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Behavioral Health Treatment Services Qualitative Assessment

For the Maryland Governor's Office of Crime Prevention and Policy (GOCPP)

Prepared by:
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GLOSSARY

Term	Definition
BH	Behavioral health: Includes the state of emotional, mental, and social well-being or behaviors that affect wellness, inclusive of mental health and substance use disorders
CF	Correctional facility: Encompasses all carceral settings, including adult and youth detention centers and prisons
DOC	Department of Corrections
HRSN	Health-related social needs
LAI	Long-acting injectables
LDC	Local detention center
MAT	Medications for addiction treatment; also, medication assisted treatment, which is a broad term that encompasses the use of medications—in combination with counseling and behavioral therapies—to treat substance use disorders
MOUD	Medication for opioid use disorder specifically refers to the use of Food and Drug Administration-approved medications to treat opioid use disorders, such as buprenorphine, methadone, or naltrexone
OUD	Opioid use disorder
SMI	Serious mental illness
SUD	Substance use disorder

EXECUTIVE SUMMARY

This qualitative assessment explores the availability, consistency, and coordination of behavioral health (BH) treatment services—both mental health (MH) and substance use disorder (SUD)—across jurisdiction-operated detention facilities in Maryland. Drawing from structured interviews with facility leadership and behavioral health staff, the report highlights key insights into the strengths and challenges of delivering care within secure environments and preparing justice-involved individuals for successful community reentry.

Facilities reported varying levels of access to mental health and SUD services. Although some jurisdictions have established therapeutic communities and formal treatment protocols, others struggle with staffing shortages, space limitations, and inconsistent program delivery. Mental health emergencies, including those individuals with serious mental illness (SMI), often pose operational challenges, especially when timely transfers to a state psychiatric hospital are unavailable or community placements are limited. Almost every local detention center (LDC) cited lengthy delays (e.g., months) in getting incarcerated people who are awaiting competency evaluations or have been ordered to a state hospital out of the LDC and into the appropriate setting.

Reentry planning also varies widely. Some facilities described proactive practices such as beginning or completing Medicaid enrollment prior to release, arranging referrals to housing and employment resources, and performing warm handoffs to community-based providers. Many jurisdictions, however, lack the infrastructure, staffing, or interagency coordination to ensure continuity of care after incarceration. Responses reflected limited housing availability, fragmented communication with external providers, and minimal structured reentry support in several jurisdictions.

Across interviews, four consistent themes emerged:

- Service inconsistency across jurisdictions
- Structural and workforce barriers to treatment delivery
- Fragmented reentry support
- Strong interest in enhanced jurisdiction and state-level support (participants expressed a clear need for sustainable funding, facility upgrades, and technical assistance to improve care delivery and post-release outcomes)

This report concludes with actionable recommendations to standardize services, expand the correctional behavioral health workforce, and strengthen cross-system partnerships to improve the health and stability of justice-involved individuals across Maryland.

PURPOSE

At the request of the Maryland Governor's Office of Crime Prevention and Policy (GOCPP), Health Management Associates, Inc. (HMA), was retained through a partnership with Health Care Access Maryland (HCAM). Specifically, HMA was charged with gathering and compiling qualitative and quantitative data from Maryland jurisdiction local detention centers (LDCs) to determine behavioral health treatment capacities, system strengths, and service gaps using qualitative and quantitative data. The findings would be used to guide strategic planning, steer reinvestment funding, and better meet the behavioral health needs of individuals in detention.

METHODOLOGY

This study used a mixed-methods design to examine mental health (MH), substance use disorder (SUD) treatment, and reentry practices across Maryland's 24 jurisdiction-operated LDCs. HMA's approach included a brief foundational quantitative survey followed by in-depth qualitative interviews with facility leadership and key staff. The goal was to develop a comprehensive understanding of service availability, implementation barriers, and system-level needs from both a data-informed and an experiential perspective.

