



**THE 2016 ANNUAL REPORT OF  
THE MARYLAND BEHAVIORAL HEALTH  
ADVISORY COUNCIL**

**HB § 7.5-305 and SB0174/Ch. 328 (2015)**

**Yngvild Olsen, M.D., M.P.H.  
Chair**

**Dan Martin, Esquire  
Vice Chair**



# State of Maryland Behavioral Health Advisory Council

*Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Dennis R. Schrader, Secretary*

December 30, 2016

The Honorable Larry Hogan  
Governor  
State House  
Annapolis, Maryland 21401

The Honorable Thomas V. Mike Miller, Jr.  
President of the Senate  
H-107 State House  
Annapolis, MD 21401-1991

The Honorable Michael E. Busch  
Speaker of the House  
H-101 State House  
Annapolis, MD 21401-1991

**RE:** HB § 7.5-305 and SB0174/Ch. 328 (2015) – Behavioral Health Advisory Council Annual Report and HB 0682/Ch.406 and SB0551/Ch. 405 (2015) – Interim Report of the Maryland Crisis Services Committee

Dear Governor Hogan, President Miller and Speaker Busch:

We present to you two reports for your review: the 2016 Annual Report for the Maryland Behavioral Health Advisory Council, pursuant to the Annotated Code of Maryland, Health General 7.5 - 305, Federal Public Law (PL) 102-321, and in compliance with Senate Bill 174; followed by the Interim Report of the Maryland Crisis Services Committee based on House Bill 682/Senate Bill 551. This Annual Report provides an overview and summary of the activities of this Council during calendar year 2016 and the Interim Report summarizes activities, so far, toward the goal of developing a strategic plan for Maryland Crisis Services.

This is the first full year of the existence of the Maryland Behavioral Health Advisory Council, established in statute in October 2015. The legislation provided for the membership, duties, and purpose of the Council to promote and advocate for:

(i) planning, policy, workforce development, and services to ensure a coordinated, quality system of care that is outcome-guided and that integrates prevention, recovery, evidence-based practices, and cost-effective strategies that enhance behavioral health services across the state; and

(ii) a culturally competent and comprehensive approach to publicly-funded prevention, early intervention, treatment, and recovery services that support and foster wellness, recovery, resiliency, and health for individuals who have behavioral health disorders and their family members.

The Council membership consists of 55 members from the recovery community, families, the advocate community, behavioral health organizations, the legislature, local behavioral health authorities, and state agencies. The Council met bi-monthly since November 2015 and has elected officers, developed by-laws, and established a committee structure that gives greater focus to specific areas of interest within the behavioral health arena and across the lifespan. These areas include planning, prevention, cultural and linguistic competency, children and adolescents, adults and older adults, criminal justice, crisis services, and community behavioral health services.

This has been an active year for the Council and we look forward to the continued process of monitoring and enhancing the behavioral health system of care, advocating for continued and increased access to services, and promoting adequate and appropriate wellness and prevention activities for individuals with mental illness, substance use, and other addictive disorders. We will continue submitting suggestions and recommendations to the BHA leadership and to you, as appropriate, to improve the work of the Public Behavioral Health System in Maryland.

Sincerely,



Yngvild Olsen, M.D., M.P.H.  
Chair  
Maryland Behavioral Health  
Advisory Council



Dan Martin, Esquire  
Vice Chair  
Maryland Behavioral Health  
Advisory Council

Enclosure

cc: Tiffany Robinson, Chief of Staff, Office of the Governor  
Dennis R. Schrader, Secretary, Maryland Department of Health and Mental Hygiene (DHMH)  
Barbara J. Bazron Ph.D., Executive Director, Behavioral Health Administration (BHA)  
J. David Lashar, Chief of Staff, Office of the Secretary, DHMH  
Kathleen A. Morse, Assistant Attorney General, DHMH  
Cynthia Petion, Assistant Director, Systems Planning, BHA  
Webster Ye, Director, Office of Governmental Affairs, DHMH  
Kim Bennardi, Special Assistant, Office of Appointments and Executive Nominations, DHMH  
Sarah T. Albert, MSAR# 10584 and 10868, Department of Legislative Services

## INTRODUCTION

This report is the Annual Report of the recently established Behavior Health Advisory Council, which, according to statute, is due to the Governor at the end of the calendar year.

Senate Bill 174 (2015) established the new Council as of October 1, 2015, to promote and advocate for planning, policy, workforce development, and services to ensure a coordinated, quality system of care that is outcome-guided and that integrates prevention, recovery, evidence-based practices, and cost-effective strategies that enhance behavioral health services across the state. Also, the Council will promote and advocate for a culturally competent and comprehensive approach to publicly-funded prevention, early intervention, treatment, and recovery services that support and foster wellness, recovery, resiliency, and health for individuals who have behavioral health disorders and their family members.

The Maryland Behavioral Health Advisory Council consists of 55 members - 28 in statute Ex-Officio members (or designees) representing state and local government, the Judiciary, and the Legislature; 13 members appointed by the Department of Health and Mental Hygiene (DHMH) Secretary, representing behavioral health provider and consumer advocacy groups; and 14 representatives that include a diverse range of individuals who are consumers, family members, professionals, and involved community members. According to the legislation, membership is appointed/selected to be composed of balanced representation from areas of mental health and substance use disorders and a range of geographical areas of the state. Membership is also representative of ethnic, gender, cultural, and across the lifespan (parents of young children with behavioral health disorders) diversity. Sign language interpreters are available at meetings for an individual representing the Governor's Office of Deaf and Hard of Hearing.

