THE 2019 ANNUAL REPORT OF

THE MARYLAND BEHAVIORAL HEALTH ADVISORY COUNCIL

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

Barbara L. Allen
Co-Chair

Dan Martin, Esquire
Co-Chair

Maryland
DEPARTMENT OF HEALTH
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Maryland Behavioral Health Advisory Council
Attn: Greta Carter
55 Wade Avenue, Dix Building, SGHC
Catonsville, MD 21228

October 4, 2019

The Hon. Larry Hogan
Governor
100 State Circle
Annapolis, Maryland 21401–1991

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

The Hon. Adrienne Jones
Speaker of the House
H-101 State House
Annapolis, MD 21401–1991

RE: Health-General Article § 7.5–305—Behavioral Health Advisory Council Annual Report

Dear Governor Hogan, President Miller, and Speaker Jones:

Pursuant to Health-General Article § 7.5–305, the Maryland Behavioral Health Advisory Council submits its 2019 annual report. The attached report provides an overview and summary of the activities of this Council during calendar year 2019.

The establishment of the Maryland Behavioral Health Advisory Council was codified October 2015. The law provides 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 has met bi-monthly since January 2019. In addition to continuing to sharing information regarding various happenings in the Public Behavioral Health System, the Council has also been very active with such things as: changes to Committee names; holding a strategic planning retreat, elected a new co-chair, submitting a legislative cleanup bill, and welcoming new members. The Councils committees have continued to meet to focus on 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, and community behavioral health services.

This year has been an active one and the Council looks 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 Behavioral Health Administration leadership and to you, as appropriate, to improve the work of the Public Behavioral Health System in Maryland.

Sincerely,

Barbara L. Allen
Co-Chair
Maryland Behavioral Health
Advisory Council

Dan Martin, Esquire
Co-Chair
Maryland Behavioral Health
Advisory Council

Enclosure

cc: Robert R. Neall, Secretary, Maryland Department of Health (MDH)
Webster Ye, Director of Governmental Affairs, MDH
Aliya Jones, M.D., MBA, Deputy Secretary for Behavioral Health, MDH
Sarah T. Albert, MSAR #10584 and 10868, Department of Legislative Service

INTRODUCTION

This report is the annual report of Maryland's Behavioral Health Advisory Council, which, according to statute, is due to the Governor at the end of each calendar year.

Senate Bill 174 (2015), codified as Health-General Article (HG) § 7.5–305, established the 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 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 Secretary of the Maryland Department of Health, representing behavioral health providers 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 HG § 7.5–305, 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.

The following pages include the membership list, highlights, and activities of the council for FY2019.

Maryland Behavioral Health Advisory Council

Barbara L. Allen, Co-Chair
Community Advocate for Substance Use Disorders

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

Makeitha Abdulbarr
The Maryland County Behavioral Health Advisory Councils

Barbara L. Allen
Community Advocate for Substance Use Disorders

Robert Anderson
The Maryland Department of Juvenile Services

Dori S. Bishop
Family Member

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

T'Kea Blackman
Consumer

Lori Brewster
The Maryland Association of County Health Officers

Mary Bunch
Family Member (Child)

Lisa A. Burgess
The Office of the Deputy Secretary, Maryland Department of Health

John Pierre Cardenas
The Maryland Health Benefit Exchange

Kenneth Collins
The Maryland County Behavioral Health Advisory Councils

Shayna Dee
The Office of the Secretary Maryland Department of Health

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

Kathryn Dilley
The Maryland County Behavioral Health Advisory Councils

Lillian Donnard
The Maryland Association for the Treatment of Opioid Dependence

Catherine Drake
The Maryland Division of Rehabilitation Services

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

Lauren Grimes
On Our Own of Maryland, Inc.

Shannon Hall
The Community Behavioral Health Association of Maryland

Roseanne Hanratty
The Maryland Department of Aging

Carlos Hardy
The Maryland Recovery Organization Connecting Communities

Dayna Harris
The Maryland Department of Housing & Community Development

Joyce Harrison
Academic/Research Professional

James Hedrick
The Governor's Office of Crime Control and Prevention

Sylvia Lawson
The Maryland State Department of Education

Sharon M. Lipford
Community Advocate

The Hon. George Lipman
The Maryland Judiciary District Court

Theresa Lord
Family Member (Child)

Dan Martin
Mental Health Association of Maryland, Inc.

