their roles and responsibilities, and described the role of the evaluation partners.

Strategic Prevention Framework Partnerships for Success (SPF-PFS)

During FY 2020 BHSB continued implementation of the SPF-PFS project, which focuses on the reduction of underage and binge drinking among adolescents and young adults, ages 12-24, with four key strategies:

1. regulating alcohol outlet density through licensing,
2. supporting the city-wide initiative on alcohol outlet density through policy change,
3. conducting compliance checks (underage and over-service compliance) and issuing alcohol citations to retailers and
4. advancing community-based processes to support media, advocacy, and capacity-building.

BHSB continued to leverage partnerships with community organizations that have shared goals and developed a new partnership with City Schools. One TIPS (Training for Intervention ProcedureS) training was conducted, with a total of eight attendees. TIPS is a skills-based, alcohol training and certification program that is designed to prevent intoxication, underage drinking, and intoxicated driving. Monitoring of the Liquor License Board hearings continued, and compliance checks were conducted in SPF-PFS catchment areas by Baltimore City police. A total of 42 liquor establishments were checked, of which five were discovered to be permanently closed. All others were compliant with regulations.

BHSB spent the first few months of FY 2021 planning for the conclusion of the SPF-PFS project, as funding for the statewide initiative ended in September 2020. The focus was on supporting structures that would sustain the strategies after funding ended. BHSB provided education to stakeholders and community partners and offered resources and technical support to coalitions with shared goals, such as the Baltimore Good Neighbors Coalition and the Oliver East Community Association. However, BHSB was recently notified of a no-cost extension of SPF-PFS funding through the end of FY 2021. BHSB will use the funds to continue implementation of the strategies to educate community members on the effects of underage and binge drinking.

Opioid Misuse Prevention Program (OMPP)

During FY 2020 BHSB is continuing implementation of the Opioid Misuse Prevention Program (OMPP), focusing on two key strategies:

1. refusal of transport to the hospital after a non-fatal overdose and
2. community-based opioid prevention.

BHSB partners with City Schools, the Baltimore Police Department (BPD), and Baltimore City Fire Department (BCFD) to advance the OMPP strategies. *Operation Prevention*, which is a national educational program developed by the U.S. Drug Enforcement Administration (DEA) and Discovery Education to prevent opioid misuse among elementary, middle, and high school students, is being implemented in school settings. Kick-off events were held in several schools during American Education Week in November 2019, and BHSB promoted prevention activities and resources during community events sponsored by City Schools. During FY 2021 BHSB has continued to support the implementation of *Operation Prevention* in school and community sites. BHSB staff participated by talking to school-age youth in their virtual classrooms, attending provider events, and providing materials on prevention on BHSB's various social media pages.

BHSB partnered with BPD and BCFD during FY 2020 to address the secondary trauma of first responders by providing self-care kits, resources, and information. Secondary trauma is the emotional duress that results when an individual hears about or witnesses the firsthand trauma experiences of others.¹⁷ First responders are on the front lines of the opioid epidemic, repeatedly responding to overdoses, sometimes involving the same people. Over time, exposure to this recurrent stress can take an emotional toll that compromises professional functioning and diminishes quality of life. BHSB also began conversations with Emergency Medical Services (EMS) about hosting secondary trauma trainings for EMS personnel to educate EMS personnel about secondary trauma and the effects that they may be experiencing and to provide them with tools to build resilience.

Another OMPP strategy that has been implemented is to collaborate with Bmore POWER to supplement opioid overdose education for the community and address the reluctance of overdose survivors to accept transport to a hospital emergency department for critical follow up treatment. BHSB also hosted a series of community conversations around opioid overdose and misuse in the community and schools and partnered with another organization to host a community health fair about opioid overdose. These strategies are continuing during FY 2021.

Sub-Grantee Monitoring

BHSB employs various processes to monitor administrative, fiscal, and programmatic contractual performance. Each contract is assigned a Program Lead, Grants Accountant Lead,

¹⁷ *Secondary Traumatic Stress*. The National Child Traumatic Stress Network. <https://www.nctsn.org/trauma-informed-care/secondary-traumatic-stress/>

Contract Administrator Lead, and Quality Coordinator Lead. Each Lead performs assigned oversight functions:

- Program Lead: Reviews and approves the budget and proposed staffing in accordance with the scope of services, as well as the program reports that are submitted on a schedule as required in the contract. If deliverables are not being met or there are concerns about the quality of service delivery, the Program Lead collaborates with the sub-vendor throughout the contract term to ensure that issues are addressed on an ongoing basis. Fee-for-service and consultant contracts require the submission of an invoice, which is reviewed and approved by the Program Lead in accordance with the scope of services. The Program Lead maintains communication with the sub-vendor throughout the contract term and provides collaborative support to manage challenges and resolve problems as they arise. Technical assistance is provided if indicated.
- Grants Accountant Lead: Reviews and approves budgets, invoices, and fiscal reports along with any supporting detail documentation, if applicable, that are submitted by sub-vendors on a schedule as required in the contract. If budgets or fiscal reports include unallowable expenses or other errors, the Grants Accountant Lead explains the issues to the sub-vendor and requests that they make the corrections and resubmit an accurate budget or fiscal report. Mathematical errors can be corrected by the Grants Accountant.
- Contract Administrator Lead: Reviews and ensures all required documentation is submitted by sub-vendors on a schedule as required in the contract. This includes the Risk Assessment Form, W-9, insurance documentation, and independent financial audit(s). The Contract Administrator Lead ensures that BHSB contracts are issued and executed within the appropriate timeframe.
- Quality Coordinator Lead: Conducts an annual audit of all sub-grantees at the conclusion of the contract term to review if service delivery met contractual requirements and complied with relevant federal, state, and local regulations. The audit structure varies depending on the total annual contract award:
 - \$99,999 or less: There is an annual desk audit. Sub-vendors are required to submit documentation electronically, and the review is completed remotely.
 - \$100,000 or greater: There is an annual audit that alternates every other year between a desk audit and an onsite audit. Desk audits are conducted remotely, as described above, and onsite audits are conducted at the location where services are provided.

Based upon funder or other requirements, the schedule of audits may be conducted outside of these parameters.

BHSB's Chief Financial Officer (CFO) ensures that all financial audits are reviewed to determine if conditions exist that may prevent sub-vendors from delivering services and/or fulfilling the terms and conditions of the contract.

G. Data and Planning

The *Data and Planning* section of this report includes three subsections that describe Baltimore City's demographics and social determinants of health, behavioral health indicators, and the impact of the dual pandemics of COVID-19 and racial trauma.

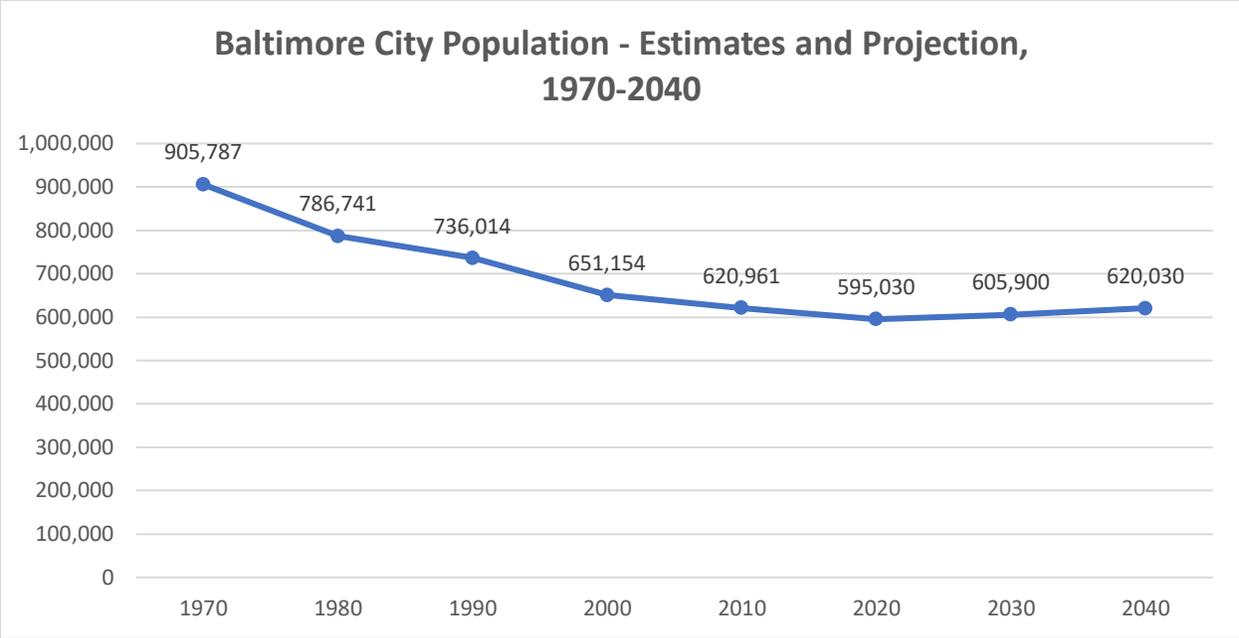
Baltimore City Demographics and Social Determinants of Health

The demographics and social determinants section of this report presents data describing Baltimore City's population and characteristics of the city relevant to behavioral health. These characteristics include age, race, health, income, and housing status, which are factors that impact the incidence of behavioral health disorders and the utilization of behavioral health services. They highlight the *social determinants of health*, which are the conditions in which people are born, grow, live, work, and age, and which are affected by the distribution of money, power, and resources. These determinants result in enormous health disparities between communities.¹⁸

Population

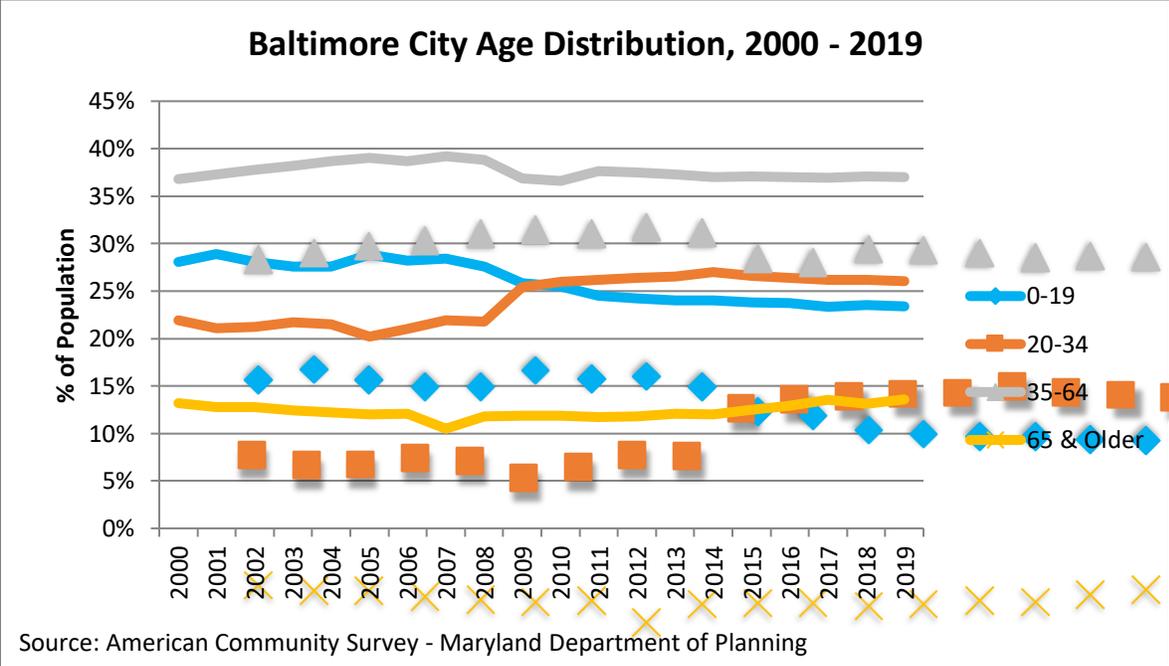
Baltimore City is the 30th most populous city in the nation and the largest city in Maryland, comprising 10.1% of the state's population in 2019, with approximately 609,032 people, based on American Community Survey (ACS) estimates. Although census data indicate that the city's population has decreased significantly since the 1970s, the Maryland Department of Planning projects continued decrease over the next few years, with a nadir of 600,000 people in 2025, but thereafter predicts a population of 620,030 by 2040.

¹⁸ World Health Organization. "About Social Determinant of Health." http://www.who.int/social_determinants/sdh_definition/en/



Source: Maryland Department of Planning - December 2020

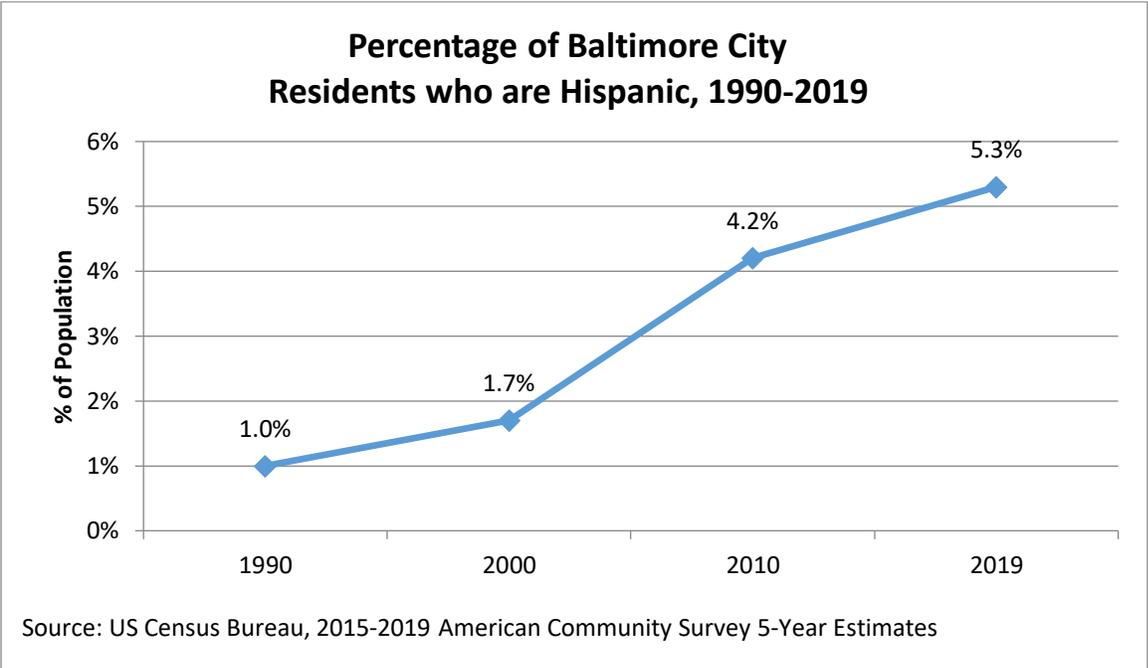
The age distribution in Baltimore City has remained relatively stable over the past ten years, except that the population of individuals aged 65 and over is increasing. In 2019, there were an estimated 125,823 children under the age of 18 and 483,209 adults in Baltimore City. Overall, the median age in Baltimore City was around 35.4 during 2018, whereas the median age in the state is 38.7 years. The distribution by gender was 47.0% (male) and 53.0% (female).

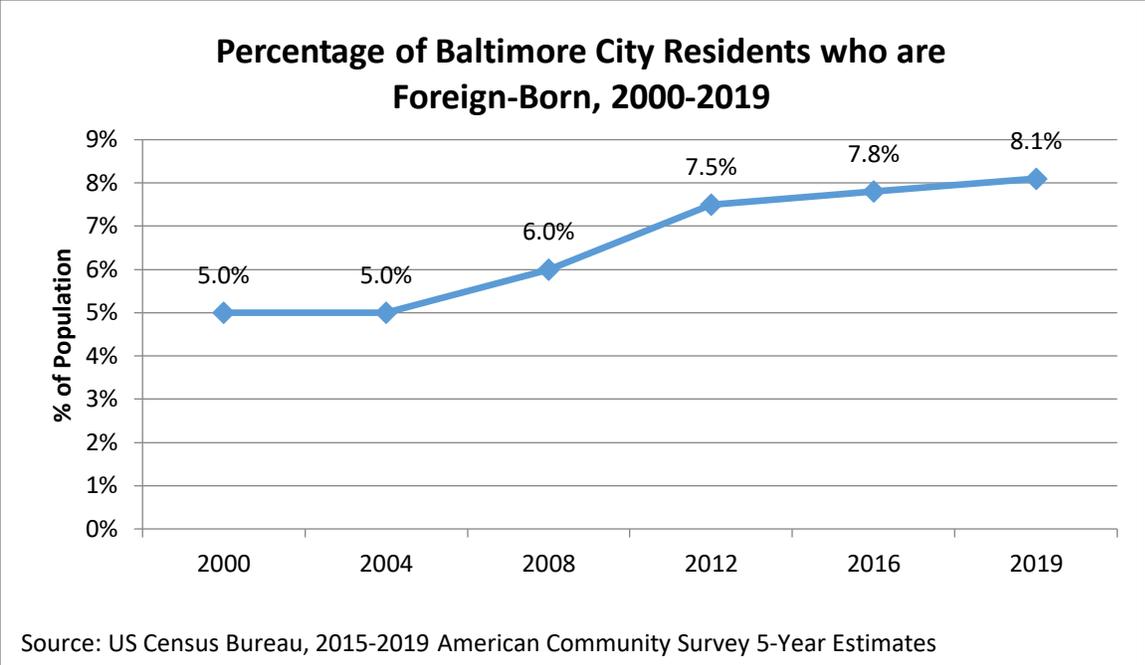


Source: American Community Survey - Maryland Department of Planning

The city’s racial/ethnic distribution is bimodal, with 61.8% non-Hispanic Black individuals and 27.5% non-Hispanic white individuals. The remaining 10.7% is comprised of Hispanic, Asian, and other race or ethnicity, which includes Native American or Alaskan Native, Native Hawaiian and other Pacific Islander, two or more races, and other race.

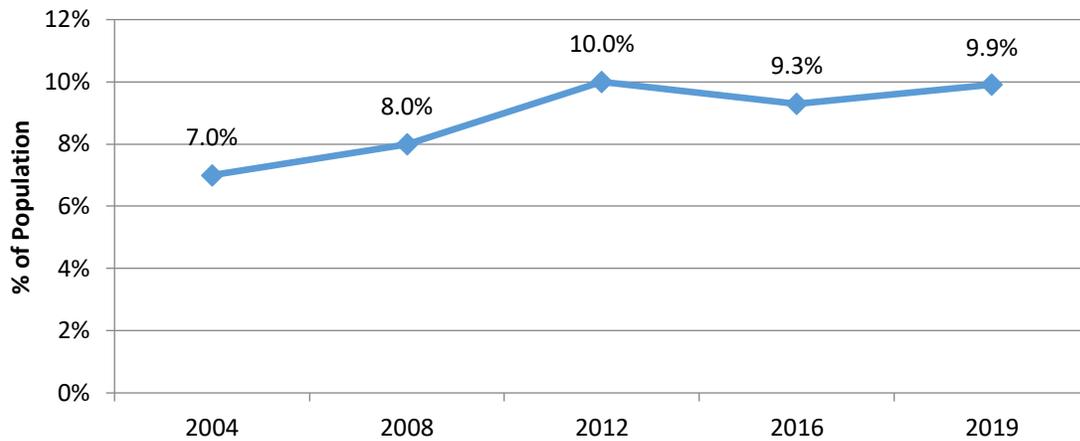
The population is slowly becoming more diverse, as indicated by an increase in the percentage of Hispanic and Asian residents, both of which have almost doubled since 1990. This growth has tapered off in the last ten years, though the populations of Hispanic and Asian residents are likely to be under-counts at present. It is difficult to accurately count immigrant residents, many of whom may be undocumented and often do not show up in official population counts.





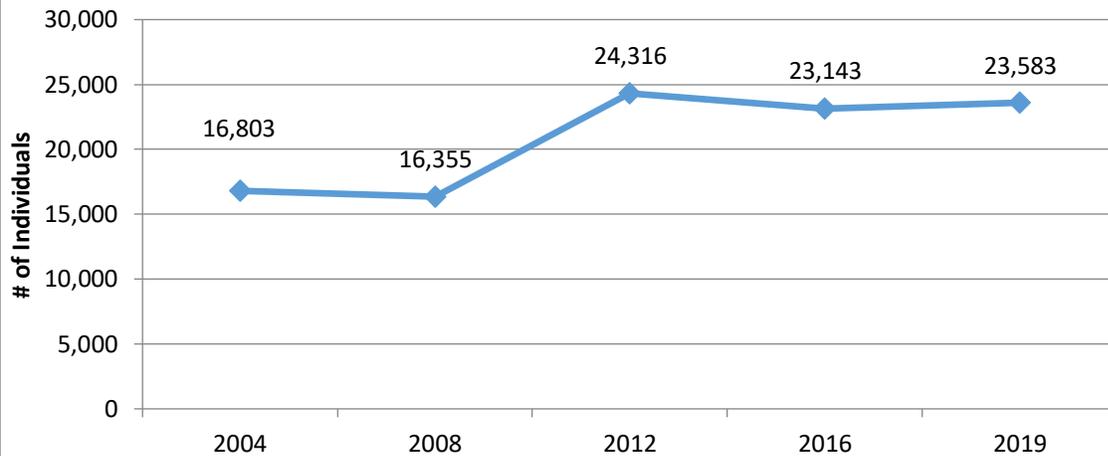
The number of people in Baltimore City who speak a language other than English at home, or who have limited English proficiency, increased over the first decade of the 2000s and has leveled off in the last ten years. With 10% of the population of the city speaking a language other than English at home, culturally competent care requires accessible services in the languages spoken by the people requiring that care. While BHSB receives limited direct calls from consumers, to increase accessibility for those with limited English proficiency, it implemented telephonic interpretation services during 2020 in the top five languages spoken in Baltimore City. According to the 2015 and 2016 American Community Survey, those languages are Spanish, Chinese, French, Korean, and Arabic. The data from the most recent survey suggests that Russian might have transitioned into the top five languages and should be considered in BHSB's future planning.