On the following pages, we have included the membership list, highlights, and activities of the Council's first full year.

# Maryland Behavioral Health Advisory Council

Yngvild Olsen, Chair  
The Maryland Association for the Treatment of Opioid Dependence

Dan Martin, Vice Chair  
The Mental Health Association of Maryland, Inc.

Makeitha Abdulbarr  
The Maryland County Behavioral Health Advisory  
Councils

Barbara J. Bazron  
The Maryland Behavioral Health Administration

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

Lori Brewster  
The Maryland Association of County Health Officers

Mary Bunch  
Family Member (Child)

Sara Cherico-Hsii  
The Office of the Secretary, Maryland Department of  
Health and Mental Hygiene

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

The Hon. Adelaide Eckardt  
Maryland State Senate

Kate Farinholt  
The National Alliance on Mental Illness of Maryland

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

Elaine Hall  
The Maryland Health Care Financing, DHMH

Christina Halpin  
Consumer (Youth/Young Adult)

Dayna Harris  
The Maryland Department of Housing & Community  
Development

Barbara L. Allen  
Community Advocate

Dori S. Bishop  
Family Member

\*Anne Blackfield  
The Maryland Department Of Disabilities

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

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

Kenneth Collins  
The Maryland County Behavioral Health Advisory  
Councils

Catherine Drake  
The Maryland Division Of Rehabilitation Services

Stevanne Ellis  
The Maryland Department Of Aging

Robert L. Findling  
Academic/Research Professional

Lauren Grimes  
On Our Own of Maryland, Inc.

Shannon Hall  
The Community Behavioral Health Association of  
Maryland

Carlos Hardy  
The Maryland Recovery Organization Connecting  
Communities

Virginia Harrison  
The Maryland Association of Boards of Education

## Maryland Behavioral Health Advisory Council

The Hon. Antonio Hayes  
Maryland House of Delegates

\*Gayle Jordan-Randolph  
The Office of the Deputy Secretary Behavioral Health,  
DHMH

Jonathan Kromm  
The Maryland Health Benefit Exchange

Susan C. Lichtfuss  
The Maryland County Behavioral Health Advisory  
Councils

The Hon. George Lipman  
The Maryland Judiciary District Court

Jonathan Martin  
Maryland Department of Budget and Management

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

Kathleen O'Brien  
The Maryland Addiction Director's Council

Charles Reifsnider  
Consumer

Linnette Rivera  
The Maryland Department Of Disabilities

\*Karen Salmon  
The Maryland State Department of Education

\*Penelope Thorton Talley  
The Maryland State Department of Education

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

\*Phoenix Woody  
The Maryland Department Of Aging

John Winslow  
The Maryland County Behavioral Health Advisory  
Councils

Japp Haynes, IV  
Consumer

Joel E. Klein  
Medical Professional

Sylvia Lawson  
The Maryland State Department of Education

Sharon M. Lipford  
Community Advocate

Theresa Lord  
Family Member (Child)

Dennis L. McDowell  
Family Member

The Hon. Dana Moylan Wright  
The Maryland Judiciary Circuit Court

Mary Pizzo  
The Office of the Public Defender

Keith Richardson  
The National Council on Alcoholism and Drug  
Dependence of Maryland

Catherine Simmons-Jones  
Medical Professional

Brandi Stocksdales  
The Maryland Department of Human Resources

Tracey Webb  
The Governor's Office for Children

Anita Wells  
Academic/Research Professional

\*Kathleen Woell Seifert  
Consumer (Youth/Young Adult)

\*Michelle Wojcicki  
The Maryland Health Benefit Exchange

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

BHA Staff Support: Cynthia Petion, Assistant Director, Systems Planning; Hilary Phillips, Robin Poponne, and Greta Carter, Office of Planning; Larry Dawson, Office of Prevention and Wellness for Public Health; Deirdre Davis, Office of Treatment and Recovery Services; Thomas Merrick and Michael Hawkins, Office of Children's Services

## **ANNUAL REPORT – 2016**

### **Highlights and Activities of Maryland’s Behavioral Health Advisory Council**

During its first year, the Council focused on three main accomplishments: the election of a Chair and Vice Chair; the finalization and adoption of by-laws; and the formation of Committees. Throughout the year, the Council also continued to help monitor the progress of goals and efforts of the Behavioral Health Administration (BHA) as it continues to shape and refine the process of behavioral health integration.

The Council met bi-monthly, six times during the year. The newly elected Chair and Vice Chair led the process of developing final by-laws by the spring, which, in concert with SB 174/Ch. 328 (2015), the legislation that created this body, delineated the duties and procedures by which the Council operates.

During the full Council meetings, members received and shared pertinent information from BHA leadership, people in recovery, families, and other involved stakeholders through presentations on a variety of topics from the areas of mental health, substance use, and other addictive disorders. Topics discussed at Council presentations focus on Behavioral Health Integration, the 2016 Legislative Session, Crisis Services, forensic and hospital bed capacity issues, the block grants for mental health and substance use, and the issues and initiatives of Maryland Medicaid that impact Behavioral Health. Over the last two and one half years, BHA, in concert with DHMH, Medicaid, and the Administrative Services Organization (ASO) has continued to refine the Public Behavioral Health System (PBHS). The Council has been closely following these efforts through interface with the Executive Director, Barbara J. Bazron, Ph.D., who is an appointed member of the Council and provides updates on the PBHS, also known as “The Director’s Report”, to the Council.