Jonathan Martin
Maryland Department of Budget and Management

The Hon. Dana Moylan Wright
The Maryland Judiciary Circuit Court

Randall Nero
The Maryland Department of Public Safety and Correctional Services

Luciene Parsley
Disability Rights Maryland

William Patton
The Maryland County Behavioral Health Advisory Councils

Keisha Peterson
The Maryland Department of Human Resources

Mary Pizzo
The Office of the Public Defender

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

Kirsten Robb-McGrath
The Maryland Department of Disabilities

Jacob Salem
The Governor's Office of Deaf and Hard of Hearing

Dana Sauro
Consumer (Youth/Young Adult)

Sabrina A. Sepulveda
Medical Professional

Jeffrey P. Sternlicht
Medical Professional

Deneice Valentine
Consumer

Ambrosia Watts
The Behavioral Health Unit, Maryland Medicaid, Maryland Department of Health

Tracey Webb
The Governor's Office for Children

Anita Wells
Academic/Research Professional

Kim Wireman
The Maryland Addiction Director's Council

Behavioral Health Administration Staff Support: Division of Systems Management, Division of Planning: Cynthia Petion, Sarah Reiman, Judith Leiman, Tsegereda Assebe, and Greta Carter.

Highlights and Activities of Maryland's Behavioral Health Advisory Council

Maryland's Behavioral Health Advisory Council (MBHAC or Council) met bi-monthly (six times during the year), and members engaged in several activities and presentations that included: legislative updates, the efforts to address Maryland's opioid epidemic, committee discussions to address criminal justice, prevention, cultural and linguistic competency, a Strategic Planning Retreat, and children and adult services issues in the Public Behavioral Health System (PBHS).

Legislative Highlights

Representatives from the Council were engaged in addressing ongoing behavioral health issues during the 2019 Legislative Session and continue to update the Council on legislation that impacts behavioral health. The Council was pleased with many victories; some more significant examples being the passing of HB1122/SB944, which changed the Medical Director requirements for Outpatient MH Centers, allowing Psychiatric Nurse Practitioners to now serve as a medical director for behavioral health programs either onsite or through telehealth (HB570/SB178), as well as HB427 regarding the Outpatient Civil Commitment Program.

Several of the Council members provided legislative updates specific to their organizations. The Mental Health Association of Maryland (MHAMD), in collaboration with the Behavioral Health Coalition, continued to ask legislators to "Keep the Door Open" for Marylanders with behavioral health needs by advocating for increased access to mental health and substance use disorder services and to implement progressive reforms for Marylanders of all ages. This was done by advocating for several bills addressed to protect and increase funding for Community Behavioral Health Services, increasing school behavioral health supports, promoting medication-assisted treatment for substance use disorders, and diverting individuals with behavioral health disorders from emergency departments. Just a few of the bills passed to address these issues were:

- **SB280/HB166:** introduced to increase Maryland's minimum wage over a period of years. The Coalition supported the increase with an amendment to provide an increase in funding for community mental health and substance abuse treatment by 22% over the six year minimum wage implementation period.
- **SB1030:** provides funding each year to each local school system to fund dedicated mental health services coordinator in each district. It also creates a Concentration of Poverty School Grant Program to provide increased resources to schools in which at least 80% of the students are eligible for free and reduced-price meals. Schools receiving Program funding are required to employ staff to coordinate specific wraparound services including enhanced access to behavioral health resources and mental health practitioners.
- **HB116:** requires that individuals entering local correctional facilities be assessed for Opioid Use Disorder (OUD) and that Medication Assisted Treatment (MAT) be available as appropriate. The bill applies initially to four specific counties, with gradual expansion to the remaining jurisdictions by January 2023.

- **SB631/HB599:** coverage for mental health benefits and substance use disorder benefits; requires commercial carriers to use American Society of Addiction Medicine (ASAM) criteria when making medical necessity determinations for substance use disorder treatment.

