Pascal Crisis Services, Inc.
Robert A. Pascal Youth & Family Services, Inc. • Pascal Crisis Stabilization Center
1215 Annapolis Road, Suite 204, Odenton, MD 21113
(410) 975-0067

February 15, 2023

VIA Email

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
Attn: Ms. Ruby Potter

Re: Pascal Crisis Services, Inc.
Establish a Track Two ICF
Matter No. 22-02-2459

Dear Ms. Ruby Potter,

As requested, on behalf of applicant Pascal Crisis Services, Inc., we are submitting Pascal's response to MHCC notification of interested parties and their individual comments in one document. A copy of this response was emailed to the interested parties per direction.

I hereby certify that the information contained within this application is true and accurate to best of my knowledge.

Katherine Bonincontri, M.H.R., M.S., LCPC-S
President and Executive Director

CERTIFICATE OF NEED APPLICATION
INTERMEDIATE CARE FACILITY
Matter No. 22-02-2459

Pascal Crisis Stabilization Center
43 Community Place
Crownsville, Maryland 21032

Response to MHCC notification of Interested Parties' comments from Gaudeniza Inc. and Hope House Treatment Centers

February 15, 2023

PASCAL
Crisis Stabilization Center

Gaudenzia, Inc. Qualifies as an Interested Party:

Gaudenzia #2:

"Gaudenzia is located virtually next door to the proposed new facility (driving distance of .1 mile) and services patients from Anne Arundel County, the Central Maryland Planning Region, and across the entire State of Maryland. Located in Crownsville, it is reasonable not only that Pascal will serve patients that are currently served by Gaudenzia, who originate in the Anne Arundel County/Crownsville area, but draw patients from Gaudenzia's broader service area."

Applicant Response:

Gaudenzia, Inc.'s services provided at 105 Circle Drive and 107 Circle Drive, Crownsville MD 21032, **are not similar to Pascal, and accordingly any comparison of driving distance is not relevant or germane.** Gaudenzia's services are primarily focused on substance use treatment, where Pascal provides a full spectrum of treatment. This is borne out by a comparison of the licensing and accreditation, demonstrating that Pascal is **the only agency that obtained a license and is accredited for Residential Crisis Services (RCS), which is residential mental health beds for which persons receive crisis stabilization services for an average length of stay of 10-days in addition to other residential substance use disorder beds, 3.1 WM, in one physical location.**

The chart below shows these critical and necessary elements that sets Pascal apart from all other providers in our jurisdiction including Gaudenzia, Inc. and Hope House Treatment Center Crownsville.

Licensed and Accredited Programs CARF Accreditation Provider Profile		
Pascal Crisis Services, Inc. Pascal Crisis Stabilization Center 43 Community Place Crownsville MD 21032	**Gaudenzia, Inc. 105 Circle Drive Crownsville MD 21032**	**Gaudenzia, Inc. 107 Circle Drive Crownsville MD 21032**
ASAM Level of Care 3.1 Certified		
ASAM Level of Care 3.7 Certified		
Detoxification/Withdrawal Management Substance Use Disorders/Addictions		Detoxification/Withdrawal Management Substance Use Disorders/Addictions
Community Housing (BH) Substance Use Disorders/Addictions	Community Housing (BH) Substance Use Disorders/Addictions	Community Housing (BH) Substance Use Disorders/Addictions
Inpatient Treatment (BH) Substance Use Disorders/Addictions		Inpatient Treatment (BH) Substance Use Disorders/Addictions
Intensive Outpatient Treatment (BH) Substance Use Disorders/Addictions		
Crisis Stabilization (BH) Mental Health		
Outpatient Treatment (BH) Mental Health Adult		
Outpatient Treatment (BH) Mental Health Children and Adolescents		
Call Centers (BH) Mental Health		
	Outpatient Treatment (BH) Substance Use Disorders/Addictions	Outpatient Treatment (BH) Substance Use Disorders/Addictions
	Residential Treatment (BH) Substance Use Disorders/Addictions	Residential Treatment (BH) Substance Use Disorders/Addictions

**Data location: www.carf.org/providerProfile.aspx?cod=210780*

Gaudenzia, Inc. does *not* offer the mental health care and substance use treatment in the same manner or approach that Pascal offers at the Pascal Crisis Stabilization Center. Individuals served by Pascal receive a combination of services to maximize the access to care and focuses on the individual patient needs through optimizing the Maryland Public Behavioral Health System's licensure of programs and accreditation to provide a high-quality level of treatment.

Gaudenzia, Inc.'s background paragraph outlines the programs that are offered in Crownsville, none of which are for mental health or mental health crisis stabilization, a specialty that is distinctly different than substance use crisis stabilization services.

In addition, the 175-bed facility located at 107 Circle Drive, Crownsville MD 21032, treats a high number of court-ordered individuals from the correctional system – and those individuals are only given the option of substance use treatment at Gaudenzia Crownsville in lieu of prison time – therefore choice is never part of the referral equation. While substance use treatment is provided for these individuals, treatment is not available to the general public. No other provider has a contract with the Health Department to perform services for the 8505/7 prison and detention center population but Gaudenzia, Inc. within Anne Arundel County. Building 105 is within 100 feet of building 107 and because of the close proximity, the environment within their facility contrasts sharply with Pascal's community oriented, non-detention centered milieu. Clients may not feel comfortable accessing behavioral health treatment in Gaudenzia's Crownsville facilities and prefer treatment at Pascal purely due to the majority of Gaudenzia's census being comprised of male clients referred from the detention centers.

Gaudenzia #3.
State health plan standards and review criteria not met by Pascal alternatives.

> *"Pascal's proposed project fails to meet this "more cost-effective alternatives" standard because existing facilities, including Gaudenzia, have the ability to serve the population that Pascal proposes to serve. Pascal's assertions are that its clinical services in Anne Arundel County are unique are incorrect. According to Pascal, it has unique attributes which other existing providers do not have."*

Applicant Response:

As the above chart demonstrates, Pascal and Gaudenzia provide different care, with Pascal providing broader care than Gaudenzia. While Gaudenzia states in their interested party response that Gaudenzia, Inc. "serves the same population as Pascal," the reality is this: **treatment for persons with complex psychiatric disorders, are *not* provided by Gaudenzia, Inc,** and often, individuals in need of high mental health treatment are either turned away by Gaudenzia, Inc. staff or not provided the care they desperately desire.

Pascal meets the Availability of More Cost-Effective Alternatives criteria through offering consolidated services in one physical location that reduces the amount of time an individual will need to receive similar services at multiple locations. Based on the data collected and referenced above, Pascal provides a more cost-effective and efficient treatment solution as individuals admitted to the Pascal Crisis Stabilization Center are provided with a combination of services in one physical location.

Gaudenzia, Inc., is not licensed or accredited to provide mental health services at either 105 Circle Drive or 107 Circle Drive, Crownsville MD locations. **Pascal's RCS license** and other complement of mental health licenses demonstrates the uniqueness of the services available to every client admitted to the Pascal Crisis Stabilization Center and further **exemplifies Pascal as distinctly different then Gaudenzia, Inc.**

While Gaudenzia, Inc. is located in an adjacent building to the Pascal Crisis Stabilization Center on the Crownsville Hospital Campus. Gaudenzia, Inc. does not provide the same services is supported by an admission by Gaudenzia in September 2021, when the Regional Director for Gaudenzia, Inc.'s filed a complaint with the Anne Arundel County Department of Health, Director of Behavioral Health, stipulating that Pascal was referring individuals to Gaudenzia's W.A.R.M.S. center with co-occurring mental health illness and substance use disorder and emailed the President and Executive Director of Pascal the following: (Exhibit 1)

> *"Please remind your staff that we are primarily an SUD provider with the ability to treat co-occurring disorders **within a scope**. Again, if there is confusion or a need for clarity, I am happy to prove that."*

In contrast, Pascal treats the entirety of the scope of mental health client needs, including the most acute, Severe Persistent Mental Illness (SPMI), and while Gaudenzia, Inc. claims to treat *"…persons with complex psychiatric disorders…"* the reality is unlike Pascal, Gaudenzia, Inc. routinely denies admission to individuals with high mental health needs.

Based on the documentation to date, during the last eight months, 27 individuals discharged or chose to AMA from Gaudenzia's Crownsville location and were referred to or directly admitted immediately upon discharge from Gaudenzia to the Pascal Crisis Stabilization Center due to co-occurring substance use and high mental health treatment needs.

Since December 1, 2022, there have been 11 individuals who were either discharged by Gaudenzia, Inc. Crownsville staff or left AMA and subsequently admitted to the Pascal Crisis Stabilization Center for co-occurring substance use and high mental health treatment.