### **The Committees of the Behavioral Health Advisory Council**

The Council has established committees to further support its purpose as well as to enhance full participation of members and other stakeholders, in developing recommendations for input and advocacy for the PBHS in Maryland and its overarching mission and duties for individuals with mental health, substance use, and addictive disorders. There are two Standing Committees, and six Ad Hoc Committees. Committee participation is open beyond Council membership. The following section highlights committee activities for the period covering March to November 2016:

- **Planning Committee: Co-Chairs – Dori Bishop and Dennis McDowell**  
The duties of this committee include participation in a yearlong planning process comprised of development, review, and final recommendation of the Maryland Behavioral Health Plan and Federal Mental Health Block Grant Application which may be used to inform special projects. The Committee, which is a standing committee, also identifies focus areas/issues to be monitored and makes recommendations to the Council.

The Planning Committee provided initial and final reviews of BHA's Behavioral Health Plans, including the strategies linked to the federal block grant applications. They made recommendations to shape the document toward further support of the priorities of the PBHS by addressing the areas of trauma-informed care, suicide prevention, and peer support, among others. Recommendations were also made to enhance the collaborative efforts between BHA and the local behavioral health authorities (LBHAs), as well as highlighting the inclusion of other addictive disorders such as gambling. Additionally, the Committee reviewed the Implementation Report of the FY 2016 Behavioral Health Plan in November and made recommendations for future planning efforts that support access and coordination of care.

- **Prevention Committee: Co-Chairs – Sharon Lipford and Lori Brewster**

The purpose of the Prevention Committee, also a standing committee, is to meet the Substance Abuse and Mental Health Services Administration's (SAMHSA's) requirement of the Strategic Prevention Framework (SPF) grantees to form a Strategic Prevention Framework Advisory Committee (SPFAC). This committee, acting as a SPFAC, monitors the progress of BHA's SPF grant and strengthens and informs grant activities by making recommendations to the BHA, if needed. Additionally, the duties of this committee include providing guidance and advocacy in the areas of prevention across the lifespan.

The committee reviewed its purpose and the federal grant funding requirements related to prevention activities. Presentations and discussions, led by the BHA's State Technical Assistance and Evaluation Team, were held over multiple meetings to review youth substance use and consequences data, such as the Maryland Youth Risk Behavioral Survey (YRBS) and the Substance Use and Outcomes 2015 Epidemiological State Profile. During the committee meetings, members facilitated a process for analyzing and ranking the substance use and consequences data and using the rankings to support priorities and make recommendations. The members also viewed and discussed presentations related to suicide prevention and problem gambling to inform future committee activities.

- **Lifespan Committee I: Children, Young Adults, and Families Co-Chairs – Ann Geddes and Japp Haynes IV**

The duties of this ad hoc committee are to identify recommendations for the development of strategies and initiatives, including evidence-based practices, which are important for a system of care of behavioral health services and supports for children, young adults and families.

The committee has identified priorities in the areas of: (1) prevention and intervention – provide support and services navigation to families of children with mental health needs before problems become severe, with a single point of access, and to expand implementation of substance-use prevention programs in schools; and (2) stigma reduction – expanding awareness and use of tools such as Youth Mental Health First Aid and increasing communication and education about the opioid epidemic. Discussions included the use of Children's Mental Health Matters Campaign as a



model to support early intervention and to help decrease stigma for substance use. The Committee will further examine information on the results of the YRBS, data on evidence-based substance use prevention programs, and data on the percentage of federal Block Grant expenditures for children and adolescents.

- **Lifespan Committee II: Adults and Older Adults Co-Chairs – Barbara Allen and \*Phoenix Woody**

The duties of this ad hoc committee are to identify recommendations for the development of strategies and initiatives, including evidence-based practices, which are important for a comprehensive system of behavioral health services and supports for adults and older adults.

In an effort to help shape the discussions and priorities of the Committee, presentations were provided by key BHA staff who are responsible for overseeing the implementation of: behavioral health services to adults and older adults as well as the evidence-based practices models of supported employment, Assertive Community Treatment, and Family Psycho-Education.

The Committee welcomed the challenge to identify recommendations to further improve the PBHS. Key focal points of the Lifespan Committee II included but were not limited to:

- Overdose prevention – Saving lives through naloxone access and stabilizing the expanding opioid epidemic;
- Promotion of anti-stigma efforts – Addressing the stigma of mental health and substance use disorders; and
- Timely access to a full range of continuum of care – Crisis intervention, housing (recovery housing, supported housing), wrap around services, supported employment, and effective standards of care.

There are many other areas the Committee will prioritize in the future. However, to support these efforts, the Committee will continue to increase its membership, as well as collaborate with other Council committees to reduce duplicative efforts.

- **The Cultural and Linguistic Competence Committee Co-Chairs – Makeitha Abdalbarr and Kelby Brick**

The duties of the Cultural and Linguistic Competence Committee are to assist the Council in its role of gathering and disseminating information about the role diversity – including language and culture - plays in the delivery of behavioral health services in the public behavioral health system. This includes efforts to generate recommendations and concepts that will facilitate the development of cultural and linguistic competence and culturally responsive services, and efforts to shape and inform strategies for the BHA Cultural and Linguistic Competence Plan.

