



**THE 2018 ANNUAL REPORT OF
THE MARYLAND BEHAVIORAL HEALTH
ADVISORY COUNCIL**

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

**Barbara L. Allen
Co-Chair**

**Dan Martin, Esquire
Co-Chair**



State of Maryland Behavioral Health Advisory Council

Larry Hogan, Governor – Boyd K. Rutherford, Lt. Governor – Robert R. Neall, Secretary, MDH

October 30, 2018

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. Michael E. Busch
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 Busch:

Pursuant to Health-General Article § 7.5-305, the Maryland Behavioral Health Advisory Council submits its 2018 annual report. The attached report provides an overview and summary of the activities of this council during calendar year 2018.

The establishment of the Maryland Behavioral Health Advisory Council was codified in 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 2018, proposed by-law amendments, elected new co-chairs, submitted a cleanup bill to legislature regarding membership, and its 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,

c/o Behavioral Health Administration

Spring Grove Hospital Center – 55 Wade Avenue – Dix Building – Catonsville MD 21228 – (410) 402-8473
TTY: (800) 735-2258

prevention, cultural and linguistic competency, children and adolescents, adults and older adults, criminal justice, 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 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, Deputy Chief of Staff, MDH
Barbara J. Bazron, Ph.D., Deputy Secretary for Behavioral Health
Sarah T. Albert, MSAR #_____

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 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 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 FY18.

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

Barbara J. Bazron
The Office of the Deputy
Secretary, Maryland Department
of Health

Dori S. Bishop
Family Member

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)

John Pierre Cardenas
The Maryland Health Benefit
Exchange

Kenneth Collins
The Maryland County Behavioral
Health Advisory Councils

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

Robert L. Findling
Academic/Research Professional

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

Lauren Grimes
On Our Own of Maryland, Inc.

Elaine Hall
The Maryland Health Care
Financing, MDH

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

Virginia Harrison
The Maryland Association of
Boards of Education

The Hon. Antonio Hayes
Maryland House of Delegates

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

Michael Ito
The Maryland Department of
Juvenile Services

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

Dennis L. McDowell
Family Member

The Hon. Dana Moylan Wright
The Maryland Judiciary Circuit
Court

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

Kathleen O'Brien
The Maryland Addiction
Director's Council

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

Charles Reifsnider
Consumer

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)

Catherine Simmons-Jones
Medical Professional

Clay Stamp
The Office of the Secretary,
Maryland Department of Health

Jeffrey P. Sternliet
Medical Professional

Tracey Webb
The Governor's Office for
Children

Anita Wells
Academic/Research Professional

Behavioral Health Administration Staff Support: Cynthia Petion, Systems Management Division; Sarah Reiman, Judith Leiman, Tsegereda Assebe and Greta Carter, Office of Planning; Michael Baier, Office of Prevention and Wellness for Public Health; Kim Qualls, Office of Treatment and Recovery Services; and Michelle Fleming, Office of Court Ordered Evaluations and Placements.

ANNUAL REPORT—2018

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 that included: the development and submission of the Crisis Services Strategic Plan, discouraging the efforts to address Maryland's opioid epidemic, and committee discussions to address criminal justice, prevention, and children and adult services issues in the Public Behavioral Health System (PBHS).

The Council presented their Crisis Services Strategic Plan during the 2018 Legislative Session. Then, in early 2018, the Legislature was informed that the plan was approved; and from the plan, two bills were passed: House Bill 1092 and Senate Bill 703. These bills are a result of MBHAC's charge through Senate Bill 551 (2016), which required the development of a strategic plan for ensuring that clinical crisis walk-in services and mobile crisis teams are available statewide, 24/7, and a direct result of the hard work of the Council and the Steering Committee. The outcome of these bills established the Behavioral Health Crisis Response Grant Program. This program is designed to establish and expand crisis services at the local services to establish and expand behavioral health crisis response systems and services throughout the State.

The Council was consistently kept informed of the efforts to address Maryland's opioid epidemic. BHA informed the Council on grants related to the Maryland Opioid Recovery Response (MORR) initiative. Just over 10 million dollars was awarded in Year 1 and another 10 million in Year 2, which began in May 2018 and will extend until April 2019. Maryland's Opioid Operational Command Center (OOCC) and the Maryland Department of Health (MDH) will receive an additional \$66.2 million through the State Opioid Response (SOR) grant, which supports a comprehensive response to the opioid epidemic and expands access to treatment and recovery support services. Council member Clay Stamp, executive director of the OOCC, has been diligent in keeping the Council abreast of the Center's accomplishments and endeavors.