The qualitative inquiry was designed to examine BH—both MH and SUD treatment—and reentry practices in Maryland's LDCs. Through structured interviews with facility leadership and staff, the project explored available services, perceived gaps, operational challenges, and support needs.

Sample and Recruitment

All 24 Maryland LDCs were eligible to participate. Recruitment began with a standardized email invitation that was sent to each facility. It included a link to an online survey hosted on the Qualtrics platform. LDCs that completed the survey were subsequently invited to engage in one-on-one interviews with an institutional leader who could provide more detailed responses and offer more context-specific insights. Of the 24 LDCs contacted, 20 (83%) completed the survey, and 15 (62.5%) participated in both the survey and the follow-up interview. These 15 LDC representatives constituted the final sample for the qualitative portion of the study.

Phase I: Quantitative Data Collection

The initial data collection tool was a 26-question Qualtrics survey designed to capture baseline information about each LDC's mental health and SUD programming. The survey included:

- **6 multiple-choice questions** to assess service types, program availability, and staffing models
- **15 open-ended questions** to gather narrative responses about practices, strengths, and challenges
- **5 matrix-style questions** to capture frequency, scope, and infrastructure data related to key service domains

The survey served as a foundational tool for identifying variation across jurisdictions and informed the development of interview prompts used in the second phase.

FROM LDC INTERVIEWS

"Even when we have the right programs in place, we don't have enough people to run them the way they're intended."

Phase II: Qualitative Data Collection

After completing the survey, participating facilities received a follow-up email inviting a representative to engage in a semi-structured interview. These interviews, conducted by trained members of the research team, lasted approximately 60 minutes and took place virtually. The interview protocol was developed to elicit rich facility-specific insights into behavioral health services, crisis response, MH and SUD treatment, reentry planning, and interagency collaboration.

Interviewers used a semi-structured interview guide to allow for both consistency across sites and flexibility to explore unique facility characteristics and challenges. Topics included the impact of delays in psychiatric transfers, workforce constraints, coordination with state partners, and barriers to post-release service connection. A total of 15 LDC staff engaged in these interviews.

Qualitative Analysis

Interview responses were analyzed using thematic analysis grounded in an open coding framework. Researchers reviewed transcripts and notes, tagging excerpts that corresponded with core domains, such as treatment access, staffing, infrastructure, crisis response, and reentry services. Through iterative coding and review, the research team identified cross-cutting themes that reflect common experiences and systemic issues that are affecting local detention centers across the state.

This process involved both inductive and deductive approaches, allowing themes to emerge from the data while also mapping findings to behavioral health (BH) system challenges in correctional settings. Themes were compared across facility types, geographic regions, and reported levels of service capacity to identify patterns and opportunities for policy and practice improvement.

Emerging Themes

1. **Service Inconsistency:** Services vary widely across counties
2. **Structural and Operational Barriers:** Space and staffing needs outweigh supply and availability.
3. **Need for Coordinated Reentry Planning:** Fragmented or one-off approaches are often used.
4. **Desire for Support:** Funding and technical assistance are explicit needs.

KEY FINDINGS

Mental Health Services: Availability, Gaps, and Systemic Barriers

LDCs across Maryland report that they offer a range of MH services, most commonly individual counseling, group therapy, and medication management. The scope and structure of services, however, vary considerably between jurisdictions. Some facilities have implemented robust internal behavioral health departments capable of delivering routine mental health care. For example, one administrator noted, *"We have a robust mental health department, including individual and group counseling and psychiatric care."* Others operate more informally, offering crisis response on an as needed basis without structured therapeutic programming. As one staff member said, *"Crisis intervention is provided as needed. We don't have a formal program."*

Several jurisdictions described innovative efforts to expand service access, such as the use of therapeutic communities within the LDC correctional environment. One facility, for instance, implemented a co-occurring therapeutic community model designed to serve both men and women.