Percentage of Individuals in Baltimore City Over Age 5 Whose Primary Language is Not English, 2004-2019



Source: US Census Bureau, 2015-2019 American Community Survey 5-Year

Baltimore City Residents Whose Primary Language is Spanish, 2004-2019

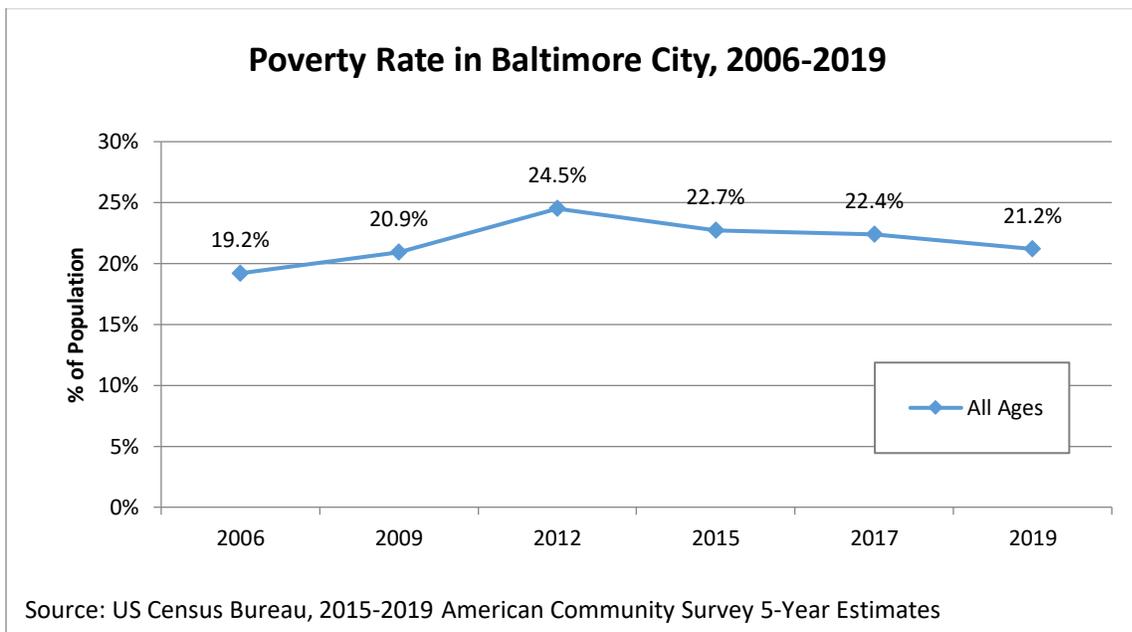
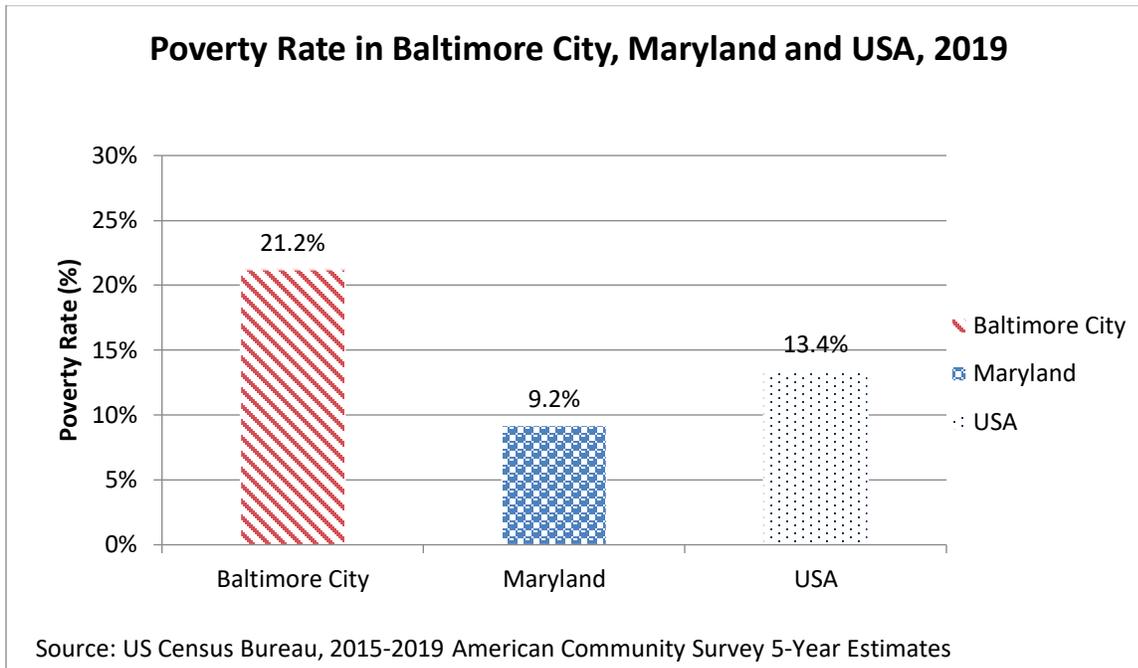


Source: US Census Bureau, 2015-2019 American Community Survey 5-Year

Poverty

There is a disparity in poverty rates between Baltimore City and the state. In the calendar year 2018, Baltimore had the second highest poverty ranking among counties in the state. In 2019 the Baltimore City median household income was \$50,379, whereas the state median income

was \$84,805. In addition, 21.2% of Baltimore households were below the poverty line, as compared to 9.2% of state households.

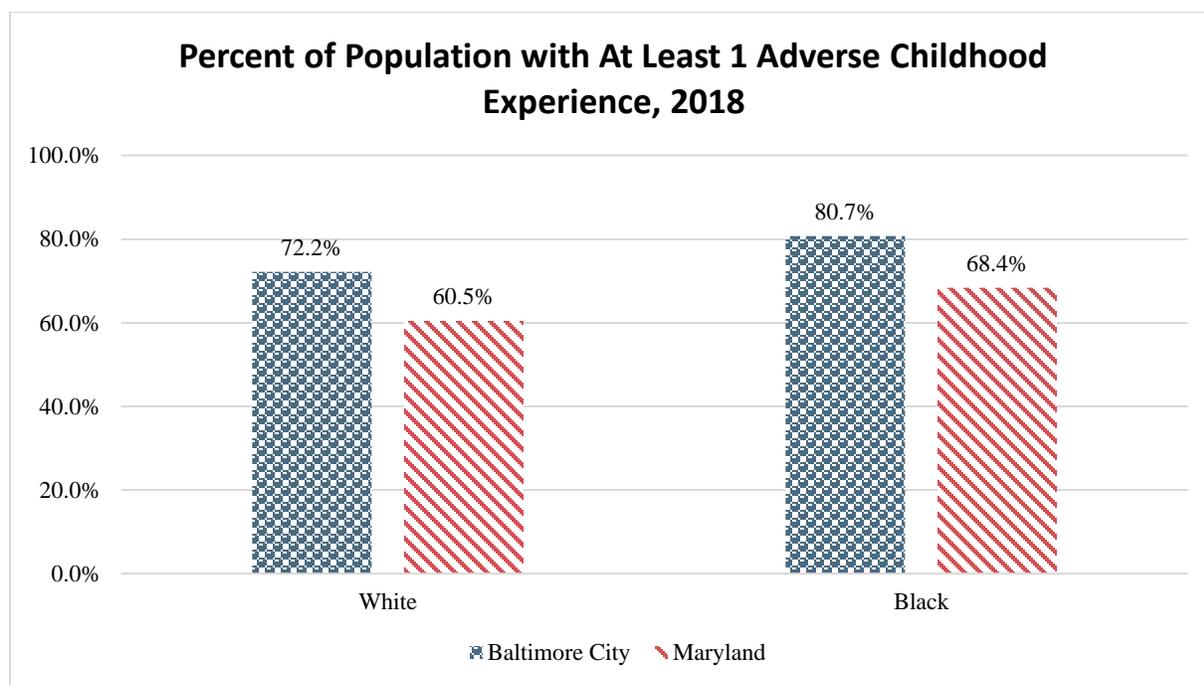


Adverse Childhood Experiences (ACE)

The Centers for Disease Control and Prevention’s (CDC) landmark 1998 study on Adverse Childhood Experiences (ACE) demonstrated the connection between traumatic childhood experiences and many emotional, physical, social, and cognitive impairments that lead to

increased incidence of health risk behaviors, chronic disease, and premature death.¹⁹ ACEs have a strong dose-response relationship to health and social problems throughout the lifespan. As the number of ACEs increases, there is an increased likelihood of risky behaviors and chronic physical and mental health conditions.

Maryland began collecting ACEs data through the Centers for Disease Control Behavioral Risk Factor Surveillance System (BRFSS) in 2015. The BRFSS is a statewide survey that collects data on the behaviors and conditions that put individuals at risk for chronic diseases, injuries, and preventable infectious diseases. Over 8,500 Maryland households anonymously participate in this survey each year. In 2018, statewide, the prevalence of one or more ACEs was 62%, whereas for Baltimore it was 77%. The prevalence of four or more ACEs was 14% for the state and 20% for the city. In both jurisdictions, Black individuals were more likely to have experienced ACEs than White individuals.²⁰



Source: MD-IBIS - Query Builder - Maryland Behavioral Risk Factor Surveillance System (BRFSS) Data - Adverse Childhood Experiences Score, 2018

¹⁹ Felitti, V.J., et al. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *American Journal of Preventive Medicine*, 14(4) 245-258. doi: [http://dx.doi.org/10.1016/S0749-3797\(98\)00017-8](http://dx.doi.org/10.1016/S0749-3797(98)00017-8)

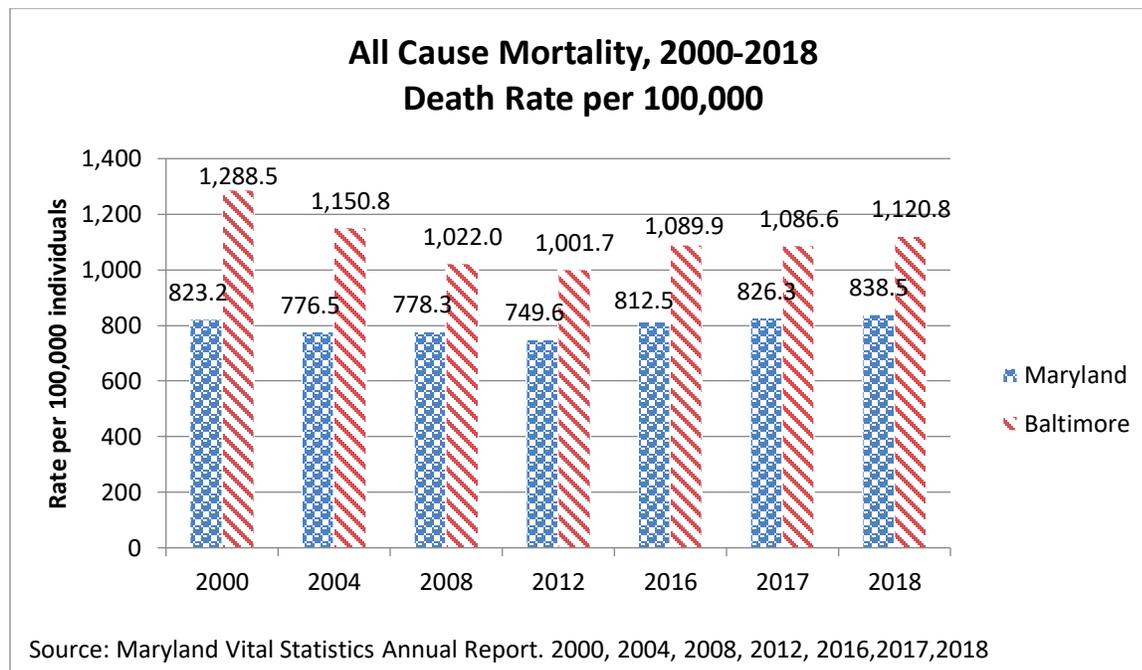
²⁰ [MD-IBIS - Query Builder - Maryland Behavioral Risk Factor Surveillance System \(BRFSS\) Data - Adverse Childhood Experiences Score, 2018](#)

Health Status

The data in the following section are from the Maryland Vital Statistics Annual Report 2018. Data are not updated to 2019 numbers because they were not available at the time this report was written.

Health indicators suggest that Baltimore City residents experience a significantly greater burden of illness, disability, and mortality compared to the state, with substantial disparities between neighborhoods within the city. The average life expectancy is 72.8 years for Baltimore City residents and 79.2 years for Maryland residents. The Baltimore City Health Department Neighborhood Profiles data comparing Baltimore City neighborhoods found an average life expectancy range of 68.4 years in Poppleton/The Terraces/Hollins Market, versus 83.9 years in Greater Roland Park/Poplar Hill.²¹

While Baltimore's all-cause mortality rate has declined by 13% over the past eighteen years, it remains significantly higher than the state's rate and rose 3% in the past year.

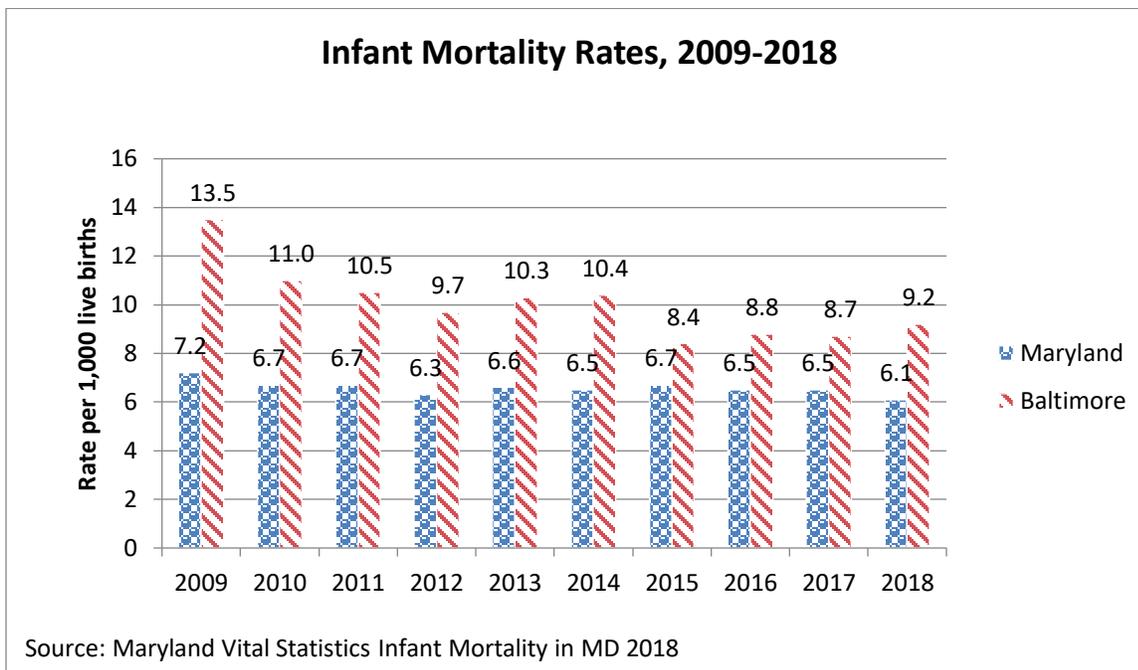


The Baltimore City 2018 infant mortality rate was 51% higher than the state's overall rate. Based on vital statistics data:

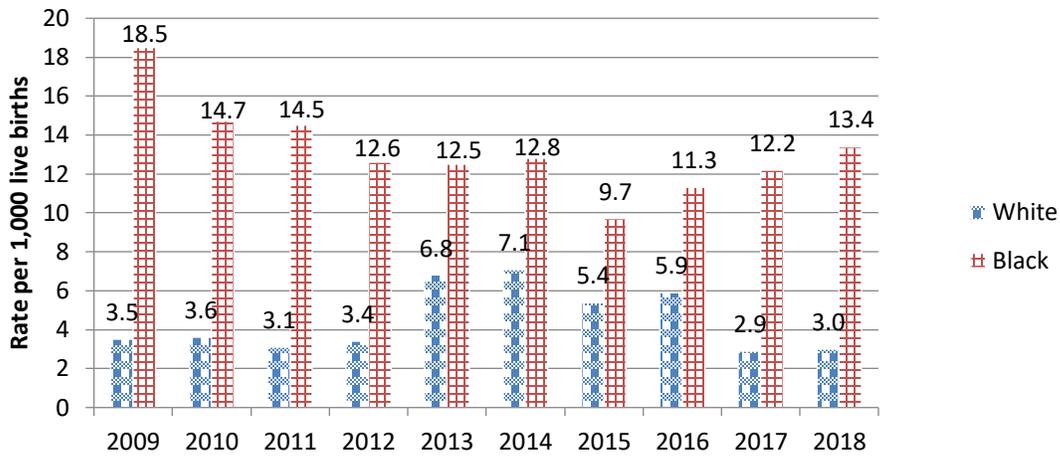
- There has been a decrease in the overall infant mortality rate of 31% between 2009 and 2018.

²¹ Baltimore City Health Department Neighborhood Profiles, 2017. <https://health.baltimorecity.gov/neighborhood-health-profile-reports>

- There are significant disparities by race. The mortality rate for Black babies was over four times that of White babies in 2018. It is the biggest gap in the last five years.
- Infant mortality rates among Black infants have decreased by 28% in the same period; however, after a low point in 2015, the mortality rate among Black infants has increased by 38% over the last three years.
- Between 2013 and 2016, mortality rates among White infants in Baltimore City were higher than the previous four-year period (2009-2012), but in 2018 decreased to the second lowest rate in the past eight years. However, the number of White infant deaths is low enough such that small changes in the number of deaths can lead to great fluctuations in the White infant mortality rate from year to year.

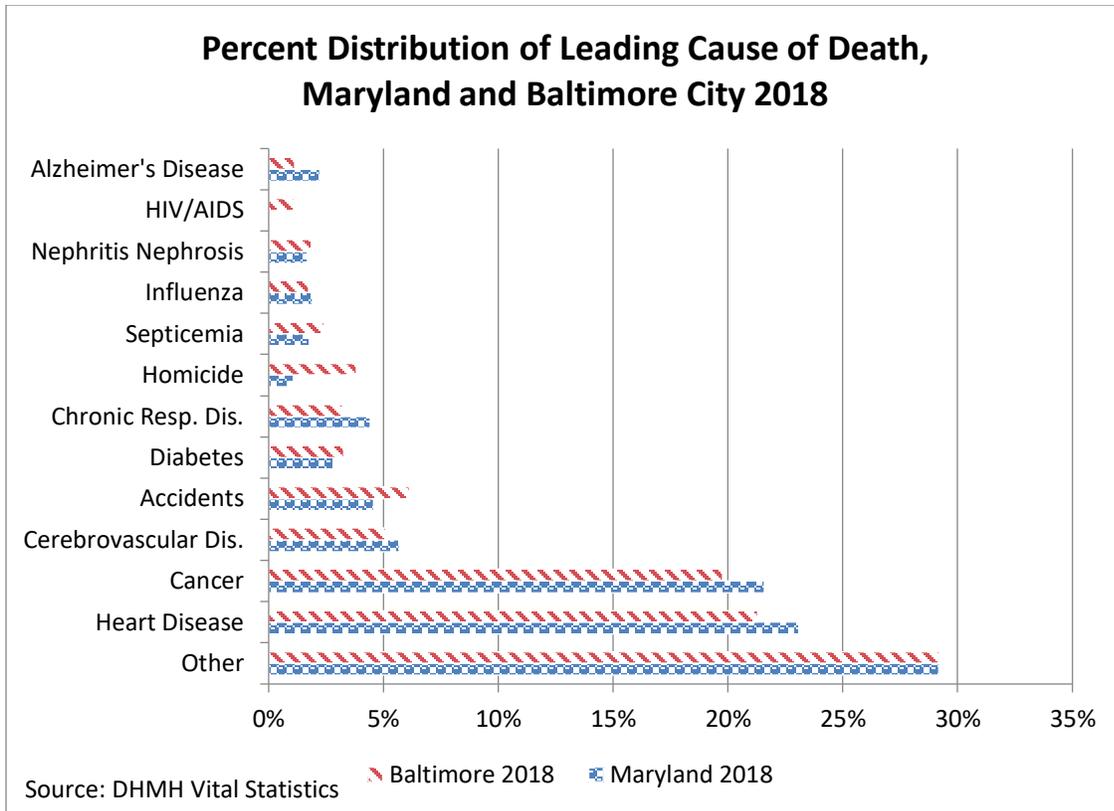


Baltimore City Infant Mortality Rates by Race, 2009-2018



Source: Maryland Vital Statistics Infant Mortality in MD 2018

The leading causes of death varies between Baltimore City and Maryland. Homicide and septicemia were not in the top eight causes of death in the state in 2018, but were the fifth and eighth in Baltimore City, respectively. Though the Baltimore City population is approximately 10% of the state population, HIV/AIDS deaths in the city made up 41% of the total HIV/AIDS deaths in the state.