The following data presents evidence in support of the facts:

GAUNDENZIA CLIENT REFERRALS TO THE PASCAL CRISIS STABILIZATION CENTER		
Date	**Client ID**	**Disposition**
5/27/2022	2004481153	Client admitted to PCSC after going to Gaudenzia three times in the past week and not able to receive MAT and sent to Anne Arundel Medical Center. CRS referred the client to Pascal.
6/2/2022	2004505434	Gaudenzia referred client to PCSC after initially being referred to Gaudenzia by Sinai. Gaudenzia staff assessment determined the client's MH needed higher level of care. Client referred to PCSC by Gaudenzia.
6/4/2022	2004494085	Client admitted to PCSC after spending 24-hours at Gaudenzia and not receiving co-occurring mental health treatment.
6/29/2022	2004504885	Client discharged from Gaudenzia after 24-hours. Client admitted to PCSC.
7/1/2022	2004486694	Client discharged from Gaudenzia due to the lack of timely care and MH treatment needed. CRS referred the client to PCSC.
7/20/2022	2004515166	Client admitted to PCSC after completing prior 8507 at Gaudenzia and asking not to return.
7/31/2022	2004506343	Client referred to PCSC, same day, after initially admitting to Gaudenzia, due to needing a higher level of care.
8/13/2022	2004506597	Client discharged from Gaudenzia and admitted to PCSC. Client stated he needed mental health care and Gaudenzia did not offer the service.
8/19/2022	2004506696	Client was admitted to Gaudenzia and after the initial assessment, client was transported by CRS to BWMC for psychiatric assessment. Client admitted to PCSC upon discharge from hospital.
9/6/2022	2004506954	Client AMA from Gaudenzia stating that his depression was not being treated. Client admitted to PCSC.
9/12/2022	2004507089 2004507098	PEP stated that Gaudenzia gave these clients (2) Pascal's number and referred them to PCSC. Both admitted.
9/16/2022	2004488987	Client left Gaudenzia and admitted to PCSC.
9/22/2022	2004507226	Gauendzia staff escorted client to PCSC. Upon arrival, Gaudenzia staff stated the client needed mental health care. Client did not admit to PCSC that evening but did return 2-days later.
10/6/2022	2004505790	Client was discharged from Gaudenzia to the hospital. Client elected to not return to Gaudenzia. Client reported that there were two overdoses on the Gaudenzia's unit and he desired a different agency to receive treatment. Client admitted to PCSC.
10/10/2022	2004507626	Client was discharged from Gaudenzia when staff discovered she was pregnant. Client went to a Safe Station and was subsequently admitted to PCSC.
11/6/2022	2004508039	Client discharged from Gaudenzia after 24-hours. Client admitted to PCSC for co-occurring treatment of substance use and mental health.
12/1/2022	2004508432	Client was discharged from Pascal. The client was escorted over to Gaudenzia's WARMS center. The WARMS center staff contacted CRS and the CRS Director showed up at PCSC asking why Pascal would send a mental health patient to Gaudenzia when Gaudenzia does not provide mental health treatment. The client was dual dx.
12/5/2022	2004508510	Client admitted to PCSC after discharging from Gaudenzia and not receiving co-occurring mental health treatment.
1/2/2023	2004508600	Gaudenzia discharged client due to high MH. Client was located by police brought to Pascal. Pt admitted.
1/4/2023	2004486224	Client was court ordered to Pascal after requesting Gaudenzia. The judge deemed Pascal more fitting to address the co-occurring needs of the client.
1/13/2023	2004496164	Gaudenzia referred client to Pascal due to a confrontation with another patient at Gaudenzia. Pt admitted.
1/13/2023	2004491653	Gaudenzia referred client to Pascal due to high mental health. Pt admitted.
1/14/2023	2004509093	CRS referred client to Gaudenzia over the weekend, but due to Mental Health needs and the client requesting to come to Pascal. The client was admitted to Pascal.
1/16/2023	2004505790	Gaudenzia referred the client to Pascal due to them being on a Do Not Re-Admit list. The client is known for having difficulties with treatment facilities. The client was admitted.
1/16/2023	2004484916	Client was discharged from Gaudenzia and referred to Pascal. Pascal was admitted to PCSC.
1/18/2023	2004507646	Client initially was admitted to Gaudenzia but discharged to Harbor Hospital for mental health care. The client was discharged from the hospital and sent to Pascal. Client admitted to PCSC.
1/25/2023	2004475912	Client referred to PCSC from Gaudenzia due to a need for mental health treatment. Client was admitted to PCSC.

**Data can be verified via the Maryland Public Behavioral Health System*

Gaudenzia #3(a):

Gaudenzia, Inc. makes an improper comparison with the assertion,

"Pascal is not the only provider with the ability to move a patient from an SOR bed and refer a patient internally to a residential level of care. Gaudenzia also has SOR beds and is able to move a person from a SOR bed into a treatment bed within 24-48 hours."

Applicant Response:

Pascal, in previously submitted responses to the Commission's request for additional information, correctly identified Pascal as the **only** provider with the ability to move a client from a SOR bed to a Licensed Residential Crisis Services (RCS) (Mental Health Bed), a type of licensed bed that Gaudenzia, Inc. does not maintain a license for at their Crownsville or at any location, nor have they ever operated the service type whatsoever. To compare a SOR bed to an RCS bed once again highlights Gaudenzia's lack of understanding of the vital difference between crisis stabilization bed types. ***Gaudenzia can only move a SOR bed to another SUD level of treatment within their organization.***

Unlike Pascal, Gaudenzia, Inc. simply does not have the comprehensive range of mental health and substance use treatment services and licensure for an individual seeking behavioral health treatment, nor do they provide the same high-quality system of care that is unique to Pascal.

Finally, Pascal contracts with a Primary Care agency that offers somatic medical treatment to individuals on-site at the Pascal Crisis Stabilization Center.

Gaudenzia #3(b):

> *"Last, Pascal also maintains that it has had to maintain a waiting list which makes no sense to Gaudenzia. Gaudenzia does not utilize a wait list as it has not been needed."*

Applicant Response:

Gaudenzia, Inc. points out that Pascal's waiting list is not valid because Gaudenzia does not use a waiting list, however, **the comparison actually highlights those individuals, when given a choice for treatment provider, choose Pascal overwhelmingly as opposed to Gaudenzia or other treatment providers in Crownsville.**

From December 1, 2022 – January 31, 2023, the Pascal Crisis Stabilization Center call center received 547 unduplicated individual screening calls for a bed. The data is undeniable, the need exists and whether or not Gaudenzia utilizes a waiting list, the facts remain that the patients require care, such that Pascal maintains a waiting list.

The 547 individual incoming calls during period referenced above are captured in one or more of the following categories:

- 52 MH only (previous SUD dx but no recent substance use, or unable to qualify for anything but RCS mental health bed)
- 495 actively using some type of substance
- 127 used only alcohol
- 343 met criteria for SOR beds
- 13 others met criteria for Substance Other Than Opioid (STOP)
- 12 others used substances that didn't meet SOR or STOP criteria (such as a self-referral using xanax)
- 109 specifically reported the desire for detox

Multiple clients reported they had been to at least one of the local 3.7/3.7WM facilities in the past, indicating that individuals seeking care are aware of the currently licensed detox agencies, but are either choosing to call Pascal first, or cannot be admitted at the time of their call. Of the 547, 55 were admitted to a current 3.7/3.7WM provider in the past:

- 23 reported Hope House | 23 reported Gaudenzia | 9 reported Pathways

Gaudenzia #4:

COMAR 10.24.01.08G(3)(f). Impact on Existing Providers and Health Care Delivery System

"Pascal has failed to meet the "impact" standard. The Project will result in additional (and unnecessary) health care costs and negatively impact the existing providers in the Central Maryland health planning region, particularly in Anne Arundel County. Pascal also has failed to provide any meaningful analysis of the impact on existing providers, simply asserting that the project will have no or minimal impact…"

Applicant Response:

Gaudenzia, Inc's assertion that approving Pascal's application for 20 3.7/3.7WM Track 2 ICF beds will impact their agency negatively is unsubstantiated.

Pascal will transition 20 SOR beds to 20 3.7/3.7WM Track 2 ICF beds upon the Commission's approval of their application. The approval of Pascal's application for 3.7/3.7WM detox beds **will not impact other providers** as the current census served by Pascal for Withdrawal Management treatment will be unchanged; individuals will simply then have access to full detox 3.7/3.7WM beds.

