

SECTION III

PERFORMANCE GOALS AND ACTION PLAN

TO IMPROVE THE SERVICE SYSTEM

Adult Mental Health Plan

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ADULT PLAN

CRITERION #1: Comprehensive Community – Based Mental Health Service System

Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.

AVAILABLE SYSTEMS OF TREATMENT, REHABILITATION, AND SUPPORT SERVICES

Services Available

At this time, community-based services in the fee-for-service benefits package include:

- Psychiatric hospitals
- Psychiatric units of acute care general hospitals
- Residential treatment centers (RTCs) (children and adolescents only)
- Psychiatric day treatment (also called partial hospitalization)
- Outpatient mental health clinics (many of which provide school-based and after-school treatment programs)
- Psychiatric rehabilitation programs (PRPs)
- Residential rehabilitation programs (RRPs)
- Mobile treatment services (MTS)
- Supported living programs
- Supported employment (SE) and vocational services
- Respite care
- Residential crisis services
- Therapeutic behavioral aides
- Mental health related laboratory services

Finally, MHA also provides funds through contracts to programs that offer specialized services (e.g., mobile crisis) that do not fit the fee-for-service model. These programs are eligible to apply for funds, as are consumer support programs such as peer support programs, family support groups, consumer-run businesses, and protection and advocacy services (at least two of which are peer-run). Case management is currently contracted through the core service agencies; however, in FY 2010, MHA worked with Medicaid to amend the Medicaid State Plan and regulations for case management. Once CMS approval is received, MHA in collaboration with the CSAs and the ASO will implement and monitor the transition from contracted case management services to the fee for service system (FFS) for Medicaid recipients and uninsured individuals. **[NFC 2]**

Any provider who meets appropriate licensing, certification, accreditation, or other applicable standards is eligible to become a provider in the fee-for-service system. Eligible providers include facilities, programs, and individual practitioners. Individual

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practitioners include physicians, psychologists, nurse psychotherapists, clinical social workers, occupational therapists, and certified professional counselors who are allowed to practice independently under their Practice Acts. This increase in the provider community offers consumers an expanded choice of providers.

In addition, services such as those for individuals who are deaf or hard of hearing, involved in the criminal justice system, or have co-occurring (mental illness and substance abuse) issues are available. Examples for these specific populations are depicted on the following pages:

Services for the Deaf and Hard of Hearing. The Director of MHA's Office of Special Needs Populations, in collaboration with CSAs, works with community-based programs, the state hospital and the Governor's Office of the Deaf & Hard of Hearing (ODHH) Advisory Council to coordinate community and inpatient services for persons who have a serious mental illness (SMI) and are deaf or hard of hearing. MHA currently operates a separate unit at a State hospital for deaf consumers in need of hospitalization. The unit provides full accommodations for deaf consumers and employs a full complement of deaf mental health professionals who are fluent in American Sign Language. MHA also provides \$761,482 in contract funding to CSAs in order for 161 deaf consumers to access outpatient treatment, psychiatric rehabilitation services, case management, and residential rehabilitation services which have interpreters and/or staff fluent in American Sign Language. Additionally, limited outpatient clinic and residential rehabilitation services are available to individuals who have a SMI who are deaf or hard of hearing through the fee-for-service system.

In FY 2009, MHA chaired the mental health subcommittee for the Maryland Advisory Council for Individuals who are Deaf and Hard of Hearing and served as the Department of Health and Mental Hygiene's representative on the Maryland Advisory Council for Individuals who are Deaf and Hard of Hearing. MHA continued to work with the ODHH Advisory Council to explore alternative technological approaches, i.e. remote video interpreting, telepsychiatry, and the development of strategies to improve access to outpatient treatment and housing for individuals who have SMI who are deaf or hard of hearing. Also in FY 2009, MHA provided technical assistance and supports to Mid-Shore Mental Health Systems to develop and provide eight trainings through Gallaudet University to enhance treatment providers and others knowledgeable in working with individuals who are deaf or hard of hearing. Six of the trainings were provided in FY 2009. Training topics include: Substance abuse among deaf and hard hearing people, hearing loss in later years; child abuse and neglect among deaf and hard of hearing children; measuring effective clinical practice with deaf and hard of hearing consumers; challenges growing up deaf; and parents and the school system. The trainings are available on Gallaudet University Website with captions.

Additionally, the Office of Special Needs Populations partnered with the University of Maryland, School of Psychiatry to submit an application for funding to the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) to develop a Center of Excellence on Telemental Health for

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Special Needs Populations. If funded, the University of Maryland's School of Psychiatry will provide culturally competent treatment services to individuals who are deaf or hard of hearing in rural areas and provide training and consultation to transition consumers to the community from inpatient hospitalization.

Services for Individuals in the Criminal Justice System. In 1995, the U.S. Department of Housing and Urban Development (HUD) awarded MHA a five-year, \$5.5 million Shelter Plus Care grant to provide housing for individuals who are homeless with serious mental illnesses (with or without accompanying substance abuse) and their dependents, who are being released from the detention center or are in the community on the intensive caseloads of parole and probation. Last year, the FY 2009 Shelter Plus Care Housing grant was renewed for \$3,862,442, which includes \$592,916 through five small grants targeted to seven specific jurisdictions. The jurisdictions awarded the five-year grants were Allegany, Anne Arundel, Baltimore, Cecil, Frederick, Harford, and Prince George's Counties. Effective July 1, 2009 (FY 2010), MHA was awarded funding in the amount of \$3,306,900 for 16 Shelter Plus Care renewal grants and \$513,678 through the five small grants. Currently, MHA is serving a total 653 persons - 147 single individuals with mental illnesses, 172 families with 281 children, and 53 other family members through all of the Shelter Plus Care programs.

The Maryland Community Criminal Justice Treatment Program (MCCJTP), with total state funds of \$1.9 million, supports specific programs targeted at adults 18 years of age and older with SMI in detention centers. The development and delivery of care extended to these individuals is rooted in two key principles: 1) create a continuum of care by providing a variety of services by mental health professionals working within the jail and in the community; and 2) develop a local advisory board to conduct a needs assessment particular to the jurisdiction. In FY 2009 the MCCJTP operated in 22 Maryland counties and received a total of 7,000 referrals from which 6,300 received treatment. Program reports identify 30,200 clinical hours and 22,171 case management hours. Units of service are defined in this document as finite time of service/support provided through psychiatry, psychotherapy, or case management. While MCCJTP is unable to track recidivism from county to county until information technology is in place, the current recidivism rate is estimated to be five percent (5%). Baltimore City recidivism is reported separately under the FAST program. (See the following discussion.)

In addition to working with the counties, MHA continued to partner with Baltimore City to provide post-booking aftercare planning through the Forensic Aftercare Services Team (FAST). In FY 2008 FAST screened more than 1,000 individuals for program appropriateness.

Maryland's efforts to address the issues of individuals with mental illnesses in the criminal justice system were also driven by legislative action which led to the establishment of various workgroups. In FY 2007, a "think-tank" was established in response to House Bill (HB) 990/Senate Bill (SB) 960 charged with exploring issues targeted at "breaking the cycle of re-arrest and re-incarceration" for individuals with

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mental illnesses. The “think-tank” worked with corrections, mental health, substance abuse, consumer and advocacy groups, and other key stakeholders and developed a survey to gather data on the number of individuals with mental illnesses involved with the criminal justice system. Data focused on services currently available for individuals involved in the criminal justice system, services needed, cost of the services needed, and recommendations to improve access, quality and the scope of services. The survey was distributed to State and the local correctional facilities in Maryland. In FY 2007, MHA and the workgroup submitted a final report of the findings from the survey.

The Mental Health Transformation Office (MHTO) continues to move forward in supporting efforts that will create a continuum of care for persons with mental illnesses who also have involvement with the criminal justice system. House Bill (HB) 281 required that a work group be developed to address these concerns. The HB 281 Workgroup included representatives from the Department of Public Safety and Correctional Services (DPSCS), Mental Hygiene Administration (MHA), Department of Health and Mental Hygiene (DHMH), Department of Human Resources (DHR), and mental health, legal, correctional, social service, and mental health consumer and advocacy communities. The Workgroup, currently referred to as the Mental Health and Criminal Justice Partnership (MHCJP), started meeting in June 2007 and prepared a report with recommendations, which was submitted to the legislature in January 2008. Also, the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council, in collaboration with the Mental Health & Criminal Justice Partnership and the Interagency Forensic Services Committee, continued to promote the development of services including early intervention, diversion, and re-entry for individuals with mental illnesses who encounter the criminal justice system. Additionally, in accordance with HB 281, 2007 Legislative session, MHA submitted a report detailing its plan to enter into memoranda of understanding with local detention centers to establish a data sharing initiative. The data sharing initiative, DataLink, provides for the transmission of arrestee’s names from the detention center to MHA’s Administrative Service Organization (ASO). The ASO will then compare the names and other identifiers to the list of consumers receiving services from the Public Mental Health System (PMHS). A list of names that match will be forwarded to the local CSA so that with the arrestee’s permission, clinical information may be shared with the Detention Center. The first DataLink was established in January 2007, linking the ASO, Baltimore Mental Health Systems, and DPSCS (as the recipient and operator of the Baltimore City Detention Center). HB 281 required the state to develop a plan to expand the data sharing initiative to other jurisdictions.

In FY 2009, MHA’s Office of Forensic Services in collaboration with the Mental Health & Criminal Justice Partnership will continue to provide support for services to individuals in the criminal justice, judicial and PMHS regarding community psychiatric services for inmates with mental illnesses upon release and the development of diversion services. [NFC 2]

MHA also provides state general funds for a program which provides treatment for incarcerated men and women who have histories of trauma and also have mental

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illnesses. The inmates may also have a co-occurring substance abuse disorder. The TAMAR (Trauma, Addictions, Mental health, And Recovery) program served more than 615 individuals in FY 2009 with a combination of services to include individual and group counseling, grief counseling, and case management. The project is available in nine county detention centers: Anne Arundel, Baltimore, Caroline, Dorchester, Frederick, Garrett, Howard, Prince George's and Washington Counties and at Springfield Hospital Center. Integrated within TAMAR are HIV/AIDS risk awareness and prevention strategies. In July 2008, MHA was awarded the H.O.P.E. award from the Substance Abuse and Mental Health Services Administration' (SAMHSA) National Center for Trauma Informed Care for the state's leadership in providing trauma-informed care and the TAMAR Program. [NFC 5]

In FY 2009 MHA, in partnership with MHTO, applied for funding from SAMHSA to develop a jail diversion and trauma recovery program for veterans suffering from post-traumatic stress disorder (PTSD) and other trauma-related disorders. If funded this grant will develop a pilot program in Baltimore City, Baltimore County, and the Mid-Shore counties to divert veterans from the criminal justice system, educate veterans about available services, provide trauma treatment, organize linkages to community resources, unite veterans with family, and re-integrate veterans into services.

In 2007, Maryland-produced a documentary film, "Behind Closed Doors," which highlights the impact of trauma on the lives of four women. Their compelling stories of recovery offer hope and demonstrate the potential for trauma-informed, innovative programming. This nationally recognized film was produced by the Maryland Disability Law Center with support provided through Maryland's Alternatives to Seclusion and Restraint Project, funded by a SAMHSA grant. The four individuals featured in the film have experienced childhood trauma and re-traumatization in psychiatric hospitals through forced drugging, isolation, or restraints. Three of the women are now leading successful, productive lives in the community with their children. The film has received wide recognition among advocates, administrators, and mental health professionals and spurred forward the movement to eliminate psychiatric abuses. In 2007, it was nominated by SAMHSA for the Voice Award. The National Technical Assistance Center has incorporated the film into their national and international trauma-informed care trainings for publicly funded institutions.

The majority of the women with co-occurring disorders in the criminal justice system have children and a smaller population is pregnant while incarcerated. MHA was instrumental in developing and implementing the TAMAR's Children Program. Pregnant women who were incarcerated or at risk of incarceration in local detention centers and the Maryland Correctional Institute for Women (MCIW) became eligible for this program. The TAMAR's Children Program was initially funded through a SAMHSA Targeted Capacity Expansion grant program known as Building Healthy Communities, the Department of Housing and Urban Development (HUD) program (additional Shelter Plus Care), a Department of Justice Residential Substance Abuse Treatment grant, local and state in-kind service commitments, and private foundation funding.

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The program, as originally constructed ceased operation near the close of FY 2006. However, involved agencies remained committed to serving this population. In 2007, MHA collaboratively worked with the Department of Public Safety and Correctional Services, the Administrative Office of the Courts, the Alcohol and Drug Abuse Administration, the Family Health Administration, Baltimore Mental Health Systems, Inc. and the Archdiocese of Baltimore to create a new statewide diagnostic and transitional program for pregnant women who are at least 18 years of age who might otherwise be incarcerated. As a result of this collaborative partnership, a new program named, the Chrysalis House Healthy Start Program was created. This program, funded through state general funds, consists of a 16-bed diagnostic and transitional facility (in the former location of the Tamar's Children Program) for pregnant and post-partum women and their babies. Pregnant women are referred by the court, the state, Defense Attorney, or DHMH. A comprehensive assessment is conducted by a licensed clinician and an individualized treatment plan is developed between each woman and the treatment team. After the newborn's birth, the mother and baby remain in the residential facility and receive a comprehensive array of services. Services include medical care through contract with a health care organization, mental health treatment which includes trauma and attachment-based treatment interventions, substance abuse treatment and co-occurring treatment services, legal services, parenting and childcare services which includes involvement from the Healthy Start and Family Tree Programs, housing, after-hours residential support, health education, and other support services.

In FY 2009, nine (9) women graduated from the Chrysalis House Healthy Start (CHHS) Program and moved into permanent housing with community supports. Five of the nine women who graduated continue to receive treatment at CHHS on an outpatient basis. Two of the women who graduated became employed and one entered college.

Services for Individuals with Mental Illness and Substance Abuse. Under the HealthChoice program, managed care organizations (MCOs) provide enrollees with somatic care and, when needed, substance abuse treatment.

In the past, Maryland has emphasized cross-training of staff and coordination of services as a means of providing access to services by individuals needing both mental health and substance abuse services. A number of existing mental health treatment and rehabilitation programs, as well as programs established through the DHMH Alcohol and Drug Abuse Administration (ADAA), have developed dual diagnosis capability and are able to offer substance abuse treatment services to individuals with mental illnesses. MHA, in collaboration with ADAA, sponsors a program for the treatment of co-occurring disorders. The program is operated by a private provider, Second Genesis, in a 16-bed unit on the grounds of the former Crownsville Hospital Center. Specialized hospital programs have been developed at Upper Shore Community Mental Health Center and Springfield Hospital Center.

For the past six years, various CSAs in Maryland have started to build an integrated system of care for individuals with co-occurring mental health and substance use disorders. Based on the findings of the "Consumer and Family Workgroup" of the

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National Consensus Panel, there are five criteria that are necessary for services to effectively address the needs of this population of consumers:

1. Welcoming
2. Accessible
3. Integrated
4. Continuous
5. Comprehensive.

The counties that appear to have demonstrated the most progress are those who have developed a system of care utilizing the Continuous, Comprehensive, Integrated System of Care (CCISC). This model has provided an opportunity for local jurisdictions to implement change within the multiple relevant agencies that usually provide services for this population through the formation of local Leadership or Steering Committees. The overarching goal is to create a system of care with “No Wrong Door”.

MHA continues to address the challenge of how to implement evidence-based practices to improve services for individuals with the co-occurring disorders of mental illness and substance abuse. In FY 2008, MHA continued multiple collaborations with DHMH to promote integrated treatment for consumers with co-occurring disorders at the local level. Currently representatives from MHA and DHMH regularly meet with county leaders to provide assistance and support for regional initiatives. MHA has also supported and encouraged the use of the “Comprehensive, Continuous, Integrated Systems of Care” (CCISC)” model as developed by Kenneth Minkoff, M.D. and Christie Cline, M.D. and has provided technical assistance to local jurisdictions. Worcester, Montgomery, Anne Arundel, Baltimore, Prince George’s, and St. Mary’s Counties are currently involved in strategic planning processes. [NFC 5]

Recognizing national data reflecting that approximately 50% of individuals with a mental illness will experience a substance abuse problem during their lifetime, MHA has identified a need for Dual Diagnosis Capability (DDC) throughout the PMHS. To further develop MHA’s vision for DDC throughout the PMHS, MHA has expanded the University of Maryland’s Evidence Based Practice Center’s (EBPC) training and consultation program. The EBPC hired a co-occurring disorder (COD) expert as the Consultant/Trainer for this initiative. The trainer provides ongoing technical assistance related to CCISC by drawing from the experiences and lessons learned during the earlier implementation period.

In March 2008 MHA advised all core service agency directors on MHA training initiative for consumer with co-occurring mental health and substance use disorders. MHA had adopted regulations requiring the use of evidence-based screening and assessment practices for individuals with CODs who appear in outpatient mental health clinics. MHA held several meetings with stakeholders to discuss the implementation of the Evidence-Based Practice of Integrated Dual Disorders Treatment (IDDT). As a result, the MHA has decided to roll out a three-stage plan, to expand the capacity for COD services system wide. Through this process, each jurisdiction will ultimately be

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able to inventory where they are in the delivery of services for the highly prevalent population of individuals with co-occurring disorders, and to subsequently gain technical assistance to further the development of appropriate services. A comprehensive discussion of Maryland's efforts to disseminate evidence-based practice in co-occurring disorders is presented in criterion five under Workforce Development.

An important development in the provision of co-occurring services to individuals with mental illnesses and substance disorders was the Substance Abuse and Mental Health Services Administration (SAMHSA) grant awarded to provide substance abuse and mental health services for people who are homeless. The grant will enable communities to expand and strengthen their treatment services for individuals who are homeless with substance abuse disorders, mental illness, or co-occurring (substance abuse disorders and mental illness). In Maryland, People Encouraging People, long a leader in mental health services and outreach to the homeless in Baltimore City, was awarded \$400,000 per year for five years to create a comprehensive dual-diagnosis treatment program for persons who are homeless and have substance abuse and mental health problems.

Within the Department of Health and Mental Hygiene, new legislation has established the Office of the Deputy Secretary for Behavioral Health and Disabilities. This position supervises three administrations: Alcohol and Drug Abuse, Developmental Disabilities and Mental Hygiene. The Office will expand the development of a system of services for individuals with co-occurring disorders to include not only substance abuse and mental health, but also developmental disabilities and somatic care. The Office will also look at forensic issues, with the goal of addressing systems change and implementing treatment and supports.