The Council's Committees have been conscientious in their energies in reviewing the issues related to criminal justice, prevention, and child, adolescent and adult concerns in the mental health and recovery world. In addition, the Cultural and Linguistic Competency committee was instrumental in providing input in the development of the Behavioral Health Administration's (BHA) Cultural and Linguistic Competency Strategic Plan.

At the September 2018 meeting, Council members voted on recommended by-law amendments regarding name changes to two Council Committees, and the voting of new Council Chairs.

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 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:

- **Behavioral Crisis at the Workplace**
- **Challenges faced by Hospitals' Emergency Departments in addressing the needs of behavioral health patients**
- **Right-Sizing Maryland's Community Behavioral Health System**
- **Opioid Intervention Teams (OIT) Update**
- **Parity Act**

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 the Executive Director, Barbara J. Bazron, Ph.D., 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 2018 Legislative Session, and progress within the PBHS related to integration. A few of the updates provided to the Council by the Director are as followed:

PBHS Integration Updates

- ***Transfer of Grants—Substance Use Disorder (SUD) Residential Treatment Services***

Residential substance use disorder (SUD) service levels 3.3, 3.5, 3.7, and specialty services, which will include individuals court ordered under § 8–507 and pregnant women with children, was successfully transferred to a fee-for-service (FFS) in January 2018. American Society of Addiction Medicine (ASAM) 3.1 transition to FFS is in the third phase in the behavioral health integration process. Proposed regulations and rates will go into effect on January 1, 2019.

- ***Accreditation***

All behavioral health providers were to be scheduled to obtain accreditation by an approved accrediting organization no later than January 1, 2018, in order to be licensed by April 1, 2018, to provide community-based behavioral health services. As of July 2018, 912 sites have been licensed under Code of Maryland Regulations (COMAR) 10.63.

- ***State Hospital Admissions/Discharges***

An intensive discharge planning process was created to assist with moving individuals out of state facilities who no longer meet medical criteria. There was an increase in the number of beds in state facilities and a decrease in the length of time to place court ordered individuals. The cycle time from when an order for placement is received to the time of placement for all hospitals is just over seven days.

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

BHA will be working with all 24 local jurisdictions to implement the Local Systems Management Integration Plan to improve health, wellness, and quality of life for individuals. A plan was developed in collaboration with local and statewide stakeholders. Jurisdictions will take a comprehensive, integrated approach to systems management for their local publicly-funded behavioral health system. Local jurisdictions are at different levels of this integration process and it will take few years to effect full systems management integration both at the state and local levels.

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

- ***Mental Health Block Grant***

- Maryland's FY18 Final Mental Health Block Grant Allotment is \$11,767,081. 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***

- BHA will receive \$34 million in block grant funds to support substance use treatment, prevention, and intervention services.

Efforts to Address the Opioid Crisis in Maryland

- ***State Opioid Response (SOR) Grant:***

On June 14, 2018, SAMHSA released a funding opportunity announcement of \$930 million to fight the opioid crisis. That funding included a 15% set aside for 10 states hardest hit by the opioid crisis, Maryland is one of those 10 states. The grant will provide Maryland \$32,874,550 a year for two consecutive years.

- ***Maryland Opioid Rapid Response (MORR)***

Maryland received funding under the auspices of SAMHSA's CURES Grant, created through an Act requiring federal support to states to address the opioid epidemic. The State Targeted Response (STR) renamed the grant the MORR grant, which will assist in initiatives that coordinate with the efforts of the OOCC. Total funds awarded to Maryland in Year 1 (May 1, 2017 through April 30, 2018): \$10,036,843. BHA moved into year 2 of the MORR grant \$10,036,000 (May 1, 2018 thru April 30, 2019) and will continue activities that were started in year 1.