Based on Anne Arundel County Health Department data (Exhibit 4) reported on December 2, 2022, there were 55 out of 56 SOR referrals resulting in admissions to the Pascal Crisis Stabilization Center during the month of November 2022. **If Gaudenzia, Inc. provided the similar services as stated in their opposition to Pascal's application, the stark difference between admissions and referrals at the respective agencies would not exist.**

AACO HEALTH DEPARTMENT
SOR Grant CSS Provider Meeting
CSS OUD DISPOSITION DATA
November 2022

PROVIDER	Bed Capacity**	# of Admissions	Follow-on Tracking after discharge from SOR						
			SUD Tx	AMA	Crisis Bed	ER	RH	Other (Admin, Home)	In Bed
PASCAL	**20**	**55**	**34**	**11**	**4**	**1**	**1**	**1**	**3**
GAUDENZIA	16	1	1	0	0	0	0	0	0
HARBOUR HOUSE	4	0	0	0	0	0	0	0	0
TOTALS	40	56	35	11	4	1	1	1	3

REFERRAL SOURCE	Safe Stations	CRS ODSOS	DOH ODSOS	CRS Other	Other Hospital	**Self-Referral**
TOTALS	6	4	0	7	1	**38**

**Data is from the December 2, 2022 SOR Grant Provider Meeting*
***Pascal's bed capacity includes five self-referral SOR beds*

Gaudenzia, Inc. stipulates that their Crownsville locations are available for patient admissions 24/7/365 and yet their SOR admissions are nearly zero. Of the 56 total SOR admissions for Anne Arundel County, 38 individuals sought care directly from the Pascal Crisis Stabilization Center, 18 were referred by other authorities to Pascal. **Only 1 individual was referred to Gaudenzia, Inc. as compared to 55 individuals referred to Pascal in the month of November 2022, which provides more evidence that Pascal's current census will not impact existing providers after implementing an approved application for 3.7/3.7WM beds.**

Gaudenzia #4(a):

On page 7 Gaudenzia, Inc. referenced Pascal's assertion that staffing impacts will be negligible with the following:

> *"When asked about how approval of the Pascal application will impact other providers regarding staffing availability and costs" (September 23 Pascal Response p. 17), Pascal responded that the impact will be negligible again without providing any specific data or analysis."*

Applicant Response:

Once again, Gaudenzia's claim *"Clearly the staffing shortages will impact existing providers…"* is not accurate due to the misunderstanding that this request will result in a need for expanded staffing when, in fact, Pascal currently maintains staff required for program implementation.

Pascal maintains adequate direct care staff, in addition to licensed Registered Nurses, LPN(s), CRNP(s) and a Medical Director in order to currently operate Pascal's Withdrawal Management license and the same staff will remain in place will transition from providing Withdrawal Management services to SOR clients to providing care to the requested 20 3.7/3.7WM Track 2 ICF beds if approved by the Commission.

Staffing continues to be an issue for all providers and employers across the state, however, Pascal currently maintains the required staff for program implementation and hiring from other providers is not necessary.

Viability of Proposal

"…Gaudenzia maintains that the Pascal project is not financially viable and therefore does not meet the standard... reported in the November 3, 2022, Maryland Daily Record."

Gaudenzia, Inc. utilized public information regarding Pascal's disputed claim of overpayment by Optum in an attempt to discredit the viability of Pascal's application and create concern with Pascal's financial stability in an effort to convince the Commission to deny Pascal's application.

Gaudenzia, Inc.'s misstatements of Pascal's reconciliation process are demonstrably wrong. Gaudenzia is unaware of Pascal's discussions, not only with Optum, but also the State of Maryland Department of Health and the Legislature regarding the Administrative Service Office's (ASO) responsibilities to the provider network. Pascal is financially stable without question, and the Optum reconciliation process is not unique to Pascal, as all behavioral health providers were impacted by Optum's inability to process claims when they transitioned to be the new ASO for the State of Maryland, a fact well-documented in the press.

Hope House Treatment Center, Inc. interested party opposition:

Hope House #1:

"We are right now in the process of temporarily closing our Laurel Facility due to the lack of referrals to 3.7 and 3.7WM."

Applicant Response:

Hope House Treatment Center's closure of the Laurel Facility is contrary to the well documented need for detox services which Pascal provides.

The University of Maryland School of Medicine, Division of Addiction Research and Treatment has conducted exhaustive studies regarding the need for more providers licensed to provide detox services in combination with mental health treatment. In March 2019, a research article (Exhibit 2) published in the Journal of Substance Abuse Treatment "Behavioral Health Treatment Utilization Among Individuals with Co-Occurring Opioid Use Disorder and Mental Illness: Evidence from a National Survey", co-authored by Priscilla Novak, University of Maryland, College Park, School of Public Health, Department of Health Services Administration, Kenneth A. Feder, Johns Hopkins University, Bloomberg School of Public Health, Mir M. Ali, Office of the Assistant Secretary for Planning & Evaluation, US Department of Health & Human Services and Jie Chen, University of Maryland, College Park, School of Public Health concluded,

> *"A high proportion of individuals with OUD and co-occurring mental illness are not receiving needed care."*

The study also produced the following results:

> *"47% of individuals with OUD and co-occurring mild/moderate mental illness did not receive any behavioral health treatment, and 21%, of those with co-occurring serious mental illnesses did not receive any behavioral health treatment. Among those with OUD and co-occurring mild/moderate mental illness, 16% reported receiving both substance use disorder and mental health treatment; among those with co-occurring serious mental illness the rate was 32%."*
>
> *"The most common form of treatment was prescription medication for mental health, and this was true regardless of whether or not the individual had any mental illness. More than 50% of the study population reported financial difficulties as a barrier to treatment."*

The research and the data are conclusive, more 3.7/3.7WM ICF beds are needed now and providers must adapt to the changing environment. The COVID pandemic increased the mental health acuity to record levels and individuals are seeking substance use to escape from extended periods of isolation, loss of relationships, jobs, and death as a result of the virus. The old model of treatment for substance use disorders in isolation is not adequate for many as individuals often require combining a mental health treatment component to provide higher levels of treatment success.

The need for detox services is so great that, according to the Center for Injury Prevention and Control stated in 2016, *"Recent estimates indicate that an individual is now more likely to die of opioid-related issues than in a motor vehicle crash."* With the need for detox services growing exponentially, the approval of Pascal's application would not have any impact on neighboring providers.

Given that Hope House Treatment Center Laurel, per their interested party comments, is currently, *"…in the process of temporarily closing our Laurel facility due to lack of referrals to 3.7 and 3.7WM."* their closure is likely attributable to Hope House Treatment Center's treatment approach and business model.

For example, admission timing is difficult at Hope House Crownsville for new clients. In an email dated July 7, 2021, (Exhibit 3) Hope House Crownsville staff informed Pascal of a newly implemented process to *"…schedule admissions at staggered times and cannot allow multiple patients to show up at the same time…"* in addition to requiring the referral agency's driver to wait while the individual screened in order to be considered for admission. This policy remains in effect today creating additional hurdles to access treatment at Hope House Crownsville as compared to Pascal's easily accessible 24/7/365 admission policy at the Pascal Crisis Stabilization Center.

The admission by Hope House Treatment Center of their intention to reduce available Track 2 ICF beds within Anne Arundel County pragmatically supports the swift approval of Pascal's application to fill the anticipated additional treatment bed gap. Pascal's unique service delivery system is modeled off the dynamic national format that integrates substance use treatment, mental health and primary care services in one location. This model enables Pascal to offer a wide range of treatment services and enhances the overall benefit to the individual. Hope House Treatment Center's decision to reduce access to desperately needed 3.7/3.7WM Track 2 beds contraindicates the nationally available data supporting the need for more treatment beds as referenced above. Pascal is providing treatment at the Pascal Crisis Stabilization Center with a consistent volume and waitlist that supports Pascal's application for 20 3.7/3.7WM Track 2 ICF beds.

Hope House #2:

"We do Not and have NEVER referred patients for Detox to the Pascal Crisis Center. How can we refer patients to them for Detox when we are licensed, and they are not? Yes, we have referred patients for Crisis Stabilization."

Applicant Response:

Hope House Treatment Center inappropriately references a portion of Pascal's application due to a misinterpretation of the language regarding referrals. Pascal did not claim to receive referrals directly from Hope House Treatment Center specifically for Detox only; conversely, providers within the same jurisdiction have referred clients to the Pascal Crisis Stabilization Center who are in need of Detoxification/Withdrawal Management, a licensed service Pascal operates, due to the clinical capability of managing complex psychiatric involving persons with high mental health acuity in need of crisis stabilization.

According to SAMHSA, www.samhsa.gov

> *"Detoxification, in and of itself, does not constitute complete substance abuse treatment. The detoxification process consists of three essential components, which should be available to all people seeking treatment:*
>
> - *Evaluation*
> - *Stabilization*
> - *Fostering patient readiness for and entry into substance abuse treatment*
>
> *"Detoxification can take place in a wide variety of settings and at a number of levels of intensity within these settings. Placement should be appropriate to the patient's needs."*

Pascal has provided all three of these components since 2017 at the Pascal Crisis Stabilization Center. Hope House's assertion which implies that Pascal is preforming a service that they are not licensed to provide is incorrect. **Pascal is accredited in Detoxification/Withdrawal Management by CARF and licensed to provide Withdrawal Management by the State of Maryland; terminology is used in a combination as one standard for CARF accreditation.**

Hope House Treatment Center has referred individuals to the Pascal Crisis Stabilization Center 36 times since October 1, 2021. These referrals are predominantly to stabilize the individual prior to admission to Hope House Treatment Center's Detox inpatient program. The vast majority of these referrals were for individuals in need of Detoxification/Withdrawal Management from alcohol, or other substances which defies explanation; these individuals were not directly accepted for admission to Hope House despite the fact they claim to operate an inpatient program for Psychiatric and Substance Use Disorder for 3.7 and 3.7WM.

36 individuals initially screened for treatment at Hope House but were denied admission and subsequently referred to the Pascal Crisis Stabilization Center from Hope House since October 2021.