Despite these promising efforts, facilities reported significant environmental limitations. Several respondents highlighted that their facilities' physical infrastructure was unfavorable to delivering trauma-informed or confidential care. The LDC respondents reported that they often have inadequate accommodations for individuals with high needs, limited space for the provision of clinical services, and that privacy can be an issue.

A critical and recurring concern across all counties was the inability to transfer individuals in crisis to higher levels of care. Facilities reported that the Maryland Department of Health (MDH) has few inpatient psychiatric beds available, even for individuals who have been deemed incompetent to stand trial. Staff described situations in which individuals who required hospitalization remained at the LDC for weeks or months, receiving suboptimal psychiatric care in an environment designed to manage less acute psychiatric needs. One correctional leader stated, *"We don't even know where we'd send them. There are no state beds available, and they're a security risk here."* Another said, *"It's not unusual for someone who has been deemed incompetent to wait over two months for placement. In the meantime, we're not equipped to provide what they need."*

These extended delays not only compromise clinical outcomes, but also create substantial operational strain, including delays in transferring detainees to other areas within the facility, increased maintenance costs due to destruction of property, higher overtime costs, assaults on staff, and negative effects on staff morale, which, in some instances, resulted in resignations. Collectively, these findings underscore the urgent need for expanded inpatient capacity, better coordination between MDH and LDCs, and capital investments to ensure correctional environments are equipped to manage behavioral health needs appropriately and humanely.

SUD Services and Workforce Shortages

Nearly all Maryland LDCs reported that they offer some form of SUD services, although the type and intensity of programming varied across jurisdictions. Common offerings included medically managed withdrawal services, outpatient counseling, and medications for addiction treatment (MAT). Several facilities described coordinated internal protocols and partnerships to support continuity of care. As one respondent reported, *"We offer medically managed withdrawal and MAT. We also partner with the courts for structured placements."*

Some jurisdictions have developed more comprehensive models, such as therapeutic residential programs within the correctional environment. One respondent highlighted the implementation of a specialized in-house treatment community, stating, *"We established a residential therapeutic community to address long-term substance use treatment."* These models represent a shift toward more structured, evidence-based care for individuals with chronic substance use needs.

Nonetheless, staffing limitations remain a significant barrier to program delivery and sustainability. Across LDCs, administrators described difficulty recruiting and retaining qualified clinical and treatment staff, particularly those trained in behavioral health or addiction medicine. One participant noted, *"We have difficulty maintaining the workforce. People come and go constantly, which makes continuity hard."* The LDCs reported some of the most common reasons for difficulty maintaining staff are insufficient staffing, low morale, and the high-stress environment.

In some jurisdictions, turnover has disrupted access to services entirely, and in others, it has limited the consistency of treatment engagement or case management. Facilities also reported challenges in maintaining adequate staff coverage to provide individualized support or in-reach programming from community providers. As one administrator said, *"Even when we have the right programs in place, we don't have enough people to run them the way they're intended."*

Overall, though SUD treatment services are present in most LDCs, their effectiveness is constrained by persistent workforce shortages, funding limitations, and the absence of sustainable staffing pipelines. These gaps underscore the need for targeted investment in the BH workforce, both within the LDCs and through partnerships with external treatment providers.

FROM LDC INTERVIEWS

"It's not unusual for someone who has been deemed incompetent to wait over two months for placement. In the meantime, we're not equipped to provide what they need."

Impact of Delays and Structural Challenges

LDC staff consistently reported that delays in transferring individuals with acute MH needs to external treatment settings have had significant operational and clinical consequences. Many facilities lack the capacity to manage individuals experiencing psychiatric crises for prolonged periods yet often find themselves doing so because of bottlenecks in the broader BH system. One administrator described the burden succinctly, stating, *"They're security risks. We end up holding them far longer than we should. It disrupts our ability to manage general population operations."*

These delays were particularly acute for peoples determined to be incompetent to stand trial. Despite court orders that these individuals receive hospital-level care, facilities reported that transfers to state-operated psychiatric hospitals can be delayed for weeks or months because of bed shortages. During this time, LDCs are expected to house and supervise individuals with serious mental illness, often without the clinical resources or appropriate environments needed for stabilization. Several jurisdictions were concerned about potential future sentinel events because of their inability to manage psychiatric and behavioral challenges.