The Cultural and Linguistic Competence (CLC) Committee has begun the following tasks, to be completed in 2017:

- Reviewed state and national resources on CLC as well as identified areas in the PBHS that could benefit from increased levels of Cultural and Linguistic Competence. The Committee will also concentrate on gathering and disseminating information to the Maryland Behavioral Health Advisory Council and Committees.
  - The Committee will review the local behavioral health planning documents to identify continuum of care efforts, strengths, needs, and gaps in the local jurisdictions as they relate to CLC and make recommendations to the BHA and LBHAs.
  - The CLC committee will identify and recommend strategies for the delivery of behavioral health services to be included in the development of the BHA's Cultural and Linguistic Competence Strategic Plan and future planning activities.
- **Criminal Justice/Forensics Committee Co-Chairs - Hon. George Lipman and Kathleen O'Brien, Ph.D.**

The purpose of this ad hoc committee is to advise the Administration regarding the delivery of behavioral health services to individuals who are involved with the criminal and juvenile justice systems, including those who: are court-ordered to DHMH for evaluation, commitment, and/ or treatment relative to competency to stand trial or criminal responsibility; are court-ordered to DHMH for a substance related evaluation and/or for substance use disorders treatment; are released into the community from a DHMH facility under court-mandated conditions of release; or have psychiatric, substance use, or co-occurring disorders and are incarcerated, or are at risk of incarceration, in jails, prisons, or juvenile detention facilities.

Committee members have been focusing on:

- The clarification of the Maryland's Health General §§ 8-505 and 8-507, which describe orders for commitment of individuals to a behavioral health facility or residential treatment by the court. 8-505 allows the court, before sentencing, to order DHMH to evaluate a defendant to determine if the defendant is in need of or may benefit from treatment for drug or alcohol addiction. Barriers exist regarding 8-507, which allows the courts, with the defendant's consent, to commit that defendant for treatment;
- Efforts to ensure that a statewide diversion system provides access, sufficient capacity and high-quality care to individuals requiring substance use treatment; determining the parameters within which the Committee may make recommendations for using three million supplemental budget dollars allocated to support drug addiction treatment services in prisons and to reduce drug-related crime and recidivism;
- The impact of barriers faced by individuals eligible for discharge from state facilities, and the reduction of the waiting list for state hospital beds;

- Implementation of the Justice Reinvestment Act, Senate Bill 1005/Ch. 515 (2016), that manages and allocates criminal justice populations in a more cost effective manner, and reinvests savings in strategies that decrease crime, and strengthen neighborhoods; and
  - Examining gaps in Maryland’s current substance use treatment system and evaluate issues around quality of care delivered throughout the State and developing a set of recommendations to submit to the Governor.
- **Certified Community Behavioral Health Clinic Planning Grant Committee Chair – Kate Farinholt**  
The charge of this committee is to assist BHA in the implementation of the Certified Community Behavioral Health Clinic (CCBHC) Planning Grant, awarded by SAMHSA to the BHA. The purpose of the CCBHC Planning Grant is to: support states to begin the process of certifying clinics as certified community behavioral health clinics (CCBHCs) and establishing prospective payment systems for Medicaid-reimbursable services.

The Committee met to begin its charge related to stakeholders involvement toward the development and implementation of the initial planning grant. However, after considerable review of the grant, Maryland made a decision not to proceed with further planning at this time.

- **The Steering Committee for Clinical Crisis Walk-in Services and Mobile Crisis Teams Strategic Plan Co-Chairs – Yngvild Olsen, M.D., M.P.H. and Dan Martin, Esquire**  
In 2016, Senate Bill 551/Ch. 405 (2015) and House Bill 682/Ch. 406 (2015) were passed requiring the Behavioral Health Advisory Council to develop a strategic plan for ensuring that clinical crisis walk-in services and mobile crisis teams are available statewide. One approach, facilitated by the Council, was to establish a Steering Committee, comprised of the Council Chair, Vice Chair, and Committee Co-Chairs, also referred to as the Executive Committee of the Council, to guide the process for the development of the Maryland Crisis Services Strategic Plan. Additionally, this Committee’s work will be integrated into the DHMH/BHA Forensic Services Advisory Council to further support the recommendations to increase the availability of community crisis services as identified through the Forensic Services Workgroup process. Two Council members are also representatives on the Forensics Services Advisory Council.

As required by statute – Senate Bill 551 - “on or before December 31, 2016, under 7.5-305 of the Health-General Article, an update on the development of the strategic plan [for clinical crisis walk-in services and mobile crisis teams, shall be included] in the Annual Report.” The update can be found as an attachment to this document.

The Behavioral Health Advisory Council, created in 2015, will continue to advocate for effective treatment and recovery support for individuals with mental health, substance use, and other addictive disorders. We look forward to the further development of behavioral health integration as we move into 2017.

# Appendix

## **MARYLAND BEHAVIORAL HEALTH ADVISORY COUNCIL BY-LAWS**

### **PURPOSE:**

Pursuant to the Annotated Code of Maryland, Health General 7.5 - 305, and Federal Public Law (PL) 102-321, the State of Maryland has established the Maryland Behavioral Health Advisory Council to promote and advocate for:

- (i) planning, policy, workforce development, and services to ensure a coordinated, quality system of care that is outcome-guided and that integrates prevention, recovery, evidence-based practices, and cost-effective strategies that enhance behavioral health services across the state; and
- (ii) a culturally and linguistically competent and comprehensive approach to publicly-funded prevention, early intervention, treatment and recovery services that support and foster wellness, recovery, resiliency, and health for individuals who have behavioral health disorders and their family members.