Housing for Adults with Psychiatric Disabilities

Housing that is affordable, accessible, and integrated in the community is a major factor in enhancing the recovery of persons with serious mental illnesses (SMI). Toward this end, MHA actively collaborates with the Maryland Department of Housing and Community Development (DHCD), federal Housing and Urban Development (HUD), county housing authorities, local housing coalitions, and county agencies as well as non-profit developers and mental health providers. These partnerships promote access to housing development that is affordable with assistance from specialized government-supported housing opportunities. DHCD is represented on the Joint Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council.

To assure that consumers of mental health services have a continuum of housing and other residential options, MHA encourages the CSAs to work with local housing authorities and housing developers to develop affordable and safe housing in their regions. This has resulted in extensive partnerships to provide consumers with affordable housing and rental subsidies along with accompanying support services as needed and requested by the consumer. Providers of residential rehabilitation services with CSA support have submitted applications for HUD 811 that comes with designated Flexible Housing Choice Vouchers. However, due to changes in the federal budget priorities and

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the increase cost of all housing, access to new housing vouchers for individuals with disabilities has been limited. Currently, MHA is collaborating with other organizations to respond to new federal housing initiatives. Despite this, MHA will continue to work with CSAs to expand mainstream rental opportunities that enhance affordable housing options for individuals with SMI. At the provider level, many mental health providers have also helped consumers successfully pursue rental assistance for three years through the Bridge Subsidy Pilot Program, Housing Choice Vouchers and other local rental assistance services. The Bridge Subsidy Pilot Program began in January 2006 in several counties around the state including the eight Eastern Shore and two Western Maryland counties. Currently the Bridge Subsidy program is providing rental assistance to more than 65 consumers with mental illnesses across disabilities in more than 16 counties. The Bridge Subsidy program overall has provided rental assistance for 97 individuals served by end of FY 2009, with 14 individuals moving from residential rehabilitation programs (RRPs) to independent housing. [NFC 2]

Additionally, MHA has encouraged and provided some financial incentives to establish non-profit housing development entities. Many of these entities, as well as mental health provider organizations, have developed affordable housing through community bond grants through Maryland's DHMH's Administration-Sponsored Capital Program. MHA has identified housing as its priority for receipt of these bond monies. Several of this year's Capital Program awards addressed this priority. [NFC 2]

MHA continues to fund Main Street Housing, Inc., a consumer-operated project, whose mission is to enable consumers with limited income to live in the least restrictive setting. Main Street Housing, a subsidiary non-profit corporation of On Our Own of Maryland, is dedicated to providing decent, safe, and affordable housing to persons with psychiatric disabilities. Main Street Housing is now designated as a Community Housing Development Organization (CHDO). Under the MHT-SIG grant, they are developing a tracking system of housing outcomes, so that mental health services can be offered to consumers when their housing is in jeopardy.

Main Street is located in the following counties: Allegany, Washington, Frederick, Howard, Harford, Queen Anne's, Talbot, Caroline and Dorchester counties. The program supports 14 buildings with 26 units and 51 tenant slots of which there are 5 additional participants who are children living with parents. Total number served is 56.

Other partnerships with mainstream housing developers, Community Housing Development Organizations (CHDOs), and other non-profit housing agencies have also produced a steady growth in affordable housing:

Examples include:

- Baltimore City: Community Housing Associates, Inc. (CHA), a private, non-profit housing development agency, provides low-cost housing for individuals with psychiatric disabilities through an innovative combination of grants, loans, and tax incentive programs. CHA now owns a total of 87 units that provide housing for 163 individuals and 78 families (88 adults and 97 children). In addition, CHA administers 161 Shelter Plus Care certificates. CHA works with

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the Baltimore Mental Health Systems (BMHS) to provide case management and other supports to help consumers remain in their own homes.

- Anne Arundel County: Supported Housing Developers, Inc. (SHD), a non-profit agency, currently operates 35 units/residences providing housing with the potential of serving 60 individuals (currently housing 53 individuals). SHD maintains a landlord – tenant relationship and encourages occupants to exercise choice about participation in mental health programs. Psychiatric rehabilitation programs (PRPs) in the county provide, to the extent needed, support services to the consumers.
- Montgomery County: Housing Unlimited, Inc. (HUI), a CHDO formed by the Montgomery County chapter of the Alliance on Mental Illness, maintains a landlord-tenant relationship with each resident, who may elect to receive mental health services from a local provider of his or her choice. Currently, 39 residences provide housing to 118 tenants (adults) in scattered-site housing throughout the county.
- MOSAIC, Inc. and its housing subsidiary, ReChodo, Inc., provide housing for 78 individuals in 25 residences in suburban Baltimore County, Baltimore City and Carroll County.
- Turning Point in Washington County reports that they are providing supportive housing to seven individuals in four apartments. Tenants have the option to access mental health services through a variety of community resources.
- Way Station in Frederick County supports 20 housing units that provide housing to 28 individuals. Way Station is also providing five supportive housing units in Howard County that serve six tenants. Individuals in each county can choose to access mental health services through a variety of community resources.

Currently, in collaboration with the MHTO, MHA has contracted and received a report from the Technical Assistance Collaborative, Inc., (TAC), a Boston consulting agency to obtain an assessment of current housing programs, funding resources and recommendations for inclusion in a housing plan for future improvements and expansion of housing opportunities for priority consumer groups, including individuals with mental illness or with co-occurring mental illness and substance abuse disorders. The plan will maximize funding (including DHMH's Administration-Sponsored Capital Program grant community bond) from federal, state and local funding sources to expand housing opportunities for individuals with mental illnesses. The recommendations will integrate MHA's plans with HUD, DHCD and DHMH Office of Capital Planning demonstrations. Additionally, DHMH, DHCD and the Department of Disability (DOD), jointly developed a strategic plan for the development of affordable independent housing for persons with disabilities, specifically those with SMI and those with a developmental disability. The plan includes recommendations and strategies to maximize utilization of existing

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resources, efforts to generate rent subsidies and approaches to overcome barriers to development of housing.

MHA has long funded residential rehabilitation programs (RRPs), which are programs that offer residential services to persons with SMI in need of intensive services and supports to eventually integrate into the community. Expansion of RRP beds in the last several years has been targeted to specific initiatives. Currently there are 2,470 RRP beds in the system. As noted in the MHBG Performance Indicator, a total of 3,908 individuals with SMI received RRP services and a total of 4,081 adults had claims submitted for RRP services. MHA continues to encourage the expansion of the supported living model through which individuals with psychiatric disabilities may access an array of flexible service delivery programs, including PRPs, case management and other supports to enable them to live in housing of their choice. In this model, consumer housing is not dependent on the receipt of services. Persons with SMI also access housing through licensed assisted living providers located throughout the state.

Vocational and Educational Opportunities

MHA has prioritized increasing employment opportunities for individuals with psychiatric disabilities as an important role of the PMHS. MHA and the Division of Rehabilitation Services (DORS) have a Memorandum of Understanding between the state agencies to promote employment for individuals with mental illnesses through training and increased collaboration. MHA staff meets regularly with DORS staff to promote collaborative relationships at both the system level and the individual level toward the evolution of a more cohesive, integrated, and seamless system of services for individuals with SMI who desire successful employment experiences. Budgetary shortfalls had led to an extensive waiting period for DORS-funded vocational services and its temporary closure in FY 2008. However, efforts of mental health advocacy groups, the Maryland Advisory Council on Mental Hygiene/ Planning Council, and other stakeholders resulted in a legislative approval of an increase in DORS budget that led to a reopened and period reduction of the waiting list. Supplemental federal funding through the American Recovery and Reinvestment Act of 2009 has assisted DORS in avoiding the placement of eligible individuals with the most significant disabilities on the waiting list for services.

MHA, in collaboration with the DORS, launched its Evidence-Based Practice (EBP) in Supported Employment Initiative in 2002. Throughout the Initiative, Maryland has consistently ranked first or second, among states participating in the National EBP Project, in the rate of competitive employment achieved across existing EBP sites. In FY 2004, MHA and DORS received the Crystal Award from the Johnson & Johnson Foundation for the production and filming of an employer-focused job development video in Maryland, sponsored and underwritten by the New Hampshire-Dartmouth Psychiatric Research Center and the Johnson & Johnson Foundation. In 2007, MHA was awarded the Science to Service Implementation Award for the dissemination and implementation of Evidence-Based Practice in Supported Employment (SE) in Maryland. [NFC 5]

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MHA has worked with the EBPC and other national researchers on dissemination materials and implementation protocols for EBP in SE. As noted in the Adult- Goals Targets and Action Plans section for the Indicator: Evidenced based – Number of Practices, supported employment is provided through 51 programs statewide and 2,051 adult consumers received services in FY 2008. Thirty of these programs are participating in the evidence-based practice project in supported employment with 15 achieving fidelity in FY 2009. It is anticipated that 3 more will achieve fidelity in FY 2010. The EBP Initiative is also developing supported employment outcome measures and data collection methods for implementation across all sites.

This year, MHA has used three distinct training modalities: one with the existing Consultant and Trainer at the University of Maryland Evidence-Based Practice Center (EBPC), one through identified Training Resource Programs (TRPs); and one through a Collaborative Learning Implementation Process (CLIP) approach. TRPs are established SE programs which have already been effectively trained in the EBP service approach and which have consistently met all of the requirements to be a model supported employment program (SEP). In the second approach, the TRPs have provided a mechanism for the ongoing training and technical assistance in the EBP in Supported Employment (SE) service approach to newly selected SEPs. Access to model TRPs provide collegial support, resource and information sharing, job shadowing, and expert consultation from experienced staff who have been involved in all phases and at all levels of EBP in SE implementation. The third approach is a condensed three-month learning collaborative that incorporates effective features of the two earlier training modalities and is designed to build a community of practice. It is MHA's expectation that this latter training approach will impact greater numbers of programs and their staff.

Under the PMHS, SEPs are reimbursed for providing authorized services during each phase of the individual's course in the program. MHA reimburses for: 1) pre-placement services, including vocational assessment, referral to DORS, service planning, education regarding entitlements and work incentives, and job placement; 2) intensive job coaching, if not otherwise reimbursed; and 3) extended support, at a monthly rate. A new unified supported employment referral, application, authorization, and eligibility determination protocol has been implemented to create a more seamless transition to DORS services upon entry to supported employment within the PMHS. With this new protocol, individuals who are eligible for PMHS services, and meet eligibility criteria for supported employment, will be automatically presumed eligible for DORS services and prioritized for DORS funding. Vocational rehabilitation plan development, job development and placement follow immediately, thereby expediting supported employment service provision across the two systems, streamlining and eliminating duplicative administrative processes, and reducing the paperwork burden for DORS counselors and providers. Additionally, supported employment services are available for older adolescents. MHA and DORS work collaboratively to foster an understanding of the needs of youth with psychiatric disorders.

In FY 2004, MHA combined rates and simplified the rate structure for SEP services. In addition, MHA initiated a new service and rate for Psychiatric Rehabilitation

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Program (PRP) services delivered to individuals receiving SEP services, increasing the overall reimbursement level for SE services. In FY 2007, MHA has developed incentives within its rate structure to promote the use of the evidence-based practice (EBP) model of SE. Programs currently implementing the practice, which have been trained through one of the various training options and which have achieved adherence to the practice, as evidenced by meeting or exceeding certain MHA defined criteria on a SE fidelity assessment, are paid a higher rate for these enhanced services than those programs who have not met such criteria. This includes reimbursement for clinical coordination to integrate supported employment efforts with mental health treatment.

In Maryland, 70 per cent of the current vocational programs have successfully converted to the SE EBP. This has been due to the strong relationship between MHA and the state vocational rehabilitation service, DORS under MSDE. Each agency has displayed a commitment to assist individuals with mental illnesses to develop, to attain, and to maintain successful employment. [NFC 5]

The federal Ticket to Work and Self-Sufficiency Program was authorized by the 1999 Ticket to Work and Work Incentives Improvement Act. The program has been phased in across the states and the program is now fully available in Maryland. Under the auspices of this Act, Social Security beneficiaries are eligible to receive a ticket to purchase vocational services from an identified Employment Network (EN). An EN is any qualified entity which has entered into an agreement with the Social Security Administration (SSA) to provide coordination and delivery of employment, vocational rehabilitation, and other support services to eligible beneficiaries in a designated service area. Services may be provided directly to the beneficiary or by entering into agreements with other organizations. MHA plans to implement a demonstration project, under the auspices of the new Ticket To Work regulations which connects selected core service agencies (CSAs) - Harford County, Anne Arundel County, and Baltimore City CSAs- and the respective supported employment programs within those jurisdictions, into a single EN consortium. The Ticket program complements the focus on integrated, competitive employment and encourages long-term career development by requiring that SEPs assist individuals to achieve significant levels of earnings. The Ticket Program is an opportunity to reward SEPs for the successful outcomes that they are already achieving and to create incentives to strengthen their ability to support more individuals in competitive employment and at higher levels of wages and hours worked.

A committee formed by DHMH, in collaboration with the Coalition for Work Incentives Improvement and other stakeholders, has continued implementation of a Medicaid Infrastructure Grant. The goal of the grant is to develop the needed infrastructure and operational capacity to permit employed individuals with disabilities to attain and preserve access to Medical Assistance (MA) upon employment. The committee continues to meet monthly with MA's Office of Planning and Finance to coordinate activities to expand and promote a Medicaid Buy-in option for other Medicaid beneficiaries who choose to return to gainful employment. This program, the Employed Individuals with Disabilities (EID) Program began in FY 2007. In FY 2008, a total of 455 consumers received training on the Employed Individuals with Disabilities (EID)

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program. EID enables consumers to return to work and continue to qualify for Medicaid by paying monthly premiums ranging from \$0 to \$55, depending on the level of countable income. MHA works with On Our Own of Maryland to implement provider-specific and consumer-focused workshops on the EID program. This program is offered to all supported employment sites, psychiatric rehabilitation programs, NAMI affiliates, and On Our Own affiliates. [NFC 2]

During the 2010 fiscal year, OOOMD's certified community work incentives coordinator (CWIC) will provide individualized, one-on-one benefits counseling to consumers utilizing their Social Security Ticket at the Ticket to Work sites that are part of the Maryland Mental Health Employment Network. This pilot benefits counseling is part of a larger statewide initiative within MHA and DORS to build the technical capacity of Evidence-Based Practice (EBP) supported employment providers statewide to facilitate employment-centered benefits counseling and advisement services which encourage individuals with psychiatric disabilities to return to work and to maximize their employment potential by maintaining needed benefits and access to health insurance. On the basis of converging empirical evidence from multiple experimental studies, benefits counseling has recently been added as the seventh core EBP principle for the effective implementation of EBP SE. Studies indicate that consumers who receive SE and specialized benefits counseling achieve significantly greater earnings from employment than those who receive SE alone.

In particular, this initiative is designed to assist consumers to: recognize that competitive employment is a viable possibility by explaining to consumers in one-on-one sessions with a certified benefits counselor precisely how employment will affect their benefits; and provide hands-on assistance in accessing available work incentives, as needed. A Benefits Counselor will be in residence at each site for a pre-determined number of hours or days per month, depending on the needs of the agency. In addition to benefits counseling, OOOMD will implement a 90-120 minute workshop about SSI, SSDI, and work incentives for both staff and consumers at the Ticket to Work sites as well as the Wellness and Recovery centers throughout the state.

Access and linkage to educational services are primarily managed through Psychiatric Rehabilitation Programs (PRPs). The rehabilitation assessment includes review of the individual's strengths, skills, and needs for education and vocational training. Based upon the assessment, the individual rehabilitation plan includes a description of needed and desired program services and interventions and, when appropriate, identification of, recommendations for, and collaboration with other services to support the individual's rehabilitation. Some PRPs offer GED programs within their own service continuum, while those who do not have developed the necessary linkages to refer consumers to classes offered elsewhere. Community colleges and local universities in many counties are sites for higher education and a spectrum of low cost/subsidized programs (both federal and state subsidies) are available to individuals with disabilities. Many PRPs utilize a "supported education" model, supporting the consumer in his/her choice and pursuit of education in the community at large. [NFC 2]

Consumer and Family Involvement

Maryland has a rich tradition of an ongoing commitment to consumer and family involvement in planning, policy and program development, and evaluation. MHA has encouraged the input of advocates on all levels. As previously discussed in Section II, Maryland is proud of its commitment to system transformation and maintains a focus on consumer and family involvement to assure that services are continuously examined and redesigned to best support recovery and resiliency. MHA, in collaboration with the Maryland Mental Health Transformation Office (MHTO), has made a number of significant investments in promoting consumer-driven care through several specific programs/initiatives.

The MHA Office of Consumer Affairs (OCA) participates in systems level activities at all pertinent MHA meetings. This past year MHA, in collaboration with the CSAs has supported On Our Own of Maryland's (OOOMD) initiative to transform its consumer network toward a wellness and recovery-oriented system, including enhanced peer support activities and the use of best practices within the community. The Wellness Recovery Action Plan (WRAP) was introduced into all Wellness and Recovery centers as a model for peer support. In the last year, 135 people have participated in the 3-day introductory WRAP training and have completed a personal Wellness and Recovery Action Plan. The training was successful in engaging consumers and assisting providers in planning for mental health recovery. Additionally, three 2-day and two 1-day sessions were held. To date, 63 consumers are trained as certified WRAP facilitators. WRAP is transformational in that it supports consumer-driven care.

OOOMD, in collaboration with MHA, continues to conduct workshops and trainings through their Recovery Training Project (formerly the Advocacy Training Project). An emphasis on Recovery is a crucial element of a consumer-driven mental health system, capitalizing on consumers' individual strengths and communicating a message of hope. MHTO contracted with OOOMD, to provide training to adult psychiatric rehabilitation programs (PRPs), outpatient mental health clinics (OMHCs), and consumer groups as a step in a longer term effort to assist Maryland's Public Mental Health System (PMHS) to begin or continue to incorporate practices based on recovery into their agencies. Three Workshops have been developed within this project to include "Motivational Vitamins", a workshop that provides information on workforce issues and provides information to help participants to work through common hesitations about entering or re-entering the workforce. "Discovering your Recovery Muse", which approaches recovery from a non-traditional angle introduces participants to better health through various creative processes such as art, dance, music, and writing; which they can use to enhance their recovery. This workshop in FY 2009 reached 201 participants. A third workshop entitled, "Steps to a Healthier You", is designed to motivate and inspire participants to make smarter choices about nutrition, increase physical activity, and develop helpful habits. In FY 2009, this workshop reached 335 participants

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The Consumer Affairs Liaison within the Office is involved in coordinating and implementing the Leadership Empowerment Advocacy Project (LEAP). This project has been funded by the MHA since 1990. A major goal of LEAP is to expand the number of consumers playing a prominent role within state and local policy-making bodies. Through participation in LEAP, consumers acquire the necessary skills to become leaders and advocates within the PMHS. LEAP also teaches skills that enhance the participants' ability to direct peer support groups and to hold other consumer-related positions within the state. In FY 2009, the Office of Consumer Affairs offered LEAP to 12 graduates with training on both the state level as well as the federal level allowing them to receive hands on experience within MHA and legislative advocacy as a continuation of their training. LEAP graduates continue to be in high demand for advisory boards, employment and other leadership roles throughout the state. The future goals of the LEAP internship program will be expanded to include placements at state and federal agencies.