The National Council on Alcoholism and Drug Dependence (NCADD) reported on many of the same bills that passed that MHAMD reported. In addition, they noted the 3.5% reimbursement rate increase for community-based behavioral health providers that was included in the final FY2020 budget. They also updated the Council on bills that had been withdrawn, such as SB482/HB846 which was the proposal to end the existing carve-out in Medicaid and have all SUD and mental health services managed by the Managed Care Organizations (MCOs), and what their response had been, as well as bills that had failed.

Council member Senator Addie Eckardt provided her legislative wrap up. Senator Eckardt also supported the reimbursement rate increase for providers serving those with behavioral health needs in the continuing fight against the opioid epidemic. Other passed sponsored legislation included:

- **SB178/HB570—Behavioral Health Programs – Medical Directors – Telehealth** requires regulations governing behavioral health programs to include a provision authorizing a behavioral health program to satisfy any regulatory requirement that the medical director be on site through the use of telehealth by the director.
- **SB524/HB605—Maryland Medical Assistance Program – Telemedicine – Psychiatric Nurse Practitioners and Psychiatrists** includes psychiatric nurse practitioners who provide Assertive Community Treatment (ACT) or mobile treatment services (MTS) as those eligible to receive reimbursement for telemedicine health care services.
- **SB944/HB1122—Behavioral Health Programs – Outpatient Mental Health Centers – Medical Directors** allows for psychiatric nurse practitioners to serve as the medical director of an outpatient mental health center, including through the use of telehealth.

The Community Behavioral Health Association of Maryland (CBH) also provided the Council with updates on their participation in the legislative session. CBH supported many of the bills supported by the other Council members such as SB178/HB570, SB524/HB605, and SB944/HB1122, as well as the legislation regarding rate increases for providers, the minimum wage increase, and the financial carve-in model for publicly-funded behavioral health services. In addition, they supported SB395/HB77 a bill that was passed that bans the prosecution of attempted suicide as a crime.

For next year's legislative session, the Council will be submitting a legislative clean-up bill with the purpose to remove extraneous and overly burdensome membership requirements.

Strategic Planning Retreat

The MBHAC held a Strategic Planning Retreat in July 2019. The purpose of the retreat was to clarify the strategic focus and expected activities to ensure that the MBHAC has an effective impact on improving the Public Behavioral Health System in Maryland; and to develop a shared understanding and strengthened commitment to MBHAC activities in FY2020. In preparation for the retreat, all MBHAC members were asked to complete a short survey. The results were used to refine the retreat agenda and meeting materials. The MBHAC Committees provided FY2019 reports that addressed the purpose and lessons learned, impact or outcomes achieved, obstacles and challenges, and recommendations going forward. The retreat also looked at future MBHAC activities, using the survey results to create a baseline understanding of perspectives shared by the MBHAC members. Small groups allowed members to brainstorm suggestions for improvements and about potential MBHAC activities. From these small groups, five main areas of interest arose:

- MBHAC Impact
- Role Clarity
- Communication and Outreach about MBHAC
- Improve Understanding of System
- MBHAC Support

At the conclusion of the retreat members were able to identify next steps that involved convening a meeting with BHA staff and the MBHAC chairs to review the summary from the retreat, reaching out to key MDH and Governor's Office staff to discuss the retreat summary and to get their advice, providing a copy of the summary to those members who were not able to attend the retreat, and draft the Council's work plan for FY2020. From the summary, four goals were also outlined as possible content for a draft FY2020 work plan.

- Ensuring MBHAC purpose, value and roles are clear
- Increasing awareness of the value of MBHAC and promoting it as a resource
- Increasing the impact of MBHAC
- Improving collaboration among MBHAC members

Council Presentations and PBHS Updates

The Council was consistently kept informed of the efforts to address Maryland's opioid epidemic. The new Executive Director for the Opioid Operations Command Center (OOCC) met with the Council and discussed the Command Center's focus and scope of work, as well as provided the Council with data on overdoses and decreases in opioid prescriptions in the state.

