Mental Health Advisory Committee's Top Priorities FY-25

The Montgomery County Mental Health Advisory Committee (MHAC) is committed to working collaboratively with our community partners to monitor, advise, and advocate for a comprehensive mental health system of care for Montgomery County residents. We appreciate the support of County Executive Marc Elrich and the County Council, especially the HHS committee which includes Councilmembers Albornoz, Luedtke and Sayles, for funding so many critical programs and services.

The following are MHAC's top priorities for FY-25. Three of these priorities have implications to the County's Budget. The remaining four are advocacy recommendations. MHAC intends to elevate two of the advocacy recommendations through our subcommittee work.

1. Bolster the Infrastructure of Community-Based Family Peer Run and Adult Peer Run Organizations funded through Montgomery County DHHS Behavioral Health and Crisis Services

Peers are individuals with lived experience who are trained and certified to provide support to individuals in their treatment and recovery. As indicated in the attached infographic from the Substance Abuse and Mental Health Services Administration (SAMHSA), peers increase a patient/client's activation and sustained engagement in treatment; decrease patient hospitalization; and reduce stigma within clinical and public safety settings. Across the country, peers have worked in emergency departments, with law enforcement, in courts, jails, and crisis stabilization health settings.

Montgomery County has several peer-led community organizations that support the peer workforce to get trained and certified; and then deploys those certified peers into multiple settings (e.g., the STEER program; Family Peer Support Services to families who have youth with behavioral health challenges). The peer-led organizations also provide backbone support, similar to a union, to protect peers from burnout and potential relapse. Peer organizations also play a primary role in providing respite care (an intervention that can divert from crisis needs), as well as post-treatment recovery-based services.

Community-based peers funded through Montgomery County DHHS Behavioral Health and Crisis Services make substantially less than their counterparts directly employed by the county government. In some instances, peers, who often need to work in frontline difficult environments, are only making minimum wage. And contracts with peer-led organizations have not kept pace with the cost-of living, nor allowed for maintaining adequate infrastructure needs. The chart below conveys the disparity between community and direct county staff wages.

Position	County Hourly Rate	Community-Based Hourly Rate
Peers (Grade 16)	$46K-$74K	$27K-$34K
Peer Supervisor Grade 24)*	$65K- $107K	$36K

*County Supervisors are therapists while community supervisors are certified peer supervisors.

The need for peers continues to increase. MHAC is requesting that the Montgomery County Council funds additional support to community-based peer organizations in their infrastructure and staffing needs. This will allow for training of more peers and provide more competitive salaries. The estimated cost for this request is $**558,000.00.**

2. *Embed Social Workers into Community Rec Centers*

MHAC asks that the Montgomery County Council support County Executive Elrich's request for a pilot program to expand youth mental health support through existing programs at County recreational centers. The target audience is high-risk youth in middle and high school and the program will start with five recreational centers. The approach - multisystematic therapy - is an evidence-based practice for this population. This effort would complement the work being done by MCPS and DHHS to expand coordinated mental health services among schools and community providers. Since all the programming is already built into the rec centers, the additional cost will be just to cover the clinical services provided by social workers and nominal youth incentives (refreshments, awards, etc.). The estimated cost for this request is $**571,000.00.**

3. *Address the Behavioral Health Workforce Shortage*

The workforce shortage is a national concern that is complex and persistent. MHAC has a subcommittee focused on addressing the behavioral health workforce shortage and recommends that that the County Council fund two workforce-based actions – one addressing an immediate concern; the other moving forward towards a more systemic strategic solution.