The Maryland Consumer Leadership Coalition (MCLC) was created by MHA's Office of Consumer Affairs (OCA) in FY 2008. The MCLC is comprised of leaders in the consumer movement from diverse cultural and organizational backgrounds who work as mental health advocates at the state and national level. Its long-term goals include facilitating leadership and involvement of consumers in their mental health treatment in every jurisdiction, and preparing them for the responsibility of partnering with mental health professionals and administrators in shaping the mental health system in Maryland. Workforce development strategies will be implemented in collaboration with Johns Hopkins Sars Levitan Center and MHTO. An employee will be hired to handle administrative responsibilities and a possible statewide workforce development summit has been planned for FY 2010. This summit will focus on workforce development for consumers of mental health services to create viable and meaningful employment and will emphasize what recovery looks like in Maryland. The summit is expected to accelerate the transformation of the mental health system by sustaining and strengthening the role of the MCLC and engaging more consumers in the workforce development process.

MHA and its local CSAs have been instrumental in encouraging the development of local advocacy organizations throughout Maryland. In FY 2009, an annual meeting of the CSA directors and the directors of Wellness & Recovery centers was established to increase effective communication and develop cohesive strategies to enhance the recovery process. There are 25 Wellness and Recovery centers (formerly known as drop-in centers) in Maryland. Twenty-two of those centers are affiliates of OOOMD. Many of these centers address co-occurring disorders of mental illness and substance abuse within their programming. Many other consumer-run support groups are held in the centers on a regular basis. There will be an increased focus on the involvement of the Wellness and Recovery centers in surrounding community organizations and activities to allow the centers and their members to become active members of the greater community.

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OOOMD and MHA continue to collaborate to fight stigma within the mental health system through the Anti-Stigma Project (ASP). The ASP uses workshops to help participants identify stigmatizing behaviors and attitudes as well as possible solutions, communication techniques, and actions as vehicles for change. Workshops may be designed and tailored to address specific populations and situations such as issues related to cultural competency, housing, co-occurring disorders, and the reduction/elimination of seclusion and restraint. Workshops are presented in many educational settings, as well as several local Wellness & Recovery centers. OOOMD continues to receive requests for the teaching videotape, "Stigma...In Our Work, In Our Lives", which is now being used in more than 39 states and four other countries. Additionally, there are several requests for "Stigma: Language Matters" posters. In FY 2009, the ASP presented 51 workshops throughout the state in a wide spectrum of venues, such as housing authorities, homeless shelters, and statewide conferences and universities. Eight hundred and eighty-two people were trained in the full program and reached at least 1,330 more participated on various levels. A new workshop has been added on internalized stigma, "An Inside Look at Stigma," as well as a workshop on creating non-stigmatizing environments. Once again, all of the workshops this year were extremely well-received, with 97% of participants rating the workshops "excellent" or "good". Ninety-seven percent rated the facilitators "excellent" or "good," and 93% said they would recommend this workshop to others. Work is continuing with international researcher Dr. Patrick Corrigan to establish quantitative measures that will augment the voluminous amount of anecdotes showing the effectiveness of the workshops. This year three new facilitators were trained and four articles on stigma were written and published. [NFC 1]

MHA, in partnership with OOOMD, developed a project under the federal Olmstead Planning Grant titled the Olmstead Peer Support Program. Three Peer Support Specialists (PSS), who are also, WRAP facilitators, worked part-time with patients in three state facilities: Springfield Hospital Center, Eastern Shore Hospital Center, and Finan Hospital Center. In FY 2009 a total of 118 consumers in state hospitals were seen by the PSS staff. During this quarter the PSS contacted a total of 44 new individuals. The PSS staff facilitates consumer discharges and provides ongoing support during the consumers' transition into the community. PSS staff also provided help and referrals to Wellness & Recovery centers, CSAs, and other organizations that work to enhance recovery. MHA and OOOMD are working with state hospitals to continue to develop procedures to ensure the continued success of the program.

MHA and the Mental Health Transformation Office (MHTO) implemented a consumer self-directed care pilot program in Washington County managed through the local Office of Consumer Advocates. The Self-Directed Care program currently has 51 active cases. Peer Advocates help consumers develop and implement their own "recovery plans", which include "directing" the use of their benefits to access both public mental health services and non-traditional support services. Future activities may include MHA's exploration of the use of Medicaid reimbursement for systemic long-term financing.

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In addition, MHA launched a Consumer Quality Team (CQT) initiative, which assures consumer input into quality assurance in the PMHS. To date, the CQT has held confidential, qualitative interviews with more than 800 consumers. The CQT is transformative as it is the one of the first projects with an emphasis on meaningful involvement of consumers and families in evaluation activities. This is also the first project where the evaluation is consumer-operated. The project also protects and enhances rights by obtaining first hand information from consumers about their experiences in programs and takes an active role in resolving issues right at the program level and, as needed, at other system levels. CQT also conducts 15 feedback meetings with MHA staff, CSAs and providers. Both consumers and program staff have reported significant program changes made as a result of the reports. [NFC 2]

Finally, Maryland provides support to the statewide National Alliance on Mental Illness of Maryland (NAMI MD) organization and its local affiliates. MHA worked successfully with NAMI MD in promoting the NAMIWALKS, a successful kick-off event for promoting *MAY MENTAL HEALTH MONTH*. NAMI MD has developed a strong Family-to-Family Education presence in the state. The “In Our Own Voice” program is an informational outreach program on recovery. Peer-to-Peer is a unique, experiential learning program for people with serious mental illness who are interested in establishing and maintaining their wellness and recovery. With support from MHTO, NAMI MD has begun two initiatives to support the integration of physical and mental health – NAMI MD’s Healthy Hearts and Minds education program and an information dissemination project. Additionally, NAMI MD presents an annual education conference for families, consumers, and providers. In FY 2010 MHA will continue to support NAMI MD’s public education and training efforts. Maryland’s strong, well-developed network of consumer, family, advocacy, and provider participation continues to play an essential role in the ongoing success of the PMHS. [NFC 2]

Case Management

Over the past several years, the MHA has increased both the availability and comprehensiveness of case management services and had created a mechanism for funding case management activities through CSA contracts. MHA has emphasized implementing the strengths model of case management, which recognizes the individual’s assets and promotes access to services that optimize the individual’s quality of life. Providers have indicated that they utilize various formats in delivering case management. For autonomous case management programs, the broker model, case management services which coordinate and link consumers to community resources, is prescribed by MHA policy.

Under the PMHS, the ASO collects and reports on data regarding utilization and costs of mental health services. CSAs can review this information and determine whether those individuals with high volume and costly service utilization are receiving appropriate services or whether another strategy, including use of case management, will be helpful in bringing about utilization of the most effective constellation of services.

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Case Management Delivery

In FY 2007, a decision was made to change the financing for mental health case management due to new requirements from the Centers for Medicare and Medicaid Services (CMS) on rate setting methodology. Rather than use Maryland's Medicaid state plan option and protocol for case management, MHA contracted with the CSAs, who in turn, contracted with approved case management providers for the service. Case management programs are operated in 24 jurisdictions throughout the state. The CSAs in each jurisdiction contract with one or more case management programs to provide linkage services and resources that will assist the consumer in stabilizing into the community. Several counties have also provided case management through the PATH program, Shelter Plus Care community outreach programs, or special jail-based programs. Additional case management services are provided in some counties through this federal block grant. All case management services were previously funded outside the fee-for-service system.

In FY 2010, MHA will work with Medicaid to amend the Medicaid State Plan and regulations for case management. As of September 1, 2009, approved case management providers will be funded by the fee-for-service system and receive the federal match through MA. Each CSA will monitor services and renew contracts every five years. Information for authorizations will be reported to the ASO and payment will be based on the level of care that the individual needs in the community. General level allows for less intensive services with a maximum of two face-to-face visits per month while intensive level services allows for five face-to-face visits per month. Reviews for uninsured individuals will be monitored by the ASO and CSA.

Mobile Treatment /Assertive Community Treatment Delivery

Mobile treatment is Maryland's model which approximates assertive community treatment (ACT). Mobile treatment programs are conceptually defined as combined clinical and case management treatment programs for a specific subset of the MHA priority population, i.e., those individuals who have not engaged in traditional treatment and rehabilitation activities. As of July 1, 2009 twenty-four (25) mobile treatment programs were operating throughout the state, with eight now meeting fidelity to the evidence-based practice model of assertive community treatment (ACT). Regulations require the delivery of clinical and case management services and the availability of multidisciplinary staff, preferably in a team approach.

In FY 2004, MHA was awarded a SAMHSA/Center for Mental Health Services (CMHS) grant for State Training and Evaluation of Evidence-Based Practices. Maryland's application focused on ACT. MHA contracted with the University of Maryland Evidence-Based Practice Center and Systems Evaluation Center to carry out activities under this grant. This grant ended in FY 2009 and trained four existing mobile treatment programs and helped to develop two new ACT teams. The University of Maryland continues to provide training and consultation in the development of ACT teams. Each ACT team has an annual monitoring visit to determine if the program continues to meet fidelity.

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The closure of Crownsville Hospital and reallocation of funds for community-based services afforded the state the opportunity to establish two ACT teams. These teams adhere to the evidence-based practice model and are evaluated according to the Dartmouth Assertive Community Treatment Scale (DACTS) fidelity scales. A wireless system allows for real-time communication and data entry for staff, increasing efficiency and accountability. This project also includes rural areas and an adaptation of the ACT model has been implemented in those areas for both adults and children/adolescents. The adapted in-home intervention teams have a greater rehabilitation focus (rather than clinical treatment) and include implementation of the Illness Management and Recovery evidence-based practice. A modified DACTS fidelity scale measures adherence to the adapted model. In Baltimore City a Forensic Assertive Community Treatment Team (FACTT), that currently meets fidelity criteria, was established. This team serves up to 80 forensic clients. Individuals with a legal status of Not Criminally Responsible who have lengths of stay of six months or more in state psychiatric facilities are included in the population served by the team. The provider has also obtained private foundation funding to assist with housing costs; however, state general funds now cover this cost. [NFC 5]

Other Supports

Medicaid is the joint federal and state program that provides health and long-term care coverage to low-income individuals. The main low-income populations covered under Medicaid include children and their parents, pregnant women, older adults, and individuals with disabilities. Medicaid also covers Medicare cost-sharing for certain low-income Medicare enrollees.

Federal Medicaid requires coverage of the following services: inpatient and outpatient hospital; physician, nurse midwife and certified nurse practitioner; laboratory and x-ray; nursing home and home health care; rural health and federally qualified health centers; and early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21. EPSDT requires coverage of all medically necessary services, including dental services, for children under age 21. Maryland's Medicaid also covers "optional" services such as medicines, therapies, medical day care, and personal care. A new Medicaid initiative, Medicaid for Families, which began July 1, 2008, provides comprehensive health care coverage to parents and other family members caring for children. Eligibility depends on family size and income. Additionally, funding was increased for Medicaid dental services over the next three years. The state has also set aside additional funds in a grant program for Maryland's 24 jurisdictions to help local governments and non-profits to create new or expanded sources of dental care services that will increase the number of Maryland residents with access to a comprehensive and continual source of dental care. [NFC 4]

In Maryland, about 80% of Medicaid beneficiaries are in HealthChoice, Maryland Medicaid's mandatory managed care program. Individuals choose a primary care provider (PCP) and enroll in one of seven HealthChoice managed care organizations (MCOs). MCOs provide almost all Medicaid benefits, except for certain "carved-out"

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services that are provided on a fee-for-service basis. Specialty mental health is a key carve-out service. MCOs also provide additional services. For example, Maryland Medicaid does not cover dental services for adults, but all seven MCOs have opted to offer a dental benefit to their adult enrollees. The state requires MCOs to cover dental services for children and pregnant women.

Certain individuals are not in an MCO and receive their services on a fee-for-service basis. These populations include individuals who are eligible for Medicare, age 65 or over, eligible for Medicaid under a “spend down” category, continuously enrolled over 30 days in a long-term care facility, or qualify for and opt to be in the Rare and Expensive Case Management (REM) program.

DHMH promotes coordination of MCO and fee-for-service specialty mental health services. Enrollees can self-refer to the Specialty Mental Health System, and Medicaid regulations state that an MCO or an MCO primary care provider (PCP) shall refer an enrollee to the Specialty Mental Health System when the MCO PCP cannot meet the enrollee’s needs. The regulations also state that an MCO shall cooperate with the Specialty Mental Health System in developing referral procedures and protocols.

Meetings among Medicaid and MHA staff, MCO medical directors, and the administrative services organization’s (ASO) medical directors promote coordination. Special needs coordinators at the MCOs currently have access to identified care managers at the ASO, who are specifically commissioned to fulfill this coordinating function. In addition, information on pharmacy utilization is shared across systems. Medicaid receives real-time information on MCO and fee-for-service pharmacy claims in order to prevent drug contraindications at the point-of-sale. On a monthly basis, Medicaid sends reports to each MCO of their enrollees’ fee-for-service mental health drug use, so MCOs and PCPs have information on the mental health drugs their enrollees are taking. [NFC 6]

The Primary Adult Care (PAC) program provides a limited benefit package of primary care, pharmacy, and outpatient mental health services to low-income adults who are not eligible for Medicaid or Medicare. Similar to HealthChoice, individuals in PAC select a PCP and enroll in one of three participating MCOs. Two MCOs have opted to offer a dental benefit as an added PAC service. Individuals in PAC receive their mental health services through the PMHS. Eligibility for PAC is the same as for the previous Maryland Pharmacy Assistance Program (MPAP). Any Maryland resident age 19 and over, who is not on Medicaid or Medicare, and whose income is no more than 116% of the Federal Poverty Level (FPL) and whose assets are no more than \$4,000 may be eligible. For couples/households of two, the income limit is 100% FPL with assets less than \$6,000. All individuals previously enrolled in MPAP moved either to Medicare Part D to receive their pharmacy benefit (if they were Medicare-eligible) or to PAC if they were not Medicare-eligible. The Maryland Pharmacy Discount Program which previously served Medicare recipients was also discontinued with the advent of Medicare Part D drug coverage.

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In ongoing efforts to manage pharmacy costs, Medical Assistance (MA) developed a Preferred Drug List (PDL) to make better use of less expensive, but equally effective medications. Cooperating drug manufacturers have offered the state additional revenue in the form of supplemental rebates for purchasing some of the brand name drugs. Fifty-three classes of drugs currently fall under the preferred drug list. According to PDL regulations, for each therapeutic class where there are three or fewer drugs, the PDL may be limited to only one drug; for each therapeutic class in which there are four or more drugs, at least two drugs must be included on the PDL. Prescribing of non-preferred drugs requires a preauthorization. The PDL affects all fee-for-service recipients and those HealthChoice and Primary Adult Care (PAC) recipients who take certain mental health drugs. The PDL impacts nearly all MA fee-for-service prescribers and, since mental health drugs are “carved out” from the MCOs’ formularies, affects MCO prescribers of mental health drugs. Atypical antipsychotics and antiretroviral agents have been excluded from the PDL and can be prescribed without preauthorization; however, atypical antipsychotics are limited to U.S. Food and Drug Administration (FDA) recommended quantities. Preauthorization phone numbers and fax are available for prescribers who prefer to use non-PDL drugs. Preauthorizations for non-preferred drugs are granted upon request and require no justification or criteria at this time. There is also a hotline for recipients to use if they feel they are having difficulty getting their medications.

The Maryland General Assembly established the Maryland Health Insurance Plan under the Health Insurance Safety Act of 2002. A Board of Directors governs the plan, which operates as an independent unit of Maryland Insurance Administration. Individuals who are not eligible for group health coverage, COBRA, government – sponsored health insurance programs and some other special categories, may be eligible. The MHIP includes in its benefits coverage for mental health services. MHIP also has a prescription drug program which provides coverage at different levels and includes a deductible. MHIP also operates another prescription assistance program, targeted toward Maryland seniors. The Senior Prescription Drug Assistance Program (SPDAP) provides a subsidy for Medicare beneficiaries who have incomes below 300% of poverty to pay for all or some of the co-insurance, monthly premiums and co-pays that are required under Medicare Part D. Enrollment in the program is subject to available funds, and MHIP is required to maintain a waiting list for those individuals who meet the eligibility requirements but are not able to enroll because of lack of funds.

Some individuals who receive services through the PMHS are not Medicaid or waiver-eligible and not enrolled in MCOs, and some of these individuals do not have a regular PCP. CSAs have found innovative ways to promote somatic and dental care for uninsured adults in their jurisdictions, e.g., through pro bono initiatives, medical and dental school clinics, or pharmaceutical companies. Additionally, CSAs have been provided with some funds to purchase needed medical/pharmacy/laboratory services for uninsured individuals who cannot afford their costs and for whom no other source of funds or access to the service/drugs are available. These funds are frequently used to prevent the need for more intensive levels of service or reduce the risk of hospitalization. Another resource is the Maryland Medbank Program, which assists low-income,

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uninsured persons in gaining access to free medicines available through pharmaceutical manufacturers' patient assistance programs. Individuals are referred by their physicians and must meet income and other eligibility criteria set by the supplying drug companies. Only brand name drugs are available and are subject to supply. [NFC 1]

Hospitalization under the Public Mental Health System

Hospital Utilization. The MHA has promoted the development of community-based services and the concurrent reduction of State psychiatric hospital census for over 25 years. Community expansion initiatives, census reduction initiatives, capitation projects, and demonstration financing projects have been used to affect these reductions in census and increases in community-based services. Over the past twenty plus years, MHA has reduced the average daily population (ADP) of State-operated psychiatric hospitals from over 2,500 to 1,071 in FY 2009. The ADP this year for the adolescent unit at Spring Grove Hospital Center was 12. MHA has not operated beds for children under age 12 since FY 1994. Residential rehabilitation program (RRP) beds, which are generally utilized when long stay individuals are discharged from the hospital, have only been increased through special initiatives since FY 2002. With the closure of Crownsville Hospital Center at the end of FY 2004, one million dollars in reallocated savings was made available for community placements. Another four million dollars was reallocated to the five counties most affected by the closure. These counties have developed a variety of services, focusing on diversion from and alternatives to State hospitalization. Assertive community treatment teams, in-home intervention programs for adults and children and adolescents, and services in the jails are examples of the types of services developed.