Structural issues further exacerbate the situation. Many facilities noted that their physical infrastructure is ill-equipped to support individuals with significant behavioral health needs. For example, group programming and private counseling are difficult to provide in spaces intended for non-therapeutic purposes. As one respondent explained, *"Our physical plant isn't set up for therapeutic work. It's noisy, open, and doesn't offer any privacy."*

In the absence of timely transfers or sufficient internal accommodation, staff often are placed in reactive positions, such as responding to escalating behaviors, managing increased safety risks, and attempting to deliver care in clinically inappropriate environments. These circumstances affect not only the person in crisis, but also the safety, efficiency, and morale of the broader facility population and staff.

These findings highlight the urgent need for state-level investments in psychiatric bed capacity, streamlined transfer processes, state assistance in managing individuals awaiting placement and capital improvements to correctional infrastructure. Without this support, LDCs will remain the default providers of care for people who require levels of treatment that the facilities are neither equipped nor resourced to deliver.

Reentry and Post-Release Coordination

Reentry planning and coordination with community services varied considerably across Maryland LDCs. Some jurisdictions have developed proactive practices for prerelease support, whereas others reportedly have limited capacity, have fragmented workflows, or need clarification of their responsibilities. Healthcare enrollment before release emerged as one of the more common reentry activities. Several facilities reported working to enroll individuals in Medicaid, but as one respondent said, *"Yes, we're able to enroll them in Medicaid 30 days before release, if we know their release date."* Other jurisdictions cited resource limitations that hindered systematic enrollment efforts. A staff member from one facility explained, *"We try, but it's not consistent across cases. The process could be better."*

FROM LDC INTERVIEWS

"Yes, we're able to enroll them in Medicaid 30 days before release, if we know their release date."

Housing and employment supports were even more uneven. A few jurisdictions provided basic referrals or resource lists, but most lacked formal processes or dedicated staff to support reentry planning. One respondent shared, *"We give people a list of 'felon-friendly' employers and help where we can."* Another acknowledged the absence of structured support, stating, *"We don't have direct involvement. The health department sometimes steps in for housing or job help."*

Jurisdictions consistently described post-release housing as a critical gap. Participants emphasized that limited safe and stable housing upon release undermines recovery, employment, and continuity of treatment. As one administrator noted, *"There's not enough housing, and people don't have a safe place to go. That affects everything."*

Some jurisdictions described efforts to partner with community providers, particularly in the context of continuing MAT or mental health treatment. A few facilities reported maintaining lists of community-based resources or facilitating warm handoffs to providers who could meet with individuals before release. For example, one staff member said, *"We have a Google drive with resource contacts, and we try to do a warm handoff before release."*

These efforts were often informal, reliant on relationships rather than system-level protocols and inconsistently available to people reentering the community. Several jurisdictions expressed a desire for stronger, more structured partnerships with community-based organizations and behavioral health providers.

Overall, reentry and post-release coordination remain underdeveloped in many facilities, limited by staffing constraints, housing shortages, and the absence of an integrated care planning infrastructure. These findings suggest the need for statewide standards and investments in reentry planning, including cross-system case management, housing navigation, and Medicaid enrollment support to ensure successful transitions from incarceration to community-based care.

RECOMMENDATIONS

Based on the findings from facility interviews, several actionable recommendations emerge to improve mental health services, SUD treatment, and reentry coordination in Maryland's LDCs. They are as follows.

1. Invest in Workforce Stability and Clinical Capacity

LDCs across Maryland reported significant difficulty maintaining adequate behavioral health and SUD staffing. To address this concern, the state should invest in targeted workforce strategies, including increased funding for correctional MH and SUD roles and specialized training for staff who work in secure environments. In addition, jurisdictions should be supported in establishing partnerships with community providers that can deliver in-reach services, particularly for MAT, crisis response, and care coordination.