In the last 45 days alone, 6 individuals were denied admission to Hope House, due to being "too intoxicated," "medical reasons" (open wounds) and lack of "bed availability."

The following data are referrals from Hope House to the Pascal Crisis Stabilization Center:

HOPE HOUSE TREATMENT CENTER REFERRALS TO THE PASCAL CRISIS STABILIZATION CENTER		
Date	**Client ID**	**Disposition**
10/1/2021	2004500356	Client referred to Pascal for MH stabilization and drinks alcohol. Client admitted.
11/8/2021	2004481727	Client referred to Pascal from Hope House in order to obtain withdrawal management and then dc to Hope House. client admitted to Pascal for 3 days and dc to Hope House 11/11/2021
11/8/2021	2004501215	Client used pcp and was referred to Pascal to stabilize and then dc to HHCV. She owed HHCV $403 in unpaid fees and was not authorized to admit to HHCV.
12/14/2021	2004502072	Client was at Pyrimid Walden who sent client to hospital for psych, then dc to HHCV. Hospital staff called PCSC stating HHCV could not accept the client due to mental health and referred to Pascal.
12/15/2021	2004502109	Client referred to Pascal from HHCV to stay the night and has a bed at HHCV the next day.
12/15/2021	2004498382	Client dc from Hope House due to overdose, CRS referred client Pascal and was admitted.
12/21/2021	2004502207	Client arrived at HHCV on 12/20/2021. Client and HHCV staff contacted Pascal to request addmission to Pascal and stabilize. Client was not allowed to return to HHCV. Referral from HHCV. Admitted to Pascal.
12/30/2021	2004488752	Client approved to admit to Hope House upon release from the detention center. Upon arrival to HHCV, staff would not allow the client to enter. Client waitlisted at Pascal due to lack of bed availability.
1/14/2022	2004502540	Hope House referred client to PCSC. Client admitted to Pascal.
2/1/2022	2004502879	Client admitted to HHCV, alcohol levels tested, sent to ER, released back to HHCV, then referred by HHCV to PCSC due to "not meeting their requirements" and in order to complete withdrawal management prior to HHCV admission. Client admitted to Pascal for 8 days then dc to HHCV on 2/9.
2/2/2022	2004456049	Client admitted to Pascal after being referred by Hope House due to dc for the client cheeking meds
2/3/2022	2004502924	Client admitted to Pascal to stay overnight with the plan to dc to Hope House in the morning
2/11/2022	2004503084	Client called from HHL, admitted to PCSC and dc back to HHL once stable. Client returned to Pascal for withdrawal management.
2/13/2022	2004491691	Client admitted to PCSC to stabilize and planned bed at HHCV the following Monday.
2/24/2022	2004503870	Client referred by HHCV to admit to PCSC overnight and return to HHCV in the morning.
4/20/2022	2004504498	Client referred by HHCV, admitted to PCSC and dc to Elevate.
5/4/2022	2004504840	Client walked in after being referred by HHCV. Client admitted to PCSC and then dc on 5/9/22 to HHCV.
5/19/2022	2004481481	Client screened earlier with PCSC, originally referred by HHL and then ended up being referred from CRS. Client admitted to PCSC and dc to Walden once stable.
6/17/2022	2004505681	Client screened at HHL today and was turned away due to open wounds and advised to go to hospital for clearance. Client screened at Pascal, bed was available but choose but did not admit.
6/24/2022	2004496668	Client dc from HHCV for wanting to wear a hat. HHCV referred to Pascal. Admitted to PCSC
7/21/2022	2004479458	Client has received treatment from HHCV many times in the past. Referred to PCSC due to HHCV "not working for the client." Client admitted to Pascal.
7/26/2022	2004506150	Client was assaulted at Hope House via coffee thrown and Hope House told Pascal staff that the other client who threw the coffee was allowed to finish treatment because the client had only 3 days left. HHCV referred this client and stated the client could return to HHCV after the other client finished treatment. Client admitted to PCSC
7/26/2022	2004506277	Client called HHCV to screen. HHCV referred the client to Pascal. Client admitted to Pascal and dc to HHCV on 8/1.
8/27/2022	2004498995	Client dc from HHCV for verbal altercation with another patient and admitted to Pascal via CRS referral.
9/12/2022	2004507070	Client was turned away at HHCV after showing up intoxicated and hx of seizures with a plan to go to HHCV the next day. Client admitted to Pascal and dc to HHCV the next day.
9/21/2022	2004507025	Client was referred to Pascal after being dc from HHCV for talking to a member of the opposite sex. Client was admitted to Pascal.
11/7/2022	2004508054	Client arrived at HHCV intoxicated. HHCV referred client to PCSC to detox and return to HHCV. Client admitted to PCSC and then dc to Project Chesapeake.
11/11/2022	2004508164	Client arrived at HHCV intoxicated. HHCV staff sent the client to AAMC who then referred the client to PCSC. Client admitted. Client dc to HHCV after Pascal stabilized.
11/15/2022	2004490812	Client screened at HHCV and was denied due to high MH. HHCV referred the client to PCSC with the plan to stabilize and return to HHCV after.
11/15/2022	2004508227	HHCV sent client to Pascal to detox and then return to HHCV for inpatient treatment. Client admitted to PCSC and then dc to HHCV
1/4/2023	2004508891	Client claimed that they were dc from HHCV for medical reasons. Client admitted to PCSC.
1/6/2023	2004508927	Cient showed up to HHCV too intoxicated to admit. HHCV staff referred client to PCSC.
1/27/2023	2004509345	Client referred by HHCV, added to waitlist at PCSC due to bed availability
1/30/2023	2004491668	PCSC sent clinicals to HHCV for admision. Client admitted to PCSC for 7 days while HHCV reviewed the treatment application. Client dc to HHCV.
1/31/2023	2004509408	HHCV confirmed Client had a bed today as long as the client arrived by 12pm. The arrived at HHCV at 10am and was referred to PCSC "to stay the night and come to them in the morning" client dc to HHCV
2/1/2023	2004644863	Client screened with HHCV and received admission to HHCV but was later told the bed was canceled. HHCV staff referred client to PCSC. Client was admitted.

Hope House #4:

"The 'Turn Away' Data provided by the applicant on page 28 is in direct contrast with our admissions data provided in Exhibit 1."

Applicant Response:

Pascal's Turn Away does not correspond to Hope House's data regarding lack of referrals and/or bed occupancy. Pascal's beds remain at full occupancy, requiring the need for a wait list at times due to the Pascal's unique service delivery system and desirable environment Pascal provides for individuals seeking substance use treatment, the majority of which also have co-occurring mental health needs which cannot adequately be served by other providers.

Hope House #5:

"In the last couple of months Pascal has stopped referring patients for Detox."

Applicant Response:

Pascal has not "stopped referring patients for Detox" and Hope House's claim is disproven by the referral numbers. Since March 2021, Pascal has referred 46 clients to Hope House Treatment Centers for Detox treatment; **11 of these individuals have been referred, and transported by Pascal, to Hope House in the last 60-days.**

Hope House #6:

"Our staff has found out that they are Detoxifying their patients. I have sent a letter to this effect to the Anne Arundel Department of Health on January5, 2023."

Applicant Response:

Hope House Treatment Centers sent a letter to the Anne Arundel County Health Department wrongfully claiming that Pascal is providing detox services illegally or without a license at the Pascal Crisis Stabilization Center.

Pascal is accredited by CARF for Detoxication/Withdrawal Management and is licensed by the State of Maryland to provide Withdrawal Management services at the Pascal Crisis Stabilization Center.

Sending a letter to the Anne Arundel County Health Officer to discredit Pascal's reputation or worse, to imply that Pascal is providing an unlicensed service, is both unprofessional and regrettable. Pascal will continue to provide the highest quality treatment to all individuals in need of access to care. Pascal respectfully requests the Commission approve Pascal's application for 20 3.7/3.7WM Track ICF beds.

Conclusion:

As the record demonstrates, there is a need for behavioral health and addiction healthcare services in Anne Arundel County that only Pascal offers. The public would be well served by the Commission's approval of Pascal's Certificate of Need application to ensure that facilities and services are developed in Maryland that are cost-effective, high quality, geographically and financially accessible and viable.

Pascal's proposal will not have a significant negative impact on the cost, quality, or viability of other health care facilities and services. Indeed, the opposite is true, as Pascal provides behavioral health and addiction healthcare services that are broader than Gaudenzia and Hope House, and Pascal's proposal is a positive for Anne Arundel County and its citizens.