In FY 2009, as a result budget reductions and cost containment actions, several changes occurred: Finan Center closed its adolescent unit and opened an assisted living unit for adults and Eastern Shore Hospital Center began the process of opening an assisted living unit. Springfield closed 3 units (65-75 beds). Individuals will be discharged to the community or moved to assisted living units. Spring Grove Hospital Center opened a new unit specifically for individuals not in treatment yet awaiting court determinations. In October, 2009 MHA will close Walter P. Carter Center, an acute care State facility in Baltimore City. The functions for the inpatient services will move to Spring Grove Hospital Center. With this closure, MHA will have closed 3 facilities within the last 5 years. Additionally, MHA and the Developmental Disabilities Administration (DDA) have plans to relocate 84 dually-diagnosed individuals currently in MHA's facilities. At this time twenty (20) of the sixty-four (64) individuals slated for the community have been discharged to the community and an additional 20 have been relocated to a co-occurring (mental illness and developmental disabilities) unit at Potomac Center in Hagerstown (now DDA-operated). Potomac Center has hired and trained staff for this specialized unit. Community-based services will be called upon to further meet needs. As noted earlier, the state is faced with a projected budget shortfall of more than \$700 million. Within MHA, strategic decisions will be reached to take its share of the budget reduction. Community-based services will be further challenged to meet the needs in the community and reduce hospital utilization. MHA, in collaboration

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with CSAs, will work to strengthen and support community-based services including diversion initiatives.

High occupancy rates, pressure for admissions, and long waits in emergency departments have characterized the total inpatient psychiatric care system, not only the State hospital system. Although total admissions to State psychiatric hospitals have decreased from FY 2005, forensic (court involved) admissions during the same timeframe have increased. As a portion of the total admissions, forensic admissions have grown from 30 percent to 49 percent. As the forensic population within the State hospitals expands, the percentage of individuals served in state hospitals discharged within 30 days decline. In FY 2006, for example 66% of those admitted were discharged with a length of stay less than 30 days. In FY 2008, that percentage dropped to 52%. This change is because consumers involved in the criminal justice system often need court resolution of legal status before they can be discharged from a hospital setting. As the length of stay increases, the total number of people who can be served in a state hospital must decrease, since beds become available less frequently.

The implementation of the hospital diversion projects (described below) and the increase in purchase of care (POC) beds have contributed to decreased civil admissions to state facilities. POC beds have expanded access to community-based inpatient services. Acute admissions with MA and private insurance are directed to the private or general hospital sectors. State hospital beds currently are used for uninsured individuals (when no general hospital psychiatric bed is available-Maryland's all payor system covers costs of uncompensated care for general hospitals), court-ordered individuals, individuals who have exhausted their private insurance or have already stayed 30 days in the private/general bed and continue to require hospital level care, and for those who require a longer stay in hospital level care. Emergency department visits in general are increasing and while the percentage of visits for mental health reasons remains at its historical level of 4.3%, the overall increase in visits creates a greater number of people seeking mental health dispositions. Over the last five years, there has been a 2% decrease in acute general hospital psychiatric beds. During the same time period, there has been an 8% increase in acute general beds. If the psychiatric beds had kept pace with the acute general beds, there would be 70 additional psychiatric beds, which could greatly relieve the waiting time in emergency rooms and provide resources for admission. This past year CMS clarified the Emergency Medical Treatment and Labor Act (EMTALA) policy for receiving hospitals. They cannot turn down an admission because of the individual being uninsured. This should help the ED's move people through quicker.

Hospital Diversion. MHA continued its collaboration with Montgomery County, Anne Arundel County, and Baltimore City CSAs to enhance crisis response systems and support the development and use of alternative services to reduce the need for inpatient treatment and divert adults, children and adolescents from emergency departments and inpatient psychiatric services. The hospital diversion projects developed in all three jurisdictions are showing reductions in admissions of uninsured individuals to state hospitals and presenting creative, successful use of community-based alternatives. The Montgomery County Department of Health and Human Services (MCDHHS) crisis

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system developed evaluation and triage teams that evaluate individuals in the ED who are uninsured and for whom hospitalization is being requested. Anne Arundel is diverting, and referring and accessing care through the mental health and addictions system. In addition to the expansion of the mobile crisis teams, Baltimore Mental Health Systems (BMHS), through Baltimore Crisis Response System, Inc (BCRI) has expanded the number of residential crisis beds from 12 to 21.

Additionally, MHA has altered the previous centralized admission and referral process for EDs to use in locating and accessing state hospital beds. The process now relies heavily on using local systems of care. Through changing the locus of the admission system to the state hospitals to the region where the service is located, better coordination of care has developed between the community mental health system, the CSAs, local hospitals, and the state hospitals. The collaboration better promotes the use of alternative services to hospital levels of care and facilitates the discharge of long-stay state hospital patients. The PMHS offers several services that can prevent an inpatient psychiatric admission or provide an alternative to psychiatric inpatient admissions. These services include Mobile Treatment Services (MTS) and Assertive Community Treatment (ACT). In FY 2008, over 1,100 individuals were seen by mobile crisis teams in local hospital emergency departments, of whom more than 44 percent were diverted to community-based programs.

In order to better coordinate the efforts of the hospital diversion projects and create learning communities among the projects, MHA convenes a monthly meeting of representatives from the CSAs, state hospitals, and hospital diversion projects. Both projects have successfully reduced the amount of time individuals are waiting for evaluation and treatment in EDs. This is resulting in more comprehensive systems of care and better clinical outcomes for these individuals.

Olmstead Related Activities. The Maryland Department of Disabilities develops a cross-disability plan that addresses housing, employment, transportation and consumer rights. The 2009 Plan continues to provide direction for Olmstead – related activities for the State and calls upon units of State government to cooperatively engage in a variety of activities to promote consumer self-direction and consumer-centered services. It is anticipated that the Maryland Department of Disabilities will become increasingly involved in the housing issues for persons of all disabilities, in order to streamline cross-disability efforts and maximize State and federal resources.

To facilitate the discharge of long-stay State hospital residents, MHA, with the University of Maryland EBPC, focused on the development of Assertive Community Treatment (ACT) teams and special residential projects. Fifty-two (52) individuals have been discharged from State hospitals through the support of ACT teams in Prince George's and Anne Arundel Counties. MHA evaluated these teams and determined that the ACT teams demonstrate high fidelity to ACT model. MHA continues to use the reallocated dollars from the closure of Crownsville Hospital Center for the housing subsidies that support individuals living in the community. A Housing First model is utilized, with the ACT teams providing the necessary supports in the homes. [NFC 5]

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In addition, MHA expanded residential services in Washington County to serve individuals currently hospitalized in the Finan Center. MHA continues to work with Frederick County to monitor the program assisting transition age youth with mental illness and developmental disabilities, who are aging out of residential treatment centers, in State hospitals, or returning from out-of-state placements. This project is being implemented in partnership with the Developmental Disabilities Administration. MHA continues to fund and partner with Montgomery County CSA regarding an independent living project using ten Moderately Priced Dwelling Units (MDPUs) for ten individuals from state hospitals. Finally, MHA will continue utilizing the federal Olmstead planning grant to contract with On Our Own of Maryland for peer support counselors in State hospitals who work with consumers, supporting their transition to the community. Currently peer support counselors are located in Springfield Hospital Center, Finan Center, and Upper Shore Hospital.

MHA, which is the lead agency for Traumatic Brain Injury (TBI) in Maryland, is responsible for guiding the State's plans and initiatives for this population. MHA's current TBI initiatives include a Home and Community-Based Waiver for individuals with TBI, which was initially approved by the Centers for Medicare and Medicaid Services in FY 2003 and then renewed for an additional five years in 2006. The waiver supports up to thirty individuals each year in specialized brain injury community placements. The waiver was expanded in October 2008 when Maryland changed the definition of institution that is used in the State's Money Follows the Individual Policy to include chronic hospitals. Due to this change, there is currently no cap on the number of TBI waiver slots available to individuals coming out of this setting via the Money Follows the Individual Policy. MHA is in the process of recruiting new providers and expanding capacity of existing providers to meet the increasing demand for this program. **[NFC 2]**

Additionally, the Brain Injury Resource Coordination program, which was initially developed with federal grant funding to link individuals with TBI with the community services and supports that they need, is being modified to support the expansion of the TBI waiver program. Resource Coordinators will continue to assist individuals living in the community who are at risk of institutionalization and will begin assisting individuals in chronic hospitals and state-owned and operated nursing facilities who are interested in applying for the TBI waiver program. The TBI project staff also provide education and consultation to local mental health providers and other human service agencies on recognizing the signs of TBI, and strategies for affectively serving and supporting those individuals in the least restrictive setting. Also, TBI project staff will begin assisting new TBI waiver providers with establishing brain injury training programs for their staff.

MHA also provides staff support to Maryland's TBI Advisory Board, which is legislatively mandated to report annually to the Governor and the General Assembly on the needs of individuals with TBI, including identified gaps in services and recommendations for needed services and for use of state and federal funds.

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Finally, the Baltimore Capitation Project, operational since 1995, continues to prioritize transitioning clients from state hospital facilities to the community. The Capitation Project, created with the philosophy of services for life, has been operating at full capacity for the last several years. Fifty percent (50%) of individuals served through this project are individuals who had hospitalized for longer than six months (often for much longer) and who had not been discharged to the community because their treatment needs, for both somatic and mental health care, were complex. The other 50% are individuals in the community who have frequently been admitted to psychiatric hospitals or have frequently been seen in hospital emergency rooms. In an attempt to open up more slots, BMHS is working with the providers to assist clients in graduating from the program by implementing a recovery approach to services. Borrowing from the evidence-based practice of Illness Management and Recovery (IMR) and Mary Ellen Copeland's Wellness Recovery Action Plan (WRAP) model, the Project is emphasizing effective coping, recovery and the development of a concept of self beyond that of one's illness. Consumers are taught how to minimize the impact of their symptoms through active collaboration with service providers and the use of WRAP plans. Project providers have added community integration specialists to the treatment teams to assist consumers with developing additional roles in the community other than psychiatric client. In addition the project is reevaluating its performance outcomes to better reinforce a recovery approach to services. **[NFC 1]**

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SFY 2010 OBJECTIVES FOR CRITERION 1:

SERVICES FOR ADULTS

- MHA, in collaboration with the Department of Health and Mental Hygiene (DHMH), the Mental Health Transformation Office (MHTO), and local and national advocacy organizations, will adapt the Mental Health First Aid (MHFA) curriculum to further implementation of the MHFA initiative for adults in Maryland.
MHA Monitor: Brian Hepburn, MHA Office of the Executive Director, Daryl Plevy, MHTO
- MHA in collaboration with CSAs, will continue to provide support, funding, and ongoing consultation to Maryland's mental health advocacy groups to promote and implement a series of public education and training activities to increase awareness of mental illness; mental health issues; and recovery and resiliency among children, youth, and adults.
MHA Monitor: John Hammond, MHA Office of Public Relations; Al Zachik, MHA Office of Child and Adolescent Services and Cynthia Petion, MHA Office of Planning Evaluation and Training
- Maintain and update disaster mental health response plans including MHA, Alcohol and Drug Abuse Administration (ADAA), and Core Service Agency (CSA) All-Hazards plans; provide disaster behavioral health and related disaster training for Department of Health and Mental Hygiene (DHMH) staff and for local volunteers; support the Maryland Professional Volunteers Corps Program through the provision of disaster behavioral health and National Incident Management System/Incident Command System (NIMS/ICS) training and technical assistance (TA); integrate disaster preparedness and behavioral health into the Wellness and Recovery Action Plan (WRAP) training for consumer-run Wellness and Recovery Centers statewide; provide TA to emergency management and public health on disaster behavioral health.
MHA Monitor: Laura Copland, MHA Office of Special Needs Populations
- In collaboration with DHMH and through Regional Resource Coordinators, continue implementation of Maryland's Commitment to Veterans Initiative to improve initial access to behavioral health care services provided through the United States Department of Veterans Affairs or the Public Mental Health System (PMHS) and expedite timely referrals for veterans returning from Iraq and Afghanistan.
MHA Monitor: Laura Copland, MHA Office of Special Needs Population
- Design, develop and implement a pilot benefits counseling initiative, in collaboration with On Our Own of Maryland, as a means to promote and actively support consumer recovery and economic self-sufficiency through the use of work

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incentives, individualized benefits counseling, and work supports, to include the Employed Individuals with Disabilities (EID) Program.

MHA Monitor: Steve Reeder, MHA Office of Adult Services

- Continue to implement the Maryland Mental Health Employment Network (MHEN), a consortium of Maryland mental health supported employment providers and CSAs to increase and enhance the array of choices of supported employment services available by utilizing Social Security Administration (SSA) incentives such as Ticket-to-Work.

MHA Monitor: Steve Reeder, MHA Office of Adult Service

- In collaboration with the administrative services organization (ASO), managed care organizations (MCOs), and Alcohol and Drug Abuse Administration (ADAA), work to improve: access to services for co-occurring disorders (mental health and substance abuse), coordination of care between somatic and behavioral health, and utilization of existing service delivery systems across agencies and organizations.

MHA Monitor: Gayle Jordan-Randolph, MHA Office of the Clinical Director

- Collaborate with consumers, providers, and other mental health stakeholders to promote and implement the smoking cessation initiatives at all levels in the public mental health system to reduce mortality rates.

MHA Monitor: Brian Hepburn, MHA Office of the Executive Director and Gayle Jordan – Randolph, MHA Office of the Clinical Director

- Improve communication and efforts with primary care and mental health care providers to promote coordination of care in the delivery of services to individuals with mental illnesses.

MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

- MHA, in collaboration with the Mental Health Transformation Office (MHTO) and On Our Own of Maryland (OOOMD), will continue statewide implementation of Wellness and Recovery Action Plan (WRAP) training, as part of ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, and utilize best practices within the consumer movement; and begin to incorporate WRAP within community mental health programs.

MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

- Continue to implement, evaluate, and refine the Self-Directed Care project in Washington County.

MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

- In collaboration with the Mental Health Transformation Office (MHTO) and the Maryland Consumer Leadership Coalition (MCLC), continue to further define “recovery-based mental health treatment” and establish guidelines for peer workforce development in the PMHS.

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MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

- Collaborate with family support organizations to continue the development and provision of family to family and youth to youth peer support services and family and youth training as Medicaid reimbursable services under the Section 1915(c) psychiatric residential treatment facility (PRTF) demonstration waiver.

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

- Utilize the principles and values of the Transition to Independence (TIP) program, a best practice approach to improve the quality of services for transition-age youth (TAY), to conduct a comprehensive quality improvement initiative for MHA funded programs servicing this age group.

MHA Monitor: Tom Merrick, MHA Office of Child and Adolescent Services, and Steve Reeder, MHA Office of Adult Services

- Based on recommendations of the MHA/Technical Assistance Collaborative (TAC) Housing Plan, MHA will work with other state and local funding resources to promote and leverage DHMH's Administration-Sponsored Capital Program grant (Community Bond) funds to increase affordable, safe, and integrated housing for individuals with serious mental illness (SMI).

MHA Monitor: Penny Scrivens, MHA Office of Adult Services

- Increase the number of individuals with mental illnesses to obtain affordable and safe housing through the Bridge Subsidy Pilot Program, federal housing vouchers, and rental assistance programs initiated through the American Recovery and Reinvestment Act (ARRA)/Homelessness Prevention and Rapid Re-Housing Program (HPRP).

MHA Monitor: Penny Scrivens, MHA Office of Adult Services

- MHA and Medicaid will develop state plan, amend regulations, and notify the public on plans to implement Medicaid-reimbursed case management. Once CMS approval is received, MHA in collaboration with CSAs and the ASO, will implement and monitor the transition from contracted case management services to the fee-for-service system (FFS) for Medicaid recipients and uninsured individuals.

MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

- Participate in oversight of the Consumer Quality Team (CQT) project and plan for statewide expansion.

MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

- Provide resources to continue to implement leadership activities and trainings through the Maryland Coalition of Families for Children's Mental Health Leadership Institute for parents of children with emotional disorders; the Youth MOVE (Motivating Others through Voices of Experience) peer leadership program; and the Leadership Empowerment and Advocacy Project (LEAP) for

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adult consumers.

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services;
Clarissa Netter, MHA Office of Consumer Affairs

- MHA's Office of Forensic Services, in collaboration with the Mental Health & Criminal Justice Partnership [formerly called the House Bill (HB) 281 Workgroup] and the Interagency Forensic Services Committee – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council, will continue to promote the development of services including early intervention, diversion, and re-entry for individuals with mental illnesses who encounter the criminal justice system.
MHA Monitor: Larry Fitch, MHA Office of Forensic Services
- Develop, monitor, and evaluate community placements, other services, and plans of care for consumers with traumatic brain injury (TBI) through the TBI waiver.
MHA Monitor: Stefani O'Dea, MHA Office of Adult Service
- Implement and monitor crisis response systems, hospital diversion projects, and activities to increase the diversion of inpatient and detention center utilization by individuals with mental illnesses through support of the use of alternative services in Montgomery, Anne Arundel, Baltimore, and Prince George's counties and Baltimore City CSAs.
MHA Monitor: Lissa Abrams, MHA Office of the Deputy Director for Community Programs and Managed Care
- MHA, in collaboration with the Developmental Disabilities Administration (DDA) and the Alcohol and Drug Abuse Administration (ADAA), will develop plans to assess preferences, needs, and desires of individuals hospitalized and transition or discharge individuals with developmental disabilities in state hospitals to settings (community or unit for individuals with co-occurring illness) that are most appropriate to their needs.
MHA Monitor: Arlene Stephenson, MHA Office of the Deputy Director for Facilities Management and Administrative Operations and Lissa Abrams, MHA Office of the Deputy Director for Community Programs and Managed Care
- Based on a 1987 Lisa L. Program class action lawsuit (which requires timely discharge from hospitals to appropriate placements) track and monitor children and youth in state custody in designated psychiatric hospitals as identified under COMAR 14.31.03.
MHA Monitor: Marcia Andersen and Musu Fofana, MHA Office of Child and Adolescent Services

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- Continue to interface with other agencies and administrations to support a comprehensive system of mental health, somatic health, substance abuse, and other services and community supports. The following is a listing of the agencies with which a liaison is maintained and the responsible MHA monitor.