2. Expand Access to Inpatient Psychiatric Beds and Streamline Transfers

Nearly every participant cited the inability to transfer people in psychiatric crises, especially those deemed incompetent to stand trial, as a major challenge. The state should prioritize increasing the number of beds available through the MDH and improving the timeliness and transparency of the transfer process. Dedicated liaisons between MDH and LDCs, standardized protocols for hospital placement, and data-sharing agreements would reduce delays and improve clinical outcomes.

3. Strengthen Reentry Infrastructure and Care Continuity

To support successful transitions from incarceration to the community, LDCs need structured, well-resourced reentry programs with dedicated reentry coordinators, standardized Medicaid enrollment processes, and formal linkages to housing, employment, and behavioral health services. The development of shared care planning tools across systems—especially between LDCs, behavioral health authorities, and managed care organizations—could enhance coordination and accountability.

4. Improve Correctional Facility Environments for Therapeutic Services

Many participants noted that their facilities' physical infrastructure is not conducive to safe, confidential, trauma-informed care. State and local governments should consider capital investments in facility renovations that create private counseling spaces, designated programming areas, and safer environments for individuals in crisis. These improvements are essential to support rehabilitation and reduce incidents of behavioral escalation.

5. Standardize Core Services and Access Across Counties

Service availability varies significantly from one jurisdiction to another, creating inequities in care for justice-involved individuals. The state should establish baseline expectations for behavioral health and reentry support in all LDCs, including access to individual counseling, MAT/MOUD, withdrawal management, and healthcare enrollment. Targeted technical assistance, performance monitoring, and specific financial support should be made available to support these efforts and local implementation.

6. Facilitate State and Local Collaboration

Facility leaders expressed a definite interest in ongoing engagement with state agencies and local leadership. Virtual learning communities, periodic check-ins, and technical assistance teams could create opportunities for peer learning, collaborative problem-solving, and the dissemination of best practices. A more coordinated intergovernmental approach is essential to address systemic barriers and improve outcomes for incarcerated individuals with complex BH needs.

CONCLUSION

This qualitative assessment reveals a complex and uneven landscape of behavioral health and reentry services within Maryland's LDCs. Many facilities are making concerted efforts to deliver care and support successful transitions back into the community but do so within systems that are often under-resourced, inconsistently coordinated, and structurally misaligned with the needs of individuals with SMI or SUD.

Facilities demonstrated a shared commitment to meeting the BH needs of their populations, offering individual counseling, MAT, and medically managed withdrawal; however, workforce shortages, an insufficient treatment infrastructure, and delays in accessing higher levels of care, particularly for individuals in crisis, significantly undermine their efforts. The limited number of inpatient psychiatric beds available through the MDH was among the most pressing and consistent concerns that facility leadership raised.

Reentry planning also remains fragmented. Some jurisdictions engage in proactive Medicaid enrollment and referral to community services, but most lack the capacity or infrastructure to consistently provide comprehensive discharge planning. This limitation leads to missed opportunities to connect individuals to housing, employment, and continuity of treatment opportunities when those supports are critically needed.

These findings highlight numerous opportunities for improvement. LDCs are eager for enhanced coordination with state and local partners, sustainable investment in staffing and infrastructure, and clearer expectations regarding service standards. With targeted policy and funding support, Maryland can move toward a more equitable, effective, and clinically appropriate system of care for justice-involved individuals.

Addressing these gaps is not only a matter of public health; rather, it is central to reducing recidivism, improving community safety, and ensuring that individuals leaving incarceration can achieve stability, recovery, and long-term well-being.