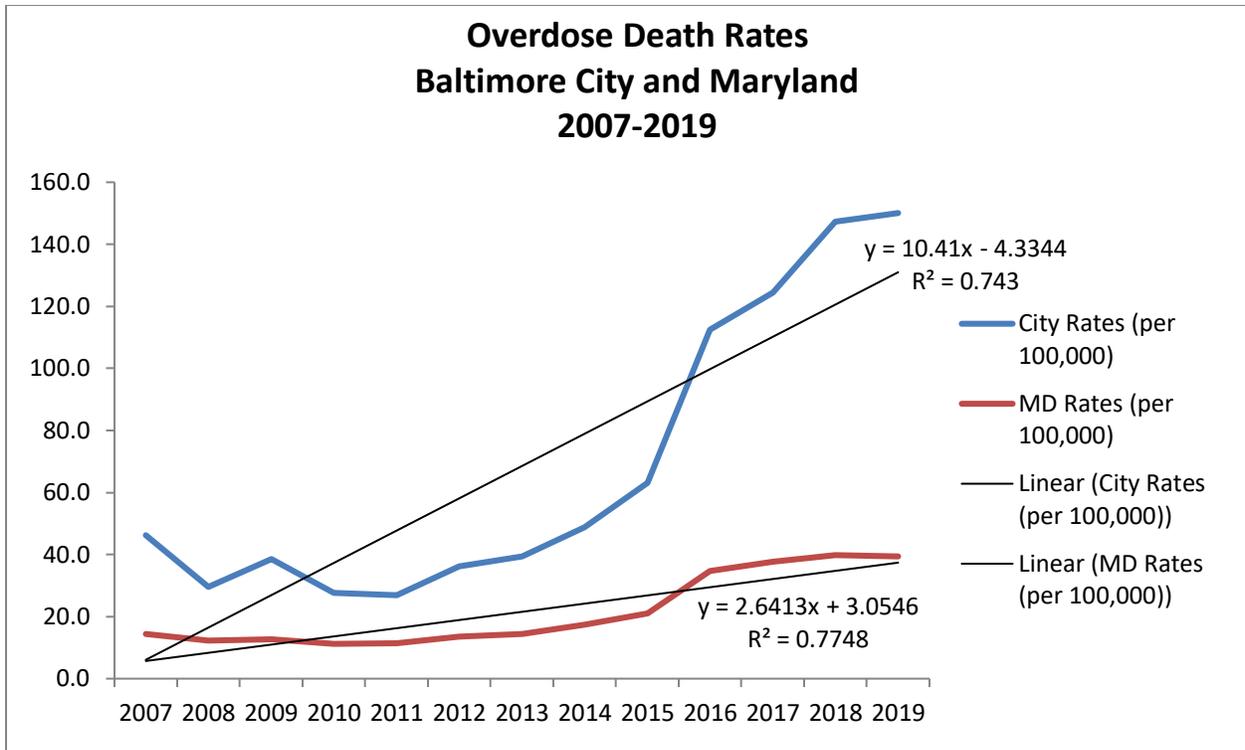
Seven percent (6.6%) of Baltimore City residents have no health insurance, and 4.0% of Baltimore City residents under 19 years are uninsured, which is a significant decline from 2006, when 14% under 19 years of age were uninsured.²²

Overdose

Baltimore City has seen an increase in the number of deaths due to overdose for the last ten years, with 914 overdose deaths occurring in 2019. Though the overdose death rate has increased substantially each year over the past five years, the increase was only 2.9% in 2019. It is important to note that the overdose mortality rate is significantly higher in Baltimore City than in the state of Maryland. This disparity has increased substantially over the past five years.

²² U.S. Census Bureau, 2014-2019 American Community Survey 5-Year Estimates

Baltimore City Deaths Due to Overdose			
Year	# of Deaths	Population	City Rates (per 100,000)
2007	287	620,306	46.3
2008	184	620,184	29.7
2009	239	620,509	38.5
2010	172	621,317	27.7
2011	167	620,889	26.9
2012	225	622,950	36.1
2013	246	623,404	39.5
2014	303	622,793	48.7
2015	393	621,849	63.2
2016	694	614,664	112.9
2017	761	611,648	124.4
2018	888	602,495	147.4
2019	914	609,032	150.1



Source: Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2019 Annual Report, Maryland Department of Health, June 2020

Suicide

Suicide was the tenth leading cause of death in the United States in 2018²³ and was in the top eight leading causes of death among Marylanders ages 15 to 64 in 2018.²⁴ Suicide rates from the CDC WONDER database indicate the suicide rate is increasing in the United States as a whole and to a lesser degree in Maryland. Though this trend does not seem to extend to Baltimore City, suicide is a rare event, and trends can be difficult to detect in small geographic regions.

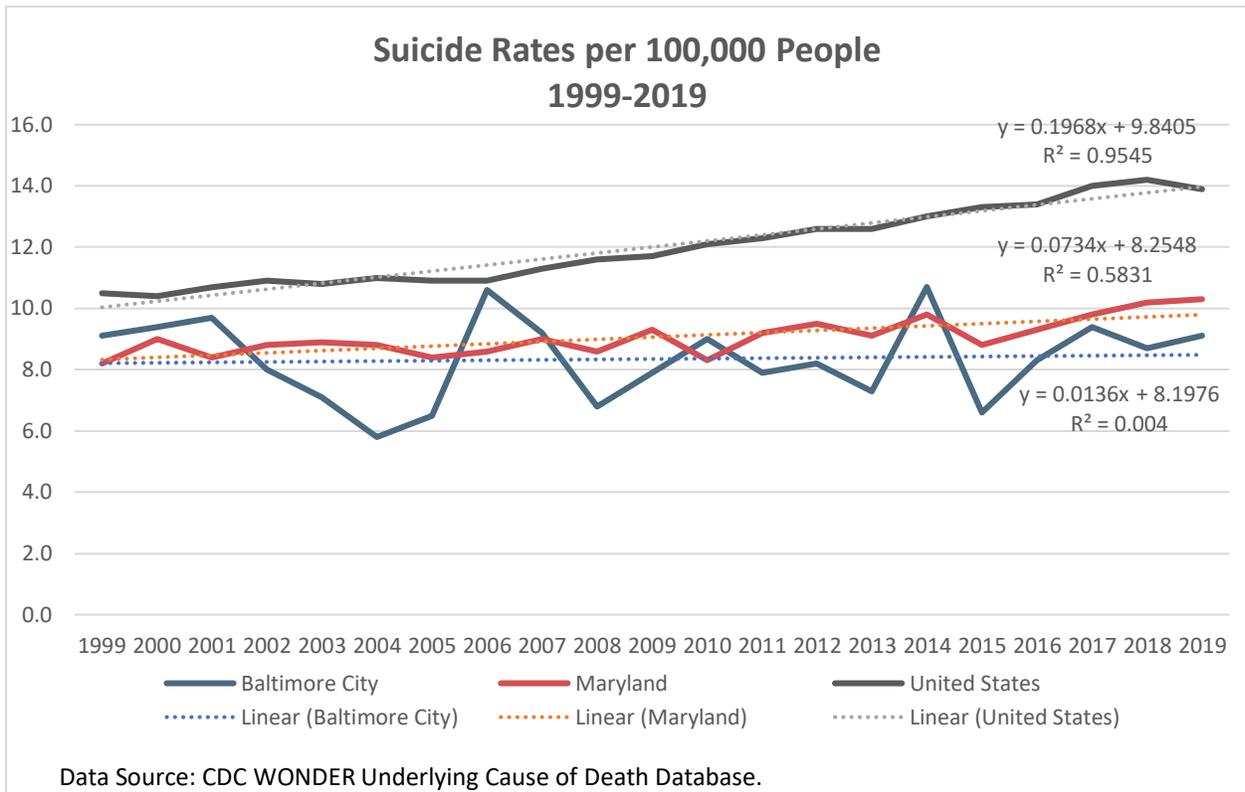
A 2019 report from the Congressional Black Caucus indicates that suicidal behavior, which includes suicides, suicide attempts, and suicidal ideations, is increasing among Black youth, which controverts historical data and public perception regarding suicide rates among Black youth.²⁵ Given the majority Black population in Baltimore City, as well as the high prevalence of ACEs, which is a known risk factor for suicidal behavior, the potential for increased suicidal behavior warrants monitoring.

²³ <https://www.nimh.nih.gov/health/statistics/suicide.shtml>

²⁴ Source: Maryland Vital Statistics Annual Report, 2018. Table 43A.

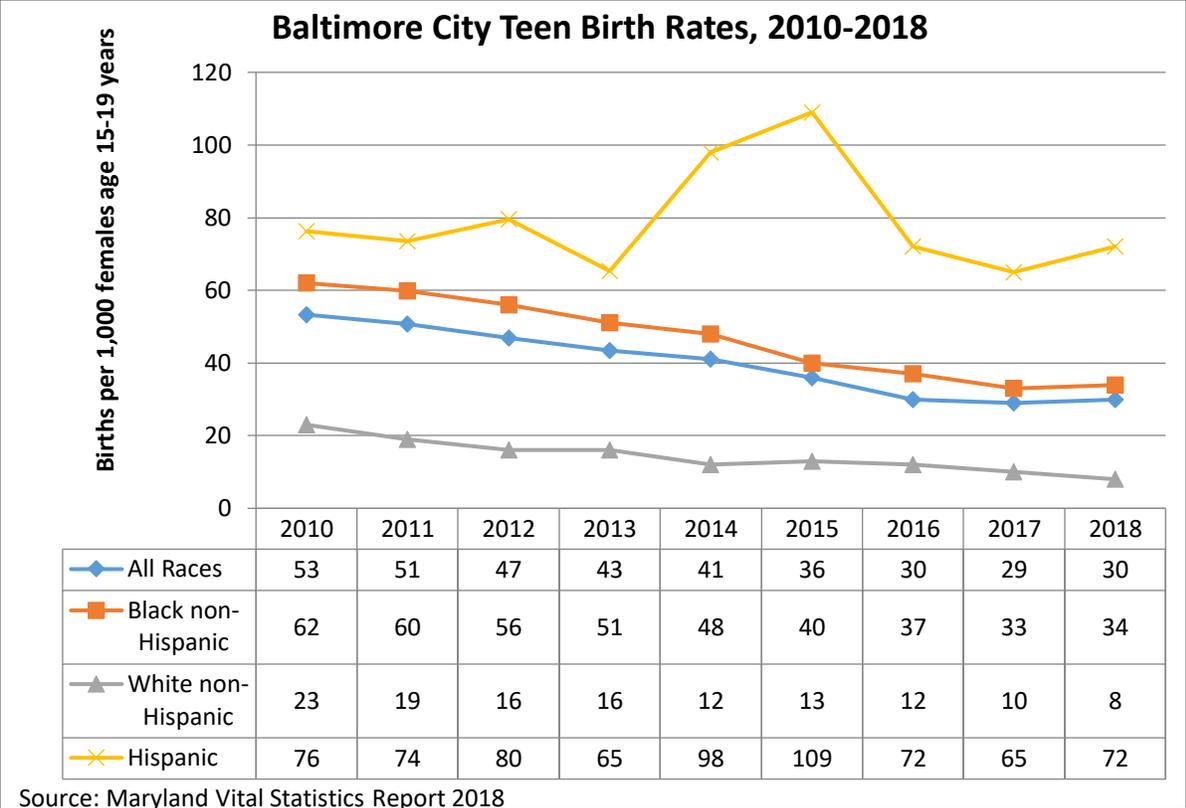
²⁵ Congressional Black Caucus Emergency Taskforce on Black Youth Suicide and Mental Health. Ring the Alarm: The Crisis of Black Youth Suicide in America.

https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf



Teen Pregnancy

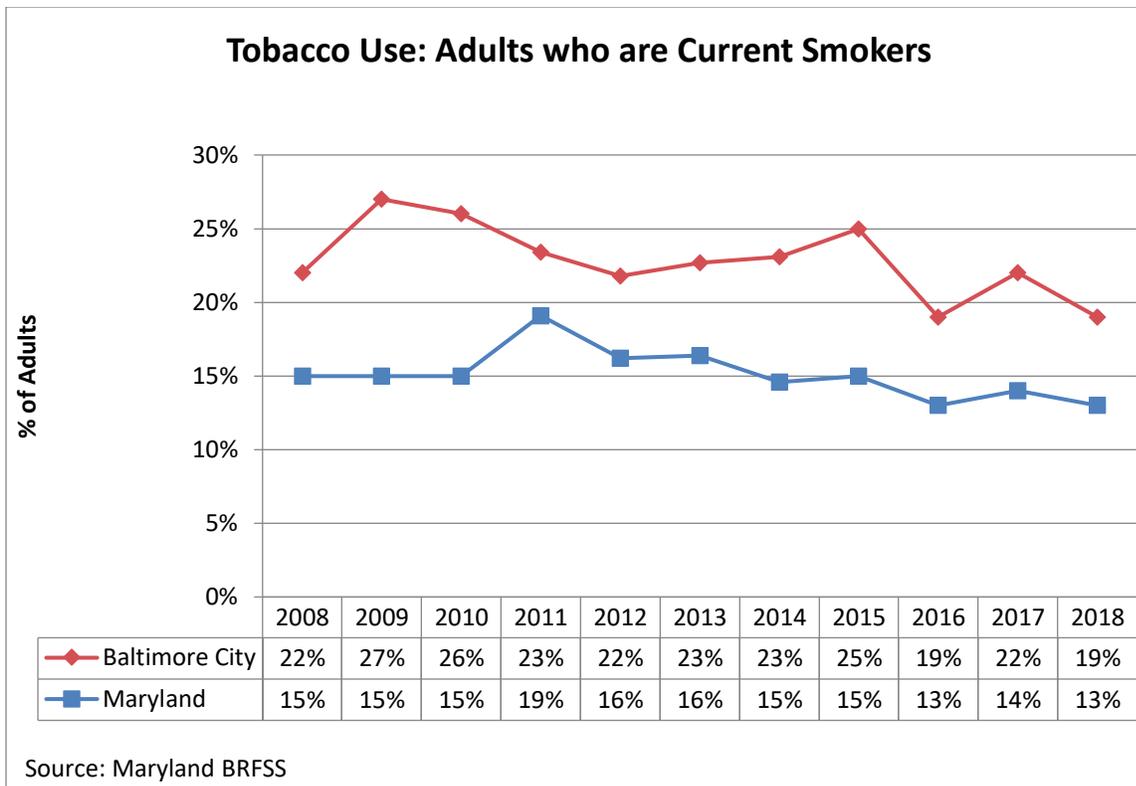
The overall Baltimore City and non-Hispanic White and Black population teen pregnancy rates have decreased or remained stable over the last five years through 2018, while the Hispanic rates have fluctuated but increased. The Hispanic teen pregnancy rates remain significantly higher than the non-Hispanic rates.



Tobacco Use

Tobacco use is a significant public health status indicator, as it results in approximately 480,000 premature deaths in the United States annually.²⁶ In the chart below, the BRFSS data shows that a higher percentage of adults in the city (19%) currently smokes cigarettes, as compared to the state (13%). The BRFSS survey also found that a higher rate of smokers who reside in Baltimore City (13.1%), compared to Maryland smokers (8.4%), identify themselves as daily smokers. A lower percentage of Baltimore City residents indicated use of e-cigarettes (2.7%) compared to the state (4.3%).

²⁶ https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm



Crime and Violence

Crime and violence remain serious problems in Baltimore City, with significant disparities between neighborhoods. In December 2020, Mayor Scott established the Office of Neighborhood Safety and Engagement, establishing public safety as a public health issue.²⁷ In 2019, Baltimore’s violent crime rate (murder, aggravated assault, robbery, and rape) (1,858.7 per 100,000) was over four times the statewide rate (454.1 per 100,000), and there were 25,748 property crimes.²⁸

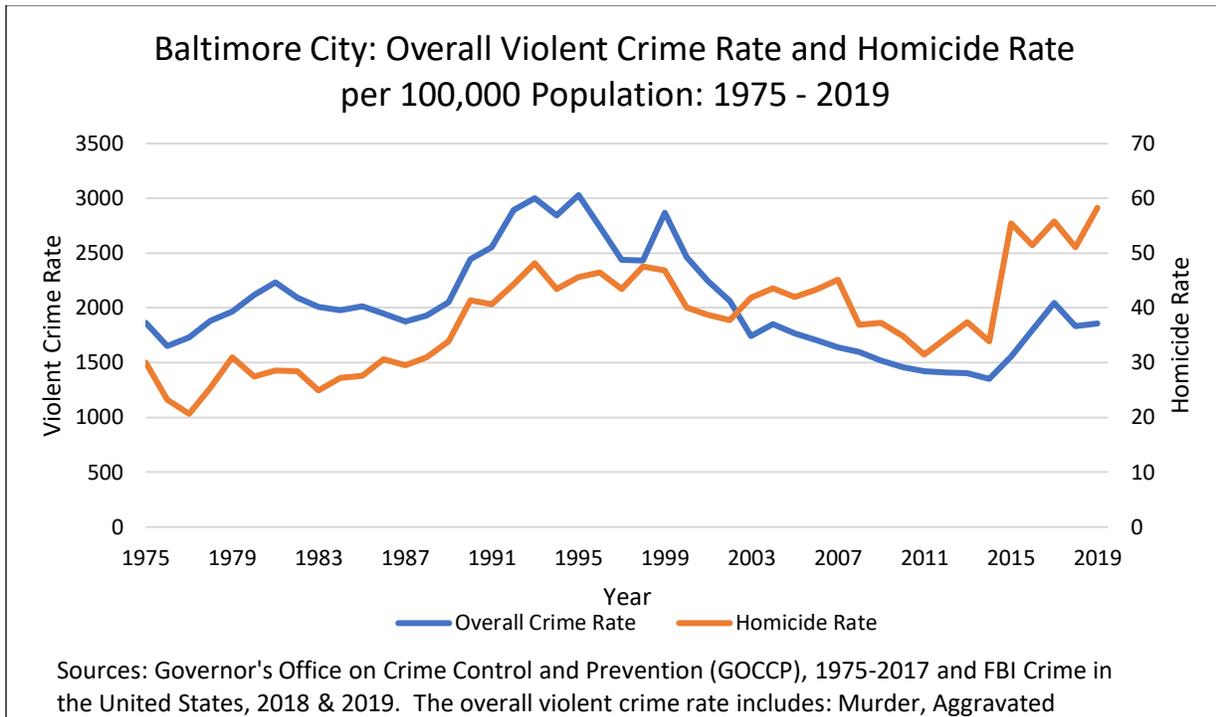
In 2019, the homicide rate was 58.3 per 100,000 individuals,²⁹ which is the first time the homicide rate has surpassed that of 2015, a time of significant social unrest. For all ages in 2019, homicide was the fifth leading cause of death in Baltimore City, the third leading cause of

²⁷ CBS Baltimore Staff. (23 December 2020). Baltimore Mayor Scott Establishes Office Of Neighborhood Safety & Engagement. <https://baltimore.cbslocal.com/2020/12/23/baltimore-mayor-scott-establishes-office-of-neighborhood-safety-engagement/>

²⁸ FBI Crime in the United States 2019, Tables 5 & 8. <https://ucr.fbi.gov/crime-in-the-u.s/2019/crime-in-the-u.s.-2019/topic-pages/violent-crime>

²⁹ FBI Crime in the United States 2019, Tables 8. <https://ucr.fbi.gov/crime-in-the-u.s/2019/crime-in-the-u.s.-2019/topic-pages/violent-crime>

death among Black city residents, and the leading cause of death for the 15-24, 25-34, and 35-44 age groups.³⁰



In addition to the tragic loss of life, each homicide has a traumatic impact on the individuals, families, and communities that survive the loss of a family member, friend, or acquaintance. Such losses, particularly when compounded by ACEs, systemic discrimination, community violence, food insecurity, and a lack of safe and affordable housing, can have long-term negative consequences on health and well-being, including mental health conditions, substance use, asthma, autoimmune, cardiac, and other chronic diseases.

Because crime victimization and other forms of violence and toxic stress do not always come to the attention of police, Emergency Medical Systems (EMS), or other health and social service professionals, surveys are an important tool to highlight the impact of crime, violence, and toxic stressors. According to the 2019 Youth Risk Behavior Surveillance Survey (YRBSS), 13.5% of Baltimore City high school students reported not going to school at least one day prior to the survey because they felt unsafe, an increase from 12.2% in 2017. In addition, 14.2% reported

³⁰ Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2019 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 1999-2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on Jan 8, 2021 12:39:52 PM.

being “being physically hurt on purpose... by someone they were going out with” one or more times in the last 12 months, an increase from 8.3% in 2017.³¹

Employment

Baltimore City’s unemployment rate is higher than Maryland and the United States, although the trend showed a steady decrease from 2010 to 2019. In 2019 the average unemployment rate for the city was 5.1%.³² The COVID-19 pandemic that hit the United States in March of 2020 caused the unemployment rate for 2020 to skyrocket. This will be discussed in the dual pandemics subsection of the data section of this report.

Homelessness

Homelessness is a persistent and growing problem in Baltimore City. In 2020, the *Baltimore City Continuum of Care: Point in Time (PIT) Count Report*³³ estimated 2,193 homeless individuals, a decrease of nearly 500 people since 2017. However, it is difficult to accurately count the number of homeless individuals, and data on the number are thought to be underestimates. Specifically, between July 2018 and June 2019, 11,800 homeless people were served in Baltimore City. The population that is identified as unsheltered makes up 13.6% of the homeless population. Among those living unsheltered, 51% were self-reported to have a serious mental illness, and 52% self-reported substance use issues. Of this group, 59% were African Americans, and 69% were considered chronically homeless.³⁴ The expectation is that homelessness has increased in the wake of the COVID-19 pandemic.