Exhibit	Description
1	Gaudenzia Email Primarily SUD Provider
2	Journal of Substance Abuse Treatment
3	Hope House Email Scheduled Admission Times
4	CSS Provider Meeting Minutes Dec. 22, 2022

Exhibit 1

From: Kristy Blalock
To: Katherine Bonincontri
Subject: Referrals
Date: Wednesday, September 8, 2021 7:50:50 PM

Katherine,

I hope all is well with you. I wanted to make you aware that we are receiving an increasing amount of referrals from hospitals that are telling us that patients are being referred by your agency to us for issues unrelated to SUD. For instance, we received a call today from Union Memorial stating that Pascal referred them to us for a patient who is Schizophrenic and could not ambulate steps. Interestingly enough, the patient had no SUD history. Our medical/clinical staff CQT Crownsville have called your crisis center numerous times and either staff refuse to provide any information, put us on hold and don't return to the phone or have even told us point blank that they are not to speak to Gaudenzia staff. We also have several recent instances (within the last six months) where we have referred appropriate patients to Pascal and they have not been admitted, stating that Pascal does not "accept Gaudenzia referrals".

In an effort to provide behavioral health services to the community appropriately and consistently, if there is an issue, I am more than happy to discuss that with you but the number of referrals that are coming to us, stating that Pascal staff is sending them (and they are inappropriate) is troublesome and appears purposeful.

Please remind your staff that we are primarily an SUD provider with the ability to treat co-occurring disorders within a scope. Again, if there is confusion or a need for clarity, I am happy to prove that.

Take care,

Kristy E. Blalock, LCPC, LCADAS, MAC, NCC, BCPC, CADS
Regional Director
Gaudenzia, Inc.
www.Gaudenzia.org

Exhibit 2

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Behavioral health treatment utilization among individuals with co-occurring opioid use disorder and mental illness: Evidence from a national survey

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ABSTRACT

Background: Past research shows that among individuals with substance use disorders, the presence of a co-occurring mental illness can influence the initiation, course, and success of behavioral health treatment, but little research has examined people with opioid use disorder (OUD) specifically.
Methods: Using the 2008–2014 National Survey on Drug Use and Health, this study examines the utilization of substance use disorder and mental health treatment among individuals with OUD and different degrees of mental illness severity. The study also examined types of treatment, perceived unmet need for treatment, and barriers to care.
Results: 47% of individuals with OUD and co-occurring mild/moderate mental illness did not receive any behavioral health treatment, and 21% of those with co-occurring serious mental illnesses did not receive any behavioral health treatment. Among those with OUD and co-occurring mild/moderate mental illness, 16% reported receiving both substance use disorder and mental health treatment; among those with co-occurring serious mental illness the rate was 32%. The most common form of treatment was prescription medication for mental health, and this was true regardless of whether or not the individual had any mental illness. More than 50% of the study population reported financial difficulties as a barrier to treatment.
Conclusion: A high proportion of individuals with OUD and co-occurring mental illness are not receiving needed care. However, nearly one in five of those with OUD but no diagnosed mental illness is receiving prescription medication for mental illness. These findings suggest that there is a need to better facilitate access to and coordinate behavioral health care across settings for individuals with OUD.

1. Introduction

The United States is in the midst of an opioid crisis characterized by historically high rates of overdose deaths, hospitalizations, and addiction treatment admissions related to the use of prescription opioid medications and heroin (Kolodny et al., 2015). Recent estimates indicate that an individual is now more likely to die of opioid-related issues than in a motor vehicle crash (Center for Injury Prevention and Control, 2016). Facilitating access to evidence-based treatment for opioid use disorder (OUD) has been identified as essential strategy for preventing overdose deaths and stopping the spread of the current crisis (Alexander, Frattaroli, & Gielen, 2015). However, most people with OUD receive no substance use treatment (Saloner & Karthikeyan, 2015).

Most research on the ongoing opioid crisis has focused on the role of health care access, prescribing patterns of providers, and supply-side policies (including prescription drug monitoring programs, pill mill laws, abuse-deterrent reformulations of opioids, rescheduling of opioids, and prescribing guidelines) (Ali, Dowd, Classen, Mutter, & Novak, 2017; Guy et al., 2017; Saloner & Karthikeyan, 2015). Less attention has been devoted to co-occurring mental health conditions in this population, yet substance use disorders often co-occur with mental illness (Grant et al., 2004; Sullivan, Edlund, Zhang, Unützer, & Wells, 2006). This is particularly true of people with OUD, among whom between half and three quarters are estimated to have a co-occurring mental health disorder (Callaly, Trauer, Munro, & Whelan, 2001; Darke & Ross, 1997; Nam, Matejkowski, & Lee, 2016; Nam, Matejkowski, & Lee, 2017). A recent study suggested that around half of all opioid

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prescriptions in the United States are written for people with a history of anxiety or depressive disorders (Davis, Lin, Liu, & Sites, 2017), and in 2015, 1.5 million adults with serious mental illness misused opioids (SAMHSA, 2016).

People with co-occurring substance use disorder and mental illness may have different patterns of treatment and likely have complex treatment needs. For example, Urbanoski, Rush, Wild, Bassani, and Castel (2007) found that people with substance use disorders who had co-occurring mental illness were more likely to receive substance use treatment, but also most likely to report dissatisfaction with the quality of their care. Research has also shown that individuals with substance use disorder but no mental illness are more likely to get mental health treatment (Ali, Teich, & Mutter, 2015). There is also evidence that people in substance use treatment with co-occurring mental illness are less likely to complete treatment (Krawczyk et al., 2017) and experience worse treatment outcomes (Compton, Cottler, Jacobs, Ben-Abdallah, & Spitznagel, 2003) than people with no mental illness. It is recommended that individuals with co-occurring mental health and substance use disorder receive treatment for both disorders at the same time (Nam et al., 2017). Among people in methadone maintenance treatment for opioids in particular, one study found that people with more severe mental illness in treatment had worse psychosocial outcomes at treatment entry and exit (Cacciola, Alterman, Rutherford, McKay, & Mulvaney, 2001). Further, the special needs of people with comorbid substance use and mental health problems may not be served well within the existing health care system where substance use and mental health treatment are often not integrated or coordinated (Burnam & Watkins, 2006; Torrens, Rossi, Martinez-Riera, Martinez-Sanvisens, & Bulbena, 2012).

As the United States seeks to expand access to evidence-based OUD treatment to combat the ongoing crisis of addiction, it is important to understand how the presence of co-occurring mental illness relates to treatment utilization and barriers to healthcare among individuals with an OUD. This study uses public use data from an annual, nationally representative survey on substance use and mental health in the United States to examine patterns of treatment utilization and barriers to treatment among individuals with an OUD and individuals with co-occurring OUD and mental illness.

2. Material and methods

2.1. Data

This study utilized data from the 2008–2014 National Survey on Drug Use and Health (NSDUH), a nationally representative survey of the non-institutionalized population in the United States conducted annually by the Substance Abuse and Mental Health Services Administration. The NSDUH collects detailed information on use of alcohol and illicit drugs, mental and substance use disorders, and behavioral health treatment utilization. Using a stratified, multi-level cluster sampling design, the survey is designed to produce nationally representative estimates of individuals aged 12 years and older living in households in the United States. Comprehensive information on the NSDUH data collection methods and survey design are available from the Substance Abuse Mental Health Services Administration (SAMHSA, 2016).

The NSDUH asks respondents questions to assess symptoms of pain-reliever and heroin use disorders (substance dependence or abuse) during the past year using the criteria specified within the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (APA, 1994). It includes such symptoms as trouble with the law, tolerance, withdrawal, use in dangerous situations, and interference in major obligations at work, school, or home during the past year. The variable for OUD in this study reflects whether the respondent met the criteria for DSM-IV abuse or dependence of either pain-relievers or heroin. In this analysis, we restrict the sample to individuals aged 18 through 64 with OUD (unadjusted pooled N = 3398). All estimates are weighted to account for NSDUH's complex survey design (clustering and stratification) and to make the estimates nationally representative (weighted pooled N ≈ 1,816,565). All analyses were conducted in STATA 15 using the 'svy' prefix command.

2.2. Measures

The primary exposure of interest was whether the individual had a co-occurring mental illness. Mental illness was identified using NSDUH's probabilistic algorithm based on a combination of a respondent's Kessler Psychological Distress Scale (K6) (Kessler et al., 2002) and World Health Organization Disability Assessment Scale (WHODAS) (Garin et al., 2010) scores (SAMHSA, n.d.). Based on these scores, participants were classified in the NSDUH as having no mental illness, mild or moderate mental illness, or serious mental illness (SAMHSA, n.d.).

The outcome of the analysis is a categorical variable with four mutually exclusive behavioral health treatment categories: substance use disorder treatment only, mental health treatment only, both substance use disorder and mental health treatment, and no substance use disorder or mental health treatment in the past 12 months. Substance use disorder treatment in the study refers to the use of any outpatient or inpatient treatment services for alcohol or drug use during the year. This treatment could be received at a self-help group, mental health center, hospital, rehabilitation facility, private physician's office, or substance abuse related emergency room visit. The treatment could also have been received in a jail or prison, although NSDUH does not survey respondents who are currently incarcerated. Mental health treatment represents the use of one or more of the following types of services during the year – outpatient treatment services (clinical or non-clinical setting), inpatient treatment services (clinical or non-clinical setting), and use of any psychotropic medication.