APPENDIXES

Appendix A. Participation

LDC and their participation are listed below:

Jurisdiction	LDC (Facility)	Survey Completed	Interview Completed
Allegany	Allegany County Detention Center	X	X
Anne Arundel	Ordnance Road Correctional Center & Jennifer Road Detention Center	X	X
Baltimore County	Baltimore County Department of Corrections	X	X
Baltimore City	*Did Not Participate*		
Calvert	Calvert County Detention Center	X	X
Caroline	Caroline County Detention Center	X	X
Carroll	Carroll County Detention Center	X	X
Cecil	Cecil County Correctional Facility	X	X
Charles	*Did Not Participate*		
Dorchester	Dorchester County Detention Center	X	
Frederick	Frederick County Detention Center	X	X
Garrett	*Did Not Participate*		
Harford	Harford County Detention Center	X	X
Howard	Howard County Department of Corrections	X	
Kent	Kent County Detention Center	X	
Montgomery	Montgomery County Correctional Facility	X	X
Prince George's	*Did Not Participate*		

Jurisdiction	LDC (Facility)	Survey Completed	Interview Completed
Queen Anne	Queen Anne County Detention Center	X	X
Somerset	Somerset County Detention Center	X	X
St. Mary’s	St. Mary's County Detention and Rehabilitation Center	X	X
Talbot	Talbot County Department of Corrections	X	X
Washington	Washington County Detention Center	X	
Wicomico	Wicomico County Department of Corrections	X	X
Worchester	Worcester County Detention Center	X	

Appendix B: Qualtrics Survey

HMA/GOCPP Survey for the Maryland Local Detention Centers (LDCs)

Thank you for taking the time to complete this short survey in advance of our virtual conversation. This will help save time and make our virtual conversation more productive. Only **one** survey needs to be completed per facility. Please do not leave any responses blank. Once you have completed the survey, our team will be in touch to schedule the virtual conversation.

1. Facility name: _____
2. Location (county): _____
3. Name of person completing this survey: _____
4. Role of person completing this survey: _____
5. Email of person completing this survey: _____
6. If you have more than one facility, please note here (include facility name and location):
   _____
7. What is your Average Daily Population (ADP) for the past year: (*Note: Input a "0" if none. All boxes must be completed.)*
   a. Male: _____
   b. Female: _____
   c. Nonbinary: _____
   d. Total: _____
8. What is the average length of stay (0-7, 8-30, more than 31 days)? *(select one)*
   a. 0-7 days
   b. 8-30 days
   c. More than 31 days
9. What percentage of the ADP is sentenced? _____

10. Check which mental health programs are available in your detention center: *(check all that apply)*
    a. Individual Counseling
    b. Group Therapy
    c. Crisis Intervention
    d. Medication Management
    e. Other (please specify) _____
11. Check which substance use treatment programs are available in your detention center: *(check all that apply)*
    a. Withdrawal Management Services
    b. Residential Programs (Residential Substance Abuse Treatment (RSAT), cohorted housing for example)
    c. Outpatient Programs (Individual Counseling, Group Therapy, Mutual Help Programs (such as Alcoholics and Narcotics Anonymous, Smart Recovery)
    d. Medication for Addiction Treatment (MAT) or Medications for Opioid Use Disorder (MOUD)
    e. Other (please specify) _____
12. How much of the ADP utilizes mental health services ONLY? *(Note: Input a "0" if none. All boxes must be completed.*)
    a. Male: _____
    b. Female: _____
    c. Nonbinary: _____
    d. Total: _____
13. How much of the ADP utilizes substance use services ONLY? *(Note: Input a "0" if none. All boxes must be completed.)*
    a. Male: _____
    b. Female: _____
    c. Nonbinary: _____
    d. Total: _____

County Behavioral Health Staff

14. Do you employ (non-contracted) county behavioral health staff (to include both mental health and SUD staff)? *(select one) For contracted staff- see question 15.*

    a. Yes

        i. How many county behavioral health staff work in the facility (to include both mental health and SUD staff)? _____

        ii. How many county behavioral health staff are in these positions? *(Note: Input a "0" if none. All boxes must be completed.)*