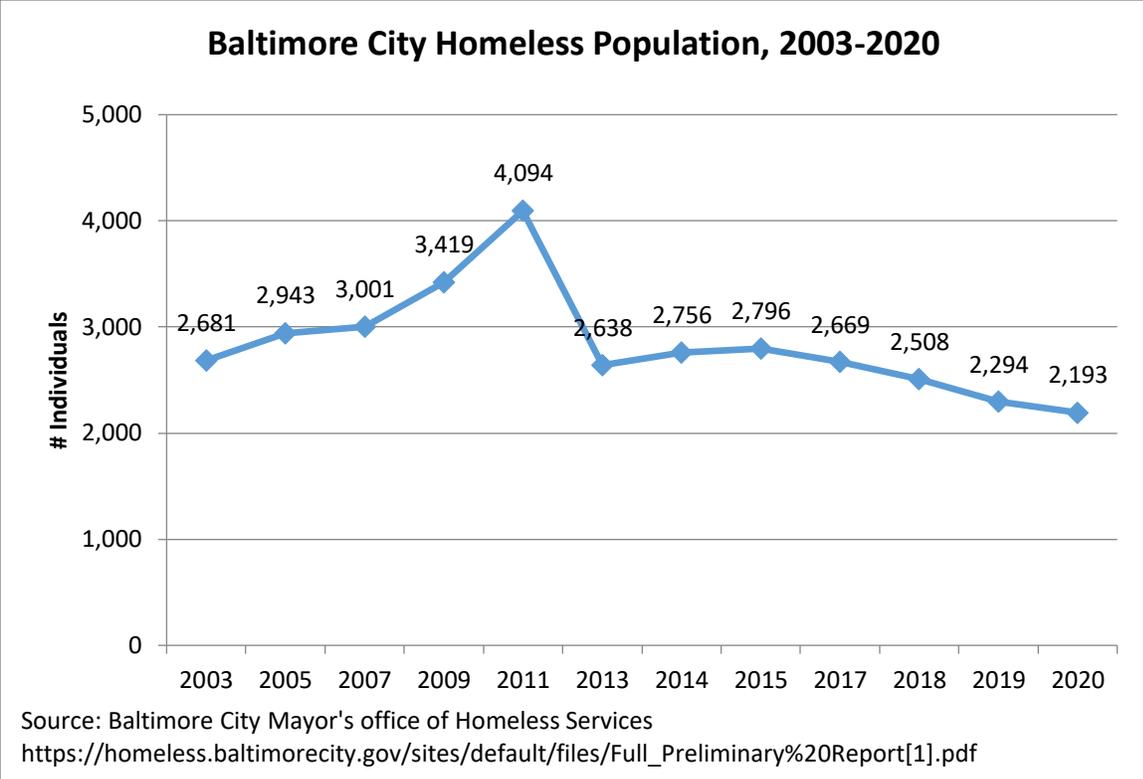
³¹ Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS) 2018-2019.

<https://phpa.health.maryland.gov/ccdpc/Reports/Pages/YRBS2018.aspx>

³² Local Area Unemployment Statistics, U.S. Bureau of Labor Statistics. <https://www.bls.gov/lau/>

³³ https://drive.google.com/file/d/197okMLOAT9BZXYNuxjSl_DXeVmNPnKcc/view

³⁴ Baltimore City Continuum of Care: Point in Time (PIT) Count Report. <https://homeless.baltimorecity.gov/hmis/read-2020-point-time-count>



Housing

Lack of access to safe and affordable housing is a significant obstacle to the recovery of individuals with behavioral health disorders. A widely accepted guideline sets a threshold of 30% of gross income to be spent on housing costs. During FY 2019 in Baltimore City, to stay under this threshold, a person earning minimum wage would have needed to work 2.4 full-time jobs to rent a two-bedroom apartment at fair market rent. This is comparable to the United States as a whole, but more affordable than Maryland.³⁵

Even when it is affordable, much of Baltimore’s housing stock is aging, substandard, or uninhabitable, with issues such as poor ventilation, mold, inadequate heating, and lead paint adversely impacting the health of residents. Of the city’s total housing, 57.4% was built before 1940, and 80.9% was built before 1960.³⁶ Owners and tenants struggle to maintain aging properties. As the data below indicate, Baltimore City’s vacancy rate is significantly higher than the state as a whole. It is also important to note that vacancy rates are generally underreported.

³⁵ National Low Income Housing Coalition. Out of Reach 2020. <https://reports.nlihc.org/oor/maryland>

³⁶ American Community Survey, 2019 5-year estimates

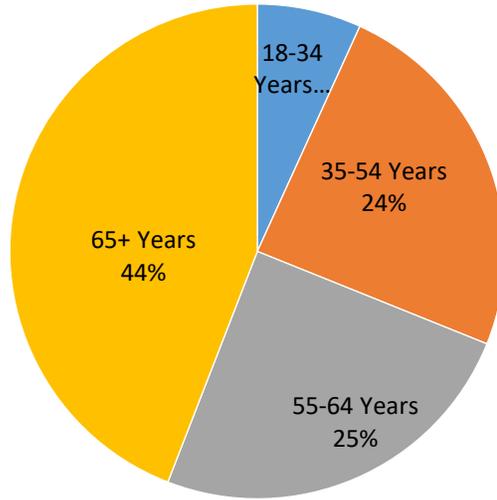
Characteristics of Housing		
	Baltimore City	Maryland
Total housing units	294,296	2,448,422
Occupied units	239,116 (81.3%)	2,205,204 (90.1%)
Vacant units	55,180 (18.7%)	243,218 (9.9%)
Vacancy rates		
Homeowner	4.0%	1.7%
Rental	7.7%	6.0%
Gross monthly rent		
Less than \$500	19,749 (16.2%)	52,062 (7.4%)
\$500 - \$999	33,902 (27.8%)	114,118 (16.2%)
More than \$999	68,640 (56.1%)	538,354 (76.4%)

The cost of housing relative to income is a significant barrier to safe and stable housing. The median monthly housing cost for renter-occupied units in Baltimore City was \$1,073, and 42.3% of renters were spending more than 35% of their household income on rent.

Veterans and War Returnees

The US Department of Veterans Affairs estimates that there are 33,034 veterans in Baltimore City, representing 8.6% of all veterans in Maryland. Adults ages 45-64 represent 42.7% of the city's veteran population, and adults over 65 years represent 40.6%. Because of the high prevalence of behavioral health needs of veterans and war returnees, this is a critical population.

Baltimore City Veterans by Age Group, 2015-2019



Source: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

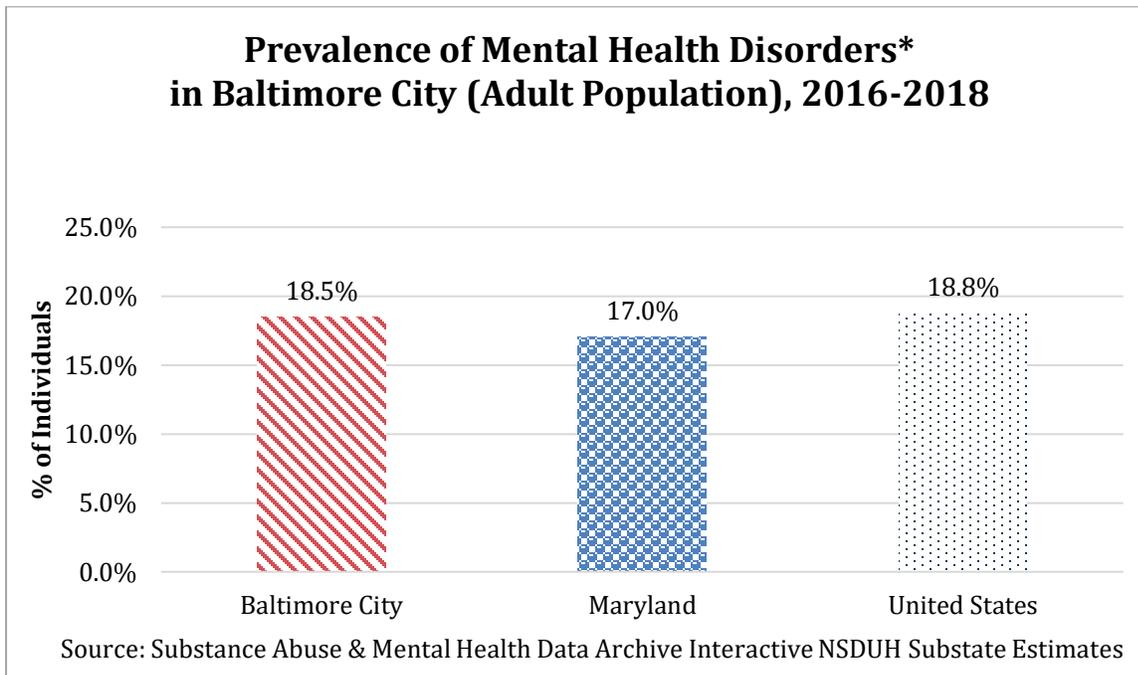
Behavioral Health Indicators of Baltimore City

Adults

The data from this section come from the Substance Abuse & Mental Health Data Archive Interactive NSDUH Substate Estimates.³⁷ The data reflect three-year rolling rates, which accounts for the small sample population in county-level jurisdictions.

Prevalence of Mental Illness

Although the rate of any mental illness during 2016-2018 in Baltimore City (18.5%) was higher than the state rate (17.0%), it remains comparable to the national rate (18.8%). Any Mental Illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, which met the criteria found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

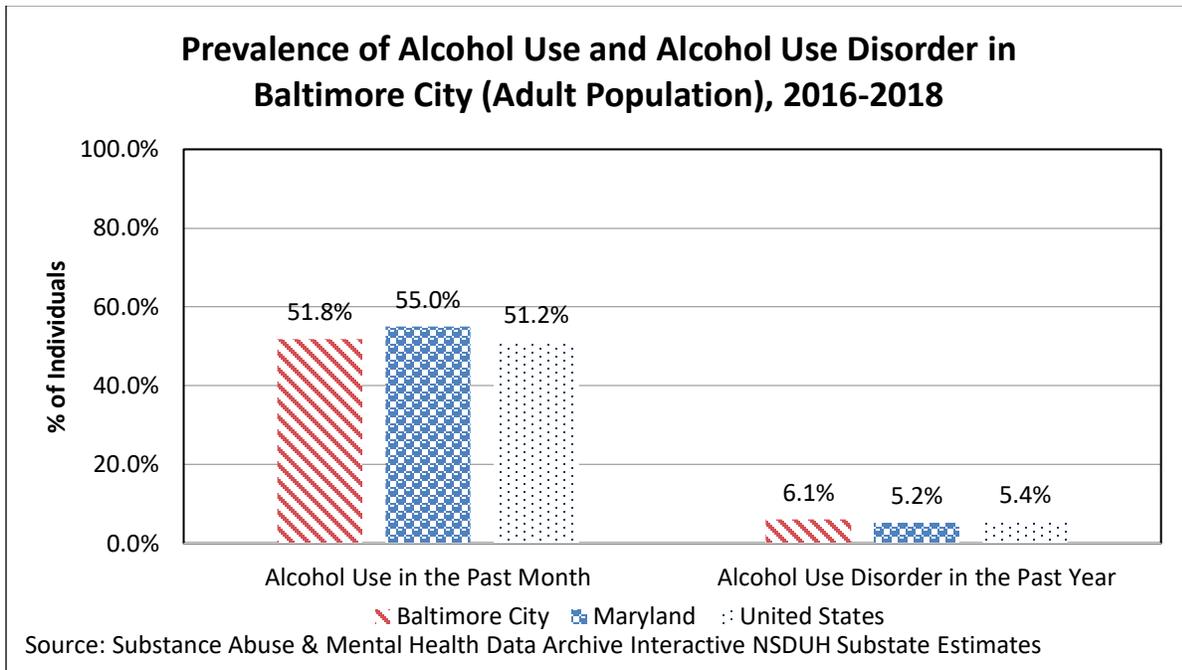


The state and city rates of a major depressive episode in the past year were 6.6%, slightly below the nationwide rate (7.0%). The Baltimore City rate for serious mental illness (4.2%) was similar to the state (4.0%) and nation (4.5%), as were serious thoughts of suicide for the city (4.5%), the state (4.0%) and the nation (4.2%).

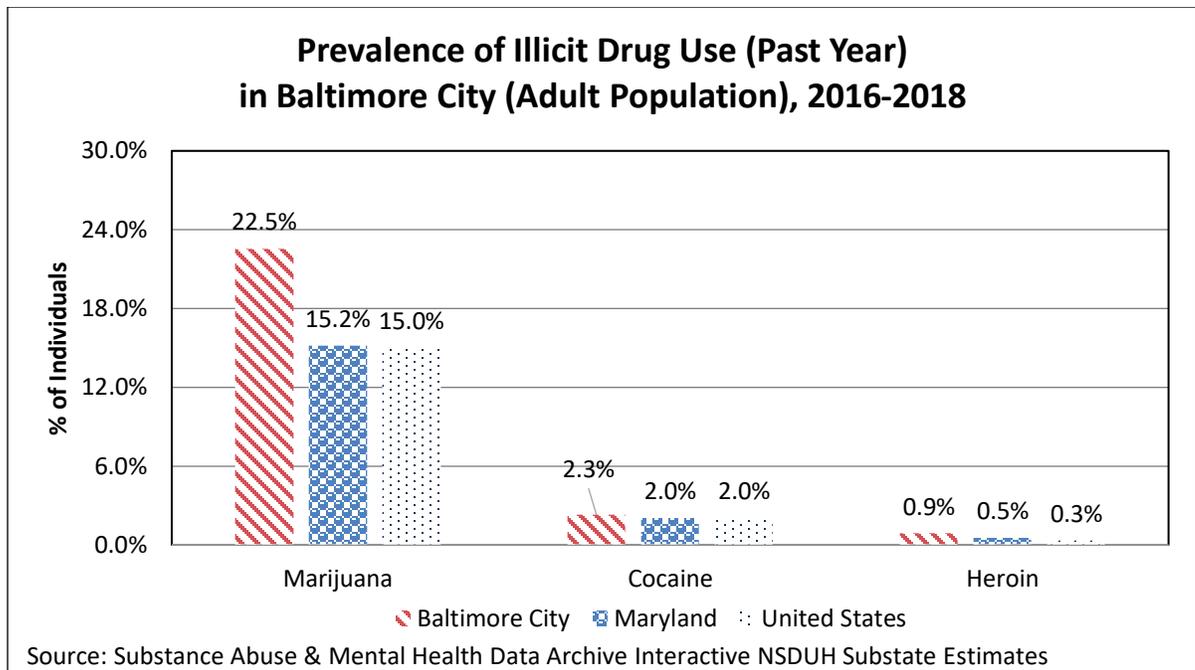
³⁷ <https://pdas.samhsa.gov/saes/substate>

Prevalence of Substance Use Disorders

Rates of alcohol use in the past month are high for Baltimore City (51.8%), Maryland (55.0%), and the United States (51.2%). Baltimore showed a higher prevalence for alcohol use disorder (6.1%) than both the state (5.2%) and the country (5.4%).



The rate of marijuana use in the past year for Baltimore City (22.5%) was 1.5 times greater than the statewide (15.2%) and national (15.0%) rates. Likewise, the rate of cocaine use in the past year for Baltimore City (2.3%) was greater than the state (2.0%) and national (2.0%) rates. A similar pattern is seen with the rate of heroin use. It is important to note that though the Baltimore City heroin use rate is less than twice that of the state, the overdose death rate in Baltimore City is nearly four times that of the state. This points to the impact of systemic racism and other social determinants of health on the outcomes of those with behavioral health conditions.



Youth

The data in this section come from the Youth Risk Behavior Surveillance System, which is available from both the Centers for Disease Control and Prevention³⁸ and the Maryland Department of Health.³⁹

Prevalence of Mental Illness

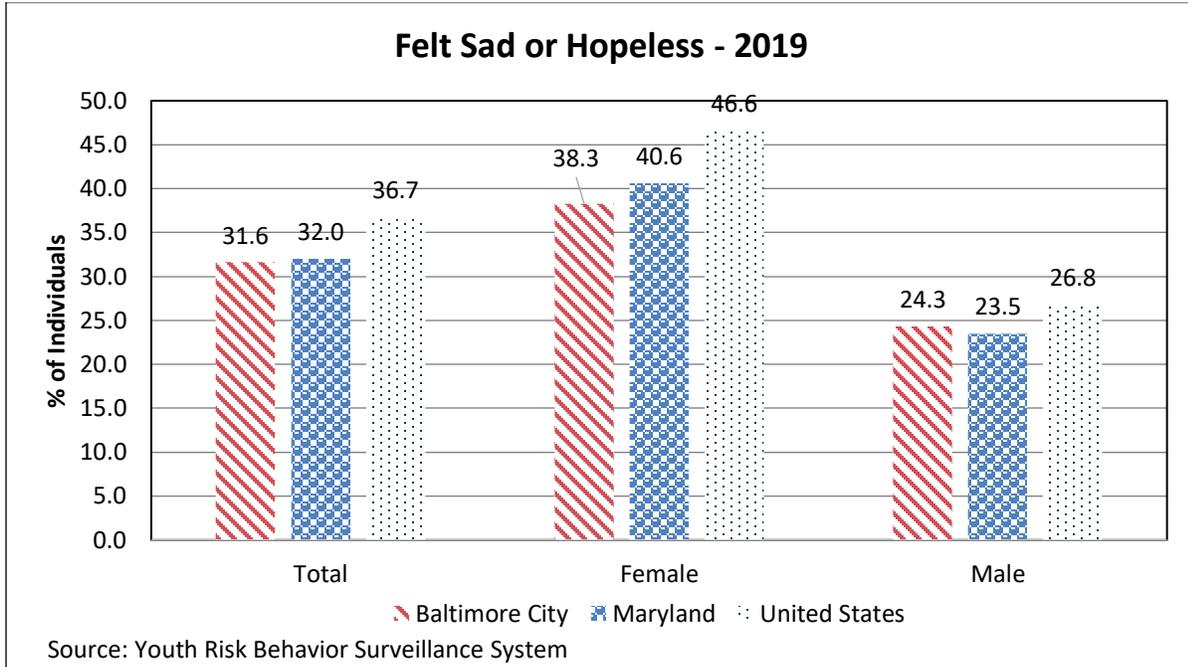
The Maryland Youth Risk Behavior Surveillance System (YRBSS) offers a unique look into the emotional needs and behavioral health risks of youth in Baltimore City. When evaluating YRBSS data, it is important to note that the results come from a representative sample of Baltimore City public middle and high school classrooms - which only includes students in attendance at the time of the survey administration. The survey is not required to be completed by all Baltimore City Public School students. Therefore, the data may not reflect the perspectives of disengaged youth (e.g., youth who experience barriers to school engagement).

A large percentage (31.6%) of high school students in Baltimore City reported feeling sad or hopeless in the prior twelve months. These rates were similar in Maryland (32.0%) but lower than the nationwide rate (36.7%). The percentage of high school students who seriously considered attempting suicide in Baltimore City (18.4%) was comparable to both the state (18.0%) and national (18.8%) rates. The percentage of high school students who made a suicide plan was higher in the city (19.5%) than the state (16.2%) and the nation (15.7%). Rates of

³⁸ <https://www.cdc.gov/healthyouth/data/yrbs/results.htm>

³⁹ <https://phpa.health.maryland.gov/ccdpc/Reports/Pages/YRBS2018.aspx>

hopelessness (51.3%), suicidal ideation (41.9%), and plans to die by suicide (37.3%) were especially high among youth in the city who identified as lesbian, gay, or bisexual.^{40,41}

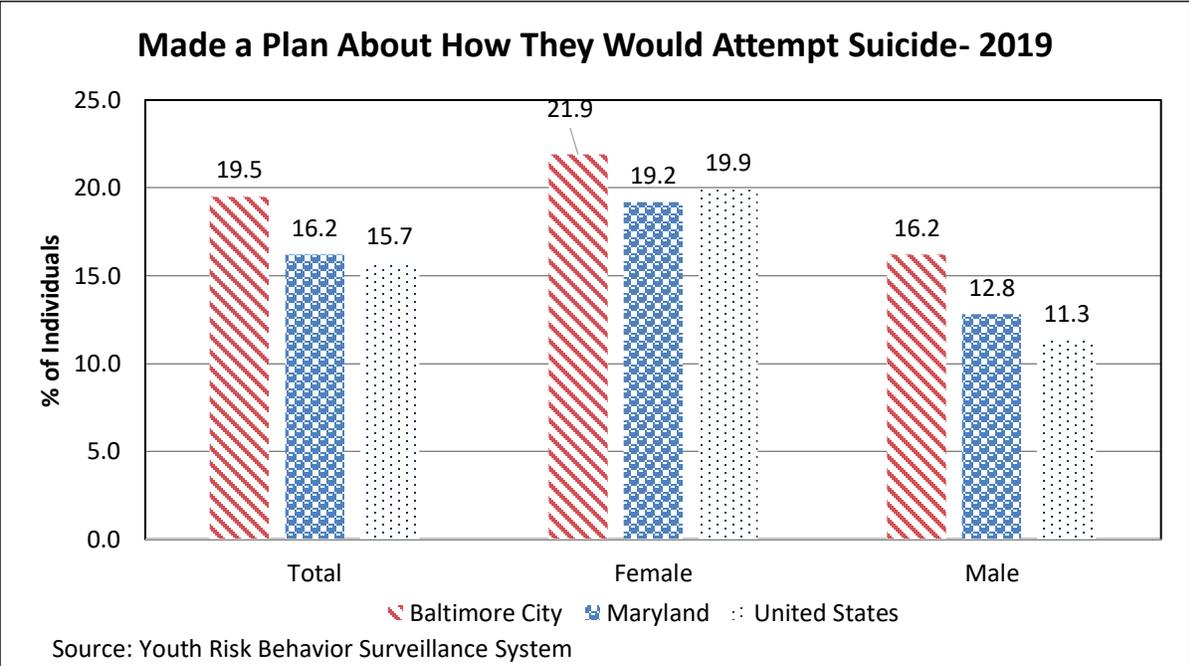
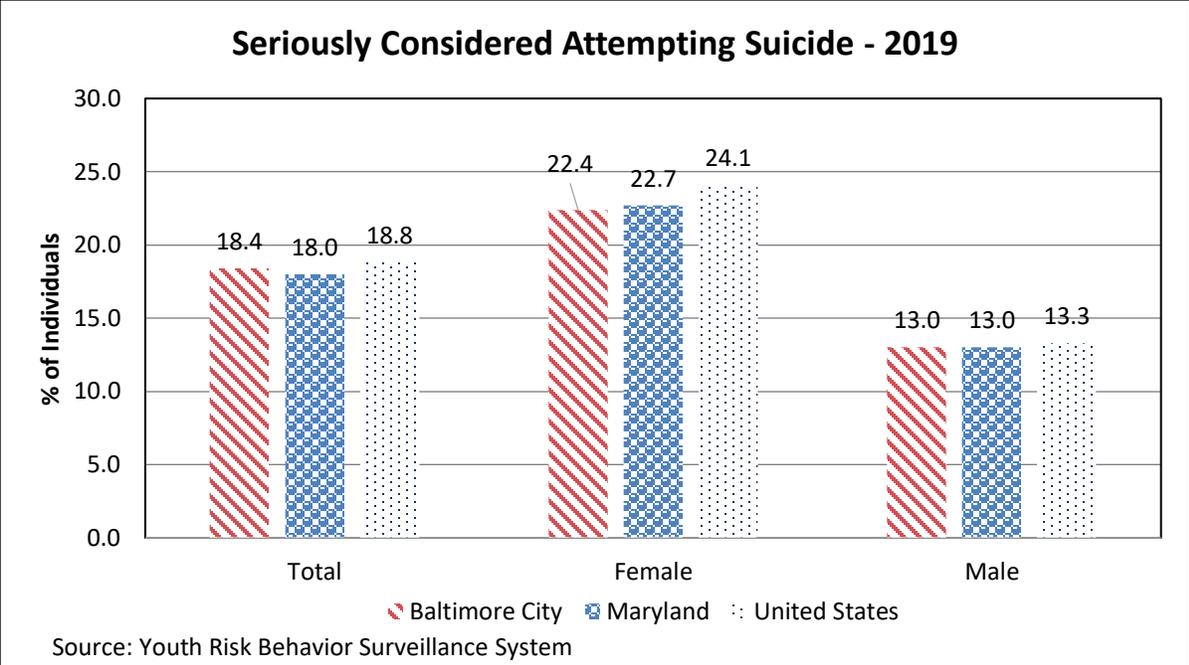


⁴⁰ Centers for Disease Control and Prevention. YRBSS Results.