BHA informed the Council on grants related to the Maryland State Opioid Response (SOR) Initiative. SOR funding is $33 million dollars for a two year period beginning September 30, 2019, through September 30, 2021. This funding supports a comprehensive response to the opioid epidemic and expands access to treatment and recovery support services. Its purpose is

to increase access to Medication Assisted Treatment (MAT), reduce unmet treatment need, and, ultimately, to decrease opioid deaths. The money provides funding for numerous projects such as Crisis Walk-In Centers, Safe Stations, Harm Reduction, and Young Adult Recovery Housing to name a few. Money will also be used for projects that were not funded in the past or that had limited funding such as sign language services, services for pregnant women and women with children, and workforce development projects.

BHA developed a Cultural and Linguistic Competency Strategic Plan in collaboration with the members of the Councils CLC Committee. The Council was also made aware of a Cultural and Linguistic Competency Seminar offered in June 21, 2019. The Seminar highlighted BHA's FY2019–2020 Cultural and Linguistic Competency Strategic Plan and focused on using the National Culturally and Linguistically Appropriate Services (CLAS) standards in Behavioral Health Work. Additional trainings on cultural and linguistic competence (CLC) and the CLAS standards for local behavioral health authorities, providers and the behavioral health workforce were offered later in the year. These trainings will also available online for three years starting January 2020 through BHA's training website.

This year the Executive Committee of the MBHAC formed a Nomination Committee to nominate individuals for co-chairs. The current co-chairs had exceeded their terms and the time had come to elect new co-chairs. An individual representing the mental health community and an individual representing the substance use community were selected. The current co-chairs approached each with the nomination, offering their insight and knowledge related to holding the position of co-chair. The individual representing the mental health community accepted the nomination, but unfortunately the individual representing the substance use disorder community declined the nomination. Attempts of outreach to other qualified individuals proved futile so the current chair agreed to stay on for one more year while the Council actively searches for a replacement.

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. Information regarding various conferences or learning communities around the state, as well as events/activities related to Problem Gambling Awareness month, Recovery Month and Mental Health Awareness Month, were shared with Council members. There were several formal presentations offered to the Council members this past year that included:

- **Active Minds-changing the conversation about mental health**
  Active Minds is student run organization, with 470 chapters on college campuses throughout the country. They are raising awareness of mental health and trying to change stigma.
- **Needs Assessment for Student School-based Behavioral Health Services**
  In response to HB1522 (2017). The bill required the Maryland State Department of Education (MSDE) and MDH to conduct a needs assessment for student school-based behavioral health services (BHS) in consultation with local

education agencies and other interested stakeholders. Based on the bill's requirement, various data were collected and analyzed to determine the need for BHS in each school district, the types of school-based BHS already offered to children, the number of children with behavioral health needs; and to identify and remove obstacles to providing BHS to all children who presented a need for such services.

- **Sobriety, Treatment and Recovery Teams (START) Initiative**
  The START Model is an interagency collaboration between DHS and BHA and is just one of several initiatives that DHS offers that addresses parental substance use. Through this initiative the agency would be serving the same families, prioritizing those with children zero to five years old, and working with staff on addiction and recovery and making resources supportive rather than punitive.

The Council has continued to help monitor the progress of goals and efforts of the BHA as it continues to shape and refine the process of behavioral health integration. The Council has been closely following these efforts through interface with BHA's Executive Director who is an appointed member of the Council and who provides updates on the PBHS, also known as "The Director's Report," to the Council. Through the Director's Report, information is shared regarding various state and federal grants that BHA monitors, the Legislative Session, and progress within the PBHS related to integration. A few of the updates provided to the Council by the Executive Director are as follows:

Public Behavioral Health System Integration Updates

- ***ASAM Level 3.1 Transition***

As of January 1, 2019, ASAM Level 3.1 Residential Treatment Services became a Medicaid reimbursable service. This is the final phase in the department's transition from grant funding to fee for service. Phase 1 began in January 2018 when Specialty ASAM Levels 3.3 and 3.5 Residential Providers were also moved to the Fee for Services (FFS) model and are being reimbursed through Medicaid and state funding.