            1. Psychiatrists _____
            2. Addiction Medicine physicians _____
            3. Psychiatric Mental Health Nurse Practitioners (PMHNPs) _____
            4. Psychologists _____
            5. Licensed Clinical Social Workers (LCSWs_____
            6. Licensed Professional Counselors (LPCs) _____
            7. Substance Use Counselors _____
            8. Peer Support Specialists _____
            9. Other (please specify) _____

    b. No

15. What is the ratio of county behavioral health staff to ADP? (e.g., 1:50) _____

Contracted Behavioral Health Staff Information

16. Do you have any contracted behavioral health staff (to include both mental health and SUD staff)?
    a. Yes
        i. What is the total number of contracted behavioral health staff (to include both mental health and SUD staff)? _____
        ii. How many contracted behavioral health staff are in these positions? (Note: Input a "0" if none. All boxes must be completed.)
            1. Psychiatrists _____
            2. Addiction Medicine physicians _____
            3. Psychiatric Mental Health Nurse Practitioners (PMHNPs) _____
            4. Psychologists _____
            5. Licensed Clinical Social Workers (LCSWs_____
            6. Licensed Professional Counselors (LPCs) _____
            7. Substance Use Counselors _____
            8. Peer Support Specialists _____
            9. Other (please specify) _____
    b. No
17. What is the ratio of contracted county behavioral health staff to ADP? (e.g., 1:50) _____

Detention Center Behavioral Health Programming

18. What are the detention center operating hours for behavioral health programming? *(e.g., 9:00 am to 5:00 pm)*
    a. Weekdays: _____
    b. Weekends: _____

19. Are behavioral health services available via telehealth?
    a. Yes
    b. No
20. What are the ongoing challenges related to BH care? (e.g., staffing shortages, funding issues, inmate reluctance to seek care, etc.) (*open response*)
21. During your scheduled interview, what would you like to discuss related to BH care? (*open response*)
22. Is there anything else that you would like to share with us? (*open response*)

Appendix C: Semi-Structured Interview Guide

1. Programs & Services Offered: This was asked in Q interview; quickly verify as an opener.
    - Mental Health Programs (check all that apply)
        - Individual Counseling
        - Group Therapy
        - Crisis Intervention
        - Medication Management
        - Other (please specify): _____
    - Substance Use Treatment Programs (check all that apply)
        - Withdrawal Management Services
        - Residential Programs (RSAT, cohorted housing for example)
        - Outpatient Programs
            - Individual Counseling
            - Group Therapy
            - Mutual Help Programs (such as AA, NA, Smart Recovery)
        - Medication for Addiction Treatment (MAT or MOUD)
        - Other (please specify): _____
2. How often is there a mental health emergency that would meet the requirements for transfer out of the facility? How many? More difficult for men/women/nonbinary?
3. What services do you provide during the holding time?
4. How do delays in transfer impact your other operations?
    - What's not happening somewhere else while you are caring for an inmate that you're holding?
    - Close watch…impact on workforce…overtime costs?
5. How often do you hold an inmate who needs a competency evaluation or is deemed incompetent to stand trial (IST)?

6. How many individuals go/how often does an inmate require transfer to an external hospital for BH (including MH and SUD) needs per month?

    - How many times a month?

7. What custody related concerns impact BH care (i.e., movement, availability of officers, transportation outside facility)?

8. Do you have delays related to BH/MH conditions when transferring to DOC- and if so why/when- is it ever diagnosis dependent?

9. How many individuals are utilizing psychiatric medication for MH reasons?

10. For pregnant detainees, are behavioral health (mental health and substance use services) provided? How?

11. Do you ask about gender identity/gender orientation in your intake?

12. For LGBTQIA+ detainees, are behavioral health services specifically offered in your facility?

13. Involuntary psychiatric medication

    - Does the CF provide non-emergency involuntary psychiatric medication?
    - Does the CF provide emergency involuntary psychiatric medications?