<https://www.cdc.gov/healthyyouth/data/yrbs/results.htm>

⁴¹ Maryland Department of Health. Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS) 2018-2019.

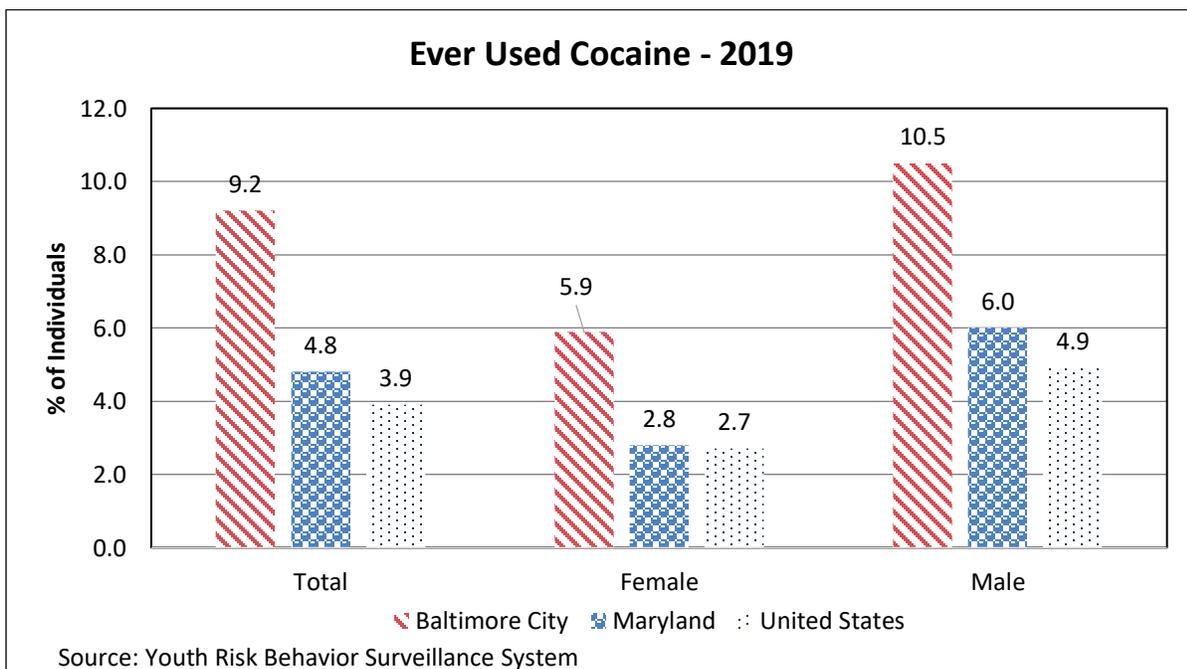
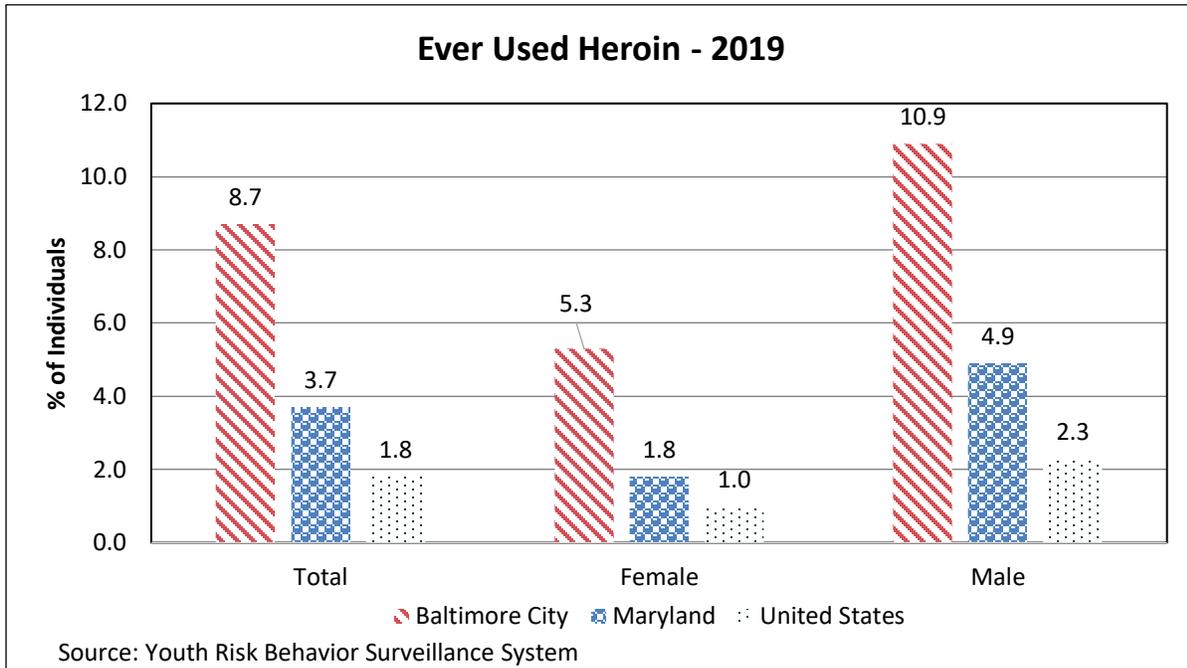
<https://phpa.health.maryland.gov/ccdpc/Reports/Pages/YRBS2018.aspx>

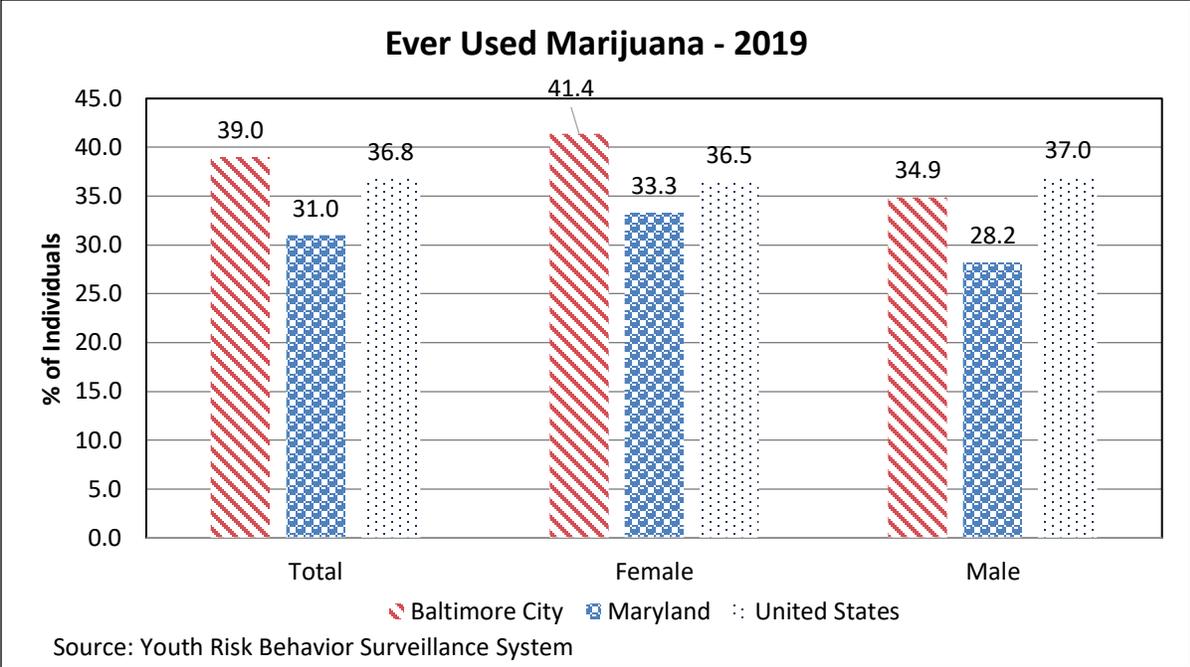


Prevalence of Substance Use

The next four charts demonstrate that a large percentage of high school students use drugs and alcohol, with the rate of use being substantially higher in Baltimore City than in Maryland and the United States for everything except alcohol. The percentage of high school students who ever used heroin is 8.7% for Baltimore City, versus 3.7% for Maryland and 1.8% nationally. This

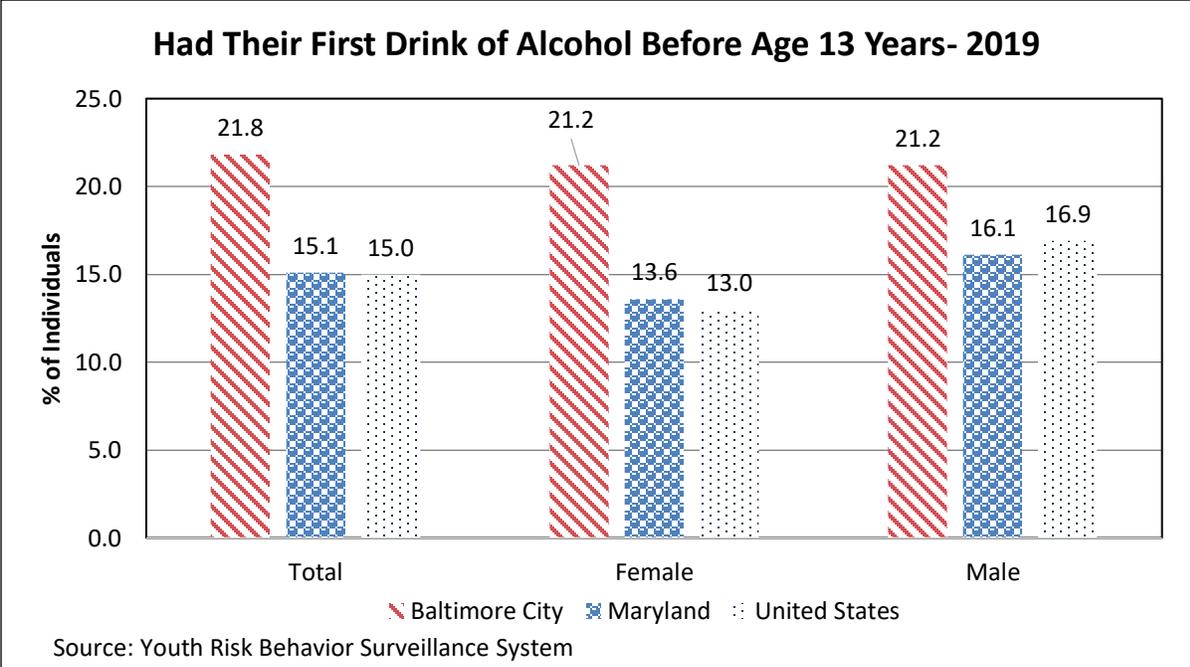
is a striking finding as a proxy of the heroin incidence and highlights the possible perpetuation of the opioid overdose epidemic in the coming years. It is an urgent warning call for prevention and health promotion strategies. Use of cocaine reflected similar disparities between Baltimore City (9.2%), the state (4.8%), and national (3.9%) prevalence rates. Use of marijuana is very prevalent (39.0%) in Baltimore City. Although the rate has declined in the past two years, it remains higher than the state (31.0%) and national (36.8%) rates.



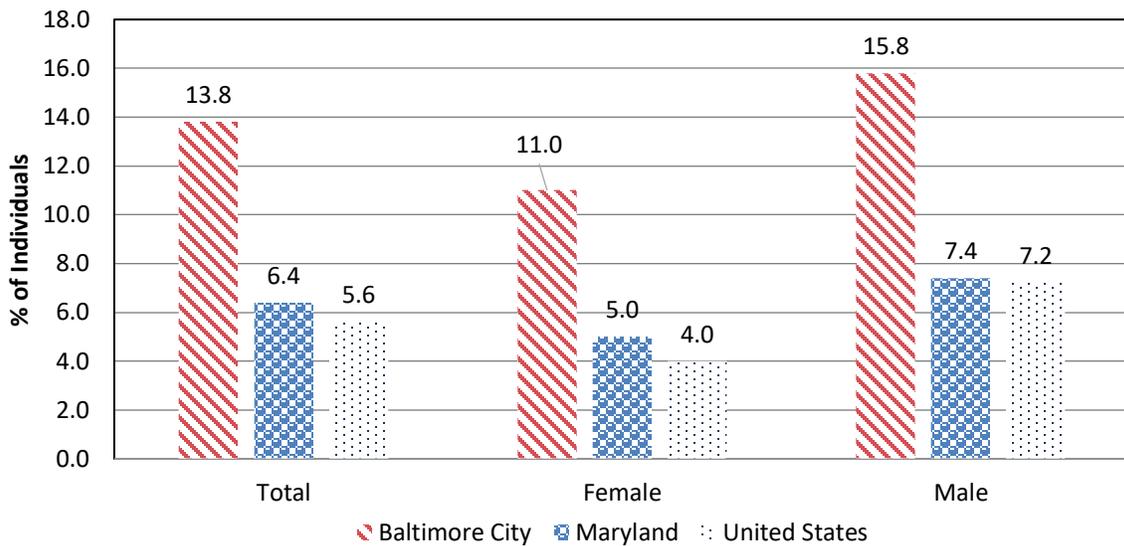


Baltimore City’s current alcohol use among youth (21.9%) was lower than the national average (29.2%), although close to the Maryland average (24.1%).

The next two charts reflect that a large percentage of youth began using marijuana or alcohol before the age of 13, again with the rate of use being higher for Baltimore City than Maryland or the United States.



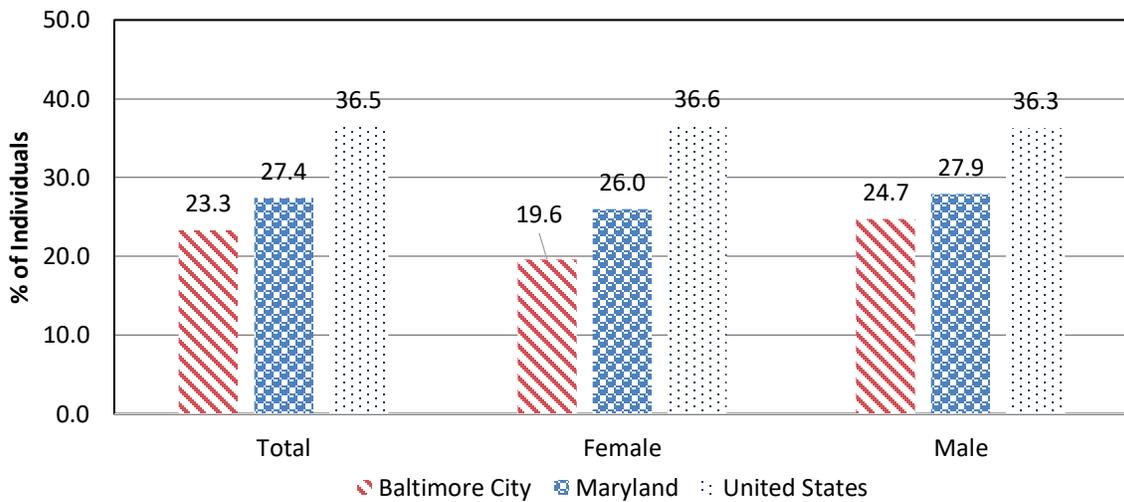
Tried Marijuana for the First Time Before Age 13 Years- 2019



Source: Youth Risk Behavior Surveillance System

Baltimore City youth use tobacco (cigarettes, cigars, smokeless tobacco, or e-cigarettes) at a lower rate (23.3%) than youth in the state (27.4%) and the nation (36.5%).

Currently Smoked Cigarettes or Cigars or Used Smokeless Tobacco or an Electronic Vapor Product- 2019



Source: Youth Risk Behavior Surveillance System

Impact of the Dual Pandemics, COVID-19 and Racial Trauma, on the Public Behavioral Health System

COVID-19 pandemic

One of the largest factors impacting utilization of the public behavioral health system in 2020 was the COVID-19 pandemic that hit the United States en masse in March of 2020 and persisted throughout the year and into 2021. According to a study published by the CDC⁴², anxiety symptoms in the United States during 2020 were three times what they were in 2019, and depression symptoms showed a fourfold increase over the same time period. A youth survey conducted by Mental Health America⁴³ concluded that nearly half of teens aged 14-18 and more than half of LGBTQ (lesbian, gay, bisexual, transgender, and queer or questioning) teens in the same age group felt hopeless about the future. Horesh and Brown contend that although a large proportion of persons exposed to COVID-19 will possess resiliency to its effects, there will be a proportion of those who are more susceptible to symptoms related to post traumatic stress disorder.⁴⁴

According to *USA Today*,⁴⁵ a Harris Poll showed that 54% of Americans feared losing their job because of COVID. In Baltimore City, the unemployment rate, which had remained steady, fluctuating between 4.7% and 5.8% in the year prior to COVID-19, skyrocketed to 11.6% in April 2020. While the unemployment rate decreased over the course of the next six months, by September 2020, the unemployment rate was still more than double what it had been in March 2020.⁴⁶

Racial Trauma Pandemic

A longitudinal cohort study of 63,666 participants found a higher prevalence of post-traumatic stress disorder (PTSD) among Black adults (17.0%) when compared to White adults (7.2%) even though both groups were exposed to the same traumatic event.⁴⁷ PTSD has been found to be linked to perceived discrimination, racial microaggressions, and racial stigmatization. When

⁴² Czeisler, et al. (14 August 2020). Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. *Morbidity and Mortality Weekly Report*. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm>.

⁴³ Young People's Mental Health In 2020: Hope, Advocacy, And Action For The Future. (9 December 2020).

<https://mhanational.org/blog/new-report-young-peoples-mental-health-2020-hope-advocacy-and-action-future>

⁴⁴ Horesh, D., & Brown, A. D. (2020). Traumatic stress in the age of COVID-19: A call to close critical gaps and adapt to new realities. *Psychological Trauma: Theory, Research, Practice, and Policy*, 12(4), 331-335.

⁴⁵ Menton. (7 August 2020). 'I'm too old to find a new career': More than half of Americans fear job losses. *USA Today*. <https://www.usatoday.com/story/money/2020/08/07/unemployment-benefits-more-than-half-americans-fear-job-losses/3301149001/>

⁴⁶ Bureau of Labor Statistics. MD Office of Workforce Information & Performance. Released 10/28/20.

⁴⁷ Giesinger I, Li J, Takemoto E, Cone JE, Farfel MR, Brackbill RM. (2020). Association between posttraumatic stress disorder and mortality among responders and civilians following the September 11, 2001 disaster. *JAMA Network Open*, 3(2), e1920476.

comparing the differential experiences of racism among African Americans, Asian Americans, and Hispanic Americans, African Americans experienced significantly more episodes of discrimination. Williams and colleagues proposed that the differential experiences of racism may provide some explanations for the etiology of PTSD among African Americans.⁴⁸ For example, Holliday and colleagues found that among a sample of 806 participants living in low-income predominantly African American neighborhoods, any person who reported experiencing any discrimination, was significantly more likely to meet criteria for PTSD.⁴⁹

Intersection of the COVID-19 and Racial Trauma Pandemics with the Impact of Structural Racism

The intersection the COVID-19 and racial trauma pandemics with the legacy of structural racism has resulted in a disproportionate impact of harm experienced by Black people. In 2020, the rate of COVID-19 deaths per 100,000 population was 123.7 for Black Americans, compared with 75.7 for White Americans.⁵⁰ The higher rate of PTSD among African Americans⁵¹ suggests that the behavioral health impact of COVID-19 could be more acutely felt by members of Black communities.⁵²

Loss of employment has also been more prominent among Black individuals. In January 2021, CNN reported that the United States had lost 140,000 jobs in December 2020, and that all of these jobs were held by women---specifically Black and Hispanic women.⁵³ A closer look at the data from the Bureau of Labor Statistics indicates that while the number of employed individuals dropped by 5.2% among White workers from December 2019 to December 2020, the number of employed Black individuals dropped by 8.3% in the same time frame.⁵⁴

⁴⁸ Williams, M. T., Metzger, I. W., Leins, C., & DeLapp, C. (2018). Assessing racial trauma within a DSM–5 framework: The UConn Racial/Ethnic Stress & Trauma Survey. *Practice Innovations*, 3(4), 242-260.