- ***Certified Recovery Housing***

In 2016 BHA was approved by MDH to serve as the designated credentialing entity to develop and administer a certification process for recovery residences. A "recovery residence" means a service that provides alcohol-free and illicit drug-free housing to individuals with substance-related disorders or addictive disorders or co-occurring mental health and substance-related disorders or addictive disorders.

In December 2018 BHA solicited proposals for recovery housing from local behavioral health authorities (LBHA's) and local addiction authorities (LAAs). Dedicated funding from the SOR Grant had been identified to expand recovery housing for young adults with an Opioid Use Disorder and for adults and older adults with an Opioid Use Disorder. The goal is to expand the number of credentialed recovery houses to support 160 adults and 812 young adults. BHA has

been working with local jurisdictions and also made selections in response to the recovery housing solicitation. Twelve jurisdictions were selected to receive funds.

- ***Local Systems Management Integration Plan***

~~In 2012 the Department of Health and Mental Hygiene (DHMH), now renamed Maryland Department of Health, was tasked with providing recommendations to the General Assembly for developing a "system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues." The system was fractured fragmented and there was a lack of coherence in Maryland's approach to individuals patients with behavioral health conditions. The goal was to provide coordinated care for individuals so the department worked with stakeholders and hired a consultant to examine options for an integrated system of behavioral health care. It was then that the two administrations, DHMH and the Mental Hygiene Administration and the Alcohol and Drug Abuse Administration (ADAA) were merged to form the Behavioral Health Administrant (BHA).~~

The Maryland Behavioral Health Administration (BHA) has been moving toward strategic integration of behavioral health, including state administrative functions, funding streams, and local systems management. As such, the FY 2017 Behavioral Health Plan sets forth the vision to provide "improved health, wellness, and quality of life for individuals across the life span through a seamless and integrated behavioral health system of care."

In addition, the 2017 Maryland State budget reaffirmed the "*policy imperative to fully integrate behavioral health services in the State*" and directed the BHA to study the feasibility, costs, and benefits of merging the Core Service Agencies (CSAs) with the Local Addictions Authorities (LAAs).[1] In response, the BHA submitted a report that addressed all elements listed in the budget language: how the experience of those counties with merged behavioral health authorities differ from the counties where these authorities remain separate; information on grants that each entity receives; information on how grants are divided among administrative and treatment costs; and provided recommendations on whether or not it would be beneficial to the oversight and efficiency of the public behavioral health system to combine CSAs and LAAs in each jurisdiction where it is not already so.

Since the larger integration the goal has been to have Maryland's jurisdictions also integrate their local authorities that offer mental health and substance disorder services. BHA has been working with all 24 local jurisdictions to implement the Local Systems Management Integration Plan to improve health, wellness, and quality of life for individuals across the life span through a seamless and integrated behavioral health system of care. The goal of integrated systems management is to support the delivery of high-quality, culturally and linguistically appropriate, person-centered behavioral health experiences in a timely manner, regardless of which "door" a person enters the system. The Integration Plan was developed in collaboration with local and statewide stakeholders. Through interviews and listening sessions, discussion groups and an

[1] *Report on the Fiscal 2018 State Operating Budget (HB150) and the State Capital Budget (HB151) and Related Recommendations*, page 79, Joint Chairmen's Report – Operating Budget April 2017.

advisory group an Integration Roadmap was developed. The Roadmap includes pathways and milestones to mark progress toward full systems management integration. It also includes a Systems Management Integration Self-Assessment Toolkit with several elements to support local jurisdictions in their own processes to increase integration. Learning Communities help local jurisdictions learn from peers and other experts. Additionally, the Integration Plan builds on an analysis of experiences in all 24 local jurisdictions, plus financial data, that indicated opportunities to increase value from systems management. While all local jurisdictions have begun the journey toward integration, and half have established a Local Behavioral Health Authority (LBHA) in lieu of their CSA and LAA, all have more integration work to do. More than dealing with organizational structure, it must also address differences in approaches to culture, leadership, budgeting, operations, workforce development, relationships and communication. Moving through these changes requires time, attention, and support.