The NSDUH asks all respondents, regardless of mental health status or treatment received, whether there was a time during the past 12 months when they needed mental health treatment or counseling but did not get it. Perceived unmet mental health need was measured based on this question, with a positive response being coded as 1 and otherwise coded as 0. Among those with perceived unmet mental health need, the NSDUH questionnaire asks respondents to categorize the reasons for not getting treatment from a list of 14 options. For this analysis, these 14 possible answers were grouped into the following six categories following the previous literature (Ali, Teich, & Mutter, 2017): affordability, treatment access, stigma, treatment not a priority, fear, and other reason. "Affordability" is defined as not getting care because the person's insurance would not pay for the treatment, or his/her insurance was not enough to cover the cost of treatment, or the person could not afford the cost,. "Treatment access" included not being able to get care because the person did not have a way, such as car or bus, to get to the treatment site, the person did not know where to go for treatment, or the treatment location was too far. "Stigma" is defined as not getting care because the person was concerned that other people, such as neighbors, would have a poor opinion, the individual did not want other people to be aware, the individual thought it might have bad ramifications for their job, or the individual had concerns about confidentiality. "Treatment not a priority" was defined as not getting treatment because the person thought s/he could handle the problem without treatment, because s/he did not have time to go for treatment, or s/he did not think treatment would help. "Fear" was categorized as not getting treatment because the person feared s/he would be involuntarily committed for treatment or forced to take medications. Finally, "other reason" is defined as some other reason for not receiving treatment.

NSDUH also asks respondents who did not receive treatment if in the past 12 months they wanted or needed treatment or counseling for their alcohol or drug use. A response of yes was coded as 1, indicating

the individual felt a need for treatment, and a response of no was coded as 0, indicating no perceived need for treatment. Among those reporting this perceived need for substance use treatment but not getting it, NSDUH asks people to categorize the reasons for not getting treatment from a list of 13 possible reasons. Similar to the mental health treatment barriers, these 13 possible reasons can be collapsed into five broad categories: affordability, treatment access, stigma, treatment not a priority, and lack of readiness to stop using. “Affordability” is defined as not receiving treatment because a respondent's insurance did not cover the treatment or the individual could not afford the cost. “Access barriers” included not receiving treatment because the individual did not have a way to get to the treatment (e.g. bus route did not go to facility, no family member to give a ride), because no program in their area had the type of treatment they needed, because there were no open slots in the program they needed, or because the respondent did not know which program or office to call to arrange treatment. “Stigma” is defined as not receiving treatment because the individual did not want other people to know, their neighbors might have a poor opinion, or thought it would have a negative effect on his or her employment situation. “Treatment not a priority” included not getting treatment because the individual reported that they did not have time for treatment, or s/he thought s/he could handle the problem without treatment. Finally, “Lack of readiness to stop using” was defined as not getting treatment because the individual did not indicate readiness to stop using the substance.

Multinomial logistic regression was utilized in the study to examine the association of mental health status with utilization of substance use treatment, mental health treatment, and both treatments among individuals with OUD because the dependent variable is a categorical variable of more than two unordered mutually exclusive outcomes. As noted previously, the four categories of behavioral health treatment utilization are: (i) substance use disorder treatment only; (ii) mental health treatment only; (iii) both substance use disorder and mental health treatment; and (iv) no substance use disorder or mental health treatment. The latter category, no treatment, was used as the reference group. For each independent variable, the analysis produces three relative risk ratios (RRR), which show how the relative risk of utilizing a particular category of treatment changes relative to not utilizing any treatment. For example, in the case of mental health status, the model estimates the association between mild/moderate mental illness and serious mental illness compared to no mental illness with treatment utilization in modeling three logit models simultaneously – (i) comparing substance use disorder treatment only with no substance use disorder or mental health treatment; (ii) comparing mental health treatment only with no substance use disorder or mental health treatment, and (iii) comparing both substance use disorder and mental health treatment with no substance use disorder or mental health treatment.

In addition, the following variables were also examined in the analysis – gender, age, race/ethnicity, marital status, education level, poverty status, employment status, health insurance status, and whether the respondent resided in a metro area – because they have been identified as predisposing and enabling factors for accessing needed health care services (Andersen, 1995; McKenna, 2017).

3. Results

Among those with OUD, 40% had no mental illness, 36% had mild or moderate mental illness, and 24% had serious mental illness. The demographic characteristics of the study population are provided in Table 1. The table shows that 70% of those with OUD and no mental illness were male, 45% were between the ages of 26 to 49 (26% between ages 26–34 and 19% between ages 35–49), 71% were non-Hispanic White, and 11% had a college degree. Among those with OUD and co-occurring mild/moderate mental illness, 56% were male, 54% were between the ages of 26 to 49, 73% were non-Hispanic White, and 9% had a college degree. Among those with OUD and co-occurring serious mental illness, 50% were male, 62% were between the ages of 26 to 49, 81% were non-Hispanic White, and 12% had a college degree. In addition, a majority of those with co-occurring OUD and mental illness were not employed full-time. Also, a majority of individuals with OUD and mental illness had incomes below 200% of the federal poverty level (FPL). Finally, one third of the study population did not have any health insurance coverage.

Table 1
Demographic characteristics of individual with opioid use disorders by mental health status, United States 2008–2014 (weighted proportions, standard error).

	No mental illness	Mild/moderate mental illness	Serious mental illness
Gender			
Male	0.7 (0.02)	0.56 (0.03)	0.5 (0.03)
Female	0.3 (0.02)	0.44 (0.03)	0.5 (0.03)
Age group			
18–25	0.39 (0.02)	0.31 (0.02)	0.25 (0.02)
26–34	0.26 (0.02)	0.31 (0.02)	0.32 (0.03)
35–49	0.19 (0.02)	0.23 (0.02)	0.30 (0.03)
50–64	0.12 (0.02)	0.13 (0.02)	0.13 (0.03)
65+	0.05 (0.01)	0.02 (0.01)	0.00 (0.00)
Race/ethnicity			
White	0.71 (0.02)	0.73 (0.03)	0.81 (0.02)
Black	0.10 (0.02)	0.11 (0.02)	0.06 (0.01)
Hispanic	0.14 (0.02)	0.12 (0.02)	0.10 (0.02)
Other	0.05 (0.01)	0.04 (0.01)	0.03 (0.01)
Marital status			
Married	0.23 (0.02)	0.26 (0.03)	0.23 (0.03)
Widowed	0.02 (0.01)	0.03 (0.01)	0.03 (0.01)
Separated	0.13 (0.02)	0.15 (0.02)	0.21 (0.03)
Never married	0.62 (0.02)	0.56 (0.02)	0.54 (0.03)
Education status			
Less than high	0.27 (0.02)	0.25 (0.02)	0.20 (0.02)
High school	0.35 (0.02)	0.34 (0.03)	0.39 (0.03)
Some college	0.27 (0.02)	0.32 (0.03)	0.30 (0.02)
College	0.11 (0.01)	0.09 (0.01)	0.12 (0.02)
Federal poverty status			
Under 100% FPL	0.23 (0.02)	0.26 (0.02)	0.30 (0.03)
100% to 200% FPL	0.23 (0.02)	0.28 (0.03)	0.27 (0.03)
Over 200% FPL	0.53 (0.02)	0.45 (0.03)	0.43 (0.03)
Employment status			
Full time	0.48 (0.02)	0.42 (0.03)	0.33 (0.03)
Part time	0.15 (0.01)	0.18 (0.02)	0.14 (0.02)
Unemployed	0.15 (0.01)	0.14 (0.01)	0.16 (0.02)
Other (including not in workforce)	0.22 (0.02)	0.27 (0.02)	0.37 (0.02)
Insurance status			
Private	0.42 (0.02)	0.36 (0.03)	0.31 (0.02)
Public	0.24 (0.02)	0.29 (0.03)	0.32 (0.03)
Other	0.04 (0.01)	0.03 (0.01)	0.04 (0.01)
None	0.30 (0.02)	0.32 (0.02)	0.33 (0.03)
Metro area			
Large metro	0.54 (0.02)	0.55 (0.03)	0.48 (0.03)
Small metro	0.31 (0.02)	0.32 (0.03)	0.36 (0.03)
Non-metro	0.15 (0.01)	0.13 (0.01)	0.17 (0.02)
N	1454	1207	737
Weighted N	727,819	656,870	431,876

The percentage of individuals with OUD who received various treatment types by mental illness status are reported in Table 2. The percentage of individuals who received substance use disorder treatment only was similar across the mental illness categories with a slightly higher percentage of individuals without mental illness and with mild/moderate mental illness receiving substance use disorder treatment only. The percentage of individuals receiving mental health only treatment increased as the severity of mental illness increased; 14% of individuals with OUD and no mental illness received mental health treatment only; 26% and 38% of individuals with mild/moderate mental illness and serious mental illness, respectively, received mental health treatment only. The percentage of individuals receiving both substance use disorder treatment and mental health treatment also

Table 2
Behavioral health treatment utilization among individual with opioid use disorders by mental health status, United States 2008–2014 (weighted proportions, standard error).