- ***Crisis Stabilization Center***

The Governor provided \$2.6 million, \$2 million from the federal Cures Act and a \$600,000 grant from MDH's Maryland Community Health Resources Commission to go towards the opening of Maryland's first crisis stabilization center. The stabilization center will provide basic first aid, withdrawal management, and screening and referral to treatment on-site for individuals with a substance use disorder. Tuerk House will administer services at the stabilization center with oversight from Behavioral Health System Baltimore, the city's local behavioral health authority. The center opened in April 2018. Persons intoxicated with alcohol or drugs are diverted from emergency

rooms to the facility by EMS or Baltimore Crisis Response, Inc. As of July 2018, 55 persons have been served.

Legislative Highlights

Representatives from the Council were engaged in addressing ongoing behavioral health issues during the 2018 Legislative Session. The Council was pleased with many victories with one of the most significant being the passing of SB 703, HB 1092. These bills are designed to assist local jurisdictions over a three year period of time in establishing or expanding behavioral health crisis response system and encourage the development of systems that address both mental health and substance use disorder needs across the lifespan, use innovative approaches to address economies of scale, make use of blended sources of funding, provide linkages to community-based care and demonstrate desired outcomes.

The Council also followed legislation that sought to ensure community providers had the tools necessary to deliver care as broadly as possible. SB 704, HB 1652 removes barriers to the provision assertive community treatment (ACT) by allowing psychiatrists in the Maryland Medicaid program to participate in ACT or provide mobile treatment services, remotely via telehealth.

The Council will be submitting a legislative clean-up bill. The purpose of this proposed legislation is to the remove extraneous and overly burdensome membership requirements for MBHAC.

Council Business

The term for the Council's co-chairs was up this year and the Council was asked to submit nominations for new co-chairs. Several Council members retired, which left four committees without co-chairs, however, new co-chairs were acquired with little difficulty. The Life Span II Committee requested a name change, a change required in the by-laws. The Committee's new name will be Recovery Services & Support Committee. This change led to a subsequent name change of the Life Span I Committee to the Children, Young Adults, and Families Committee. Both were approved by the Council members.

There were several new state-appointed members. Governor-appointed members were up for re-appointment and, of the 14 seats, 7 submitted applications for re-appointment; 1 youth seat that had been vacant was filled, and three of the members who chose not to re-apply agreed to remain until replacements are found. BHA and the Council continue to actively recruit to fill the few remaining vacant member seats. As of October 2018, one vacant seat has been approved, one is approved pending vetting and three are pending, leaving only the second youth seat vacant.

The Committees of MBHAC

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 May to September 2018:

- **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 and issues to be monitored and makes recommendations to the Council.

The Planning Committee met six times between January and November 2018 to review, comment and make recommendations on several policy documents including the Federal Mental Health Block Grant application, the State Behavioral Health Plan and the Annual Implementation Report. The committee co-chairs were members of a special steering committee consisting of all committee chairs whose purpose was to research review and report upon a plan for Maryland’s establishment of 24/7 crisis centers and mobile crisis response teams. The co-chairs participated in monthly meetings for 12 months at the end of which a formal report was completed and presented to the Legislature.

Members of the planning committee joined mental health advocates from many jurisdictions and organizations across the state to discuss key areas for building BHA’s new FY20 behavioral health plan through a series of regional stakeholder forums. The planning committee met on August 14, 2018, to review the recommendations from all four of the regional meetings. Committee members gave additional input to these recommendations to be considered in the FY20 behavioral health plan. Some of the recommendations that came out of the review included:

- **Funding:** strengthening accountability at the state and local levels.
- **Workforce Shortage:** assess the unmet needs of behavioral health workforce and develop a plan to work with state colleges and universities, using area health education centers (AHECs), to expose and recruit high school students from rural and underserved areas into behavioral health studies and careers. Increase training and professional development.
- **Transportation:** using Maryland’s current development plans and transportation mapping systems, work with MD Transportation Authority to tap into regional and state public transportation programs. Use Uber types of transportation for same day transportation planning needs. Explore what’s being done in other states.
- **Public Awareness:** work with various social services and public departments such as the Department of Aging, Department of Disabilities, Department of

Housing, Department of Transportation, and Maryland Division of Rehabilitation Services (DORS) to raise public awareness on issues related to gambling, housing, prevention, transportation, training and work.

The committee discussed the Council's role in regard to sharing information and whether the Council should have a more active role during the legislative session. The committee welcomed two new members and brainstormed on ways to recruit additional members. Dennis McDowell is retiring from his Chairman position and Senator Addie Eckhardt will be taking over that Chair position as of next year.