~~The systems integration approach involves three phases and is currently in Phase 3. Progress to date includes: implementation of the Learning Community for the Maryland Association of Behavioral Health Authorities (MABHA), development of standardizing policies and procedures using MDH's Acadia platform and completion of a self-assessment of each local authority of their systems management integration status~~.

- ***BHA Reorganization***

In response to the Governor declaration of a state of emergency in response to the State's opioid epidemic, the Department issued a directive to have some opioid-response programs reassigned to improve coordination.

The Behavioral Health Administration (BHA) continued to play a central role in supporting public behavioral health treatment services, including treatment-related planning, workforce development, service quality improvement, credentialing and licensing, and treatment grant funding, however, Public Health Services (PHS) assumed responsibility for areas of opioid response aligned with existing public health activities: surveillance, health promotion and prevention, screening, early intervention and referral into treatment. It was the expectation that both Administrations would work closely together to fully integrate these services and maximize the effectiveness of operations.

In February 2019, the following units shifted from BHA to PHS:

- The Prescription Drug Monitoring Program (PDMP), now merged with the Office of Provider Engagement and Regulation (OPER);
- Prevention Programs, under Office of Population Health Improvement (OPHI);
- Selected programs within the Office of Early Intervention and Wellness; and
- Harm Reduction; all tobacco related services; and the Hospital-based services.

The Health Promotion and Prevention Division (HPPD) has been re-titled Service Access and Innovation Division. The Division will continue oversight of the Office of Gambling Services and

Family Navigation, Workforce Development/Training. It also assumes responsibility for the Office of Consumer Affairs and the Maryland's Commitment to Veterans Program.

- ***Updates on the Maryland Federal Block on Mental Health and Substance Abuse Services***

  Mental Health Block Grant

  - Maryland's FY2020 Proposed Mental Health Block Grant Allotment is $13,546,678. States are required to set aside 10% for early intervention or first episode psychosis services. The remaining funds support crisis response systems/services, implementation of evidence-based practices, school-based mental health, and other recovery services.

  Substance Abuse Block Grant

  - Maryland's FY2020 Proposed Substance Abuse Block Grant Allotment is $34,075,886. States are required to set aside 20% for prevention services and 5% for HIV Early Intervention Services. The remaining funds support substance use treatment, prevention, and intervention services.

Maryland Behavioral Health Advisory Council Committees

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 and conversations for the period covering May to October 2019:

- **Planning Committee: Co-Chairs Dori Bishop and Senator Adelaide Eckardt**

The duties of this committee include participation in a yearlong planning process comprised of development, review, and final recommendation of BHA's State Behavioral Health Plan and Federal Block Grant Application, which may be used to inform special projects. The Committee, which is a standing committee, also identifies focus areas and issues to be monitored, and makes recommendations to the Council.

Over the past year, the Planning Committee met to review, comment and make recommendations on several policy documents including the Federal Block Grant application, the State Behavioral Health Plan and the Annual Implementation Report. The Committee reviewed the BHA State Plan Implementation Report and will be working on consultation for the upcoming two year plan. The Committee reviewed the Goals and Objectives for the FY2020–2021 BHA Plan, as well as the recommendations from BHA's regional stakeholder meetings for strategies to address goals for the 2020 State Plan.

- **Prevention Committee**: **Chair Sharon Lipford**

The purpose of the Prevention Committee is to meet the Substance Abuse and Mental Health Services Administration's (SAMHSA) 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 Prevention Committee was on hiatus for much of the year due to the reorganization of BHA's Prevention unit; the Prevention unit shifted from BHA to PHA in February 2019. While Prevention is now under PHA, BHA still continues to play a central role and will be working closely with PHA to fully integrate treatment services and public health activities and maximize the effectiveness of operations and the Committee intends to reconvene in January 2020.