<u>Maryland State Government</u>	<u>MHA Monitor</u>
Maryland Department of Disabilities (MDOD)	Brian Hepburn MHA Office of the Executive Director
Governor's Office for Children (GOC)	Al Zachik, Tom Merrick and Marcia Andersen MHA Office of Child and Adolescent Services
Governor's Office of the Deaf and Hard of Hearing (ODHH)	Marian Bland MHA Office of Special Needs Populations
Maryland State Department of Education (MSDE)	Al Zachik, Cyntrice Bellamy, and Joyce Pollard MHA Office of Child and Adolescent Services
Division of Rehabilitation Services (DORS)	James Chambers and Steve Reeder MHA Office of Adult Services
Department of Human Resources (DHR)	Lissa Abrams MHA Office of the Deputy Director for Community Programs and Managed Care Al Zachik MHA Office of Child and Adolescent Services Marian Bland MHA Office of Special Needs Populations
Department of Housing and Community Development (DHCD)	Penny Scrivens MHA Office of Adult Services Marian Bland MHA Office of Special Needs Populations

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Maryland Department of Aging (MDoA)	James Chambers and Marge Mulcare MHA Office of Adult Services
Department of Public Safety and Correctional Services (DPSCS)	Larry Fitch MHA Office of Forensic Services Marian Bland MHA Office of Special Needs Populations
Department of Juvenile Services (DJS)	Al Zachik and Cyntrice Bellamy MHA Office of Child and Adolescent Services Larry Fitch MHA Office of Forensic Services
Maryland National Guard	Marian Bland, Office of Special Needs Populations
Department of Veterans Affairs	Marian Bland, Office of Special Needs Populations
Judiciary of Maryland	Larry Fitch MHA Office of Forensic Services
DHMH Alcohol and Drug Abuse Administration (ADAA)	Pat Miedusiewski DHMH
DHMH Family Health Administration (FHA)	Al Zachik and Joyce Pollard MHA Office of Child and Adolescent Services
DHMH Developmental Disabilities Administration (DDA)	Stefani O’Dea MHA Office of Adult Services Lisa Hovermale MHA Office of the Executive Director Debra Hammen, MHA Office of Forensic Services
Maryland Health Care Commission (MHCC)	Brian Hepburn, MHA Office of the Executive Director

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Health Services Cost Review
Commission (HSCRC) Brian Hepburn
MHA Office of the Executive Director

The Children's Cabinet Al Zachik
MHA Office of Child and Adolescent
Services

DHMH Office of Health Services
(Medical Assistance) Brian Hepburn, MHA Office of the
Executive Director
Lissa Abrams, MHA Office of the
Deputy Director for Community
Programs and Managed Care
Gayle Jordan-Randolph
MHA Office of the Clinical Director

DHMH Office of Operations and
Eligibility Brian Hepburn
(Medical Assistance) MHA Office of the Executive Director
Lissa Abrams,
MHA Office of the Deputy Director for
Community Programs and Managed
Care

DHMH Office of Health Care
Quality (OHCQ) Sharon Ohlhaber
MHA Office of Quality Management
and Community Programs

DHMH Office of Capital Planning,
Budgeting, and Engineering Cynthia Petion
Services MHA Office of Planning, Evaluation,
and Training

DHMH AIDS Administration Marian Bland
MHA Office of Special Needs
Populations

Maryland Emergency Management
Administration (MEMA) Marian Bland and
Laura Copland
MHA Office of Special Needs
Populations

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ADULT PLAN

CRITERION #2: Adult Mental Health System Data Epidemiology

Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.

PMHS DATA SYSTEM

The primary PMHS data system is currently managed by an Administrative Services Organization (ASO). Effective September 1, 2009, a new vendor, ValueOptions Inc. has been selected to contract as the new ASO for the Public Mental Health System (PMHS). Historical data from the previous vendor will be transferred to ValueOptions. Historical data have also been placed at the University of Maryland Systems Evaluation Center (SEC). The SEC provides enhanced capacity for analysis of the data, particularly in relation to evaluation and outcome efforts.

The data system collects information on those who receive services in the fee-for-service system. The system is driven by a combination of authorizations and claims for mental health services. Inherent in the implementation of the PMHS is a series of extremely comprehensive data sets. Data sets on client's service authorization and events and the provider community are available. Client information is accumulated through either the Medical Assistance (MA) eligibility file or the subsidized client data forms. Unduplicated counts are calculated by using MA numbers, Social Security numbers, and/or unique identifiers. Authorizations are made on-line and added to available data. Provider data come from provider enrollment files, which are used both for referral and for payment of claims. Finally, event and cost data are derived from claims files.

[NFC 5]

The ASO is contracted to support mental health services access, utilization review, and care coordination tasks. The PMHS data are collected and displayed by demographic, clinical service, provider and outcome information relative to an episode of care, and also link multiple consumer records into useful "episodes of care." The PMHS data system through a series of interrelated databases and software routines can report over 200 elements for both inpatient and outpatient care. Also included among the numerous data fields, care management elements, and outcome indicators are:

- service authorizations and referrals
- services utilized by level of care and service
- treatment service lengths and number of units provided
- site visits, including record reviews and second opinion (peer) reviews of authorization

All stored data can be retrieved and reported either in standard form, using an automated reporting system or by way of custom programming or ad hoc reports. The data may be formatted to produce monthly, quarterly, or fiscal reports. Maryland

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operates on July-June fiscal year. Currently, over 50 standard reports are generated to assist in general planning, policy, and decision making. The data may also be accessed to produce an unlimited range of reports via ad hoc requests. Data are currently shared with the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council.

Implemented in July 2007, information on Medicaid drug prescriptions filled by consumers in the PMHS will become available through the ASO. These prescriptions are for all medications other than HIV medications, regardless of prescriber. This information is accessible to providers of mental health services. It is available to those providers with existing open authorizations to treat the consumer. The pharmacy is refreshed monthly and includes prescriptions filled during the 12 months prior to the refresh date. Information is now made available to Managed Care Organizations (MCOs), who can then communicate it to their primary care physicians. The availability of this new module has enhanced service quality and provided a rich resource to enhance data analysis efforts. [NFC 6]

An unanticipated problem resulting from PMHS implementation contributes to an undercount of persons with mental illness. The ASO Management Information System (MIS) does not capture data for individuals who receive no services reimbursed by MA and have Medicare as their only payer source. These Medicare reimbursed services cannot be subject to authorization and claims are not paid by the ASO, the two mechanisms for capturing data. Additionally, beginning July 1, 2003, claims for individuals who are qualified for federally matched MA and have Medicare, began to be processed by Medical Assistance and the data on their utilization of Medicare reimbursed services is no longer in the ASO data system. Therefore, the data on those served in the PMHS represents an undercount.

Tables on the following pages provide data on consumers served by age and number of consumers accessing care in FY 2008 (the last full fiscal year for which claims have been processed). However, FY 2009 data, based on claims paid through 5/31/09, shows that thus far, 99,159 individuals had claims submitted for mental health services through the fee-for-service system, with fifty-eight percent (58%) of the total (57,655) being adults. Sixty-five percent (65%) of adults treated met the diagnostic categories selected for serious mental illness (SMI).

Access to services is critical for any mental health system. In recent years and as an ongoing strategy in the FY 2010 State Plan, MHA will “continue to monitor the system for growth, maintaining an appropriate level of care for at least the same number of individuals in the populations who have historically utilized the PMHS”. Data relevant to this national indicator on access to services continue to support the achievement of this target.

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The ASO MIS was utilized to produce most of the data included as performance indicators in this application. Data for FY 2007, 2008, and 2009 are based on claims paid through May 31, 2009. For FY 2006 and 2007, this produces reliable numbers. Since claims can be submitted up to twelve months following the date of service, the data for FY 2009 is still incomplete. Full year projections were not made for FY 2009. Specific diagnoses were used to define SMI. An individual was categorized as SMI if, at any time during the fiscal year, a diagnosis in the specific categories was submitted on a claim.

The MHA submitted its application to SAMHSA/CMHS for a third round of Data Infrastructure Grant in June 2008. The required Basic and Developmental Tables were submitted in December 2008. All tables will be submitted this year, including developmental tables based on new consumer survey items. Data for these come from three sources. Community data are obtained from data that results from claims, authorizations, and the Outcomes Measurement System (OMS) which are within the ASO system. Some data, such as employment status and residential status along with detailed racial and ethnicity data, are not available from either standard claims or MA eligibility data sets. Efforts are made to obtain this information in the ASO system through requirements for registration and authorization by providers for services. The ASO information is supplemented by an annual Consumer Satisfaction and Outcomes Survey for many National Outcome Measures (NOMs), though the newly implemented OMS may allow MHA to move to client level reporting for some of these measures. Data from state operated inpatient facilities are obtained from a Hospital Management Information System (HMIS). Currently, information is abstracted from the HMIS and integrated into data from the community system to complete all required Uniform Reporting System (URS) and NOMs reporting. While this system does not use the same consumer identifiers at the ASO data system, there are elements common to both which MHA has used to establish a nearly unique identifier based on demographic variables. This identifier has been used to link data from the two systems. This system, which has been in place since 1986, is scheduled for replacement. Data for those tables reporting on individuals served and services provided are collected and reported at the person level. **[NFC 5]**

In addition to the ASO, MHA contracts with the Systems Evaluation Center (SEC), a component of the Mental Health Services Improvement Collaborative of the University of Maryland School of Medicine, Department of Psychiatry, Division of Services Research to assist with evaluation and data infrastructure activities. As MHA's strategic partner, SEC maintains a copy of the community services' data repository which extends back to 1999. The SEC has accepted responsibility for the oversight of the effort to collect the data necessary to complete the URS tables required to be included with Maryland's Mental Health Block Grant application. The SEC, ASO, and MHA are working jointly to further develop the OMS, described more fully in Criterion 5. In this coming year, the SEC will continue to collaborate with MHA and key stakeholders to identify areas of interest related to the PMHS that could be analyzed using multiple databases. These databases include claims, authorization, the consumer satisfaction and outcomes survey, the OMS, the HMIS, Medicaid, and other state databases, as available.

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Additionally, through Maryland's StateStat, MHA is also responsible for providing information on agency performance and priority initiatives. StateStat is a performance measurement and management tool implemented by the Governor to make our state government more accountable and more efficient.

INCIDENCE AND PREVALENCE FOR ADULTS

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For adults, the current estimate of population aged 18 and over for each county was multiplied by the rate cited in the federal definitions (5.4%).

Estimates of treated prevalence however; were of necessity based upon a somewhat stricter definition of SMI. Specific Axis I and II diagnostic codes were selected to identify the SMI treated in the system. Very slight modifications were made within the diagnostic categories this year. All data have been updated to reflect these changes. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities. Maryland's priority population remains as follows:

"Priority population" means those adults for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared priority for publicly-funded services.

Priority population includes:

- An adult, aged 18 to 64, with a serious and persistent mental disorder, which is a disorder that is:
 - Diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:
 - Schizophrenic disorder,
 - Major affective disorder,
 - Other psychotic disorder, or
 - Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; and
- Characterized by impaired role functioning, on a continuing or intermittent basis, for at least two years, including at least three of the following:
 - Inability to maintain independent employment; social behavior that results in intervention by the mental health system,
 - Inability, due to cognitive disorganization, to procure financial

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- assistance to support living in the community,
 - Severe inability to establish or maintain a personal social support system, or
 - Need for assistance with basic living skills.

- An elderly adult, aged 65 or over, who:
 - Is diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:
 - Schizophrenic disorder,
 - Major affective disorder,
 - Other psychotic disorder, or
 - Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; or
 - Experiences one of the following:
 - Early stages of serious mental illness, with symptoms that have been exacerbated by the onset of age-related changes,
 - Severe functional deficits due to cognitive disorders and/or acute episodes of mental illness, or
 - Psychiatric disability coupled with a secondary diagnosis, such as alcohol or drug abuse, developmental disability, physical disability, or serious medical problem.

- An individual committed as not criminally responsible who is conditionally released from a Mental Hygiene Administration facility, according to the provisions of Health General Article, Title 12, Annotated Code of Maryland.

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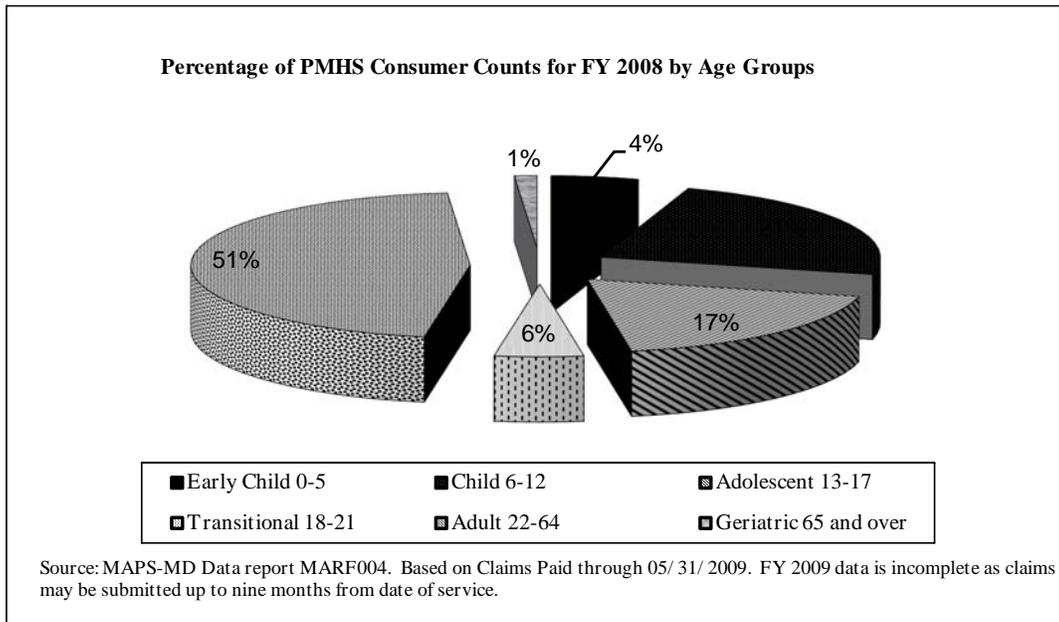
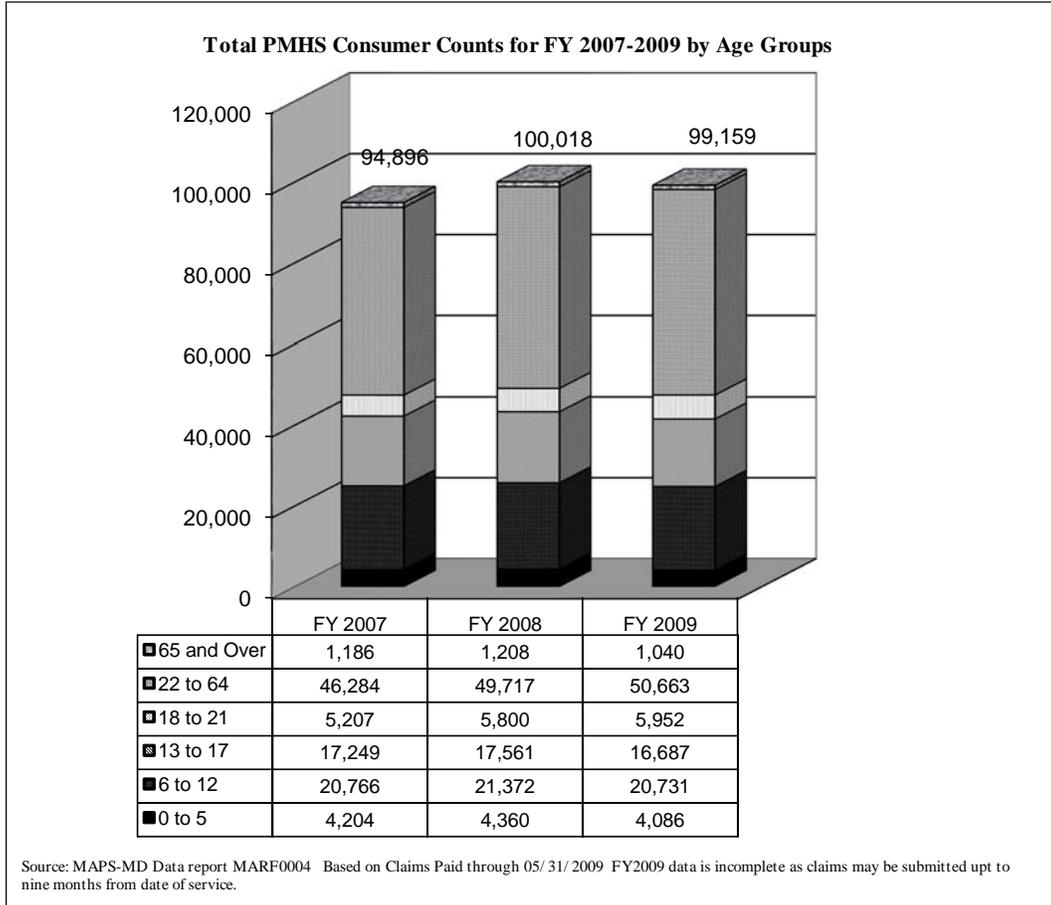
**Mental Hygiene Administration
Prevalence Estimates for Serious Mental Illness (SMI) by County
Adult Population**

County	Over 18 Population	Prevalence 5.4%
Allegany	59,010	3,187
Anne Arundel	388,557	20,982
Baltimore County	611,447	33,018
Calvert	65,881	3,558
Caroline	24,814	1,340
Carroll	127,739	6,898
Cecil	74,966	4,048
Charles	102,819	5,552
Dorchester	24,974	1,349
Frederick	166,325	8,982
Garrett	23,091	1,247
Harford	179,373	9,686
Howard	203,678	10,999
Kent	16,250	878
Montgomery	704,567	38,047
Prince George's	620,302	33,496
Queen Anne's	35,642	1,925
St. Mary's	74,219	4,008
Somerset	21,319	1,151
Talbot	28,998	1,566
Washington	111,924	6,044
Wicomico	71,723	3,873
Worcester	39,989	2,159
Baltimore City	482,300	26,044
Statewide Total	4,259,907	230,035

Data Source:

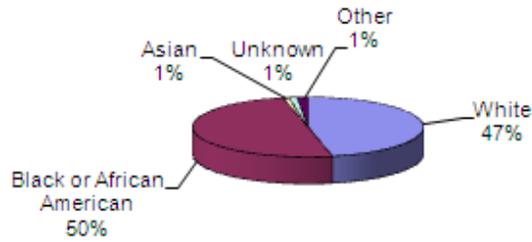
July 1, 2007 Estimated Maryland Total Population by Age Group, Region and Political Subdivision

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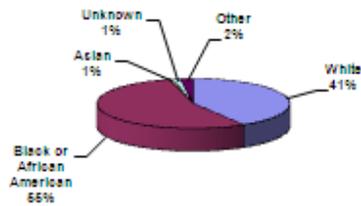


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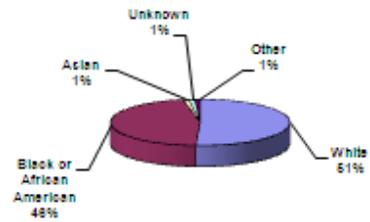
**Total Consumer Served in
in FY 2008 by Race and Age Group**