⁴⁹ Holliday, S., Dubowitz, T., Haas, A., Ghosh-Dastidar, B., DeSantis, A., & Troxel, W. M. (2018). The association between discrimination and PTSD in African Americans: exploring the role of gender. *Ethnicity & Health*, 25(5):717-731.

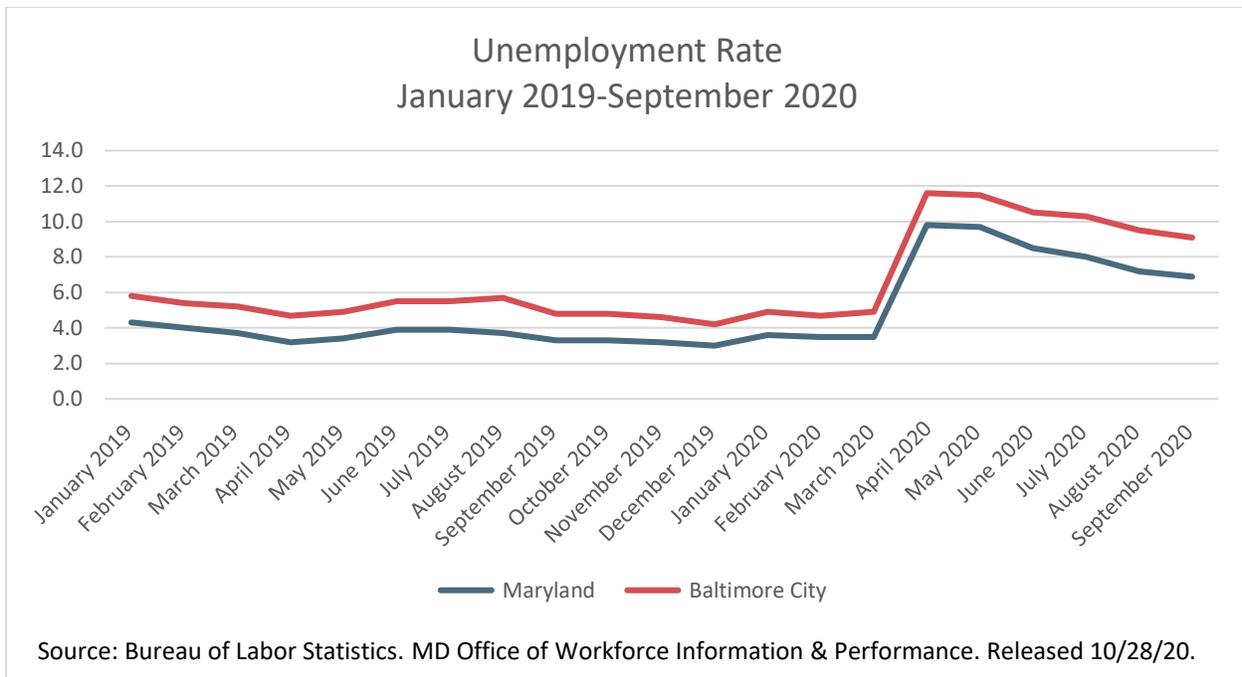
⁵⁰ Egbert, A. & Liao, K. (21 December 2020). The Color of Coronavirus: 2020 Year in Review. APM Research Lab. <https://www.apmresearchlab.org/covid/deaths-2020-review>.

⁵¹ Holliday, S., Dubowitz, T., Haas, A., Ghosh-Dastidar, B., DeSantis, A., & Troxel, W. M. (2018). The association between discrimination and PTSD in African Americans: exploring the role of gender. *Ethnicity & Health*, 25(5):717-731.

⁵² Giesinger I, Li J, Takemoto E, Cone JE, Farfel MR, Brackbill RM. (2020). Association between posttraumatic stress disorder and mortality among responders and civilians following the September 11, 2001 disaster. *JAMA Network Open*, 3(2), e1920476.

⁵³ Kurtz, A. (8 January 2021). The Economy Lost 140,000 Jobs in December. All of Them Were Held by Women. CNN. <https://www.cnn.com/2021/01/08/economy/women-job-losses-pandemic/index.html>.

⁵⁴ Bureau of Labor Statistics. (December 2020). The Employment Situation – December 2020. Table A-2. <https://www.bls.gov/news.release/pdf/empsit.pdf>.



Suicidal Behavior and the Dual Pandemics

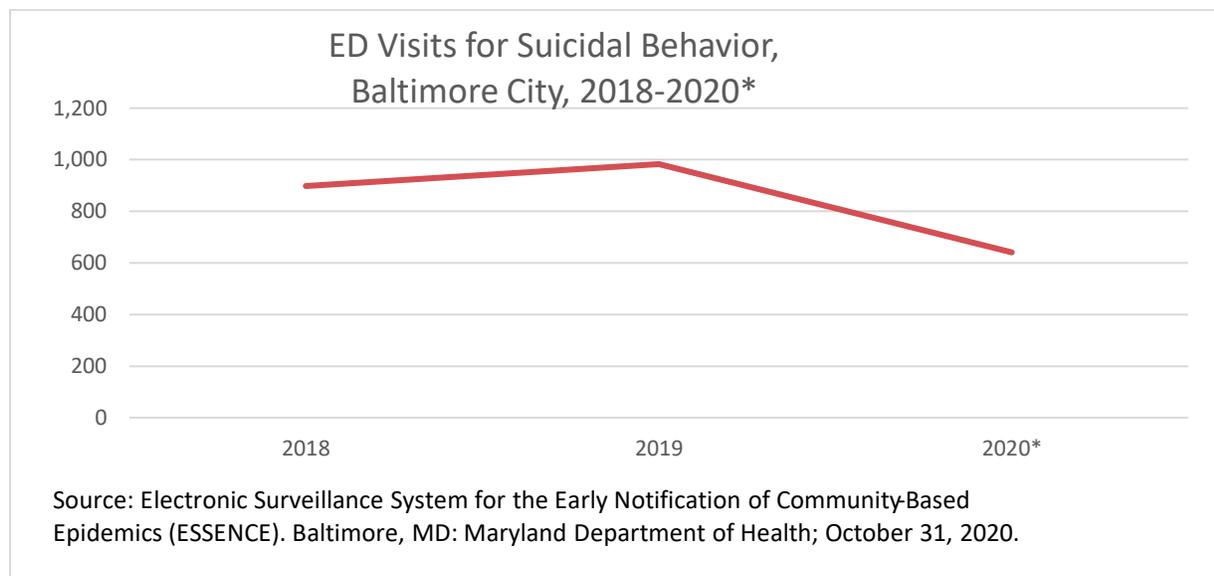
The following reported numbers for 2020 are based on estimates for the last two months of the year. These estimates assume that the final months of the year are proportional to the rest of the year.

Both Baltimore City and the state of Maryland experienced a decrease in the number of emergency department (ED) visits for suicidal behavior between 2019 and 2020 after an increase from 2018 to 2019.⁵⁵ The drop in ED visits from 2019 to 2020 in both jurisdictions was likely due in part to decreased use of the ED during the COVID-19 pandemic for non-COVID-related purposes, out of fear of contracting the virus. Moreover, there are fewer structured events, particularly for youth, which may lead to less reporting of suicidal behavior and thus fewer ED visits. The decrease in ED visits for suicidal behavior in 2020 in Baltimore City was more substantial than that in the state. This may be because fewer individuals are traveling into the city, specifically to Johns Hopkins, which has the space and resources for psychiatric evaluation. This may especially account for the decrease among the youngest age group, as foster care cases are often taken to Johns Hopkins when abuse or neglect is suspected.

The racial trauma pandemic also impacts the number of suicidal behavior ED visits in the city. Though according to the American Community Survey, approximately 62% of the Baltimore City population is Black, approximately 68% of ED visits for suicidal behavior in 2019 and 69% in

⁵⁵ Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE). Baltimore, MD: Maryland Department of Health; October 31, 2020.

2020 were by Black consumers. Moreover, though the overall number of ED visits for suicidal behavior increased from 2018 to 2019, this increase reflects changes among the Black and Other Race populations; the White population experienced a decrease.⁵⁶



Overdoses and the Dual Pandemics

The following reported numbers for 2020 are based on estimates for the last two months of the year (for all overdose-related data except for deaths). These estimates assume that the final months of the year are proportional to the rest of the year.

Baltimore City and Maryland had decreases in ED visits for opioid overdoses over the three-year period from 2018 to 2020,⁵⁷ as well as decreased hospital visits for both opioid use and any substance use.⁵⁸ However, the overall number of suspected overdoses remained stable from 2019 to 2020,⁵⁹ and the overdose death rates increased slightly (4.6% for all overdoses and 5.5% for opioid-related overdoses) from the first nine months of 2019 to the first nine months of 2020.⁶⁰ This implies that the drug utilization behavior and overdose outcomes did not change in 2020, but the response behavior did change. One factor that may have caused these decreases in ED visits in Baltimore City over this period is increased utilization of the Maryland

⁵⁶ Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE). Baltimore, MD: Maryland Department of Health; October 31, 2020.

⁵⁷ Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE). Baltimore, MD: Maryland Department of Health; October 31, 2020.

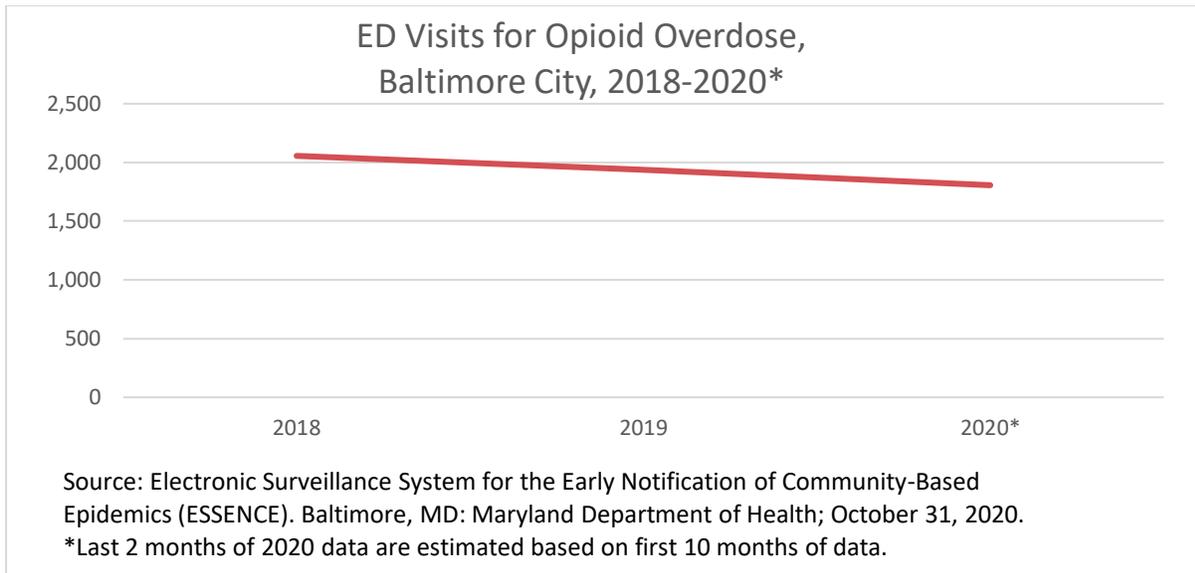
⁵⁸ Maryland Overdose Hospital Events Program, 01/01/2018-09/30/2020. Maryland Department of Health. Accessed via CRISP Drug-Related Indicators Dashboards. November 16, 2020.

⁵⁹ ODMAP. Baltimore, MD: Maryland Department of Health; October 31, 2020.

⁶⁰ Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland https://health.maryland.gov/vsa/Documents/Overdose/Quarterly%20Drug_Alcohol_Intoxication_Report_2020_Q3.pdf

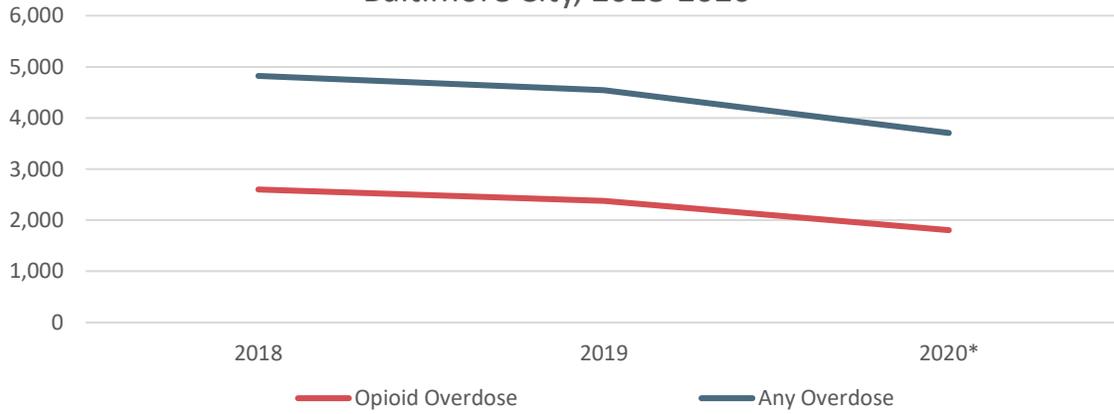
Crisis Stabilization Center, which diverts overdose cases from the ED. Additionally, as with suicidal behavior, people who overdosed may have been less willing to go to the hospital for fear of contracting COVID-19. Worth noting is that despite a policy change that loosened restrictions on take-home methadone dispensed by medication-assisted treatment programs, preliminary data suggests that the city did not experience a large increase in overdose deaths in 2020.

The racial trauma pandemic and ongoing impact of structural racism also impact the number of overdoses in the city. Though according to the American Community Survey approximately 62% of the Baltimore City population is Black, approximately 76% of ED visits for opioid overdose in 2019 and 2020 were by Black consumers. Moreover, though the overall number of ED visits for opioid overdose decreased from 2018 to 2019, this decrease occurred among White consumers; Black consumers had an increase in ED visits for opioid overdose over this time period.⁶¹



⁶¹ Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE). Baltimore, MD: Maryland Department of Health; October 31, 2020.

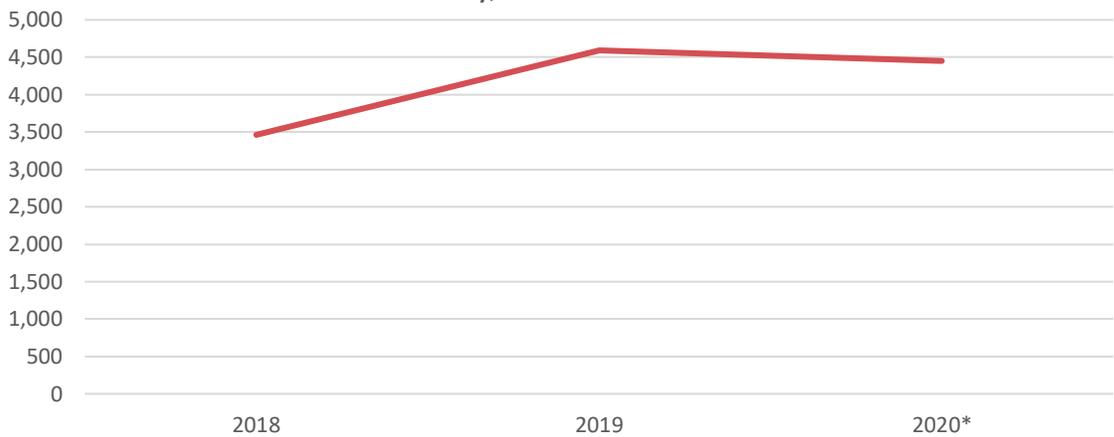
Hospitalizations for Overdose, Baltimore City, 2018-2020*



Source: Maryland Overdose Hospital Events Program, 01/01/2018-09/30/2020. Maryland Department of Health Accessed via CRISP Drug-Related Indicators Dashboards. November 16, 2020.

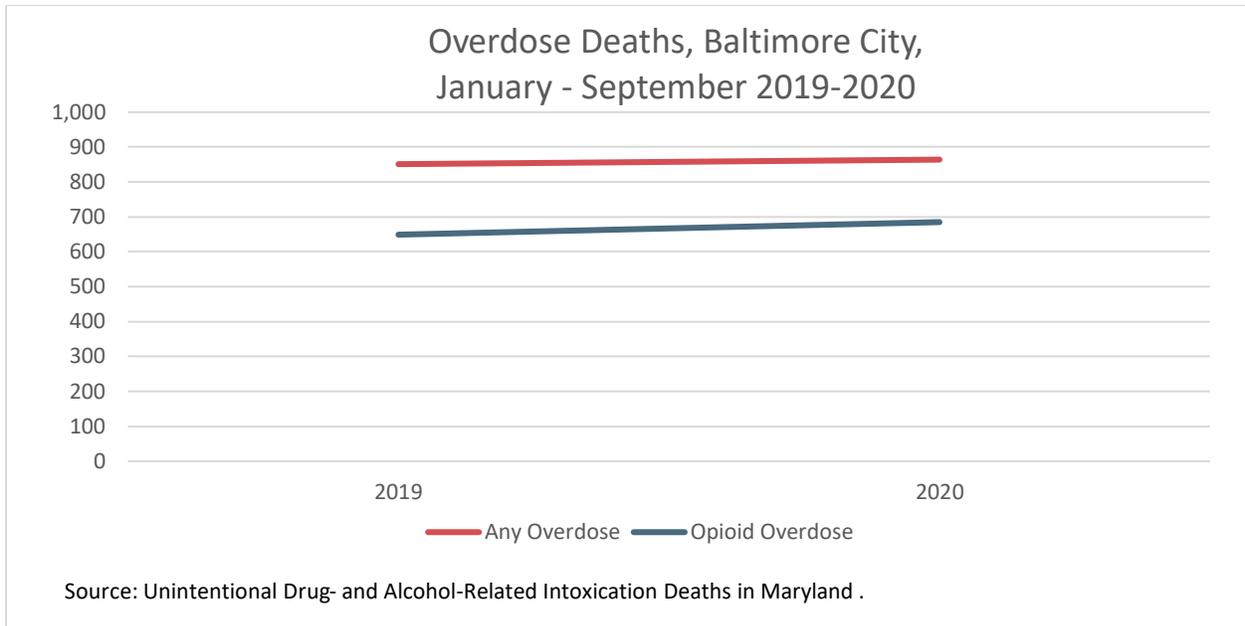
*Last 2 months of 2020 data are estimated based on first 10 months of data.

Suspected Overdoses, Baltimore City, 2018-2020*



Source: ODMAP. Baltimore, MD: Maryland Department of Health; October 31, 2020.

*Last 2 months of 2020 data are estimated based on first 10 months of data.



Utilization of Public Behavioral Health System Services

FY 2020 system utilization is not available due to challenges with the Administrative Service Organization, which has contracted with the Maryland Department of Health to administer Maryland’s public behavioral health system (PBHS). However, estimates from the Hilltop Institute indicate that 44.6% of the Baltimore City population is Medicaid eligible in FY 2021, an increase from 42.6% in FY21. Based on the Medicaid penetration rate from FY 2019 of 21.6% for mental health and 12.4% for substance use disorders, the estimated increase in utilization from FY 2019 to FY 2021 is approximately 2,300 consumers in mental health services and 1,300 consumers in substance use disorder services. Due to an increase in behavioral health symptoms and conditions due to the dual pandemics, these estimates may undercount the increase in those requiring services.

H. FY 2022 Goals

BHSB’s Board of Directors serves in a governing role, guiding the strategic vision for the organization. In addition, it serves as the local mental health advisory council and the local drug and alcohol council as defined by the State of Maryland. BHSB’s Board of Directors, along with staff, engaged in a strategic planning process during FY 2016 that resulted in a strategic plan to guide the organization through the next few years (2017 - 2020). It included 13 goals, 42 objectives, and 155 action steps. The board assigned oversight of the strategic plan implementation to the Operations and Oversight Committee.

During the fall of 2018, the Operations and Oversight Committee advised staff that the plan should be reframed to reduce its scope and focus the work of the organization on a smaller

number of broad, overarching goals. During the winter and spring of 2019, staff collaborated with the committee members to develop a revised plan. One of the primary data sources that informed this work was the *Baltimore Public Behavioral Health System Gap Analysis* report, which incorporated significant stakeholder involvement, involving 166 individuals who participated in key informant interviews or focus groups, including at least 48 consumers or family members.

The resultant *Three-Year Strategic Plan: FY 2020-2022* serves as a guide to drive BHSB's day-to-day work. To be responsive to system partners and the needs of the community, it sets a strategic direction that supports ongoing, adaptive learning and agility. To this end, each year BHSB reviews progress, assesses changing conditions, and creates action steps that will guide implementation activities for the subsequent year of this plan.

Some FY 2020 action steps were not completed because they reflected work that is ongoing beyond the boundaries of a single year. Others were not completed because BHSB adapted the work in response to shifting conditions. Action steps that were not completed or only partially completed were either revised for FY 2021 to make them more meaningful, measurable, and specific, or they were eliminated based on shifting conditions. BHSB's *Three-Year Strategic Plan, FY 2020 Implementation Report* is attached as Addendum D.

BHSB's analysis of the first year of implementation (FY 2020) is informed by its core values, one of which is innovation. Operationalizing this value requires building a culture in which all staff feel comfortable offering creative solutions, taking chances, and learning from mistakes in an environment that promotes growth and learning.

The first year of implementation provided opportunities to engage in real-time learning about how to integrate the implementation of the strategic plan into organizational processes in a way that advances equity, which is another core value. We learned that we need to engage staff across BHSB in planning action steps, which will create opportunities to increase decision making and leadership at all levels of the organization. During the winter of 2021, we are working to build an inclusive process that we will use during the spring of 2021 to develop FY 2022 action steps.

Below are FY 2021 Action Steps.

Three-Year Strategic Plan: FY 2020-2022

FY 2021 Action Steps

The public behavioral health system operates within a highly complex construct of federal, state and city policies, payment models, and priorities. To be responsive to system partners and the needs of the community, BHSB must set a strategic direction that supports ongoing, adaptive learning and agility. To this end, each year BHSB will review progress, assess changing

conditions, and adjust action steps that will guide implementation activities for the subsequent year of this plan.