- **Incentives for Therapists at the Crisis Center (immediate)** – Despite a competitive salary, it has been difficult to retain and recruit therapists at the crisis center. These staff are essential personnel. And working conditions include inclement weather and 40 hours a week of front facing work 24/7. The nature of the work can be traumatic as they respond on-scene to murders, suicides, accidents and county disasters in addition to evaluating high risk clients on mobile crisis calls and at the Crisis Center main site (walk-ins). MHAC is requesting that these staff receive a $1/hour differential increase for night shifts; a pension plan (which is offered to correctional staff); tuition reimbursement of one year for every year worked (with a maximum of two years coverage) and a salary increase for the Therapist 1 and 2 categories of $4,000. The estimated cost for this request is **$331K.**
- **Expert Consultation for a Behavioral Health Workforce Strategic Plan (Systemic) –** Because of the large-scale nature of the problem and to prevent entities from engaging in bidding wars, a more systematic strategic plan is needed. MHAC requests that a consultant be hired to develop a strategic plan. The effort should be time-limited (less than 6-months) and include stakeholder input, including MHAC representatives. The estimated cost for this request is **$20K** for a consultant.

Other Priority Areas: Investigation, Participation, and Support

MHAC also requests the Montgomery County Council incorporate the following considerations in their legislative and budget considerations:

- ***Ensure that Crisis Services Conform to Potential New COMAR Regulations****.* Maryland is updating its COMAR regulations related to crisis services which may impact on the availability of State funds for services. We recommend that the County's Department of Health advocate that the following concerns be addressed.
    - Medicaid rate must be high enough to sustain the following:
        - Salaries for specialized staff (Licensed Clinicians and Peer Support Specialists
        - Vehicle maintenance and gas
        - Other administrative support costs (Board approved supervisors on each shift, equipment-iPads, cell phones, etc.)
    - Workforce shortage places many MCTs in a position of not meeting a 2-person team as defined by BHA (licensed clinician, and paraprofessional or peer). Expansions to the definition are needed to include categories such as interns as second person otherwise grant funding must remain available to pay for services not covered by Medicaid
    - Full grant funding should remain in place for a minimum of 2 years; during which time end of year reconciliations can be utilized to reconcile services that were billed through Medicaid

- In most jurisdictions, Medicaid participant rate is not the estimated 35% (might want to look at Montgomery County's participant rate). Grant funding is needed for approximately 65-80% of individuals that utilize crisis services that are either uninsured or privately insured.

- ***Leverage Medicaid for Mental Health Services in Schools and Communities.*** MHAC urges the County Council to support and pursue the available opportunities to expand Medicaid reimbursement for mental health services provided by schools. In 2014 the Center for Medicare and Medicaid Services (CMS) issued guidance to State Medicaid Directors officially permitting reimbursement for Medicaid-covered services provided in schools. The reversal removes a major barrier for schools to obtain federal Medicaid funding for student health services. After almost a decade, numerous states have successfully amended their state Medicaid plans to allow for this reimbursement, but Maryland is lagging behind. This last year, MHAC's advocacy efforts were successful in mediating compromise amendment language from our colleagues in the Child Behavioral Health Coalition and getting this legislation thru the MD House. MHAC intends to continue this advocacy with the hopes that the legislation will eventually become law.

- ***Promote and Support Mobile Response and Stabilization Services (MRSS).*** Just as Crisis Now is a national best practice for adult crisis services, the MRSS serves as the best practice for addressing crisis needs of children, youth, young adults, and their families. Despite the momentum underway to utilize MRSS in Maryland, the Department of Health's Behavioral Health Administration (BHA) has paused a pilot program intended to expand MRSS to jurisdictions, including Montgomery County. MHAC offers our services and support to address any barriers related to implementing this important and much-needed service. We want to ensure that this initiative continues to move forward.

- ***Ensure that Activities Related to Mental-Health Services are Evidence-Based:*** **To** best utilize the scarce resources available, MHAC requests that services provided focus on evidence-based practices with fidelity. These approaches are listed in the SAMHSA website.

Thank you for your consideration,

Susan Kerin
Chair, MHAC

Libby Nealis
Vice Chair, MHAC

PEER SUPPORT

"Because of peer support I am alive!"
—Melodie

"When I saw that other people recovered, it gave me hope that I could too."
—Corinna

"Peer support allowed me to feel 'normal.'"
—Jean

WHAT IS PEER SUPPORT?

Peer support encompasses a range of activities and interactions between people who share similar experiences of being diagnosed with mental health conditions, substance use disorders, or both. This mutuality—often called "peerness"—between a peer support worker and person in or seeking recovery promotes connection and inspires hope.