Age 0-17



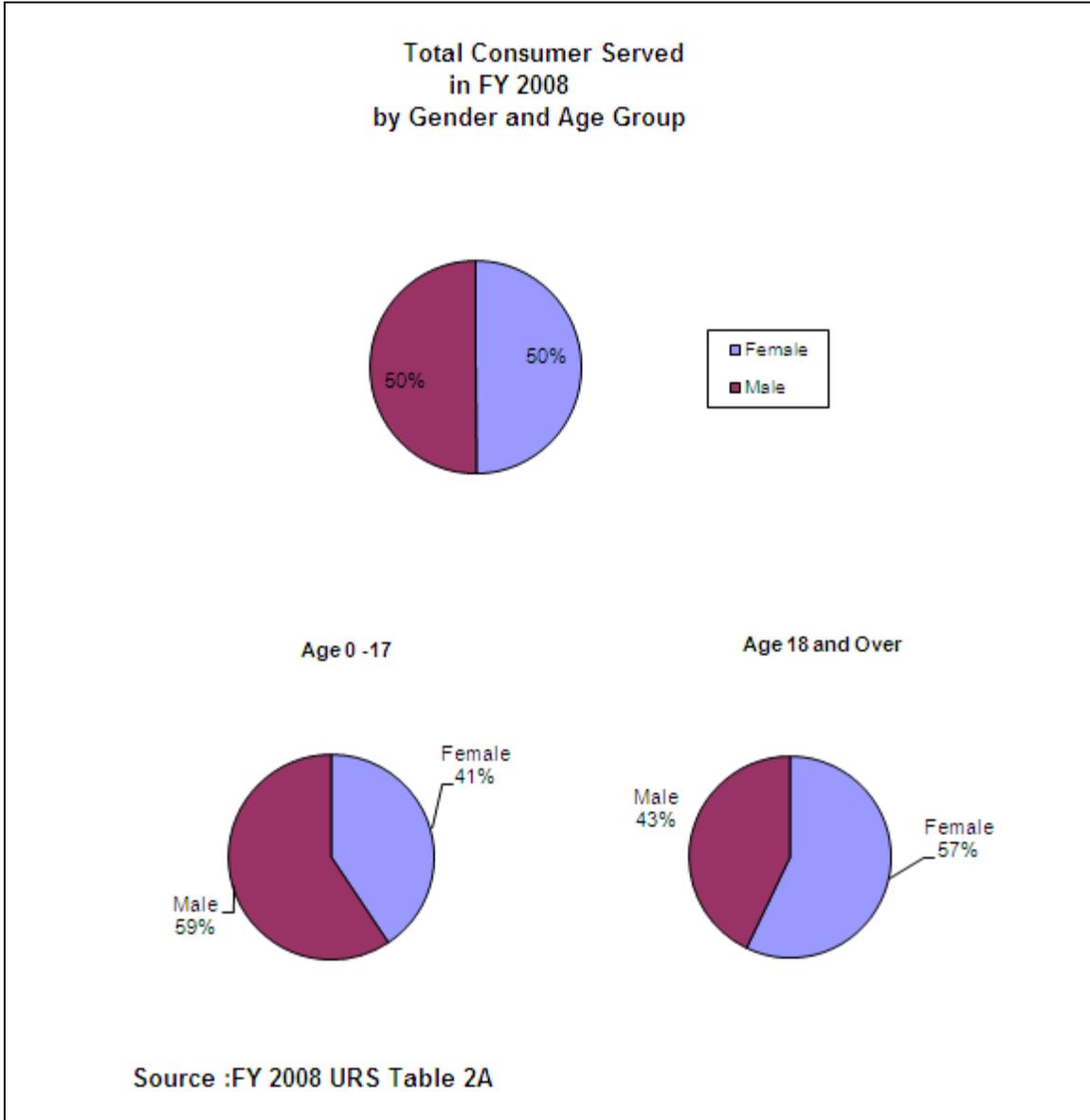
Age 18 and over



Source: FY 2008 URS Table 2A

Note: Other includes : American Indian,Native Hawaiian, Pacific Islander and those consumers with more than one race.

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SFY 2010 OBJECTIVES FOR CRITERION 2:

SERVICES FOR ADULTS

- MHA, in collaboration with the Mental Health Transformation Office (MHTO) and On Our Own of Maryland (OOOMD), will continue statewide implementation of Wellness and Recovery Action Plan (WRAP) training, as part of ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, and utilize best practices within the consumer movement; and begin to incorporate WRAP within community mental health programs.
MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs
- During the transition of the ASO and thereafter, continue to monitor the system for growth and expenditures, identify problems (including high-cost users), and implement corrective actions as needed, maintaining an appropriate level of care for at least the same number of individuals.
MHA Monitor: Lissa Abrams, MHA Office of the Deputy Director for Community Programs and Managed Care
- Enhance PMHS data collection and monitoring through continued activities to develop and/or refine management information systems.
MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

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ADULT PLAN

CRITERION #3: Not Applicable

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ADULT PLAN

CRITERION #4: Targeted services to rural, homeless, and older adult populations

Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.

TARGETED SERVICES FOR RURAL POPULATIONS

Definition of Rural Areas

Rural counties have historically been defined in Maryland as those with a population of 35,000 or less. Six counties continue to meet this criterion. Source: U.S. Census Bureau, Estimated Maryland Total Population by Political Subdivision, July 1, 2007 - Maryland Vital Statistics Annual Report 2007.

Maryland's definition was reviewed relative to the more complicated definitions of rural used by the U.S. Census Bureau. For Census 2000, the Census Bureau's classification of "rural" consists of all territory, population, and housing units located outside of urbanized areas (UAs) and urban clusters (UCs). The Census Bureau also looks at the population density with core census blocks of at least 1,000 people per square mile or surrounding census blocks with an overall density of at least 500 people per square mile. Many counties and metropolitan areas are split with UAs and UCs, often mixed with more rural areas. Based on population density alone, several other counties in Maryland, beyond the six, might be considered rural. However, other factors, including growth rate and proximity to major metropolitan areas (emerging bedroom communities), make these counties appear less rural. Based upon this, the six counties with populations under 35,000 will remain Maryland's defined rural areas for purposes of this application, while recognizing that pockets of "rural" areas exist in other counties.

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Of the six Maryland counties that qualify under this definition, one rural county—Garrett—is the western-most jurisdiction in the state, and the other five—Caroline, Dorchester, Kent, Somerset, and Talbot Counties—are on the Eastern Shore. In recent years, several Eastern Shore counties have developed past the 35,000 threshold. Typically, as a rural county develops beyond the 35,000 threshold, it experiences growth in housing, commerce, and average household income that makes it more similar to the rest of the State. (** Talbot County, with 36,196 slightly exceeds this threshold. Please see discussion of Talbot County on following page.)

Rural County Population -- July 1, 2007	
Caroline	32,910
Dorchester	31,846
Kent	19,987
Somerset	26,016
Talbot**	36,193
Garrett	29,627

Source: U.S. Census Bureau, Estimated Maryland Total Population by Political Subdivision, July 1, 2006 and July 1, 2007
Maryland Vital Statistics Annual Report 2007

While the Mental Hygiene Administration will continue to utilize the foregoing definition of rural counties for purposes of this Mental Health Block Grant Application, the Office of Health Policy and Planning of the Maryland Department of Health and Mental Hygiene in June 2007 published *The Maryland Rural Health Plan* which provides a broader discussion of rural health issues in Maryland. The following are excerpts from that plan to assist us in identifying and addressing rural mental health issues in this analysis.

“The challenges to providing quality health care services and delivery to rural Maryland largely result from their geographic isolation and lack of the critical population mass necessary to sustain a variety of primary and specialty services. Efforts to address health care disparities in rural areas are often made difficult by struggling economies and limited financial and human resources.”

“Compared with the state overall, Maryland’s rural communities tend to have fewer health care organizations and professionals, higher rates of chronic disease and mortality, and larger Medicare and Medicaid populations. Evidence indicates that rural populations fare worse in many health and economic indicators, and do not receive the same quality, effective, and equitable care as their suburban counterparts. Rural

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populations tend to be older and exhibit poorer health behaviors such as higher rates of smoking and obesity, relative to the State, although there is variability in health behaviors among rural communities.”

The DHMH Office of Rural Health convened a steering committee to create the Maryland Rural Health Plan. Among the top priority areas for rural health in Maryland identified by the Steering Committee were behavioral health (mental health and substance abuse) and improvement in behaviors leading to a healthier lifestyle.

For purposes of data analysis and comparison, all Maryland jurisdictions where at least two-thirds of the census tracts are classified as rural by the federal Office of Rural Health Policy (ORHP) are included in the “federally designated rural” group. These jurisdictions tend to fare worse in the health and economic status because they are generally more isolated and have smaller and older populations than the other jurisdictions. The ORHP classifies the following three additional counties in addition to the previously identified six jurisdictions as rural: Allegany County (with 72,831 population); St. Mary’s County (with 98,853 population); and Worcester County (with 48,866 population-year round/non summer). It is worthwhile to note that rural issues apply to other areas beyond the six most rural counties discussed in this rural section of Maryland’s mental health block grant analysis.

**Talbot County is an excellent example of a county that is in the process of transforming from a rural to non-rural area. On July 1, 2003 the population was 34,670. On July 1, 2007, the last year in which official age specific population was available, the number increased to 36,193 exceeding Maryland’s self defined “rural” threshold of 35,000 by 1,193. Projections indicate that the population of Talbot County continued to increase approximately 0.4% in 2007. For purposes of this year’s block grant application we will continue to include Talbot County among the six rural counties. (Utilization data from all six counties are used in the block grant performance indicator.) Talbot County now has an average per capita personal income of \$56,775, up from \$46,144 in 2005. (Department of Business and Economic Development <http://www.choosemaryland.org/factsandfigures/demographics/incomedata.html>)

The five Eastern Shore rural counties have personal per capita incomes ranging from a low of \$24,053 in Somerset County to the high of \$56,775 in Talbot County, compared to a statewide average per capita personal income of \$48,091. The demographics of Somerset County and most of the Shore counties also reflect issues affecting rural areas. As the second smallest county in the state, Somerset County’s population actually increased slightly by 242 individuals after a decline in the previous year according to the July 1, 2007 DHMH Vital Statistics estimates. Somerset County’s 2004 household median income was one of the lowest in the State at \$33,700. Statewide household median income was \$68,080. Over the past five years, the number of Medical Assistance Program enrollees has risen. (Economic updates from Maryland Manual 2005 estimate printed 6/24/08)

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Garrett County, in western Maryland, provides a useful example of how rural communities differ from jurisdictions in more rapidly developing areas of the State. Garrett County has one of the lowest per capita incomes (\$29,820) of the State's 24 subdivisions. The 2010-2011 Core Service Agency (CSA) Plan notes that Garrett County has 819 families, or 9.8% (same) of the 8,354 families who live in poverty. In 2007, the median household income was \$40,1150 (Maryland Department of Business and Economic Development). Garrett County ranks 21st out of 24 counties in the state, for total personal income. Unemployment rates in Garrett County are almost double that of the State of Maryland. According to the July 2007 Maryland Department of Labor statistics, the annual average unemployment rate ranged from 4.5%-4.8% in one year. Current data for April 2009 estimates a 7.3% unemployment rate in Garrett County compared to a 6.6% statewide rate. (Source US Department of Labor) In Garrett County, of the adults in the age group 25 and over, 7% have less than a ninth grade education or no diploma; 79.2% have a high school or higher education. (Statewide Web-based data indicate that in March 2009 a total of 6,345 out of the total county population of 29,627 were Medicaid eligible.) The current plan indicates 18.6% of the county residents, among the highest of Maryland jurisdictions, are enrolled in Medical Assistance. In its FY 2009 CSA Plan Update, Garrett County is described as a, rural, mountainous county in the northwestern most corner of Maryland. This area of the Appalachian Mountains has high elevations with severe winter conditions. The average yearly snowfall is over seven feet. The majority of roads are winding, the nearest large city with mental health services is Cumberland, Maryland, located in Allegany County. Limitations, typical of rural areas exist in availability of transportation, access to healthcare and health information for a number of socioeconomic, geographic, educational, and cultural reasons. Low education levels create a barrier to seeking and understanding health information. However, in April 2009 access to primary health care services was improved when a new permanent Federally Qualified Health Center (FQHC) opened on property adjacent to the Garrett County Health Department and a major mental health outpatient clinic (OMHC). There was a 6.5% increase for persons served in the OMHC from 2007 to 2008. The plan notes that some of the OMHC increases resulted from more children 6-12 being served.

Use of Technology

Perhaps the best example of the use of Technology in Maryland is the recent statewide launch of The Network of Care. The Network of Care is an information Website cited as a "best practice" for the use of technology in the President's New Freedom Commission Report on Mental Health. The site contains a listing of services; a library of mental health articles; a list of support and advocacy organizations; legislation; and a personal folder/advance directive/Wellness Recovery Action Plan (WRAP) feature. The goal is to provide simple and fast access to information for persons with mental illnesses, caregivers, and service providers. The Website was first piloted in Worcester and Anne Arundel Counties. The official statewide launch was held at the annual summer conference of On Our Own of Maryland, Inc. (OOOMD) in June 2008. Phase II of the Network of Care initiative reached out to consumers in all of Maryland's 24

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jurisdictions who now have access to information and resources in their communities. The Maryland Network of Care for Behavioral Health has recorded 104,279 visits from its May 30, 2008 launch date through Feb. 12, 2009.

Also added to the Network of Care site is a comprehensive Veteran's portal to help service men and women returning from Iraq and Afghanistan with behavioral obtain access to services. This public service is an attempt to bring together critical information for all components of the veterans' community, including veterans, family members, active-duty personnel, reservists, members of the National Guard, employers, service providers, and the community at large.

In FY 2010 MHA plans collaboration with Mental Health Transformation Office (MHTO) and CSAs, to improve implementation and provide training on Network of Care. Improved outcomes will include: Web-based platform purchased and installed throughout Maryland, utilization of site tracked, improved user friendliness, mental health community informed regarding availability of Web system, consumers trained in the utilization of personal health record features, and training in use of individual advance directives.

A child and adolescent best practices project funded by MHA, in collaboration with the directors of the departments of child and adolescent psychiatry at the University of Maryland and the Johns Hopkins Hospital, involves seminars held once per month and video-conferenced to seven sites across the state. The goal is to provide state-of-the-art information (best practices) to child practitioners in Maryland on child psychiatry, psychopharmacology, and treatment. It is a live, interactive seminar that offers slide presentations, didactic material, and interactive discussion. This project keeps state providers informed of the latest developments in their field without the need to travel many hours and/or accumulate high costs. **[NFC 3, 6]**

In 2003, Sheppard Pratt Hospital Systems was awarded a grant from the U.S. Department of Agriculture (USDA) to install and furnish telemedicine equipment at several public and private mental health facilities in the State to improve access to care, using IP lines to provide real-time interactions between psychiatrists and patients. Three units were set up in Worcester County in conjunction with the grant. Worcester County Health Department Core Service Agency, with funding from the Mental Hygiene Administration, contracted with Sheppard Pratt to provide telepsychiatry services to clients who were homeless with mental illnesses and substance abuse problems. The Worcester County Health Department Core Service Agency has since expanded on these services by funding mental health treatment to children and adolescents. Sheppard Pratt was also awarded a grant in 2006 by the Health Resources Services Administration (HRSA) to purchase equipment, train providers, and establish a telepsychiatry disaster network at several general hospitals and community mental health clinics in Maryland.

Sheppard Pratt has also completed a telepsychiatry inpatient attending physician demonstration project, one of the first in the country, with a general hospital on the Eastern Shore. The general hospital was in need of psychiatric coverage during a time of

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staff turnover, a common problem for rural general hospitals in Maryland as well as most other states. The hospital funded the professional fees portion of the pilot project as a demonstration of inpatient telepsychiatry utilization. Finally, a twice-monthly mental health grand rounds professional education program is provided via interactive video-conferencing to a number of hospitals and mental health clinics in Maryland.

Correctional Mental Health Services began utilizing telepsychiatry in 2004 at the St. Mary County Detention Center as part of a comprehensive program to provide mental health services to incarcerated individuals. This program currently provides telepsychiatry services at the St. Mary's, Charles, and Wicomico County Detention Centers. Through this program, both live and telepsychiatry services are provided to all sites which utilize telepsychiatry. Additionally, in FY 2010, Sheppard Pratt will begin providing telemedicine services to children and adolescents at the Behavioral Health Clinic, an outpatient facility in Wicomico County.

MHA, in collaboration with CSAs, is now working to develop parameters for telemedicine, including its use to address access issues for remote locations, specialty services, and special needs groups. The Maryland Association of Core Service Agencies (MACSA) applied for grants, (USDA and HRSA) to obtain funding for the purchase of equipment and has partnered in this grantsmanship effort with the Mental Hygiene Administration and the University of Maryland Department of Psychiatry. In May 2008 HRSA approved the grant for telemental health equipment in rural areas. The grant is for three years with a two-year renewal possibility. The University of Maryland Department of Psychiatry has 90 psychiatrists, many board certified, who will implement the telemental health project with Medical Assistance (MA) patients from these rural areas. MHA is providing funding for the psychiatrists services which will eventually be reimbursed by MA. Telemental health has been piloted in 26 other states. **[NFC 6]**

MHA chairs the mental health subcommittee meetings on telemental health. MHA has also met with Springfield Hospital Center (SHC), along with MHTO, and the University of Maryland to explore the possibility of installing equipment at a SHC unit to implement telemental health services for individuals who are deaf or hard of hearing.

Additionally, MHA partnered with the University of Maryland's Department of Psychiatry to submit a grant application on March 6, 2009, for the federal Health Resources and Services Administration (HRSA) funding in order to develop a Center of Excellence on Telemental health for Special Need Populations. If funded, the Center of Excellence on Telemental Health will improve access to culturally competent services for the deaf and hard of hearing population. In rural communities, MHA's Office of Special Needs Populations in collaboration with Mid-Shore Mental Health Systems and Gallaudet University, will promote a series of trainings, as well as explore the use of the Web to increase cultural awareness and sensitivity to the needs of individuals who are deaf or hard of hearing. This includes application of new communication and technology, i.e. video phone, telepsychiatry, and Web-based training.

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Available Services

At present, the range of mental health and support services in rural counties is similar to those that are available in urban and suburban jurisdictions. Some services in contiguous counties are provided by programs that provide services at multiple sites throughout the area served. Mental health providers in rural areas have a history of cooperation and coordination as well as a history of sharing resources, with each other and with other service related agencies, to address the service needs of specific populations. Through this cooperation, providers have developed innovative services that are tailored to the unique needs of their areas. [NFC 3]

The maintenance of effective core service agencies (CSAs) is a key statewide strategy to meet rural needs. The Mid-Shore Mental Health Systems, Inc. (MSMHS) is the CSA responsible for public mental health services in Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties, located on Maryland's Eastern Shore. MSMHS is currently the only regional CSA in Maryland. Of these five MSMHS counties, Queen Anne's County with a population of 42,039 was added to the Baltimore-Washington metropolitan region after the 2000 Census and is no longer considered a rural county.