### **Article I: Guiding Principles**

1. All activities and efforts of the Behavioral Health Advisory Council take into consideration cultural and linguistic competence, diversity, and gender identity.
2. Serve as a forum for the dissemination and sharing of information concerning the Public Behavioral Health System (PBHS) between Department of Health and Mental Hygiene (DHMH), Behavioral Health Administration staff, behavioral health advocates, including consumers and providers of mental health, substance-related disorders (SRDs), other addictive disorders services in Maryland, and other interested parties.
3. Advocate for a comprehensive, broad-based, person-centered approach to provide the social, economic, and medical supports for people with behavioral health needs; as mandated by Health - General § 7.5 – 305 and by PL 102-321.
4. Serve as a linkage with state agencies seeking collaboration for improved behavioral health services.

## **Article II: Duties**

The Council shall:

1. Review and make recommendations to the State on the behavioral health plan and federal grant documents/applications developed in accordance with any applicable state and federal law.
2. Monitor, review, and evaluate, not less than once each year, the allocation and adequacy of Behavioral Health services and funding; as mandated by PL 102-321.
3. The Council may consult with state agencies to carry out the duties of the Council.
4. Submit an Annual Report of its activities to the Governor and, subject to Section 2-1246 of the State Governor Article, to the General Assembly.
5. Receive and review annual reports submitted by the County Advisory Committees as mandated by Health - General § 7.5–305.

## **Article III: Membership**

In adherence to Federal Public Law PL 102-321, the membership should include:

1. Representatives of certain principal state agencies – behavioral health, education, vocational rehabilitation, criminal justice, housing, and social services.
2. Certain public and private entities concerned with need, planning, operation, funding, and use of behavioral health services and related support services.
3. Family members of adults with a behavioral health disorder and children involved with the behavioral health system.
4. Adults who are currently or formerly involved with behavioral health services.

Not less than 50 percent of the members of the planning council are individuals who are not state employees or providers of behavioral health services. The ratio of parents of children, with a serious emotional disorder to other members of the planning council should be sufficient to provide adequate representation of such children in the deliberations of the Council.

The composition below, as stated in Maryland Senate Bill (SB) 174, satisfies the federal law.

**A. Composition**

1) The Behavioral Health Advisory Council consists of 28 Ex-Officio Members (or designees) representing state and local government, the Judiciary, and the Legislature. They are listed in statute as:

- One Member of the Senate of Maryland
- One Member of the House of Delegates
- The Secretary of Health and Mental Hygiene
- The Deputy Secretary for Behavioral Health
- The Director of the Behavioral Health Administration
- The Executive Director of the Maryland Health Benefit Exchange
- The Deputy Secretary for Health Care Financing
- The Secretary of Aging
- The Secretary of Budget and Management
- The Secretary of Disabilities
- The Secretary of Housing and Community Development
- The Secretary of Human Resources
- The Secretary of Juvenile Services
- The Secretary of Public Safety and Correctional Services
- The Executive Director of the Governor’s Office for Children
- The Executive Director of the Governor’s Office of Crime Control and Prevention
- The Executive Director of the Governor’s Office of the Deaf and Hard of Hearing
- The Public Defender of Maryland
- The State Superintendent of Schools
- The Assistant State Superintendent of the Division of Rehabilitation Services
- Two representatives of the Maryland Judiciary: a District Court Judge and a Circuit Court Judge, appointed by the Chief Judge of the Court of Appeals
- The President of the Maryland Association of County Health Officers
- Four representatives from County Behavioral Health Advisory Councils, one from each region of the State

2) The Council also consists of 13 members, appointed by the DHMH Secretary, representing behavioral health provider and consumer advocacy groups. One representative shall be appointed by the Secretary from each of the following organizations:

- Community Behavioral Health Association
- Drug Policy and Public Health Strategies Clinic
- University of Maryland Carey School of Law
- Maryland Addictive Disorders Council
- Maryland Association of Boards of Education
- Maryland Association for the Treatment of Opioid Dependence
- Maryland Black Mental Health Alliance

Maryland Coalition of Families  
Disability Rights Maryland (formerly Maryland Disability Law Center)  
Maryland Recovery Organization Connecting Communities  
Mental Health Association of Maryland  
National Alliance on Mental Illness of Maryland  
National Council on Alcoholism and Drug Dependence of Maryland  
On Our Own Of Maryland

Additional representatives or individuals designated by the Council may also be appointed by the DHMH Secretary.

3) The Council shall also consist of 14 representatives that include a diverse range of individuals who are consumers, family members, professionals, and involved community members. These representatives should not be state employees or providers of behavioral health services. Two individuals, representing the mental health and the substance-related disorder treatment community, shall be appointed by the Governor from each of the following:

Academic or research professionals  
Medical professionals  
Individuals formerly or currently in receipt of behavioral health services  
Family members of individuals with mental health or substance-related disorders  
Parent of a young child with behavioral health disorders  
Youth between the ages of 16 and 25 years with a behavioral health disorder  
Individuals active in behavioral health issues within their community

Members appointed by the Governor shall be representative, to the extent practicable, of: (1) geographic regions of the state; (2) at-risk populations; (3) ethnic, gender, across-the-lifespan, and cultural diversity; and (4) balanced representation from areas of mental health and substance-related disorders.

#### **B. Term of Membership**

1. Ex-Officio Members serve as long as the member holds the specified office or designation.
2. Members appointed by the DHMH Secretary may serve as long as the organizations they represent wish to have them as a representative of the organization.
3. Members appointed by the Governor: serve a three-year term; may serve for a maximum of two consecutive terms; and after at least six years have passed since serving, may be reappointed for terms that comply with the original appointment. At the end of a term, a member may continue to serve until a successor is appointed and qualifies.