	No mental illness	Mild/moderate mental illness	Serious mental illness
Behavioral health treatment			
Substance use disorder treatment only	0.14 (0.01)	0.11 (0.02)	0.10 (0.02)
Mental health only	0.14 (0.02)	0.26 (0.02)	0.38 (0.03)
Both	0.07 (0.01)	0.16 (0.02)	0.32 (0.03)
None	0.66 (0.02)	0.47 (0.02)	0.21 (0.02)
Substance use treatment by type			
Hospital	0.07 (0.01)	0.12 (0.02)	0.20 (0.02)
Inpatient	0.09 (0.01)	0.13 (0.02)	0.21 (0.02)
Outpatient	0.12 (0.01)	0.15 (0.02)	0.23 (0.02)
Mental health center	0.06 (0.01)	0.09 (0.01)	0.2 (0.02)
Emergency department	0.04 (0.01)	0.08 (0.02)	0.15 (0.02)
Physicians office	0.06 (0.01)	0.09 (0.02)	0.13 (0.02)
Jail/prison	0.02 (0.00)	0.03 (0.01)	0.05 (0.01)
Self help group	0.12 (0.01)	0.16 (0.02)	0.27 (0.03)
Mental health treatment by type			
Inpatient	0.03 (0.01)	0.07 (0.01)	0.16 (0.02)
Outpatient	0.08 (0.01)	0.19 (0.02)	0.38 (0.03)
Prescription medication	0.17 (0.02)	0.34 (0.02)	0.63 (0.03)
Perceived need for substance use disorder treatment	0.08 (0.01)	0.16 (0.02)	0.19 (0.02)
Unmet need for mental health	0.07 (0.01)	0.30 (0.02)	0.60 (0.03)

increased with mental illness severity. Well over half of people with OUD and no mental illness (66%) received no treatment. The percentage of people receiving no treatment decreased as mental illness severity increased. Specifically, 47% of those with mild/moderate mental illness received no treatment, whereas only 21% of respondents with serious mental illness received no treatment.

The percentage of the study population receiving substance use treatment in the various settings identified in Table 2 increased as the severity of mental illness increased. The most common substance use treatment setting across all categories of mental illness was self-help group, which was used by 12%, 16%, and 27% of individuals with no, mild/moderate, and serious mental illness, respectively. Outpatient substance use treatment was the second most common substance use treatment. It was received by 12%, 15%, and 23% of respondents with no, mild/moderate, and serious mental illness, respectively.

The most common form of mental health treatment for individuals with OUD across all categories of mental illness was prescription medication, which was used by 17%, 34%, and 63% of respondents with OUD who had no, mild/moderate, and serious mental illness, respectively. Use of inpatient and outpatient mental health services increased with severity of mental illness for people with OUD.

Even though rates of substance use treatment were low, only a minority of individuals with OUD who did not receive treatment perceived a need for it. The percentage of individuals with an unmet need for substance use disorder treatment increased as mental illness severity increased, rising from 8% of those without mental illness, to 16% of those with mild/moderate mental illness, and to 19% of those with serious mental illness.

The percentage of individuals who had an unmet need for mental health treatment was lowest among those with OUD who did not have mental illness (7%). In contrast, 30% and 60% of respondents with OUD who had mild/moderate and serious mental illness, respectively, reported an unmet need for mental health treatment.

Table 3 shows the reasons that individuals with OUD and an unmet need for mental health care, by the reason that they cited for their unmet need. The most commonly reported reason across all categories of mental illness was affordability. It was cited by 46%, 65%, and 56%,

Table 3
Barriers to mental health treatment and substance use disorder treatment by mental health status among individuals with opioid use disorder (weighted proportions, standard errors).

	No mental illness	Mild/moderate mental illness	Serious mental illness
Mental health[a]			
Affordability	0.46 (0.08)	0.64 (0.04)	0.56 (0.04)
Access	0.10 (0.04)	0.19 (0.05)	0.22 (0.03)
Stigma	0.32 (0.08)	0.24 (0.03)	0.30 (0.03)
Treatment not a priority	0.21 (0.06)	0.18 (0.03)	0.19 (0.02)
Fear of involuntary treatment	0.05 (0.03)	0.09 (0.02)	0.24 (0.03)
Other	0.04 (0.02)	0.04 (0.01)	0.06 (0.01)
Substance use[b]			
Affordability	0.60 (0.06)	0.58 (0.06)	0.54 (0.06)
Access	0.22 (0.07)	0.32 (0.06)	0.25 (0.05)
Stigma	0.28 (0.08)	0.29 (0.06)	0.30 (0.05)
Lack of readiness to stop using	0.27 (0.06)	0.22 (0.04)	0.30 (0.06)
Treatment Not a Priority	0.15 (0.06)	0.08 (0.02)	0.09 (0.03)

[a] Sample for substance use disorder treatment barriers includes only individuals with perceived need for substance use treatment.
[b] Sample for mental health treatment barriers includes only individuals with perceived unmet need for mental health treatment.

of those with no, mild/moderate, and serious mental illness respectively. Stigma was the second most common reason cited by all three categories of mental illness. Treatment not a priority was the third most commonly reported reason among those with OUD and no mental illness. Access was the third most common reason cited by those with OUD and mild/moderate mental illness; for those with OUD and serious mental illness, fear of involuntary treatment was the third most common reason, cited by 24% of respondents.

Among individuals with OUD who have a perceived need for substance use treatment, Table 3 reports the reasons for not receiving treatment. Affordability reasons were identified by a significant portion of individuals with OUD regardless of their mental health status. Specifically, 60% of those with OUD but no mental illness identified affordability as a barrier to substance use treatment; followed by 58% and 54% among those with co-occurring mild/moderate mental illness and serious mental illness, respectively. Stigma was also a relatively common barrier. It was cited by 28%, 29%, and 30% of those with no, mild/moderate, and serious mental illness, respectively. Lack of readiness to stop using was also a commonly cited reason. It was reported by 27%, 22%, and 30% of those with no, mild/moderate, and serious mental illness, respectively.

Logistic regression models were also estimates with perceived need for substance use disorder treatment and unmet need for mental health as the dependent variables. The results reported in Table 4 shows that mild/moderate and serious mental illness are associated with increased odds of perceiving a need for substance use disorder treatment and

Table 4
Association of mental health status with perceived need for substance use disorder treatment and unmet need for mental health, among persons with opioid use disorder.

	Mental illness severity	Odds ratio	
		Perceived need for substance use disorder treatment	Unmet need for mental health
Adjusted[a]	Mild/moderate	2.50 (1.43–4.25)	4.80 (2.92–7.88)
	Serious	3.84 (2.17–6.82)	17.43 (9.92–30.21)
	None (reference)		

[a] Models regression-adjusted for gender, age, race/ethnicity, education, marital status, federal poverty level, employment, insurance, and metro area.

unmet need for mental health, with the odds of serious mental illness being higher compared to mild/moderate mental illness.

Appendix Table 1 reports the estimates from multinomial logistic regression models where mental illness status was the variable of interest and treatment category was the outcome variable. The results indicate that mild/moderate mental illness was associated with an increased relative risk of utilizing both mental health treatment and substance use treatment by a factor of 3 and mental health treatment only by a factor of 2 (compared to the reference category of not receiving any treatment and the reference group not having a mental illness). We observe that compared to individuals no mental illness, those with mild to moderate mental illness were had a relative risk ratio (RRR) of 3.07 (CI 1.97–4.79) to receive both mental and substance use treatment, a RRR of 2.51 (CI 1.74–3.62) of receiving mental health treatment only, and a RRR of 1.06 (0.72–1.57) for receiving substance use treatment only. Serious mental illness also increased the relative risk of receiving both substance use and mental health treatment by a factor of approximately 12. The group with serious mental illness had a RRR of 12.19 (CI 7.98–18.62) for receiving both treatments, a RRR of 7.43 (CI 5.06–10.93) of receiving mental health treatment alone, and a RRR of 1.93 (1.25–2.99) of receiving substance use only.

To check the robustness of this estimate, the multinomial logistic regression model was estimates with mild/moderate mental illness as the reference group and the results reported in Appendix Table 2 reveals a very similar pattern. In this analysis we saw that compared to the group with mild/moderate mental illness, the group with no mental illness had a relative risk ratio (RRR) of 0.39 (CI 0.23–0.67) for receiving both treatments, RRR of 0.38 (CI 0.24–0.62) of receiving mental health only, and RRR of 0.76 (CI 0.43–1.35) of receiving substance abuse treatment only.

4. Discussion

Using data from a nationally representative survey, this study explored behavioral health treatment utilization and barriers to treatment among those with co-occurring OUD and no, mild/moderate, and serious mental illness. The study finds that among those with OUD, the utilization rate of behavioral health services is low. Indeed, a significant proportion of individuals with OUD, especially those with co-occurring mental illness, report an unmet need for mental health care. In addition, the study shows that the most common form of treatment was prescription medication for mental health, regardless of the individuals' mental health status and that the most prevalent barrier to treatment was affordability.