In its Community Mental Health Fiscal Year 2010 Plan Update, MSMHS discussed the rural nature of counties in the region. Population per square mile ranges from 55.4 persons per square mile in Dorchester County to 130.1 per square mile in Talbot County, with a regional average of 89.9. The Plan emphasizes that in "planning processes to improve the system of care to assure consumer focus and one (system) that is recovery oriented, it is apparent that the unique needs of the rural jurisdictions must be given a priority." "In absence of a number of valuable mental health services that are difficult to replicate in rural communities, the CSA uses the spirit of cooperation to break down barriers to access and choice whenever possible".

The MSMHS reported special initiatives and collaborative efforts targeted towards specific populations which include individuals with mental illnesses who are homeless, dually-diagnosed (mental illness and developmental disabilities), have co-occurring disorders (mental illness and a substance addiction), are deaf or hard of hearing, returning military veterans, transition-age youth and individuals whose mental health needs are coupled with a forensic background.

In FY 2010 updated Plan, the MSMHS reported on the following accomplishments:

- Forensic Mental Health Coordinator: MSMHS has partnered with the Circuit and District Court judges to create two regional positions that will offer the criminal justice system in each jurisdiction an opportunity to provide consumers with mental illnesses voluntary, community-based assessment and treatment alternatives to traditional methods of criminal behavior punishment through: 1) access to a licensed mental health professional who understands systems management and resources in the region and can recommend and monitor those alternatives which improve outcomes to people historically poorly-served by detention centers. Monitoring of offenders in court ordered evaluation,

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- recommendations regarding community-based treatment, and facilitation of ongoing communication and collaboration where criminal justice, mental health, substance abuse, and related systems intersect. (This new initiative is supported by a reallocation of community mental health block grant resources. Success will be measured by the program's ability to lead individuals to effective community treatment and break the cycle of recidivism in the courts and detention facilities.)
- Telepsychiatry Network Program: This new program puts tele-video equipment in clinics and other provider locales in seven rural Maryland counties; including all five on the Mid-Shore. These rural sites will be able to: link to psychiatric specialists identified as not present in the region or operating with excessive waiting lists due to a chronic supply/demand imbalance in rural communities. Service commenced during December 2008, and will continue for two and a half years. [NFC 6]
 - MSMHS has taken the role of the lead agency for the HUD Continuum of Care (CoC), and was successful in the development of 35 Shelter Plus Care permanent housing units, 17 permanent supportive housing units, and a regional Homeless Management Information System. Increased availability of affordable housing/homeless shelters was one of three prioritized regional needs identified by stakeholders. The CoC has engaged three faith-based groups that have volunteered to operate shelters in the region. [NFC 3]
 - MSMHS and its providers promote a long-term recovery model for consumers with serious mental illness (SMI) and have developed outcome measures for PMHS community – based services. MSMHS collaborated with local providers to develop outcome measures for contractually funded services, as well as for selected services within the fee-for-service system, including adult psychiatric rehabilitation programs, residential rehabilitation programs, and supported employment.
 - MSMHS continues to participate on the Governor's Office of Deaf and Hard of Hearing Mental Health sub-committee, supporting the development of a statewide needs assessment and inventory of mental health services available to individuals who are deaf or hard of hearing and will develop a state proposal to include recruitment and training of culturally competent mental health professionals. Many representatives are active on the local and state mental health advisory council.
 - Chesapeake Rural Network (the region's peer support network) has been developing stability, resulting in an improved operations plan that will benefit all consumers in the region.

After several years of moderate expansion, Somerset County CSA (SCCSA) has worked to maintain the array and number of services available. As the second smallest county in the state, Somerset County's population actually increased slightly by 242 individuals after a decline in the previous year, according to the July 1, 2007 DHMH Vital Statistics estimates. Somerset County has only seen a 5.6% growth in population in the past 10 years, with little of that growth in recent years, and has one of the lowest median income rates in the state. These factors make it important to avoid duplication of effort and to acknowledge the need for collaboration with both in-county and tri-county (Somerset, Worcester, and Wicomico) stakeholders on planning, service expansion, and

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coordination of activities and efforts. The Tri-County Provider Forum continues to meet to discuss issues regarding the PMHS and to increase provider knowledge.

In the FY 2010-FY2011 Plan, the Somerset County Core Service Agency reported on the following accomplishments:

- Collaborated with Department of Human Resources to implement regional Mental Health Mobile Crises and Stabilization Services to Department of Social Services (DSS) foster care involved youth and families in the three lower counties of Somerset, Wicomico, and Worcester.
- Partnered with the Family Services Division of the Circuit Court to update and re-distribute the county resource guide;
- Support increased participation in Lower Shore Friends developing plans in FY 2009 to implement the Wellness and Recovery Action Plan (WRAP);
- Participated in the statewide effort to launch a mental health and human services Website called Network of Care (NOC) to assist individuals, families, and agencies concerned with behavioral health;
- Continued to coordinate the Somerset County Adult Multi-disciplinary Team;
- Continued working in partnership with the two other CSAs on the lower shore and received a HUD grant to provide housing in the tri-county region to address permanent housing; and
- Partnered with Seton Center, a local affiliate of Catholic Charities, to provide mental health educational information in the Spanish language. [NFC 3]

The Fiscal Year 2010-11 Plan for the Garrett County Core Service Agency (GCCSA) included recent accomplishments. Highlights included:

- Extensive collaboration and partnerships to improve services to children, youth, and adults in areas related to school mental health, peer support, addictions services, trauma and jail services, suicide prevention, and disaster planning.
- A statewide initiative for service coordination for veterans began in FY 2009. Two outpatient mental health programs in Garrett County have participated and the Western Region Resources Coordinator presented information to the community on the program at the Local Mental Health Advisory Committee (LMHAC) meeting.
- The Older Adults Transition Service (OATS) Social Worker continued to provide outreach, support and training for volunteers. This mental health professional links older adults to community services and provides consultation to nursing home staff, assisted living providers, and adult medical day service providers on mental health issues. [NFC 4]
- GCCSA continued the Adventure Sports Institute (ASI) of Garrett College, which operates the Transition-Age Youth (TAY) project. TAY graduates now act as mentors to incoming TAY participants. The Garrett County Commissioners and Garrett College have agreed to provide support for the third year of this successful project.

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- Consumer-run Wellness and Recovery Center (Harvey House) will have hours of operation expanded during FY 2010.
- Garrett County Sunrise Support Group for Survivors of Suicide will continue to meet with the GCCSA providing assistance and public awareness activities
- The Federally Qualified Health Center (FQHC) provided access to primary health care services on property adjacent to the Garrett County Health Department. There was a 6.5% increase for persons served in the outpatient mental health clinic (OMHC) from 2007 to 2008. The plan notes that part of the OMHC increases resulted from more children 6-12 (one of the identified targeted population) being served.

The following table provides an overview of the six rural counties and the major programs available. Not included in the table is the broad array of individual providers in these rural communities.

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CONTINUUM OF MENTAL HEALTH SERVICES	Mid-Shore Mental Health Systems	Somerset County CSA	Garrett County CSA
Advocacy- Adult and Child	X	X	X
Community Support Funds(pharmacy, lab, transportation, other needs)	X	X	X
Detention-Based Mental Health Services	X	X	X
Inpatient Services Adult Adolescents Child	X X X	X (youth and family services in Crisfield)	Emergency Room only
Intensive Outpatient Services	X		X
Intensive In-Home Services	X	X	X
Outpatient Mental Health Adult Child and Adolescent	X X	X X	X X
Peer Support Services	X	X	X
Psychiatric Rehabilitation Program Adult Child and Adolescent	X X	X X	X X
Respite Care Adult Child	X X	X X	X
Supported Employment Services	X	X	X
Transition Age Youth Programs	X	Go-Getters provided six residential slots	X
Targeted Case Management Adult Child and Adolescent	X X	X X	X

Service Needs

In order to best assess local service needs and implement services to meet those needs, MHA strongly supported the development of CSAs in rural counties. As noted previously, all rural counties in Maryland are served by CSAs. The rural CSAs are challenged to plan, both independently and collectively, for their residents' needs and the most efficacious use of resources. All CSAs are required to include a description of their needs assessment process and findings, including gaps in services, in their local mental health planning documents. The consistent and recurring service needs identified are: adequate number and mix of providers, need for specialty service providers, transportation, crisis treatment services, and efforts to address the needs of individuals with co-occurring disorders.

One of the major challenges for a rural area is the recruitment, retention, and ongoing training of mental health professionals. The number of qualified professionals in the Mid-Shore area has increased over time and this may be attributed to the growing nature of some of the Mid-Shore counties. Conversely, in its FY 2009 Plan Update, the Garrett County Core Service Agency reports that there is only 1.6 full-time equivalent of psychiatrist time available in the county. The need for psychiatric care for the child and adolescent population is acute. Garrett County and Kent County (as well as a number of very urban census tracts in Baltimore City with special needs related to the homeless population) are designated by the federal Department of Health and Human Services, Bureau of Primary Health Care as mental health professional shortage areas (MHPSA). MHPSA designation may provide needed assistance in the recruitment of physicians.

In FY 2010-11 Plan, the Somerset County Core Service Agency identifies the development of services in rural areas as presenting multiple challenges. Accessing services is difficult, especially with limited transportation services. Available resources are scarce compared to urban areas. There are severe shortages of specialized mental health professionals and providers. Additionally, stigma continues to be an issue.

Like many rural areas, Somerset County providers are having problems attracting and keeping behavioral health professionals, particularly psychiatrists and therapists. Additionally, psychiatrist availability can be limited. One clinic in Somerset County closed new intakes for approximately one year due to having limited psychiatrist time. In the FY 2010-2011 Plan, the Somerset County Core Service Agency identified the following areas of need to continue to address:

- Maintaining collaborative initiatives locally, regionally and statewide;
- Increasing awareness and public knowledge about mental illness and mental health resources;
- Developing strategies that address ending chronic homelessness among individuals with mental illnesses;
- Addressing the need for integrated services for individuals with mental illnesses, substance abuse, and developmental delays; and

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- Developing and implementing outcomes management objectives for all contractual obligations.

CSAs, in both rural Western Maryland and rural Eastern Shore, have identified the need to travel to adjacent counties for some services as a significant rural issue. Transportation to and from services has been a barrier not only for appointments but for consumers attempting employment and increasing involvement in their local communities. Due to the lower population density and greater distances to all types of services, rural mental health programs have acquired and operate vehicles to link individuals to services, both through mobile services and by transporting consumers to needed services. Local health departments and community action agencies also provide some publicly-supported transportation in rural counties. Additionally, CSAs have some funding in their budgets for transportation services for eligible individuals. Stigma also plays a significant role as a barrier to accessing mental health services, particularly in rural settings. The CSAs on the Eastern Shore and Lower Shore Counties work collaboratively with stakeholders to address stigma through workshops and public awareness activities.

In Mid-Shore Mental Health Systems, Inc.'s (MSMHS's) Community Mental Health Plan for Fiscal Year 2009 and 2010, a good discussion is provided of the local needs assessment process and results. The Plan discusses disproportionate representation of ethnic groups in the lower income range and the impact of the search for affordable housing as suburban counties see rapid increases in housing costs. In a chart designed to show the Mid-Shore region's continuum of care for public mental health, clear gaps in crisis services are shown. (A same day appointment service has been successfully used as a stop-gap measure.) Also the plan identifies another critical gap with regard to jail mental health delivery in the region's detention centers.

MSMHS, in collaboration with other community programs, recognizes the need for mental health services for Hispanic consumers that are uninsured. The Mid-Shore Council on Family Violence has two bilingual client advocates. For All Seasons, an OMHC, applied for a grant to obtain funding for a bilingual interpreter and MSMHS will provide the cost of the therapist, and limited psychiatrist time. **[NFC 3]**

The Garrett County Core Serve Agency's (GCCSA's) 2010-2011 Mental Health Plan focuses on solidifying and enhancing existing programs. Efforts will focus on:

- Coordination and collaboration with consumers, family members, providers and other county and state stakeholders to assure accessibility to quality mental health services;
- Implementation of Telepsychiatry services at the Garrett County Community Mental Health Center to improve consumer access to skilled mental health professionals;
- Strengthening the consumer-run center and fostering a more cohesive consumer movement for quality-based mental health services;
- Expansion of geriatric mental health services;

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- Development of a continuum of community- based housing services for individuals who have severe mental illness;
- Continuation of suicide prevention activities;
- Ongoing development of services for the co-occurring population;
- Identification of funds and programs which are targeted to increasing evidence-based practices mental health services for children and adolescents and their families;
- More supported employment opportunities/work sites for those individuals who want to work;
- Increased availability of child psychiatry services- the health department hired a part-time psychiatrist leading to a decrease in the wait time for initial medication evaluation appointment for new mental health consumers; and
- Continued availability of outpatient and psychiatric rehabilitation program providers - in March 2009 the Mental Health Center of Western Maryland, which had been providing outpatient mental health and psychiatric rehabilitation program services to children, adolescents, and adults, closed.

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SFY 2010 OBJECTIVES FOR CRITERION 4:

SERVICES FOR ADULTS

TARGETED SERVICES FOR RURAL POPULATIONS

- In collaboration with the CSAs, improve implementation and provide training for consumers at the county-level on Network of Care, a Web-based platform, which provides information, resource directories, and on-line availability of personal health record information, including advance directives.
MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis
- Collaborate with the Maryland Advisory Council for the Deaf and Hard of Hearing, the Governor's Office of Deaf and Hard of Hearing (ODHH), CSAs, advocates, other state and local agencies, and colleges and universities to provide support and technical assistance to promote statewide access to services that are culturally competent for individuals who are deaf or hard of hearing, which includes application of new communication and technology, i.e. video phone, telepsychiatry, and Web-based training.
MHA Monitor: Marian Bland, MHA Office of Special Needs Population
- Promote use of Web-based resources to educate the public and extend and improve training resources for consumers, family members, mental health professionals, and other stakeholders.
MHA Monitor: Carole Frank, MHA Office of Planning, Evaluation, and Training

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ADULT PLAN CRITERION #4

TARGETED SERVICES TO THE HOMELESS

The exact number of children and youth in Maryland who are homeless and who have mental health problems is unknown. MHA has been participating in the efforts of the Maryland Department of Human Resources (DHR) and local communities to implement the Homeless Management Information System statewide. All of the Maryland counties have established a system and most of the counties have trained shelters' staff and providers on utilizing the Homeless Management Information System. Some counties are still working to resolve issues regarding providers' resistance to using the Homeless Management Information System due to concerns about client confidentiality. Data are not broken out by age as a part of the survey. Efforts are also underway to develop a statewide data warehouse so that local homeless data may be accessed at the state level. [NFC 6]

DHR gathers and reports information only on people who have stayed in emergency shelters, transitional housing programs or who have received emergency motel placements. The data reflects the extent of shelter services provided to people who are homeless as reported by emergency shelter and transitional housing providers on a Homelessness Services Survey form. The data in DHR's report does not include an absolute count of the number of homeless people in Maryland.

DHR's FY 2008 Annual Homeless Report is unavailable at this time; therefore, MHA is using data from DHR's FY 2007 Annual Homelessness Report. Based on this report, there were 36,599 persons served in Maryland's homeless shelters in FY 2007, which represents a decrease - 834 less people served than in the prior year. There were 23,986 people served in emergency shelters, 7,248 served in transitional housing, 5,383 served through motel placements.

Another source of data that is available is Maryland's 2006 Homeless Assistance Programs Point in Time Survey which estimates 4,569 individual and family households were served in emergency or transitional housing, and 1,755 households were unsheltered. In terms of persons homeless, the Department of Housing and Urban Development (HUD) 2006 Continuum of Care (COC) estimates 6,656 persons in individual or family households were residing in emergency or transitional housing and 2,041 unsheltered persons were homeless. Also based on HUD COC Point in Time Survey in Maryland, there are 8,697 persons who are homeless. Of this number 30.7% are unsheltered and 21.1% have a serious mental illness.

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SSI/SSDI Outreach, Access, and Recovery (SOAR). Individuals who are homeless can benefit from Medicaid enrollment to obtain needed services. In FY 2010, MHA has a strategy to utilize an increase in PATH funding to provide support to hire a SSI/SSDI Outreach, Access, and Recovery (SOAR) outreach coordinator to re-launch and expand the pilot initiative in Baltimore City and Prince George's County. Outreach coordinators will work with case managers in these jurisdictions to assist 105 consumers with applying for SSI/SSDI benefits through the SOAR process.

Services for Runaway and Homeless Youth. The unmet needs of youth that are homeless are extensive, particularly the needs of the runaway and homeless adolescents with serious emotional disturbance. A special project, for runaway and homeless youth, continues in Ocean City, Maryland, the state's major beach resort area. Located in Worcester County on the Eastern Shore, Ocean City increases from a relatively small community to a population of close to 400,000 in the summer. Many runaway and homeless youth frequent the resort, some experiencing serious psychiatric disorders, almost all involved, in some way, in drug and alcohol abuse. The agencies in the community have formed a successful collaborative consortium to coordinate shelter, primary health, substance abuse, mental health, and other human services for this population. The project serves youth from all areas of the rest of the Maryland and large numbers of youth from other surrounding states in the region. Federal community mental health block grant funds have been allocated for mobile crisis services in Worcester County. This project is intensively staffed. [NFC 5]

Services for Children in Homeless Families. MHA has funded and provided technical assistance to a project for young children who are homeless because their mothers and other family members live in family shelters throughout Baltimore City. The Parents and Children Together (PACT) program provides a therapeutic nursery at the YWCA shelter in Baltimore City, and extensive consultation at The Ark, a day care program that serves many of the children who reside in family shelters across the entire city. This population is reported to experience significant developmental delays, particularly in language acquisition.

Children and adolescents with serious emotional disturbance in families that are homeless can access Maryland's Projects for Assistance in Transition from Homelessness (PATH) and Shelter Plus Care programs for services. PATH funds are used for outreach, engagement, case management, screening and diagnostic services, consultation to shelters, training, housing assistance, supportive services in residential settings, and mental health and substance abuse services. PATH funded case managers are located in shelters, detention centers, and service agencies, facilitating outreach and access to services in a timely manner. PATH provides outreach and access in urban, suburban, and all rural areas in Maryland. These services also link individuals and families to the fee-for-service system. The PATH Program is targeted to homeless consumers who have serious mental illnesses or co-occurring substance use disorders, who are disconnected from the community and lack the necessary supports to obtain permanent housing.