4. Terms of Governor-Appointed Members can be staggered so that one third of members' terms end each year. If a member is appointed by the Governor after a term has begun, he or she may serve only for the rest of the term and until a successor is appointed and qualifies. If appropriate, the Council may recommend that he or she may qualify him or herself, through the Governor's Office of Appointments, for the option of serving a second full-term.
5. Notwithstanding any other provisions of this subsection, all members serve at the pleasure of the Governor and with the consent of the Council.

### **C. Attendance**

It is the expectation of this Council that members attend the majority of the meetings, participate in Council activities, and exercise the duties and responsibilities of the Council on a regular basis.

### **Governor-Appointed Members**

Members of the Maryland Behavioral Health Advisory Council, who are appointed by the Governor, are subject to the Maryland State Government Code Annotated 8-501(2013) which states:

- (a) Member deemed to have resigned - A member of a State board or commission [applicable to this Council as well] appointed by the Governor who fails to attend at least 50 percent of the meetings of the board or commission during any consecutive 12-month period [\*] shall be considered to have resigned.
- (b) Notice to Governor - Not later than January 15 of the year following the end of the 12-month period, the chairman of the board or commission shall forward to the Governor:
  - (1) the name of the individual considered to have resigned; and
  - (2) a statement describing the individual's history of attendance during the period.
- (c) Appointment of successor - Except as provided in subsection (d) of this section, [just below] after receiving the chairman's statement the Governor shall appoint a successor for the remainder of the term of the individual.
- (d) Exception - If the individual has been unable to attend meetings for reasons satisfactory to the Governor, the Governor may waive the resignation if the reasons are made public.

\*This Council will meet six times per year. Fifty (50) percent attendance means at least three meetings per year attended.

### **Ex-Officio Designees and Department-Appointed Members**

In the event an Ex-Officio designee or Department-Appointed representative on the Council fails to attend 50 percent of the meetings during any period of 12 consecutive

months (three meetings per year), the Chairperson/Executive Committee shall send a letter of reminder to the head of the agency/organization/department of the member. If, after a reasonable period of time, there is no attendance, then the Chairperson/Executive Committee shall send a letter to the head of the agency/organization/department of that member recommending that he or she be replaced. If the agency member has been unable to attend meetings as required for reasons satisfactory to the Executive Committee or DHMH Secretary, such resignation may be waived if such reasons are made public.

### **Suspension or Removal of Governor-Appointed Members**

Additionally, as excerpted from the Maryland State Government Code Annotated, 8-502 (2013), “A member of a State board or commission shall be suspended...from participation in the activities of the board or commission [applicable to this Council for Governor Appointed Members] if the member is convicted of or enters a plea of nolo contendere to any crime that: (i) is a felony; or (ii) is a misdemeanor related to the member's public duties and responsibilities and involves moral turpitude for which the penalty may be incarceration in any penal institution. The suspension shall continue during any period of appeal of the conviction. If the conviction becomes final, the member shall be removed from the office and the office shall be deemed vacant. Reinstatement - If the conviction of the member is reversed or otherwise vacated...the member shall be reinstated to the office for the remainder, if any, of the term of office during which the member was so suspended or removed...”

## **Article IV: Meetings and Voting**

### **A. Meetings**

#### **Times and Location**

The Council shall meet at least six (6) times a year. The location to be determined as coordinated through Council Support Staff. The recommended schedule is once (day to be set as coordinated through Council Support staff) during each of the following months: September, November, January, March, May and July. Special meetings, or meetings of the Council to replace meetings postponed due to inclement weather or other circumstances, shall be authorized by the Executive Committee.

Teleconferencing will be available and counts as attendance.

#### **Agenda and Notice of Meetings**

Notice of regular meetings shall be announced by email (by mail for those without computer access). When appropriate and available, an agenda will be included in the announcement.

#### **Official Record**

The minutes of the Council meeting shall be the official record of the Council. The minutes shall be distributed to all members of the Council and to the Director of the Behavioral Health Administration within four to six weeks following a meeting.

After final adoption, minutes will be distributed to local behavioral health authorities. All minutes, recommendations, and related materials will be posted on the Behavioral Health Administration's Web site.

Ad hoc and standing subcommittee meetings may be convened whenever necessary. If necessary, the Executive Committee or any other committee can meet and converse by telephone when it is not feasible to convene and/or when an immediate decision is required. Decisions reached by telephone shall be recorded as meeting minutes for that date and considered official meeting minutes.

### **Travel Allowance**

Council members whose transportation costs are not reimbursed by an agency, group or organization, and who need financial assistance in order to attend a Council meeting and/or when officially representing the Council at other meetings, are eligible for reimbursement by the Behavioral Health Administration. Members may not receive compensation as a member of the council; but are entitled to reimbursement for travel expenses as provided for in the state budget. Travel expenses shall be consistent with the Standard State Travel Regulations and are dependent upon resource availability. Council members are responsible for completing all expense reporting forms in a timely manner, and submitting appropriate accompanying documentation as required.

### **B. Voting**

1. Ex-Officio Members in statute and Appointed Members are all considered voting members.
2. A majority of the voting members of the Council is a quorum. A simple majority of those present at a meeting (face-to-face or by teleconferencing) is sufficient to adopt a motion.
3. The Executive Committee may call for a Council-wide vote on issues of greater import. If a quorum is not present at the meeting specified for the vote, the Executive Committee shall determine the method and timeline to collect the additional votes.
4. Council Officers shall be elected according to a balanced (mental health and substance- related) slate presented by the Nominating Committee every two years or as required.