- **Children, Young Adults, and Families Committee: Co-Chairs Ann Geddes and Mary Bunch**

The duties of this 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 was previously named "Lifespan 1" but with the name change of the "Lifespan 2" Committee, Committee members felt it was necessary to change their name as well. The focus of the Committee is on current programs for young adults, the need for expansion of services, and their role in advocating for this. The Committee feels that the support they have received from BHA has been vital to their success but feel that they are facing new obstacles and challenges with the number of unfilled positions at BHA, specifically the Director for Children, Adolescents and Young Adults (CAYA) (as of September 2019 a new Director has been hired). The Committee is also concerned with the current CAYA system that appears to be obstructed at times with the involvement of multiple State agencies and the shortage of treatment beds for adolescents.

Some of the Committee Activities over the past year have included:

- Continued advocacy for the selection of a Director of CAYA Division of BHA (a Director has been hired as of September 2019). The work of the Committee has been hampered by the absence of a Director during entire FY2019, as well as the Deputy Director vacancy;
- Voicing the need for young adult peer support specialists in Early Intervention Program;
- Advocating for the diagnostic criteria to be loosened for young adults to receive services through BHA's TAY program;
- Identifying the crisis in acute beds for youth, especially youth with co-occurring mental health and developmental disabilities and working on expanding crisis services for this population;

- Highlighting the shortage of residential substance use beds for adolescents and bringing this problem to the attending of BHA; and
- Inquiring of BHA CAYA Division staff to update on work related to: sustainability of young adult programing; substance use services for adolescents; and early childhood.

The Committee identified some next steps for FY2020 to address the Committee's charge and goals:

- Meet with new Director of CAYA Division to brief her on committee's priorities; and
- Advocate for the adoption of "Building Bridges" best practice model for RTCs.

- **Recover Services and Supports Committee: Co-Chairs Barbara Allen and Carlos Hardy**

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 youth, adults and older adults.

The Committee was formerly named "Lifespan 2." The Committee changed its name to Recover Services and Supports. This name change enabled the members to reframe the focus of the Committee and to find common goals. The Committee focused on identifying strategies and initiatives, including treatment and emerging recovery focused evidence-based practices, which members believe are critical if Maryland is to recognize the goal of achieving a comprehensive, inclusive, person-centered behavioral health system. Committee areas of focus during the 2019 calendar year included extensive discussion and/or debate on the following topics:

Mental Health Parity and Addiction Equality Act

- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA). MHPAEA requires parity in the treatment limitations and financial requirements for mental health and substance use disorder (MH/SUD) benefits, as compared to medical/surgical (M/S) benefits, provided to enrollees of Medicaid managed care organizations (MCO) and coverage provided by Medicaid alternative benefits plans (ABPs) and Children's Health Insurance Programs (CHIP). ~~is intended to end historic health insurance discrimination against individuals with mental health and substance use disorders (MH/SUD). The act states that plans that provide MH/SUD benefits must have equal benefit coverage and equal access to benefits.~~ It is the Committee's belief that more can be done as far as implementation and accountability. The Committee plans to be more attuned by staying up to date on the Maryland's compliance with parity as well as the Parity Coalition activities.

Behavioral Health Integration

- The Committee intends to work on stronger advocacy efforts by Council as well as BHA in the hopes to reduce the chasm between Maryland's behavioral health and somatic care communities.

Expand and fully resource "certified" recovery residences

- Recognizing the important role recovery residences play in a person's recovery initiation and recovery sustainability, the Committee intends to advocate for greater transparency, dissemination and the inclusion of stakeholder input and feedback from the Maryland Certification of Recovery Residences (MCORR) process. In addition, the Committee would support implementation of a grievance process that allows recovery residence owners to air concerns, as appropriate.

Support and fund the expansion of Wellness and Recovery Centers throughout all jurisdictions

- The Committee supports utilizing Community Wellness Center Baltimore (www.cwcmd.org/bhs) and On Our Own (www.onourownmd.org) as a blueprint to expanding centers statewide.

The next steps for FY2020 to address the Committee's charge and goals are as follows:

- Increase membership and participation on the Recovery Services/Support Committee; and
- Continue efforts to further define and refine the Committee's target audience.