Goal 1: Increase access to high-quality, integrated behavioral health services for Baltimore City.

Strategy 1: *Partner with the Baltimore Police Department (BPD) and the Mayor's Office of Human Services to meet the behavioral health requirements of the Consent Decree between Baltimore City, BPD, and the Department of Justice by preventing people from having unnecessary contact with police and diverting people away from the criminal justice system into services that will meet their needs.*

Action Steps:

- Identify the technology to implement an air traffic control system.
- Procure a contract with an organization that has experience and expertise in implementing same day access (SDA) to immediate-need behavioral health services to provide technical assistance (TA) to behavioral health clinics and practices, addressing both the strategic and practical application of best practices to expand or begin to offer SDA.

Strategy 2: *Enhance access points within the system of care in Baltimore City.*

Action Steps:

- Continue implementing a hub and spoke model for buprenorphine treatment by adding 2 "spokes" for ongoing care after an individual stabilizes.
- Set up the GBRICS Partnership accountability structure and coalitions to support the advocacy efforts for 2021-2025.
- Conduct a procurement for a pilot evidence-based Supported Employment program to expand this service to persons with SUD.

Strategy 3: *Support the development of the behavioral health work force in the city.*

Action Steps:

- Develop a process for BHSB to reimburse people with lived experience to participate in planning and procurement activities.
- Develop a written plan to train staff of all syringe services programs statewide and implement it.

- Sponsor at least 40 professional development and training opportunities

Strategy 4: *Plan for and implement approaches that are designed to meet the unique behavioral health needs of youth and young adults in Baltimore City.*

Action Steps:

- Create opportunities for youth to engage in system planning decision making.
- Conduct a planning process to 1) develop a shared vision with an anti-racist lens to maximize BHSB’s impact on the behavioral health and wellness of children, youth, young adults, their families, and the communities in which they live, and 2) organize BHSB’s resources to operationalize the vision.
- Implement evaluation activities and tools to assist in collecting, visualizing, utilizing, and presenting data to: identify effective primary prevention strategies and practices; document the success of programs; determine if intended results to promote behavioral health and wellness were achieved and if youth were better off.

Strategy 5: *Expand methods to assess quality within the provider network.*

Action Steps:

- Define the meaning of a sub-vendor “in good standing” and create a plan for how to utilize the standard within BHSB’s monitoring and auditing activities.
- Create a Contract Compliance Policy to detail targeted elements of monitoring and verifying contractual compliance of sub-vendors and outline operating procedures that are transparent to these organizations.

Goal 2: Ensure Baltimore City’s public behavioral health system remains strong within a changing health care context.

Strategy 1: *Enhance BHSB’s capacity to be nimble and responsive within the shifting health care landscape by reviewing and revising internal policies and practices to ensure a high level of customer service with internal and external partners.*

Action Steps:

- Increase the efficiency and effectiveness of BHSB's contracting processes by completing an internal Contracting Manual that clearly documents contracting procedures.

- Develop and release a Customer Service Survey to sub-vendors for the purpose of guiding data-driven decision-making related to one of BHSB's key functions.
- Enhance Finance Sharepoint Site By Function with FAQs
- Develop and release purchasing policy updates with accompanying accounting procedures and forms.
- Develop and implement a Financial Monitoring plan for sub-vendor contracts to ensure compliance with funding agencies.
- Implement a new or update existing Contracting System to increase efficiency, collaboration, and transparency in pre- and post-award contracting processes.
- Develop Guidelines for BHA Quarterly Monitoring
- Implement a process to monitor and recapture underspending earlier in the fiscal year.
- Develop accounting procedures and financial reporting for tracking and communicating contract spending and guidelines for reallocation of funds.

Strategy 2: *Ensure that a local understanding of Baltimore City's unique strengths and challenges informs system management, planning, integration, and advocacy.*

Action Steps:

- Increase capacity to use data by implementing 3 new dashboards.
- Increase capacity to use data by adding more detailed analyses to 2 existing dashboards.
- Implement the Bmore POWER strategic plan that was developed in FY 20.

Strategy 3: *Ensure that BHSB staff have the support needed to be successful in their roles.*

Action Steps:

- Standardize all job descriptions and upload into UltiPro.
- Create and communicate to all staff expectations and standardized procedures for one-on-one meetings.

Goal 3: Increase health equity in Baltimore City by collaborating with other partners to address adverse childhood experiences (ACEs) and the social determinants of health.

Strategy 1: Promote educational opportunities to understand, prevent and mitigate the impact of systemic racism, toxic stress and trauma.

Action Steps:

- Create an organizational framework that presents the actions BHSB commits to take to advance its anti-racism, diversity, equity, and inclusion work, and the measures by which we will hold ourselves accountable.
- Sponsor a learning community for behavioral health providers that facilitates technical assistance and bi-directional learning to operationalize trauma-informed care.
- Partner with the Healing Us Together (HUT) collaborative to implement SELF Community Conversations in each of Baltimore City's 14 districts to support healing, growth, and recovery from the disparate impact of the COVID 19 pandemic and trauma due to historical and ongoing structural racism.

Strategy 2: Collaborate with other system partners to increase access to safe and affordable housing opportunities.

Action Steps:

- Issue an RFP that includes Rapid Rehousing as an eligible cost and encourage behavioral health providers to integrate this service into their model.

Impact

Individuals, families, and communities impacted by mental illness and substance use are served by a complex system of publicly funded services. BHSB must collaborate with stakeholders in other systems, such as criminal justice, schools, housing, social services, etc., to achieve positive outcomes. While BHSB cannot shift population-level outcomes alone, it is our responsibility to track key indicators in which improved behavioral health in Baltimore City is a critical factor.

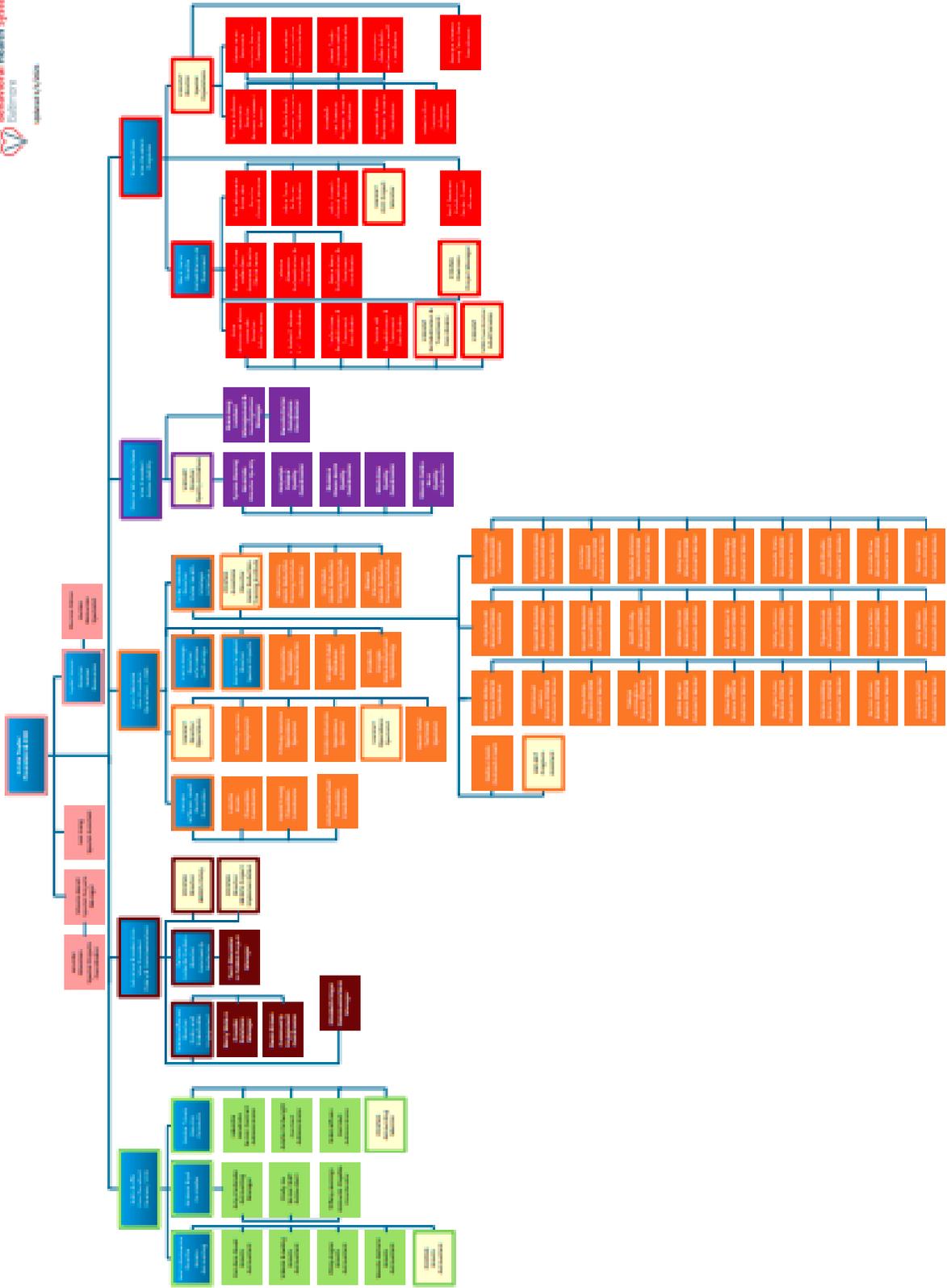
Annual Outcomes:

- Reduction in suicide deaths (*data source: Maryland Department of Health (MDH)*)
- Reduction in overdose deaths (*data source: MDH*)
- Reduction in homelessness (*data source: Mayor's Office of Human Services*)

BHSB uses dashboards to track a wide range of outputs that serve as indicators of system performance. Some key dashboards that will be created and/or monitored include:

- System Utilization
- Crisis Services
- Quality and Performance
- Behavioral Health Workforce Development
- Outreach

Addendum A: Organization Chart



Addendum B: BHSB 2020-2021 Policy Priorities



2020-2021 POLICY PRIORITIES

Advancing Behavioral Health and Wellness

STRENGTHEN AND EXPAND BEHAVIORAL HEALTH CRISIS SERVICES

A broader investment in behavioral health crisis response services is essential to divert people from ED visits and interactions with law enforcement. A comprehensive, integrated crisis response system serves as a critical access point to help individuals in crisis, while reducing harm and overall costs for the health care system. Baltimore City is fortunate to have some key behavioral health crisis response services; however, there are still gaps in services. This results in unnecessary Emergency Department visits and hospitalizations and interactions with law enforcement for people with mental health and substance use disorders. Baltimore City is under a consent decree with the US Department of Justice, which has important implications for behavioral health crisis response in the city.

SUPPORT FUNDING COMMITMENTS FOR BEHAVIORAL HEALTH

The Fiscal Year 2021 budget and beyond must include the 4 percent rate increase for behavioral health providers to ensure access to mental health and substance use treatment and recovery support services. Behavioral health programs provide a range of behavioral health care including therapeutic clinical treatment and recovery support services to assist individuals and families achieve stability and recovery. The HOPE Act of 2017 and the subsequent minimum wage legislation of 2019 provide multi-year reimbursement rate increases for behavioral health services. The rate increases support the infrastructure for public behavioral health system and increase access to life-saving services for vulnerable individuals in our community.

INCREASE SCHOOL BEHAVIORAL HEALTH SUPPORTS

To support academic achievement, full funding of the recommendations of the Kirwan Commission is needed to ensure equitable access to early intervention and school-based behavioral health services. Early intervention and access to behavioral health services in Baltimore schools can provide many students with the necessary resources to thrive in the classroom and achieve academic success. The Kirwan Commission released an interim report in January 2019 that adopted a set of recommendations to address students behavioral health needs, such as increased training for school personnel, the scaling of school behavioral health services in all jurisdictions, systemic screening and identification of student needs, and a statewide system of accountability and outcome measurement.



IMPROVE MARYLAND'S PUBLIC BEHAVIORAL HEALTH SYSTEM

Efforts to improve the system should promote integration and define and clarify the role and authority for local system management agencies to ensure there is active and consistent oversight of behavioral health services and access to a full range of behavioral health services in the community. Maryland's public behavioral health system (PBHS) is a nationally recognized model, however, there is opportunity to improve the system to ensure cost-effectiveness and quality of care. Local system management and planning agencies (LBHAs, CSAs, LAAs) play a key role in Maryland's PBHS, overseeing and coordinating access to behavioral health services and supports to address the particular needs and gaps in their community. Unfortunately, the lines of authority and responsibility for system oversight are unclear between local authorities and the state.

SUPPORT A COORDINATED RESPONSE TO ADVERSE CHILDHOOD EXPERIENCES

Adverse childhood experiences (ACEs) must be incorporated into State policies and procurement so that funding is targeted directly to communities and interventions that mitigate the effects of childhood trauma. Adverse Childhood Experiences (ACEs) are traumatic events that can have a profound impact on a child's health and well-being lasting into adulthood. Communities play a big role in supporting a child's healthy development and buffering the impact of childhood trauma and ACEs.

PROMOTE HARM REDUCTION STRATEGIES

Policies that support harm reduction interventions and promote inclusion of people who use drugs improve the health and safety of our communities must be incorporated and advanced in public policy making. Harm reduction is an approach that utilizes practical strategies to reduce negative consequences associated with drug use. Harm reduction interventions, such as naloxone distribution and overdose prevention sites provide innovative and effective ways to engage people who use drugs around safer drug use and link them to treatment and support services.

Addendum C: Cultural and Linguistic Competency Strategies

Cultural and Linguistic Competency: FY 2021 Strategies

One of BHSB's core values is Equity, and our most recent strategic plan includes a goal of increasing health equity in Baltimore City. To build capacity to advance this goal, BHSB is actively engaged in becoming an anti-racist organization. This work is enormously challenging and can only happen with deep commitment across the organization. BHSB's Equity and Inclusion workgroup, which is comprised of employees representing every department and all levels of the organization, serves as a champion. It functions in the role of change agent to promote a more equitable and inclusive workplace and citywide system of care.

One component of this work is to build structures and practices that address stigma, bias, and discrimination. The U.S. Department of Health and Human Services (HHS) developed the National Culturally and Linguistically Appropriate Services (CLAS) Standards to advance health equity, improve quality, and help eliminate health care disparities. By tailoring services to an individual's culture and language preferences, health professionals can help bring about positive health outcomes for diverse populations.

BHSB is committed to advancing the capacity of Baltimore City's public behavioral health system to deliver integrated services with cultural and linguistic competency. To guide this work, BHSB conducted a CLAS self-assessment during the fall of 2019, which informed planning to advance this work during FY 2021. However, it is important to note that the CLAS standards are geared to providers of direct services. As a local behavioral health authority, BHSB oversees providers that are part of a statewide network of care. While we offer education and support at the local level, it is outside the scope of our authority to set benchmarks or requirements for providers that we do not directly fund.

In establishing its CLAS goals for FY 2021, BHSB considered the complexity and size of the system it oversees and framed its approach with the recognition that equity, inclusion, and cultural humility are not endpoints that are achieved so much as long-term, ongoing processes. Below is an update on the implementation of the identified FY 2021 strategies.

For FY 2022, BHSB's focus is to advance toward becoming an anti-racist organization. As noted above, while this work includes building cultural and linguistic competency, it is broader in scope. BHSB's next step in this process is to create an organizational framework that presents the anti-racist actions BHSB commits to take and measures by which we will hold ourselves accountable. A group comprised of a cross-section of staff will begin collaborating to create this framework during the winter of 2021. It will guide BHSB's equity, inclusion, and anti-racist work during FY 2022, including advancing cultural and linguistic competency.

[Type the document title]

TEMPLATE

Instructions: CSAs, LAAs and LHBA's receiving funding from the MDH/BHA are required to submit Cultural and Linguistic Competency (CLC) Strategies as part of their FY 2021 Plan Submissions. The following template should be used to list your strategies to advance CLC efforts in your jurisdiction.

COVER PAGE

<p>(a) Name of Agency/Organization: Behavioral Health System Baltimore, Inc.</p>
<p>(b) Address: 100 S. Charles St, Tower 2, 8th Floor Baltimore, MD 21201</p>
<p>(c) Region (MDH/BHA designated region): Baltimore City</p>
<p>(d) Name of contact person (Agency/Organization Lead or Designee): Lynn Mumma E-mail: lynn.mumma@bhsbaltimore.org Telephone #: 443-615-7848</p>
<p>(e) Brief overview of services provided by agency/organization (no more than 95 words):</p> <p>BHSB is a nonprofit organization that serves as the local behavioral health authority for Baltimore City. In this role, BHSB is tasked by the State of Maryland with a range of activities to plan, manage, and monitor the public behavioral health system at the local level.</p> <p>BHSB works to build an efficient and responsive system that addresses the needs of individuals, their families, and communities impacted by mental illness and substance use. We do this by providing local leadership in overseeing prevention, early intervention, treatment, and recovery support services as well as developing innovative services.</p>

(f) Agency/organization mission statement:

We work to develop, implement, and align resources, programs and policies that support the behavioral health and wellness of individuals, families, and communities.

Organizational Values:

- Integrity
- Equity
- Innovation
- Collaboration
- Quality

(g) Agency/organization vision statement:

We envision a city where people thrive in communities that promote and support behavioral health and wellness.

PART 1: CLAS SELF- ASSESSMENT

Instructions: Attach a copy of the completed CLAS Self-Assessment Tool for the agency.

BHSB included the CLAS Self-Assessment in its FY 2021 Annual Plan as required by BHA.

[Type the document title]

PART 2: OVERARCHING GOALS AND SELECTED STANDARDS FOR PRIORITY FOCUS

Instructions: For each of the overarching goals below list the (a) Associated standard that is prioritized for focus, then, include the following information for each overarching goal in the space provided: (b) Strategies to build competency for the selected standard, (c) Performance Measures for achieving competency for the selected standard, and (d) Intended impact for addressing the selected standard.

Refer to your completed CLAS Self-Assessment Tool to identify the prioritized standard that has been selected for focus under each of the overarching goals. Refer to the CLCSP Guidelines for additional information. ([https://bha.health.maryland.gov/Documents/CLCSP%20final%20document%20-%20TA%2004.25.19%20\(1\).pdf](https://bha.health.maryland.gov/Documents/CLCSP%20final%20document%20-%20TA%2004.25.19%20(1).pdf))

GOAL 1: ESTABLISH AND MAINTAIN CULTURALLY AND LINGUISTICALLY COMPETENT BEHAVIORAL HEALTH SERVICES
--

<p>Selected a standard for priority focus (What is the standard selected; include language for the standard as stated in the CLAS Self-Assessment Tool):</p>

<p>Standard 2: Our organizational governance and leadership promote and use CLAS standards in policies, practices, and allocation of resources.</p>

<p>Strategies to build competency (What tasks and activities will be implemented to build competency for the prioritized standard):</p>
--

- | |
|--|
| <ol style="list-style-type: none">1. Build capacity of the internal Equity & Inclusion workgroup to impact BHSB's culture and practices and sustain this impact over time.2. Build on progress BHSB has made to create a resource guide for behavioral providers to understand regulations regarding serving consumers with limited English proficiency (LEP) by expanding technical assistance to ensure implementation across the provider network. |
|--|

<p>Performance Measures (How will success be measured):</p>
--

1. # of staff participating in the work of the Equity & Inclusion workgroup
2. # of trainings for the provider network to increase knowledge and skills in providing services to individuals with LEP
3. # of participant evaluations that rate the training as having advanced their LEP capacity.
4. # of service line meetings in which relevant, updated resources regarding serving individuals with LEP are shared

Intended impact (What is the intended impact for addressing the prioritized/selected Standard):

Educate BHSB staff and provider network about relevant regulations and promote policies and practices within BHSB and across the behavioral health network that increase access to services that are equitable, inclusive, and linguistically responsive to individuals with LEP.

Update on implementation:

- 25 BHSB employees are members of the Equity & Inclusion workgroup
- The Equity & Inclusion workgroup had been operating in a decentralized way, and leadership roles were shared by rotating facilitation and note-taking duties monthly. The group found it was difficult for members to keep track of the many priorities outlined in the workplan to facilitate meetings as cohesively as needed, so this past year, the workgroup decided to create a smaller group to help keep track of the workplan, facilitate the meetings, and take notes to increase consistency between meetings. This smaller group will rotate membership annually to give everyone an opportunity to provide leadership to the workgroup.
- BHSB created a [Language Access Resource Guide](#) that is posted to its website.
- BHSB conducted two trainings for staff during the fall of 2020:
 - Language as an Equalizer
 - How to Use An Interpreter

GOAL 2: ELIMINATE CULTURAL AND LINGUISTIC BARRIERS TO ACCESS BEHAVIORAL HEALTH SERVICES

Selected standard for priority focus (What is the standard selected; include language for the standard as stated in the CLAS Self-Assessment Tool):

Standard 8: We provide easy-to-understand print and multimedia materials and signage in the languages commonly used by individuals in our community.

Strategies to build competency (What tasks and activities will be implemented to build competency for the prioritized standard):

1. Translate behavioral health and other resource materials into the 5 languages most commonly spoken in Baltimore City, which include Spanish, Chinese, French, Korean and Arabic.⁶²
2. Contract for telephonic interpretation services and communicate to populations that have limited English proficiency that this service is available for consumers who contact BHSB's clinical services team.

Performance Measures (How will success be measured):

1. Number of materials translated.
2. Number of languages materials are translated into.
3. Number of times interpretation services are utilized.

Intended impact (What is the intended impact for addressing the prioritized/selected Standard):

Increase access to and utilization of BHSB and the public behavioral health system.

Update on implementation:

- BHSB translated 3 documents into the 5 languages most commonly spoken in Baltimore City, which include Spanish, Chinese, French, Korean, and Arabic.
- While BHSB receives limited direct calls from consumers, we opened an account with Language Line to utilize their interpretation services when a consumer calls and has limited English proficiency. Prior to implementation, BHSB conducted internal trainings to increase competencies in using interpretation services. The services have not yet been utilized.