Peer support offers a level of acceptance, understanding, and validation not found in many other professional relationships (Mead & McNeil, 2006). By sharing their own lived experience and practical guidance, peer support workers help people to develop their own goals, create strategies for self-empowerment, and take concrete steps towards building fulfilling, self-determined lives for themselves.

WHAT DOES A PEER SUPPORT WORKER DO?

A peer support worker is someone with the lived experience of recovery from a mental health condition, substance use disorder, or both. They provide support to others experiencing similar challenges. They provide non-clinical, strengths-based support and are "experientially credentialed" by their own recovery journey (Davidson, et al., 1999). Peer support workers may be referred to by different names depending upon the setting in which they practice. Common titles include: peer specialists, peer recovery coaches, peer advocates, and peer recovery support specialists.

PEER SUPPORT WORKERS

- **inspire hope** that people can and do recover;
- **walk with people** on their recovery journeys;
- **dispel myths** about what it means to have a mental health condition or substance use disorder;
- **provide self-help** education and link people to tools and resources; and
- **support people** in identifying their goals, hopes, and dreams, and creating a roadmap for getting there.

Peer support workers can help break down barriers of experience and understanding, as well as power dynamics that may get in the way of working with other members of the treatment team. The peer support worker's role is to assist people with finding and following their own recovery paths, without judgment, expectation, rules, or requirements.

Peer support workers practice in a range of settings, including peer-run organizations, recovery community centers, recovery residences, drug courts and other criminal justice settings, hospital emergency departments, child welfare agencies, homeless shelters, and behavioral health and primary care settings. In addition to providing the many types of assistance encompassed in the peer support role, they conduct a variety of outreach and engagement activities.

Peer support has been there for me no matter what, and now I am able to help others...
—Liza

BRINGING RECOVERY SUPPORTS TO SCALE
Technical Assistance Center Strategy (BRSS TACS)

SAMHSA

HOW DOES PEER SUPPORT HELP?

The role of a peer support worker complements, but does not duplicate or replace the roles of therapists, case managers, and other members of a treatment team.

Peer support workers bring their own personal knowledge of what it is like to live and thrive with mental health conditions and substance use disorders. They support people's progress towards recovery and self-determined lives by sharing vital experiential information and real examples of the power of recovery. The sense of mutuality created through thoughtful sharing of experience is influential in modeling recovery and offering hope (Davidson, Bellamy, Guy, & Miller, 2012).

DOES PEER SUPPORT MAKE A DIFFERENCE?

Emerging research shows that peer support is effective for supporting recovery from behavioral health conditions. **Benefits of peer support may include:**

Increased self-esteem and conf dence
(Davidson, et al., 1999; Salzer, 2002)

Increased sense of control and ability to bring about changes in their lives
(Davidson, et al., 2012)

Raised empowerment scores
(Davidson, et al., 1999; Dumont & Jones, 2002; Ochoka, Nelson, Janzen, & Trainor, 2006; Resnick & Rosenheck, 2008)

Increased sense that treatment is responsive and inclusive of needs
(Davidson, et al., 2012)

Increased sense of hope and inspiration
(Davidson, et al., 2006; Ratzlaff, McDiarmid, Marty, & Rapp, 2006)

Increased empathy and acceptance (camaraderie)
(Coatsworth-Puspokey, Forchuk, & Ward-Griffin, 2006; Davidson, et al., 1999)

Decreased psychotic symptoms
(Davidson, et al., 2012)

Increased engagement in self-care and wellness
(Davidson, et al., 2012)

Reduced hospital admission rates and longer community tenure (Chinman, Weingarten, Stayner, & Davidson, 2001; Davidson, et al., 2012; Forchuk, Martin, Chan, & Jenson, 2005; Min, Whitecraft, Rothbard, Salzer, 2007)

Increased social support and social functioning
(Kurtz, 1990; Nelson, Ochocka, Janzen, & Trainor, 2006; Ochoka et al., 2006; Trainor, Shepherd, Boydell, Leff, & Crawford, 1997; Yanos, Primavera, & Knight, 2001)

Decreased substance use and depression
(Davidson, et al., 2012)

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