14. What training needs do you have? Topics and for which staff?

15. Follow-up questions:

    - What training components are currently provided to staff involved in MAT
        - delivery and management?
    - What MAT/MOUD clinical resources are available for providers and clinicians working in the MAT program?
    - What training components are currently provided to staff involving those with mental health problems or serious mental illness?

16. Policies and procedures on management of SUD/MH

- Are there policies or procedures that you feel need to be revised, improved upon, etc.?
- When changes are made to policies and/or protocols, how are these changes communicated to the team?
- Is there subsequent training on policies and protocols?

17. How many people are on:

- Methadone
- Buprenorphine-
    - LAI?
- Naltrexone

18. Discharge Planning for Release to Community

- How do you plan for release for inmates with BH needs?
- How often do Multidisciplinary Team Meetings convene prior to release to plan for release for those with BH needs?
    - If so, who attends these?
    - What other ways do team members communicate with each other about patient needs?
- Who manages discharge planning or reentry planning in the detention center? BH staff or county staff?
- Is Naloxone provided to individuals being released upon discharge?
- Are Fentanyl testing strips provided to individuals being released upon discharge?
- Do you work with or contract with specific community providers to secure post-release appointments?
- Does the availability of community MH resources impact your post-release planning?
- Do you feel that you have enough SUD treatment providers in the community for connection to post-release services?

- Do you work with community providers to link individuals to housing?
- Do you work with community providers to link individuals to employment opportunities?
- Do you enroll individuals in health care prior to release?

19. Additional challenges related to BH care (e.g., staffing shortages, funding issues, inmate reluctance to seek care, etc.):

20. What support do you need from the:

    a. County?

    b. State to help serve the detainees you have in custody?

Appendix D: Screening and Assessment Webinars

As part of this engagement, Health Management Associates delivered two webinars titled Behavioral Health Screening and Assessment Tools. These virtual sessions provided an overview of evidence-based tools and best practices for identifying behavioral health conditions in correctional settings. The sessions emphasized the distinction between screening (a brief preliminary check) and assessment (a more in-depth evaluation), and outlined when, how, and by whom each activity should be conducted. HMA presenters highlighted validated tools for both adults and youth and emphasized the importance of tool selection based on population, setting, and available resources. Regular screening and reassessment were presented as critical for ensuring continuity of care and appropriate service delivery during transitions such as reentry or changes in supervision status.

This content was delivered in two sessions, May 28 and June 9, 2025, with a total of 41 attendees representing 19 Maryland jurisdictions: Anne Arundel, Allegany, Baltimore, Calvert, Charles, Caroline, Carroll, Cecil, Frederick, Garrett, Harford, Howard, Kent, Montgomery, Queen Anne's, St. Mary's, Talbot, Washington, and Wicomico counties. Attendees were encouraged to ask questions and share examples for peer-to-peer sharing with the goal of strengthening screening and assessment practices.

Evaluation feedback was overwhelmingly positive. All respondents felt the content was "just right" in terms of depth and clarity. Participants highlighted the practical nature of the tools, the value of learning from multiple perspectives, and the clear presentation style. Many participants reported that they intended to share the materials with their teams, revisit current practices, or adopt specific tools like TAPS (defined below). Some participants suggested the inclusion of additional reference documents, but most comments reflected an appreciation for the content and its immediate relevance to their work.

The presenters reviewed and shared the following screening tools:

- BJMHS- Brief Jail Mental Health Screen
- CMHS-M/W Correctional Mental Health Screen (Men/Women)
- MHSF-III - Mental Health Screening Form
- TCU Drug Screen - Texas Christian University Drug Screen
- TAPS - Tobacco Alcohol Prescription Medicine and Other Substances
- ASSIST - Alcohol, Smoking and Substance Involvement Screening Test
- MAYSI-2 - Massachusetts Youth Screening Instrument-2
- CANS - Child and Adolescent Needs and Strengths
- CRAFFT- Stands for six key words in its six screening questions regarding substance use (Car, Relax, Alone, Forget, Friends/Family, Trouble)