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

The purpose of the Prevention Committee, also a standing 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 and members of the larger Council are currently implementing the Strategic Prevention Framework Strategic Plan for the Allocation of SAMHSA Substance Abuse Prevention Funds (July 1, 2017–June 30, 2019). The plan details how BHA will use the SAMSHA SPF model to allocate its Substance Abuse Block Grant prevention funding to prevent and reduce underage drinking, non-medical use of prescription drugs and opioids, youth binge drinking, youth marijuana use, and youth heroin use. These substances were identified as state prevention priorities by BHAC's Prevention Committee in February 2017 based on the results of its statewide youth substance misuse needs assessment.

The committee identified the following next steps for 2019 to address the committee's charge and goals:

- Expand strategic focus to include:
 - population health and wellness framework;
 - multi-dimensional approach, non-traditional partners; and
 - targeting key initiatives around the state.
- Invite MSDE to join the committee.
- Identify key stakeholders who need to be at the table. Consider non-traditional stakeholders, points of sale for under-age sale of alcohol, and highway safety administration and MVA.
- Expand committee focus/title to include: Prevention and Wellness Promotion.

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

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 met three times this year focusing on current programs for young adults, the need for expansion of services, and their role in advocating for this. The committee also discussed the Building Bridges Initiative, a program model to improve outcomes of youth in Residential Treatment Centers (RTCs) and reduce lengths-of-stay. Their hope is for there to be a search for state champions to work to bring the program model to Maryland RTCs. The committee continues to have conversations regarding kids stuck in EDs and in RTCs and the breakdown of the continuum of care and what legislation will help to unclog the system.

The Children's Blueprint Committee was terminated, and it was merged with the Lifespan I Committee.

The committee reviewed the following in the 2018 session legislation:

- Crisis Bill—how to include crisis services for youth in the BHA RFP that will be going out? Jen Lowther and Ann Geddes will be serving on the group that is drafting BHA's RFP.
- Children's Data Bill—what recommendations to BHA can be made when the data required in the bill is reported?
- School Safety Act—monitor MSDE's implementation of the requirements in the bill. BHA staff are serving on the implementation team

The committee identified the following next steps for 2019 to address the committee's charge and goals:

- Need knowledgeable BHA staff to staff the committee (with the retirement of Tom Merrick), in order to continue to receive meaningful updates on BHA activities. This is especially true since the Children's Blueprint Committee (chaired by Al Zachik) was merged into the Lifespan I Committee.
 - Jen Lowther and Ann Geddes update the committee on the development of BHA's crisis services RFP.
 - Report to BHA on need for expansion of young adult services and relaxing of medical necessity criteria for young adults to receive adult services (not just adult diagnoses).
 - Identify champion within BHA to bring the Building Bridges Model to Maryland RTCs.
 - Continue to monitor implementation of 2018 legislation, especially the children's data bill, which requires BHA to report on numerous data points
- **Lifespan Committee II: Adults and Older Adults 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 met approximately five times as of November 20, 2018. The committee had encountered challenges retaining membership over time. With a refocus on the continuum of care for recovery, membership is growing. John Winslow, a key member of the committee, resigned the BHAC moving out of the area. Carlos Hardy is now serving as co-chair. Not all newer members are official BHAC members. The committee now has representation from police departments, recovery housing, treatment providers, MD Department of Disabilities, as well as advocates who are family members or consumers of services for MH/SUD. The Council lost its representative from MD Department of Aging. We've also benefited greatly from having committee staff support through Judith Leiman.

The committee approached the Council with a request for a name change to Recovery Services & Support, which was approved as of September 18, 2018. This change will officially be made in the Council bylaws.

Other committee activities include:

- Use of SAMSHA's working definition of recovery (Health, Home, Purpose, and Community) along with use of the model Stages of Change.
- Communication of "what does recovery look like" both for educational purposes as well as continuing to reduce stigma.
- Concerns for peer recovery positions regarding pay structures, job descriptions and respect along the continuum of care. Recovery housing expansion.
- Supportive employment programs including DLLR program (look at NH model?).
- Issue of access to information for recovery services—if the Council cannot find it, how do consumers? This includes issues of transportation, food, job search, vocational rehabilitation.