GOAL 3: CREATE A SYSTEM OF DATA DRIVEN DECISION MAKING PROCESSES THAT RESULT IN THE FORMATION OF CULTURALLY AND LINGUISTICALLY COMPETENT POLICIES AND PRACTICES

Selected standard for priority focus (What is the standard selected; include language for the standard as stated in the CLAS Self-Assessment Tool):

Standard 11: We collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

⁶² U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

Strategies to build competency (What tasks and activities will be implemented to build competency for the prioritized standard):

1. Analyze claims utilization data by race to identify trends and gaps to inform about potential disparate utilization of services.
2. Identify contracts for which data could be broken down by race and ethnic group and require this breakdown for FY 2021 contract deliverables.

Performance Measures (How will success be measured):

- # of contracts for which deliverables require racial and ethnic group breakdown
- # meetings with sub-vendors to review data and discuss policy and practice implications
- # of service line meetings during which utilization data broken down by race, ethnicity and primary language is presented and discussed to identify potential policy and practice changes

Intended impact (What is the intended impact for addressing the prioritized/selected Standard):

Increase the capacity of BHSB and the provider network to analyze data to understand the needs of specific populations and use it to inform policy and practice changes that increase cultural and linguistic responsiveness, equity, and inclusion.

Update on implementation:

- BHSB created tools in Tableau to analyze claims utilization data by race; however, FY 2020 and FY 2021 claims data has not been available due to challenges with the ASO.
- The other strategies were not implemented to date due to various challenges, including disruptions due to COVID-19 and the unavailability claims utilization data through the ASO system.

GOAL 4: SUPPORT THE USAGE OF EVIDENCE-BASED PRACTICES TO ADDRESS THE UNIQUE NEEDS OF INDIVIDUALS IN MARYLAND’S PUBLIC BEHAVIORAL HEALTH SYSTEM

Selected standard for priority focus (What is the standard selected; include language for the standard as stated in the CLAS Self-Assessment Tool):

Standard 13: We partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

Strategies to build competency (What tasks and activities will be implemented to build competency for the prioritized standard):

- Develop a shared understanding within BHSB regarding the effectiveness of EBPs related to the populations served in Baltimore City and increase knowledge of culturally relevant and community-informed sources of evidence.
- Partner with community-based organizations that are implementing evaluation approaches that incorporate an anti-racist lens and community engagement.

Performance Measures (How will success be measured):

- # meetings with community-based organizations
- # partnerships with community-based organizations

Intended impact (What is the intended impact for addressing the prioritized/selected Standard):

Increase capacity to identify and promote practices that have a culturally relevant evidence base.

Update on implementation:

- BHSB has begun planning community listening meetings to obtain feedback from Baltimore City residents and community stakeholders. The feedback will inform BHSB’s planning to assure decisions are made through an equity lens that ameliorates racial disparities and increases collaboration with Black, Indigenous, and People of Color (BIPOC).

GOAL 5: ADVOCATE FOR AND INSTITUTE ONGOING WORKFORCE DEVELOPMENT PROGRAMS IN CULTURAL AND LINGUISTIC COMPETENCE REFLECTIVE OF MARYLAND'S DIVERSE POPULATION

Selected standard for priority focus (What is the standard selected; include language for the standard as stated in the CLAS Self-Assessment Tool):

Standard 4: We provide orientation and training to new and existing members of our governing body, leadership, and staff on culturally and linguistically appropriate policies and practices on a regular basis.

Strategies to build competency (What tasks and activities will be implemented to build competency for the prioritized standard):

- Sponsor trainings that educate BHSB staff and the provider network about culturally and linguistically responsive, equitable, anti-racist, and inclusive practices.

Performance Measures (How will success be measured):

- # trainings
- # participants in trainings
- # participants who indicate in training evaluation that it provided at least one tool that they can use in their work

Intended impact (What is the intended impact for addressing the prioritized/selected Standard):

A workforce that has education and tools to increase its capacity to provide culturally and linguistically responsive, equitable and inclusive services.

Update on implementation:

- To date, BHSB has sponsored the below trainings and professional development opportunities for all staff during FY 2021. To support staff's ability to attend, BHSB's operations were closed during the facilitated staff discussions and REELL sessions.
 - Series of staff discussions about personal and professional experiences of racism facilitated by BHSB's Medical Director
 - *Language as an Equalizer*
 - *How to Use An Interpreter*
 - 4-part training series *Racism Education with Engagement of Leaders into Liberation (REELL)*.

- BHSB did not conduct an evaluation of the specific trainings. A racial justice organizational assessment that was conducted in the fall of 2020 collected data from staff regarding BHSB's anti-racism work at the organizational level.

Addendum D: FY Three-Year Strategic Plan, 2020 Implementation Report

Three-Year Strategic Plan: FY 2020-2022

FY 2020 Implementation Report

Background

The *Three-Year Strategic Plan: FY 2020-2022* serves as a guide to drive BHSB's day-to-day work. To be responsive to system partners and the needs of the community, it sets a strategic direction that supports ongoing, adaptive learning and agility. To this end, each year BHSB reviews progress, assesses changing conditions, and adjusts action steps that will guide implementation activities for the subsequent year of this plan.

This document reports on progress in implementing BHSB's strategic plan during FY 2020, which is the first year of a three-year plan.

Learning Opportunities

BHSB's strategic plan focuses on broad, overarching goals to build out the system of care and develop BHSB's organizational capacity to effectively lead this work. This represents a significant shift from the structure of prior plans, which were much more granular. The plan was created with the support and partnership of the BHSB Board of Directors and is structured to have static goals and strategies over the three-year span, with action steps being updated annually by staff.

BHSB's analysis of the first year of implementation is informed by its core values, one of which is innovation. Operationalizing this value requires building a culture in which all staff feel comfortable offering creative solutions, taking chances, and learning from mistakes in an environment that promotes growth and learning. Some action steps were not completed because they reflect work that is ongoing beyond the boundaries of a single year. Others were not completed because we have adapted the work in response to shifting conditions.

The first year of implementation provided opportunities to engage in real-time learning about how to integrate the implementation of the strategic plan into organizational processes in a way that advances equity, which is another core value. We learned that we need to engage staff across BHSB in planning action steps, which will create opportunities to increase decision making and leadership at all levels of the organization. During the winter of 2021, we are working to build an inclusive process that we will use to develop FY 2022 action steps.

Another area of learning is the importance of developing a shared understanding of what constitutes a goal versus a strategy versus an action step. Because the plan is structured such that action steps are updated each year, our initial area of focus is to build skills across the organization to create meaningful, specific, and measurable action steps.

BHSB embraces the ongoing growth process and opportunities that the implementation of the strategic plan has offered for us to learn together and with our partners. This report includes the status of each FY 2020 action step, along with the population-level outcome measures that serve as indicators of behavioral health and wellness across Baltimore City.

FY 2020 Action Steps Implementation Status

The implementation status of FY 2020 action steps to advance the strategies associated with each of the three goals is below. Each action step is marked as completed (green), partially completed (yellow), or not completed (red). Partially completed action steps reflect work that is ongoing beyond FY 2020. Some action steps were not completed because we have adapted the work in response to shifting conditions.

Action steps that were not completed or only partially completed were either revised for FY 2021 to make them more meaningful, measurable, and specific, or they were eliminated based on shifting conditions.

Goal 1 Action Steps and Status		Implementation Status
		■ COMPLETED ■ PARTIALLY COMPLETED ■ NOT COMPLETED
Strategy 1	Develop standards and measures for court system	
	Gap analysis of behavioral health system	
	Implement recommendations from gap analysis	
	Plan for integrated crisis response	
	Track arrests of behavioral health system consumers	
Strategy 2	Advocate for Medicaid reimbursement for crisis response	
	Assess need for staff to manage access to system of care	
	Develop capacity to work with high-need consumers	
	Finalize plan to expand crisis response system	
	Implement a hub and spokes model for buprenorphine treatment	
	Incentivize Wellness Recovery Centers	
	Increase street outreach	
	Increased utilization of Crisis Stabilization Center	
Strategy 3	Develop a training plan	
	Expand capacity to supervise interns	
	Expand MaHRTI	
	Provide continuing education and opportunities for peer recovery specialists	
Strategy 4	Develop community- and youth-driven priorities	
	Partner with youth advocacy organizations	
	Review feedback to determine ways to support youth	
Strategy 5	Assess and develop processes for assuring contractual compliance	
	Define "provider in good standing"	

Goal 2 Action Steps and Status

Implementation Status
■ COMPLETED
■ PARTIALLY COMPLETED
■ NOT COMPLETED

Strategy 1	Develop and implement a community relations plan	
	Develop and implement a provider relations plan	
	Facilitate communication between teams in managing organizational risk, compliance and financial management.	
	Implement a new payroll and timekeeping system	
	Review, revise, and document procurement and contracting procedures	
Strategy 2	Educate and plan around a value-based payment system	
	Implement an advisory board	
	Increase capacity to use data in strategic planning, advocacy, and quality improvement.	
	Integrate data as a standing agenda item in meetings.	
	Support Bmore POWER in growing and developing as a group	
Strategy 3	Create and implement a plan to integrate restorative practices	
	Create and implement a plan to solicit regular feedback from staff.	
	Create and implement a training plan for supervisors.	
	Create and implement an employee development plan.	
	Create more opportunities for staff to engage in strategy, policy, and process development.	

Goal 3 Action Steps and Status

Implementation Status
■ COMPLETED
■ PARTIALLY COMPLETED

Strategy 1	Implement a primary prevention strategy to promote behavioral health and mitigate toxic stress.	
	Sponsor an annual conference that promotes resilience and mitigates the impact of toxic stress and trauma.	
	Sponsor another Undoing Racism workshop for staff and partners.	
Strategy 2	Partner with the Behavioral Health Administration to implement lower-barrier housing options	

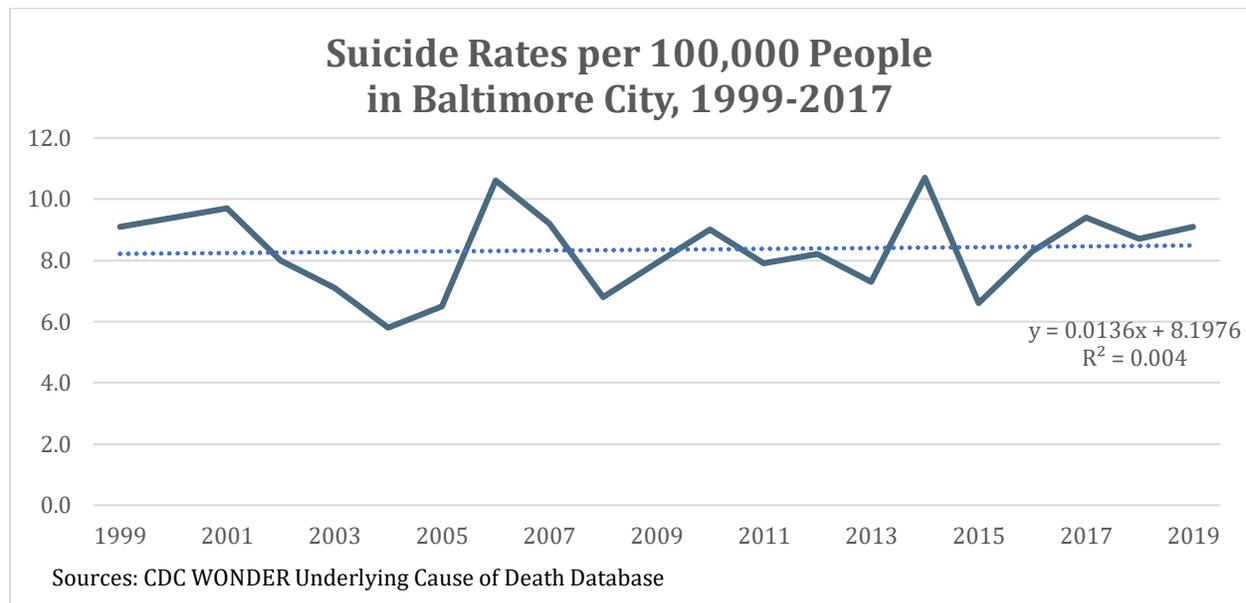
Impact

Individuals, families, and communities impacted by mental illness and substance use are served by a complex system of publicly funded services. BHSB collaborates with stakeholders in other systems, such as criminal justice, schools, housing, and social services, to achieve positive outcomes.

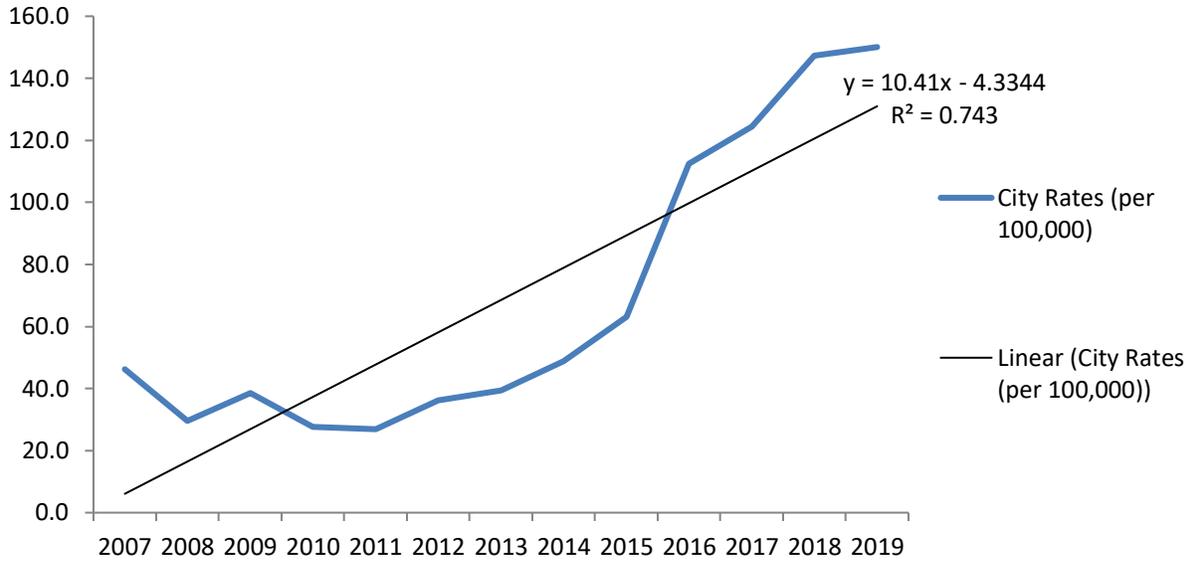
The *Three-Year Strategic Plan: FY 2020-2022* establishes five population-level outcome measures that serve as indicators of Baltimore City's behavioral health and wellness. Unfortunately, the data source for two of the five outcome measures is no longer available. The Maryland Department of Health has discontinued the use of the Outcomes Measurement System to gather data for the public behavioral health system (PBHS). It is unclear at this time if a new system will be implemented to measure outcomes for the PBHS. For this reason, BHSB is not able to report on two measures: reduction in overall psychiatric symptoms and improvement in quality of life.

Annual Outcomes

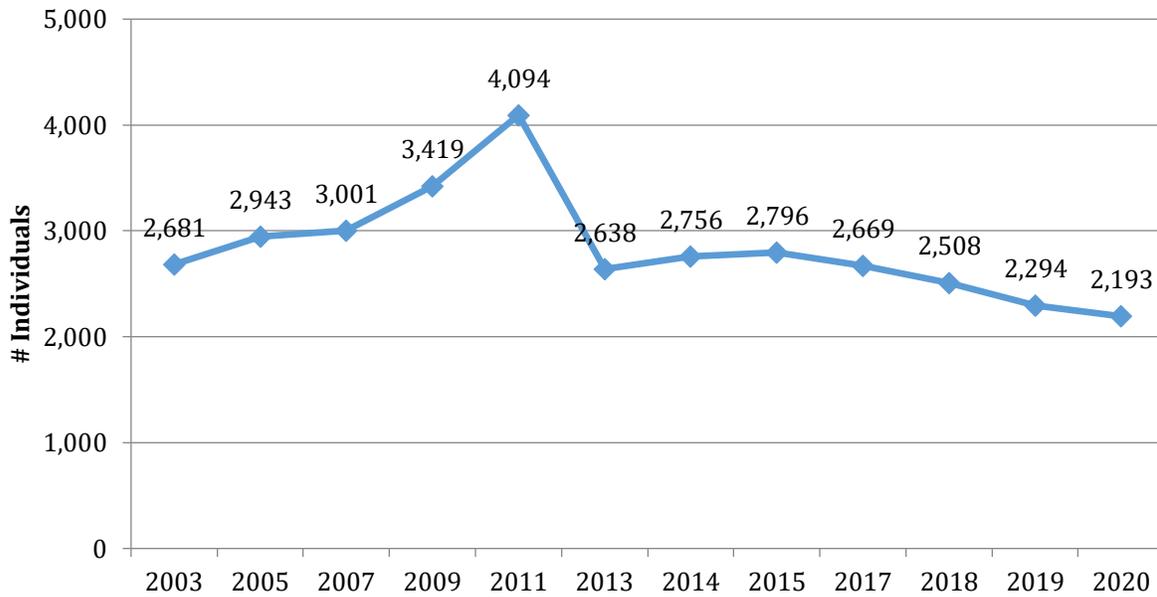
- Reduction in suicide deaths (data source: Maryland Department of Health (MDH))
- Reduction in overdose deaths (data source: MDH)
- Reduction in homelessness (data source: Mayor's Office of Human Services)
- *(data no longer available)* Reduction in overall psychiatric symptoms (data source: Outcomes Measurement System; difference between initial and follow up interviews)
- *(data no longer available)* Improvement in quality of life indicators (data source: Outcomes Measurement System: Recovery & Functioning Indicators; difference between initial and follow up interviews)



Overdose Death Rates Baltimore City and Maryland 2007-2019



Baltimore City Homeless Population, 2003-2020



Source: Baltimore City Mayor's office of Homeless Services
[https://homeless.baltimorecity.gov/sites/default/files/Full_Preliminary%20Report\[1\].pdf](https://homeless.baltimorecity.gov/sites/default/files/Full_Preliminary%20Report[1].pdf)

Addendum E: Board of Directors

2020-2021 BOARD OF DIRECTORS

Board Term October 1, 2020-September 30, 2021

Terms of Office

Letitia Dzirasa, MD, BHSB Board Chair

Ex-officio, No term limit

Commissioner of Health, Baltimore City Health Department

1001 East Fayette Street, Baltimore, MD 21202

410-396-4387

Reverend S. Todd Yeary, PhD, Vice Chair

3rd term: 2018-2019, 2019-2020, 2020-2021

Member, Executive & Governance Committees

Senior Pastor, Douglas Memorial Community Church

1325 Madison Avenue, Baltimore, MD 21217

410-523-1700

Ryan Hemminger, Treasurer

1st term: 2019-2019, 2019-2020, 2020-2021

Member, Executive Committee; Chair, Audit and Finance Committee

5618 St. Albans Way, Baltimore, MD 21212

443-536-9930

Nancy Rosen-Cohen, PhD, Secretary

3rd term: 2018-2019, 2019-2020, 2020-2021

Member, Executive Committee; Co-Chair, Communications, Advocacy and Policy Committee

Executive Director, NCADD-Maryland

28 E. Ostend Street, Suite 303, Baltimore, MD 21230

410-625-6482

Erricka Bridgeford

1st term: 2020-2021, 2021-2022, 2022-2023

Member, Communications, Advocacy and Policy (CAP) Committee

Executive Director, Baltimore Community Mediation Center

3333 Greenmount Ave, Baltimore, MD 21218

410-467-9165

John T. Bullock, PhD

1st term: 2019-2019, 2019-2020, 2020-2021

Member, Communications, Advocacy and Policy Committee

1405 Hollins Street, Baltimore, MD 21223

410-953-9575

Kevin Daniels, Ph.D., D Min., MSW (Lic.)

1st term: 2020-2021, 2021-2022, 2022-2023

Member, Audit and Finance Committee

4915 Lasalle Avenue, Baltimore MD 21206

410-428-3557

David Olawuyi Fakunle, PhD

1st term: 2019-2020, 2020-2021, 2021-2022

Member, Communications, Advocacy and Policy Committee

CEO, DiscoverME/RecoverME: Enrichment Through the African Oral Tradition

4208 Cottman Ave, Baltimore, MD 21206

410-440-8142

Corey D. Hatchet Sr., Pastor

1st term: 2/13/20-2020, 2020-2021, 2021-2022, 2022-2023

House of Refuge International Church

Expires 9/30/23; Eligible for 1 more term

711-713 Poplar Grove Street, Baltimore, MD 21216

410-566-5812

Miriam Brown Hutchins, J.D.

1st term: 2020-2021, 2021-2022, 2022-2023

Member, Audit and Finance Committee

Associate Judge, District Court of Maryland, District 1, Baltimore City (Ret.)

3423 Woodberry Ave, Baltimore 21211

443-622-8232

Kevin C. Lindamood, MSW

2nd term: 2018-2019, 2019-2020, 2020-2021

Co-Chair, Communications, Advocacy and Policy Committee

President & CEO, Health Care for the Homeless, Inc.

6602 Charlesway, Baltimore, MD 21204

410-837-5533

Nalini Negi, PhD, MSW

1st term: 2019-2020, 2020-2021, 2021-2022

Associate Professor, School of Social Work, University of Maryland, Baltimore

525 W. Redwood Street, Baltimore, MD 21201

410-706-3024

Steven Sharfstein, MD

2nd term: 2019-2020, 2020-2021, 2021-2022

Member, Operations and Oversight Committee

President Emeritus, Sheppard Pratt Health System

6501 N. Charles Street, Baltimore, MD 21202

410- 938-4200

Addendum F: Behavioral Health Disaster Preparedness Plan