- **The Cultural and Linguistic Competence Committee: Co-Chairs Jacob Salem and Dayna Harris**

  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 PBHS. 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 Co-Chairs have stated that the purpose of the Committee is to eliminate stigma, bias and discrimination. The Committee's primary focus has been implementing the recently released statewide Strategic Plan for Cultural and Linguistic Competence (CLC) and the national CLAS standards. During the process of drafting a new vision statement, it became evident that while having many different perspectives, the Committee has struggled to create a shared understanding of all CLC needs.

  The Committee reports on having the following discussions/conversations over the past year:

- National CLAS standards should be implemented by BHA throughout its work. The CLC seminar BHA sponsored in June 2019 was a good start to begin to hear and respect the "cultures" reflected in different perspectives;
- BHA should be ensuring that local authorities are incorporating the CLAS standards into their local plans;
- CLAS standards should be treated as a "living document" that meets people where they are; and
- CLC should be applied to individual case management.

- **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 BHA 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 MDH for evaluation, commitment, or treatment relative to competency to stand trial or criminal responsibility; are court-ordered to MDH for a substance related evaluation or for substance use disorders treatment; are released into the community from a MDH 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.

  Over the course of meeting the past year, the Committee focused primarily on the HG § 8–507 statute and Justice Reinvestment, which shifts funding toward treatment. Activities included identifying providers with beds to enable placement within 21 days, plus the Opioid crisis. There has been strong support for this work, with agencies and organizations willing to tap into their constituencies to deliver what is needed. There have been improvements with the HG § 8505 evaluations and judicial education is happening. Problems with delays for individuals who are ready to be discharged from a hospital still exist, but there is nowhere for them to go, which then causes a shortage of available hospital beds.

  - The Committee reports on having the following discussions/conversations over the past year:

    - Funding is needed for placement of individuals with complex needs, outside of the hospital, including ensuring that needed wrap-around services are provided (e.g., housing);
    - The treatment and length of stay should vary to meet individual's needs — Medicaid ASO has a role in this;
    - Courts can improve the coordination and responsiveness when an individual's treatment needs change;
    - More attention is needed for bail review and conditions of bail release; and

- Crisis response should be expanded to avoid individuals being arrested in the first place.

Appendix

MBHAC BYLAWS

PURPOSE:

Pursuant to HG § 7.5–305, and Federal Public Law (PL) 102–321, the State of Maryland has established MBHAC 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 MBHAC 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 PBHS among: MDH; BHA 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 HG § 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 § 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 HG § 7.5–305.

Article III: Membership

In adherence to 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% 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) MBHAC 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 Maryland Department of Health
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 Services
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 MDH 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
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 MDH 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 MDH 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% 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 chairperson 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 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% of the meetings during any period of 12 consecutive months (three meetings per year), the Co-Chairs/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 Co-Chairs/Executive Committee shall send a letter to the head of the agency/organization/department of that the 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 MDH 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 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 BHA 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 BHA's website.

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 BHA. 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. Co-Chairs

The two co-chairs shall be elected from among the full membership of the Council. The co-chairs 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 co-chairs 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 or co-chairs and members of the Nominating Committee and the chairpersons or co-chairs 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. Committee Chairs

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

Committee chairs or co-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 or co-chairs shall: follow the policy for and monitor the attendance of committee members.

Article VI: Committees

MBHAC'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 Council Co-Chairs 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, 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 MBHAC.
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 Council Co-Chairs, together with any standing committee and ad hoc committee chairs and co-chairs. 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 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 Committees 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 BHA's goals and priorities.

C. Prevention Committee

This committee will address efforts that comply with the Federal Substance Abuse Block Grant and 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 BHA 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 Council Co-Chairs 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. Children, Young Adults, and Families Committee

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. Recovery Services and Support Committee
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 youth, 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 BHA 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 MDH for evaluation, commitment, and/ or treatment relative to competency to stand trial or criminal responsibility; are court-ordered to MDH for a substance-related evaluation and/or for substance-related disorders treatment; are released into the community from a MDH 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 Co-Chairs. 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 Co-Chairs from among the Appointed and Ex-Officio Membership. If the present officers are deemed 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 up to two names for Co-Chairs.

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.

F. Ad Hoc Committees and Workgroups
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 BHA 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

BHA 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.

MBHAC Bylaws were amended and approved September 18, 2018.