The next steps for 2018 to address the committee's charge and goals are as follow:

- Stabilize membership and establish replacement co-chair for Barbara Allen.
 - Refine goals for defining the recovery continuum of care which includes identifying sources for care.
 - Continuation of items mentioned above—data gathering and goal setting.
- **The Cultural and Linguistic Competence Committee Co-Chairs—Allysa Ditmar and Jacob Salem**

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 committee met two times this year. One of their scheduled meetings was canceled by BHA. Their time was devoted to reviewing BHA’s Cultural and Linguistic Competence Strategic Plan and promoting cultural and linguistic, like deaf culture. The committee mutually agreed to establish a criteria for ensuring that every health provider has a contract in place with a sign language agency. The committee approved a finalized draft FY19–FY20 Cultural and Linguistic Competency Strategic Plan, which was submitted to Ms. Cynthia Petion on August 4, 2018, and sent to Dr. Bazron for approval.

The committee identified the following next steps for 2019 to address committee’s charge and goals:

- Receive final, approved version of the Cultural and Linguistic Competence Strategic Plan from BHA.
- Assist local mental health and substance use disorder authorities (CSAs/LAAs/LBHAs) in implementing plan’s recommendations

• **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.

The focus of the Criminal Justice-Forensic Committee has been improved access to comprehensive residential addiction treatment for criminal defendants suffering from co-occurring substance abuse and mental disorders. For many months, the committee has concentrated on the means to assure more robust co-occurring residential treatment. This has been the emphasis since the Maryland General Assembly enacted revisions to HG § 8–507, during the 2016 Session, which went into effect on October 1, 2017, and required immediate placement and a potential compliance hearing within 21 days upon the trial courts order of a defendant’s commitment to residential treatment.

The committee has spent many hours working with MDH officials, as well as with criminal justice and treatment provider partners, not only on mechanisms to effectuate prompt placement upon a trial court’s order, but also to improve the quality and scoop

of pre -commitment evaluations and to facilitate the best mechanisms for necessary and timely communication between trial courts, counsel, providers, evaluators and MDH managers during the course of the evaluation and commitment.

The committee has a comparatively large membership with a diverse core-group who actively participates in frequent meetings. Their representative membership has allowed them to bring a breadth of knowledge and experience to these discussions.

During the last year, MDH has made excellent progress in shortening the time from commitment order to actual placement, a significant accomplishment. There has been increased funding for forensic residential treatment providers accompanied with more comprehensive standards and requirements. There also have been improved mechanisms for communication between counsel, courts and MDH as to the possible impediments to placement that might be resolved by further criminal justice activity. However, many defendants, counsel and courts show hesitation in seeking § 8–507 commitment and significant procedures are not perceived as user friendly at this point. Educational efforts and some better understood procedures are called for.

As the committees discussions have progressed, an emerging focus has become meaningful continuity of care as defendant's progress through treatment. There has been much discussion regarding the clinically appropriate length of stay and how it is determined and most significantly how the courts, counsel, probation agents, providers and MDH can best exchange meaningful information as the defendant's treatment progress is reported, changes in level of care are made and aftercare planning is undertaken. These continuity of care issues, as well as furthering best practices as implemented by providers and criminal justice partners, will be continuing priority areas. In short, proactive management and the assurance of best practices for all partners may well be the key to increased appropriate utilization of co-occurring residential treatment as a meaningful alternative to incarceration for clinically appropriate defendants.

- **The Steering Committee for Clinical Crisis Walk-in Services and Mobile Crisis Teams Strategic Plan Co-Chairs—Dan Martin, Esquire, and Barbara Allen**

In 2016, Senate Bill 551/Ch. 405 (2015) and House Bill 682/Ch. 406 (2015) were passed requiring MBHAC to develop a strategic plan for ensuring that clinical crisis walk-in services and mobile crisis teams are available statewide. The Council established 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.

As required by statute the committee developed a strategic plan that was approved by the Council. The plan was included in the FY17 Annual Report and then presented at the 2018 Legislative Session in January 2018 and SB 703, HB 1092, were passed.

The committee's objective was obtained and therefore it was dissolved.

MBHAC, created in 2015, will continue to advocate for effective treatment and recovery support for individuals with mental health, substance use, and other addictive disorders. The Council looks forward to the further development of behavioral health integration in 2019.

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 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 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.

“The services and facilities of the Maryland Department of Health (MDH) 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 MDH 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