### **Article V: Officers**

A balanced representation of areas comprising the behavioral health system should be taken into consideration. Also, it is encouraged to consider at least one officer to be a recipient or former recipient of behavioral health services or a relative of such an individual. Officers shall serve for one two year term. However, an officer's term may be extended due to unusual circumstances by a vote of the full Council.

**A. Chairperson**

The Chairperson shall be elected from among the full membership of the Council. The Chairperson shall serve for one two-year term. Elections shall be held bi-annually in December and the term shall begin on January 1 through December 31 of the following year.

The Chairperson shall be responsible for:

1. Calling and presiding over all full meetings of the Council;
2. Coordinating the activities of the Council, including preparation of the required state and federal reports;
3. Collaborating in the preparation of the agenda for the meeting of the Council;
4. Serving on the Executive Committee;
5. Appointing the Chairpersons and members of the Nominating Committee and the Chairpersons of standing and ad hoc committees;
6. Signing, when appropriate, in the name of the Council, all letters and other documents;
7. Serving as Ex-Officio on standing and ad hoc committees, except for the Nominating Committee; and
8. Representing the opinion of the Council to the public.

**B. Vice Chairperson**

The Vice Chairperson shall be elected from among the full membership of the Council. The Vice Chairperson shall serve for one two-year term. Elections shall be held bi-annually in December and the term shall begin on January 1 through December 31 of the following year.

The Vice Chairperson shall be responsible for:

1. Serving on the Executive Committee; and
2. Executing the Chairperson's duties in the absence of the Chairperson.

### **C. Committee Chairs**

The Council Chair will designate a chair for each committee from among the Council membership. Chairs of each committee must be members of the Council. Committee chairs shall serve as members of the Executive Committee. Additionally, committee chairs may be called upon to be responsible for the duties of the Council Chair or Vice Chair in the absence of either or both officers.

Committee chairs are expected to convene, attend, and preside over all committee meetings of their respective group (by teleconferencing, if necessary) and designate the means for an official record (summary or minutes) to be generated of meetings held. Committee chairs shall: follow the policy for and monitor the attendance of committee members. Once the Council Chair has selected a committee chair from members who offer to serve voluntarily, the committee chair may then designate another committee member to take on chair responsibilities in the case of his/her absence.

### **Article VI: Committees**

The Maryland Behavioral Health Advisory Council's committee structure will consist of standing committees and ad hoc committees to facilitate the Council's role of gathering and disseminating information. Membership on committees is not limited exclusively to Council members except the Executive and Nominating committees. The Council may adopt procedures necessary to do business, including the creation of committees or task forces. Standing and ad hoc committees may be convened as determined by the committee chair and agreed upon by the Executive Committee. The committees will make recommendations that will enhance aspects of the behavioral health system and to ensure a coordinated, culturally and linguistically competent, quality system of care that is outcome-guided and that integrates prevention, recovery, and evidence-based practices, and cost-effective strategies in the delivery of behavioral health services state-wide.

Council members are requested to serve on at least one committee. A focus on the following themes will remain central to committee operations:

1. Facilitate a balance between mental health and substance-related disorder services and systems; maintain the understanding that representation across the behavioral health service system is required and needed, and promote discussion about the ongoing concerns and care coordination associated with the behavioral health integration process.
2. Focus on information sharing and committee coordination to avoid the duplication of effort, since multiple Council members work on other projects and stakeholder groups. Also, the Council must maintain clarity in terms of the role and duties of the Maryland Behavioral Health Advisory Council.
3. Each committee must report how it is moving toward achieving the Council's mission and core priorities and issues.

4. An official record such as minutes or a summary of actions must be taken at all standing and ad hoc committee meetings.

## **Policies and Procedures for Committees:**

### **Standing Committees**

#### **A. Executive Committee**

The Executive Committee shall be composed of the Chairperson, Vice Chairperson, committee, and ad hoc committee chairpersons. The Executive Committee shall meet as needed. The Executive Committee responsibilities include, but are not limited to, preparing, reviewing or approving testimony or other public presentations/documents/reports submitted on behalf of the Council when sufficient time does not permit review and approval of the entire Council and timing is of critical importance, etc. Another duty of the Executive Committee will be to develop and identify directives and initiatives for the work of standing and ad hoc committees, as well as provide oversight, when needed, to ensure that each committee of the Council completes assigned special projects.

#### **B. The Planning Committee**

The Planning Committee will address efforts that comply with the Federal Mental Health Block Grant (MHBG) requirement. The duties of this committee include participation in a yearlong planning process comprised of development, review, and final recommendation of the Maryland Behavioral Health Plan and Federal Mental Health Block Grant Application which may be used to inform special projects. The committee shall also identify focus areas/issues to be monitored and make recommendations to the Council. Also, the committee shall participate in the development of the Annual Report, which summarizes the activities, priorities, and recommendations of the Council and is submitted to the Governor annually. On an ongoing basis, the Planning Committee will give input to identify workgroups and targeted projects for the Lifespan Committee and, as needed, give input toward the action plans of ad hoc committees and/or special studies/workgroups/committees to ensure they are in concert with the Behavioral Health Administration's goals and priorities.