Consistent with past research, the study finds that most people with an OUD did not receive any substance use disorder treatment (Saloner & Karthikeyan, 2015). However, similar to Ali et al. (2015), the study finds that if individuals do get treatment, they are more likely to receive mental health treatment only. One third of the individuals with co-occurring OUD and serious mental illness reported receiving both substance use disorder and mental health treatment in the past 12 months, a rate that is much higher compared to those with co-occurring mild/moderate mental illness. This is consistent with a number of studies showing that people with more severe behavioral health problems use more behavioral health treatment services (Bender et al., 2001; Helzer & Pryzbeck, 1988; McAlpine & Mechanic, 2000; Mojtabai, 2005). In the case of OUD, it may be that the addition of co-occurring mental illness might have influenced individuals to seek treatment.

While it is encouraging that behavioral health treatment utilization is higher among those with serious mental illness, on the whole, the results suggests that there is room for much improvement in coordination of substance use disorder and mental health treatment. In addition, utilization of psychotropic medication among those with OUD but no mental illness may be especially problematic because some of these medications may be opioid potentiators that heighten the effects of opioid use (Wilens, Zulauf, Ryland, Carrellas, & Catalina-Wellington, 2015).

Past research has shown that, among individuals with substance use disorders who perceive a need for treatment, financial concerns are the most common barriers to treatment (Ali, Teich, & Mutter, 2017). This was true in this study population as well. These findings highlight the importance of reducing economic barriers to treatment and providing individuals with needed access to behavioral health services. The relatively high percentage of people who report stigma, treatment not a priority, and fear of involuntary treatment as reasons for having an unmet need for mental health treatment indicate the need for evidence-based information to be provided to the public about mental illness and the effectiveness of treatment.

The findings of this study should be viewed in the context of some limitations. First, the data were cross-sectional and based on self-reported responses, which might have introduced measurement error in estimating treatment utilization. However, these limitations are not unique to this study, and the NSDUH is the only nationally representative dataset that contains information on treatment utilization and barriers to treatment among those with substance use disorder and mental illness. Second, the research design did not allow estimation of causal mechanisms to understand the reasons behind treatment utilization patterns among those with co-occurring OUD and mental illness. While the study findings are an important contribution to the literature, future research might consider utilizing causal models to understand why behavioral health treatment utilization is low among this population. Third, while this study distinguished between mild/moderate and serious mental illness, it did not examine differences in specific mental health conditions (e.g., depression, anxiety) and OUD. Finally, this study focused on individuals with OUD and included those using heroin or pain-relievers together; however, future work may explore whether these sub-groups have different treatment utilization patterns.

Despite these limitations, the data presented here offer new information about behavioral health treatment utilization among those with OUD and co-occurring mental illness. Since more than half of the population with an opioid use disorder had a co-occurring mental illness, there is a need to improve coordination of mental health and substance use care for people with OUD. Many states are making efforts to expand access to and improve the quality of treatment for opioid use disorder, supported by new funding from the 21st Century Cures Act (Mutter, Patton, & Ali, 2017); these data make clear that it will be essential to ensure the coordination of these expanded substance use treatment options with mental health services.

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Appendix A

Appendix 1

Association of mental health status with utilization of substance use treatment, mental health treatment, and both treatments, among persons with opioid use disorder.

	Mental illness severity	Relative risk ratio		
		Both treatments	Mental health only	Substance use only
Adjusted[a]	Mild/moderate	3.07 (1.97–4.79)	2.51 (1.74–3.62)	1.06 (0.72–1.57)
	Serious	12.19 (7.98–18.62)	7.43 (5.06–10.93)	1.93 (1.25–2.99)
	None (reference)			

[a] Models regression-adjusted for gender, age, race/ethnicity, education, marital status, federal poverty level, employment, insurance, and metro area.

Appendix 2

Association of mental health status with utilization of substance use treatment, mental health treatment, and both treatments, among persons with opioid use disorder.

	Mental illness severity	Relative risk ratio		
		Both treatments	Mental health only	Substance use only
Adjusted[a]	Serious	4.17 (2.26–7.69)	3.22 (1.85–5.60)	2.70 (1.35–5.38)
	None	0.39 (0.23–0.67)	0.38 (0.24–0.62)	0.76 (0.43–1.35)
	Mild/moderate (reference)			

[a] Models regression-adjusted for gender, age, race/ethnicity, education, marital status, federal poverty level, employment, insurance, and metro area.

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Exhibit 3

From: Laura Adler <ladler@hopehousemd.org>
Sent: Wednesday, July 7, 2021 11:41 AM
To: Markell Wilkerson <markell.wilkerson@pascalcsi.org>
Cc: Ashly Merritt <adavis@hopehousemd.org>; Andrea Paskin <apaskin@hopehousemd.org>; Lisa Misra <lmisra@hopehousemd.org>; Gelila Paulos <GPaulos@hopehousemd.org>; Gail Ngamkhuntod <gailmn@gmail.com>
Subject: Scheduled admission times

Good Morning All,
Moving forward, we will no longer allow patients to be dropped off before their scheduled admission time. There are very good reasons (related to patient and staff safety) for why we schedule admissions at staggered times and cannot allow multiple patients to show up at the same time. While I am sympathetic to the fact that this may cause an inconvenience for the transportation staff who are dropping off multiple patients at different locations, this does not warrant compromising patient and staff safety by changing our policy. In pre-covid times, if a patient came early and was willing to wait in the waiting room for his admission to be done, this was not a safety issue. It is now, as no one is allowed into the building waiting area until after all covid results are in and we will not have patients dumped out to wait unattended on the street or in the facility parking lot. Please adhere strictly to the scheduled admission times or be prepared to have your driver wait with the patient until the patient's scheduled admission time.

Also, drivers arriving at the scheduled admission times are required to wait until the patient is actually escorted into the building by the nursing staff after they receive a negative rapid Covid result. They are not to leave the patient. Covid has inconvenienced ALL of us, and we must work together to make safety a priority, regardless of the inconvenience this causes.
Thank you all,

Laura J. Adler, BSN, RN, CARN
Hope House Treatment Center
26 Marbury Drive
Crownsville, MD 21032
410-923-6700 x 131
Cell:240-426-3015

Exhibit 4

SOR Grant CSS Provider Meeting
Minutes December 2, 2022

In Attendance: Christen Monroe (DOH), Michele Privette (DOH), Dr. Natasha Herbert (DOH), Joanne Metzger (DOH), Susan Lindley (DOH), Crystal Judy (Peers), Diane Casey (Gaudenzia), Michelle Hoyas (Gaudenzia), Markell Wilkerson (Pascal)

System, Planning & Management Updates

- SOR III – No new updates at the moment. Hopefully, more communication in January.
- New RCCs – Our new Recovery Care Coordinator, Kia Banks has started and will continue training. We're currently in the interview process for our second RCC.
- Client Access - Per the agreement, our RCCs are required to meet with all clients within 24 hours of admission, including weekends.
- CSS Provider Meeting – The CSS Monthly Provider meeting will no longer be bi-monthly. It'll now be scheduled quarterly. The next meeting is March 3, 2023.
- Against Medical Advice (AMA) v Against Agency Rules (AAR) - AMAs – Client refusing treatment and asking to leave. AAR – Simply against agency rules. Examples are threatening clients or staff, theft, drugs on premises etc.

CSS Data

- BHA Data Reports – SOR II – Add success story to monthly report starting in January. (New)
- DOH Stats – See chart below

Provider and Referral Updates

- Pascal – No updates at the moment.
- Gaudenzia – Hired a new peer that meets with WARMS clients' every day. Diane Casey has been promoted to Division Director of Crownsville. Kurt Haspert has been hired as the Senior Director of Health Services. Gaudenzia also hired a Psych NP that sees WARMS clients 4 days a week.
- Harbour House - Not in attendance.
- Crisis Response Services – Not in attendance.
- Peer Support Services – Crystal Judy reported that Jerome our SOR Peer is doing well. PEERS have a shared google drive for success stories.

Next Meeting: March 3, 2023 @ 10:00 am, via ZOOM.

				CSS OUD Dispositions					
Provider	Bed Capacity	# of Admissions	Sud Tx	AMA	Crisis Bed	E R	R H	Other (Admin, Home)	In Bed
Pascal	15	46	28	8	4	1	1	1	3
Harbour House	4	0	0	0	0	0	0	0	0
Gaudenzia	16	1	1	0	0	0	0	0	0
Totals	35	47	29	8	4	1	1	1	3

Referral Source	
Safe Stations -	4
CRS ODSOS	3
Various Tx Prov	0
CRS Other	5
DOH ODSOS	0
Self-Referral	35
Various Hospi	0
Total	47

				CSS Non OUD Dispositions					

Provider	Bed Capacity	# of Admissions	Sud Tx	AMA	Crisis Bed	E R	R H	Other (Admin, Home)	In Bed
Pascal	15	9	6	3	0	0	0	0	0
Harbour House	4	0	0	0	0	0	0	0	0
Gaudenzia	16	0	0	0	0	0	0	0	0
Totals	35	9	6	3	0	0	0	0	0

Referral Source	
Safe Stations -	2
CRS ODSOS	1
DOH ODSOS	0
CRS Other	2
Other Hosp	1
Self-Referral	3
Total	9