#### **C. Prevention Committee**

This committee will address efforts that comply with the Federal Substance Abuse Block Grant (SABG)/Strategic Prevention Framework Grant (SPFG) which is currently in phase 2. The SPFG began in September, 2015 and ends on September, 2020 at \$1.6 million per year. The focus during the second phase of the initiative is to prevent and reduce underage drinking and youth binge-drinking. The Prevention Committee will serve as Maryland's required Strategic Prevention Framework Advisory Committee (SPFAC), a requirement for Strategic Prevention Framework grants from SAMHSA for monitoring progress and strengthening the initiative by making recommendations to the Behavioral Health Administration if needed. Additionally, the duties of this committee include providing guidance and advocacy

in the areas of prevention across the lifespan. This may include areas such as substance-related prevention, suicide prevention, and addictive behaviors such as gambling. This committee may examine data, research, identify risk factors, evidence-based resources, and make recommendations or suggest strategies to the Administration as appropriate and/or as elements for further study.

### **Ad Hoc Committees**

These committees will be formed, as needed, to address specific duties, needs, or issues as deemed appropriate by the Executive Committee or Council. The Chairperson may appoint temporary committees or Council representatives for a specified purpose and time. Upon completion of the task, the committees shall be dissolved. Another duty of the Executive Committee will be to develop and identify directives and initiatives for the work of standing and ad hoc committees, as well as provide oversight, when needed, to ensure that each committee of the Council completes assigned special projects.

#### **A. Lifespan Committee I: Children, Young Adults, and Families**

The duties of this committee will be to identify recommendations for the development of strategies and initiatives, including evidence-based practices, which are important for a comprehensive system of care of behavioral health services and supports for children, young adults and families.

#### **B. Lifespan Committee II: Adults and Older Adults**

The duties of this committee will be to identify recommendations for the development of strategies and initiatives, including evidence-based practices, which are important for a comprehensive system of behavioral health services and supports for adults and older adults.

#### **C. The Cultural and Linguistic Competence Committee**

The primary objective of the Cultural and Linguistic Competence Committee will be to assist the Council in its role of gathering and disseminating information about the role culture plays in the delivery of behavioral health services in the behavioral health system. The Cultural and Linguistic Competence Committee will generate recommendations and concepts that will facilitate the development of cultural and linguistic competence and culturally responsive services important for the behavioral health system, providers, and communities across the state. Recommendations and concepts generated by the committee will be general and will also make reference to specific cultural groups and communities across the state of Maryland, including those related to gender, gender identity, and disability. The recommendations and concepts made by this Committee will be used to shape and inform strategies that are part of state, federal, and local planning processes.

#### **D. Criminal Justice/Forensics Committee**

The purpose of this committee is to advise the Administration regarding the delivery of behavioral health services to individuals who are involved with the criminal and juvenile justice systems, including those who: are court-ordered to the Department of Health and Mental Hygiene (DHMH) for evaluation, commitment, and/ or treatment relative to competency to stand trial or criminal responsibility; are court-ordered to DHMH for a substance-related evaluation and/or for substance-related disorders treatment; are released into the community from a DHMH facility under court-mandated conditions of release; or have psychiatric, substance-related, or co-occurring disorders and are incarcerated, or are at risk of incarceration, in jails, prisons, or juvenile detention facilities.

#### **E. The Nominating Committee**

##### **Composition**

The Nominating Committee shall consist of a chairperson and four other members, all appointed by the Council Chairperson. Members shall represent a balance in the areas of mental health and substance-related disorders.

##### **Slate**

The Nominating Committee shall convene bi-annually in September and conduct a search for the offices of Council Chairperson and Council Vice Chairperson from among the Appointed and Ex-Officio Membership. If the present officers are eligible to serve a second term, it is appropriate that the Nominating Committee take their names into consideration for the slate. Additionally, the Committee must consider the need to maintain the balance between the areas of mental health and substance-related disorders when considering names for the slate. The slate shall consist of one name each for Council Chair and Council Vice Chair.

##### **Voting**

The slate shall be presented electronically to the full Council, bi-annually in October, and voted to be approved or not approved the following November during a meeting with a quorum of Council members present. If the slate is approved, those named will begin their term on the following January 1. If the slate is not approved, then the Nominating Committee will be requested to develop an alternate slate of names.

Additional ad hoc committees or special studies workgroups may be convened to: address a specific behavioral health priority area identified by the Council for review, presentation, and possible advocacy recommendation; or to meet the requirements of other legislative processes or task forces.

The membership of ad hoc committees or special studies/workgroups may include an individual(s) representing the Council on various Behavioral Health Administration or other agency or organization-sponsored task forces, workgroups, etc.



Membership on committees is not limited exclusively to Council members. Non Council members may serve on committees, ad hoc committees, and specialty workgroups, except the Executive and Nominating committees.

**Article VII: Support Services**

The Behavioral Health Administration shall provide support staff for administrative coordination, as necessary, to support the functions of the Council.

**Article VIII: Amendments**

The By-laws may be amended by recommendations of the Executive Committee and two-thirds of the voting members of the Council who are present, provided that copies of the proposed amendments and notice for consideration have been mailed to every member at least two weeks before the date of the meetings, during which adoption of the amendment(s) would be considered. The amendment goes into effect immediately upon its adoption unless otherwise specified.

**The Maryland Behavioral Health Advisory Council By-Laws were approved March 15, 2016.**

“The services and facilities of the Maryland State Department of Health and Mental Hygiene (DHMH) are operated on a non-discriminatory basis. This policy prohibits discrimination on the basis of race, color, sex, or national origin and applies to the provisions of employment and granting of advantages, privileges, and accommodations.”

“The Department, in compliance with the Americans with Disabilities Act, ensures that qualified individuals with disabilities are given an opportunity to participate in and benefit from the Department’s services, programs, benefits, and employment opportunities.”

For copies of the Maryland Behavioral Health Advisory Council’s Annual Report,  
contact:

The Behavioral Health Administration  
(410) 402-8473