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The PATH program provided services in 22 of 23 counties and Baltimore City in FY 2009. In FY 2008, the funding level was \$1,052,000. Local PATH supported agencies identified 3,847 homeless individuals with mental illnesses. Of these, 2,082 actually enrolled for PATH services. In FY 2009, the PATH funding level was decreased to \$1,032,000 due federal cuts in the PATH Program. The \$20,000 shortfall in FY 2009 was taken from Baltimore City's PATH award. In FY 2010, PATH was increased by \$140,000 which will fund SOAR Outreach Specialists in Baltimore City and Prince George's County. In FY 2010, PATH will be funded at \$1,172,000. PATH programs are projected to serve an estimated 2,238 individuals and families in FY 2010. The following table presents a summary of the most current PATH program information:

SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2010 FUNDING	PROJ. # SERVD. SFY 2010	SERVICES PROVIDED UNDER PATH
Allegany County	Allegany County Mental Health Systems	\$54,955	40	ALLEGANY COUNTY MENTAL HEALTH SYSTEMS - Community outreach, case management, staff training, housing assistance, supportive services, referrals to primary health services, job training, educational and relevant housing.
Baltimore City	BMHS Baltimore Mental Health Systems, Inc.	\$268,856	340	BALTIMORE MENTAL HEALTH SYSTEMS-Position funded in BMHS to provide technical assistance in locating and developing affordable housing, room and board training, registry of house resources.
				UNIVERSITY OF MARYLAND MEDICAL SYSTEMS- SSI outreach, linkage to services and housing, case management, liaison to homeless outreach teams, outreach assessment.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2010 FUNDING	PROJ. # SERVD. SFY 2010	SERVICES PROVIDED UNDER PATH
				<p>HEALTH CARE FOR THE HOMELESS-Street outreach, SSI Presumptive Eligibility Project, mental health and addictions treatment, and case management. SOAR Outreach Specialist to develop and maintain relationships necessary to achieve more rapid SSI/SSDI application approvals, including relationships with SOAR partners, Disability Determination Services, Social Security Administration, Policy Research Associates, Mental Hygiene Administration and others. Provide technical assistance to case managers and other SOAR trained providers with outreach to homeless individuals and completing SSI/SSDI applications for benefits.</p>
				<p>PRISONER'S AID ASSOCIATION-Outreach, case management, linking women who have a history of mental illness and trauma to services and housing</p> <p>CHRYSALIS HOUSE HEALTHY START PROGRAM - 16 bed diagnostic and transitional facility for pregnant and post-partum women and their babies. The participants will be women who are incarcerated in local detention centers and have misdemeanor charges. Comprehensive assessment, outreach assessment, housing assistance, case management, access to appropriate treatment resources and services will be provided.</p> <p>STATEWIDE TRAINING</p>

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2010 FUNDING	PROJ. # SERVD. SFY 2010	SERVICES PROVIDED UNDER PATH
Baltimore County	Dept. of Health Bureau of Mental Health CSA	\$96,200	150	PROLOGUE, INC. – Outreach, screening and diagnostic services, training, case management, housing coordination and matching, security deposits, one-time rentals (eviction prevention), support and supervision in residential settings, staff training.
Calvert County	Calvert County CSA	\$30,380	120	CALVERT COUNTY MENTAL HEALTH CLINIC Outreach, screening, case management relevant housing services, referrals for primary health, community mental health services, substance abuse treatment, job training programs, educational services.
Carroll County	Carroll County CSA	\$37,000	50	KEYSTONE SERV.OF MD – Outreach, intensive case management, screening and diagnostic, assistance with linking to housing and services linking to training, support in residential settings.
Cecil County	Cecil Co CSA	\$5,000	8	CECIL COUNTY CORE SERVICE AGENCY -One - time only rental assistance, security deposits and training, contract with outreach and case management services.
Charles County	Charles County CSA	\$35,000	75	SOUTHERN MARYLAND DIVISION OF CATHOLIC COMMUNITY SERVICES – Outreach, referral to intensive case management, mental health, linkage to mental health services, screening and diagnostic treatment, assistance in planning for housing, technical assistance with housing, referrals to alcohol and drug treatment, medical care, pharmacy assistance, job training, educational legal assistance, and assistance with security deposits.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2010 FUNDING	PROJ. # SERVD. SFY 2010	SERVICES PROVIDED UNDER PATH
Frederick County	Frederick County CSA	\$77,400	300	FREDERICK COMMUNITY ACTION AGENCY – Outreach, case management, referrals for health care, job training, alcohol and substance abuse treatment, transportation, housing coordination, supportive and supervisory services, and the development of Med bank services to link PATH clients to free prescription medications made available through patient assistance programs.
Garrett County	Garrett County CSA.	\$24,500	27	GARRETT COUNTY CSA. - Screening, housing coordination, security deposits, one - time only rental assistance linkage to permanent housing, and referrals for mental health and other services.
Harford County	Harford Co CSA	\$71,524	95	CORE SERVICE AGENCY IN COLLABORATION WITH ALLIANCE, INC. – Outreach, case management, linkage to housing, assessments, and referrals, substance abuse and assertive treatment services, services to prevent re-incarceration and improve access to services upon release from incarceration.
Howard County	Howard County CSA	\$35,478	30	GRASS ROOTS CRISIS INTERVENTION CENTER – Case management, psychiatric services, referral, housing assistance, assistance with entitlements.
Mid-Shore (Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties)	Mid-Shore Mental Health Systems, Inc.	\$52,624	80	MIDSHORE MENTAL HEALTH SYSTEMS, INC. – Contracts with vendors to provide homeless outreach to all five counties, assessments, housing security deposits assistance, case management, conduct needs assessment, one - time only rental payments.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2010 FUNDING	PROJ. # SERVD. SFY 2010	SERVICES PROVIDED UNDER PATH
Montgomery County	Montgomery County CSA	\$115,588	300	MONTGOMERY COUNTY DETENTION CENTER- Outreach, engagement, linkage to mental health and co-occurring treatment services, case management, and housing assistance.
				VOLUNTEERS OF AMERICA- Outreach on streets, at emergency shelters, day programs, soup kitchens and to those on the psychiatric crisis intervention unit, case management and linkages to entitlements and services.
Prince George's County	Department of Family Services, Mental Health Authority Division	\$119,264	85	QUALITY CARE INTERNET BEHAVIORAL HEALTH – Outreach, screening, assessment, case management, supportive services in residential settings, housing assistance, referrals to mental health services, medical, housing, rehabilitation, and vocational training, one-time only rental assistance and security deposits. Prince George's County Department of Social Services or selected vendor will target Thirty (30) individuals and assist them with completing SSI/SSDI applications based on technical assistance and training provided by SOAR Outreach Specialist.
Somerset County	Somerset County CSA	\$10,000	8	SOMERSET COUNTY CORE SERVICE AGENCY-Outreach, housing services, i.e. one-time only rental assistance to prevent eviction, security deposits, planning of housing, and minor renovations to existing housing.
St. Mary's County	St. Mary's Department of Human Services	\$45,950	120	DETENTION CENTER MENTAL HEALTH - to serve homeless, detention center inmates with mental illness, screening, assessment, linkage to community resources. Two hours per week of telepsychiatry in a mental health clinic to assist with aftercare planning.
				THREE OAKS SHELTER – Outreach and case management services and aftercare which includes housing are its goals.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2010 FUNDING	PROJ. # SERVD. SFY 2010	SERVICES PROVIDED UNDER PATH
Washington County	Washington County CSA	\$37,000	320	TURNING POINT – Case management outreach, job training, supportive and supervisory services, screening and diagnostic services. 2 positions: homeless outreach worker and outreach assistance.
Wicomico County	Wicomico County CSA	\$22,000	40	WICOMICO COUNTY CSA- Assessment, service planning, linkage to mental health, housing, medical, employment, outreach, and case management.
Worcester County	Worcester County CSA	\$33,281	50	HEALTH DEPARTMENT – MENTAL HEALTH PROGRAM – Mobile assessments, assertive outreach, training one - time only rental payments, security deposits, minor renovation, expansion and repair of homes, mental health and case management.
TOTAL Maryland	23 Jurisdictions	\$1,172,000	2,238*	

In previous years, data on the number of persons served included those served through outreach and those receiving ongoing PATH services. Due to changes in definition, PATH consumers who are engaged through outreach are no longer included in the number of persons to be served. PATH providers are currently counting only those who are considered enrolled (client file opened and service plan developed) as the number served in FY 2009.

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In 1995, the U.S. Department of Housing and Urban Development (HUD) first awarded MHA a five-year, \$5.5 million Shelter Plus Care grant to provide housing for individuals who are homeless with serious mental illnesses and their dependents who are being released from the detention center, or are in the community on intensive caseloads of parole and probation. Last year, the FY 2009 Shelter Plus Care Housing grant was renewed for \$3,862,442. The renewal grant was increased largely due to increases in the Fair Market Rental Values determined by HUD. Additionally, in FY 2009 MHA received \$592,916 through five small grants targeted to specific jurisdictions. The jurisdictions awarded new five-year grants over the past years through MHA included Allegany, Anne Arundel, Baltimore, Cecil, Frederick, Harford, and Prince George's counties. [NFC 2]

For FY 2010, MHA was awarded funding in the total amount of \$3,306,900 for 16 Shelter Plus Care renewal grants. Additionally in FY 2010, MHA received \$513,678 through five small grants targeted to the specific jurisdictions as mentioned. Currently, MHA is serving a total of 653 persons, 147 single individuals with mental illness, 172 families with 281 children and 53 other family members through all of the Shelter Plus Care grant programs.

Since 1995, the process for applying for funding through the U.S. Department of Housing and Urban Development (HUD) has changed. In 1996, HUD introduced to communities the Continuum of Care model to strategically address the problems of housing and homelessness in a more coordinated and comprehensive fashion. The model required local communities to develop a strategic plan to address the use of HUD resources and this also became the application process for obtaining HUD funding. As a result of this change, MHA lost its ability to directly apply for Shelter Plus Care Housing grant funds to HUD and to apply for funding using a single statewide application. The new process requires MHA and other state and local entities to apply for funding through the local Continuum of Care Planning group. In FY 2009, MHA submitted 16 renewal grants to thirteen Continuum of Care Planning groups as a part of their application for HUD funding. Each local Continuum of Care of Plan must incorporate MHA's Shelter Plus Care application into its local plan annually.

Advocates for the homeless and for housing for people with disabilities in Maryland have expressed concern with proposed changes in the Housing Choice Voucher Program. If fewer vouchers are available for individuals with disabilities, then it will be more difficult to advance consumers from Shelter Plus Care to other housing choice programs.

Individuals who are homeless are also served by traditional mental health treatment and support programs, including existing psychiatric rehabilitation programs, case management entities, crisis service providers, and mobile and on-site clinic services. In addition, outreach and eviction prevention services, as well as coordination with needed mental health services are provided to homeless individuals. In Baltimore City, Baltimore Mental Health Systems, Inc. obtained grant funds to provide case management

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and other services for homeless individuals with mental illnesses. State general funds and mental health block grant funds support additional services and programs for the homeless population.

People Encouraging People, a mental health provider and long a leader in mental health services and outreach to the homeless in Baltimore City, was awarded \$400,000 per year for five years to create a comprehensive dual diagnosis treatment program for persons who are homeless and have substance abuse and mental health problems in June 2005. During the last reporting period, January 1, 2009- March 31, 2009, 69 clients were engaged for services. Ten (10) clients consented to receive case management or intensive outpatient services and participate in a COD evaluation for medication and psychosocial assessment. Sixty-seven (67%) were housed within 60 days of initial agreement to receive services and 100% of consumers remained housed for 180 days. Twenty-seven (27%) of consumers not already receiving Temporary Cash Assistance (TCA) receive Transitional Emergency, Medical, and Housing Assistance (TEHMA), food stamps or other accessed benefits.

MHA provides state general funds to support statewide training for mental health providers, which includes providers of PATH services. In addition a portion of Baltimore Mental Health Systems PATH funding is targeted for statewide training for PATH providers and/or to send providers to national, state, and local trainings to enhance skills of staff delivering services to PATH eligible clients. Additionally, MHA has quarterly meetings with PATH providers to discuss clinical and programmatic issues and to provide an opportunity for information sharing between local providers. The following trainings or conferences were held in FY 2009:

- MHA's Office of Special Needs Populations in partnership with MHA's Office of Adult Services and the University of Maryland Mental Health Training Center had a two-day training on Motivational Interviewing for case managers and PATH providers that empowered them to address client motivation by "meeting the client where they are", reducing unrealistic expectations, strengthening and consolidating the client's commitment to change. A total of 25 people attended the training.
- MHA's Office of Special Needs Populations was also involved in the planning for MHA's Adult Services Annual Case Management Conference titled "A Stimulus Package for Case Management." The Director of Shelter Plus Care and PATH Programs presented along with a PATH provider a workshop entitled "Moving Individuals Along the Continuum of Care to Housing." A total of 60 people attended the workshop and the overall attendance at the conference was 270.
- MHA's Office of Special Needs Populations assumed leadership of the state's SOAR initiative in April 2008 and MHA, over the past year, has provided technical assistance to two pilot sites (Baltimore City and Prince George's County). In addition, MHA has met with Anne Arundel County, Baltimore

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County and Montgomery Country to implement a SOAR initiative in their local jurisdictions. MHA's Office of Special Needs Populations will continue to meet with other jurisdictions to expand SOAR statewide during FY 2010.

- Technical assistance and "Train the Trainer" activities on SOAR implementation was provided to the Maryland Department of Public Safety and Correctional Services Social Workers and to mental health case managers/benefits specialists. This training effort will continue in FY 2010.

In FY 2009 MHA continued to meet on a quarterly basis with community service providers that receive PATH funds. MHA staff also attends the Continuum of Care Planning group meetings on a regular basis. Since December 2004, MHA has been participating in the development of the state's Interagency Council on Homelessness Ten-year Plan to End Homelessness in Maryland. This planning committee is chaired by the Department of Human Resources (DHR) and co-chaired by DHMH. MHA also participated on the State's SSI/SSDI, Outreach, Access and Recovery Technical Assistance Initiative, and work group which-provides training to case managers working with individuals who are homeless on strategies to expedite processing of SSI/SSDI applications. Additionally, MHA collaborates with other agencies and departments that provide services or have resources to meet the needs of individuals who are homeless with psychiatric disorders, including DHR, the Department of Housing and Community Development, the Department of Housing and Urban Development, the Department of Public Safety and Correctional Services, and the Department of Economic and Employment Development. Within DHMH itself, MHA collaborates with the Alcohol and Drug Abuse Administration, Family Health Administration, Medical Care Policy Administration, and the AIDS Administration. MHA encourages and provides technical assistance on request to encourage similar interaction at the local level to facilitate effective service provision for homeless individuals of all ages with psychiatric disorders.

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SFY 2010 OBJECTIVES FOR CRITERION 4:

SERVICES FOR ADULTS

TARGETED SERVICES TO THE HOMELESS

- Utilize increase in Projects for Assistance in Transition from Homelessness (PATH) funding to provide support to hire a SSI/SSDI Outreach, Access, and Recovery (SOAR) Outreach Coordinator to re-launch the pilot initiative in Baltimore City and Prince George's County and expand SOAR regionally.
MHA Monitor: Marian Bland, and Keenan Jones, MHA Office of Special Needs Populations
- Continue to provide funding for rental assistance to CSAs through the Shelter Plus Care grants from the federal Department of Housing and Urban Development (HUD).
MHA Monitor: Marian Bland, and Keenan Jones, MHA Office of Special Needs Populations

TARGETED SERVICES TO OLDER ADULTS

During FY 2009, approximately 1,200 persons aged 65 and older were served through the PMHS fee-for- service system. Services rendered included case management, crisis, inpatient, mobile treatment, outpatient, inpatient, psychiatric rehabilitation, residential rehabilitation, respite care, and supported employment. Older adults access services in the PMHS in the same way as other age groups. Access to outpatient services can be challenging due to the reduced fees paid by Medicare. Providers are, at times, reluctant to provide this service to large numbers of Medicare recipients. The PMHS also provides non-Medicare covered services to older adults who meet the eligibility and medical necessity criteria for the service.

In addition to these services in the fee-for-service system, MHA funds specialized services for elderly individuals through the CSAs. Since 1988 MHA has utilized a team of psycho-geriatric nurse specialists and social workers to provide consultation services to nursing homes and community programs which serve older adults with mental illnesses. These positions are mentored by MHA's geropsychiatric nurse specialist in their efforts support older adults with psychiatric disabilities maintain and improve quality of life. The goal is to continuously increase the knowledge base and skills of community providers in managing the somatic and psychiatric needs of older adults. MHA's Coordinator of Services to Older Adults, MHA's R.N. consultant, and the local consultants are each affiliated with the Maryland Gerontological Association as well as the Mental Health Association of Maryland's "Coalition on Mental Health and Aging". The Coalition's meetings are a vehicle to share information from the local, state, and national levels regarding policies, procedures, regulations, and legislation that affect older adults. The Coalition has produced a resource guide titled, "Mental Health in Later Life: A Guidebook for Older Marylanders and the People Who Care for Them". MHA's Coordinator of Services to Older Adults continues to work closely with the National Association of State Mental Health Program Directors' (NASMHPD's) Older Persons Division by participating in the monthly conference calls, through volunteering on various committees, and through attending the division's annual meetings. [NFC 4]

MHA also contracts with CSAs to fund MHA residential rehabilitation programs in Anne Arundel County, Prince George's County, and Baltimore City to provide nursing services and additional supports for residents with complex medical conditions and those who are elderly. Approximately 150 persons were served through these programs. Additional programs funded by MHA, through the CSAs, include senior outreach in public housing in Baltimore City; a senior peer support mentoring project in Baltimore County; and elderly outreach in Calvert, Frederick, and Prince George's Counties. Additional MHA funded services that elderly individuals may access include mobile crisis teams, client support, peer support, and emergency psychiatric services. CSAs also participate with other county agencies in sponsoring some specific services. The list below provides some highlights on these MHA funded/CSA sponsored programs:

- Baltimore City:
The Psycho-geriatric Assessment, Treatment in City Housing program (PATCH)- sponsored by the Johns Hopkins and Bayview Hospitals is an outreach program

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available to older adults with serious mental illnesses, residing in East Baltimore City “high-rise” housing developments at 17 sites. PATCH offers an alternative for seniors unable to access traditional out-patient treatment services, including medication management and assessments. During the calendar year 2008, approximately 110 persons were served through this program.

The Senior Outreach Services (SOS) program-sponsored by the University of Maryland Medical Systems, is an out-reach program similar to the PATCH program available to older adults with serious mental illness (SMI), throughout Baltimore City neighborhoods not covered through the PATCH program. In the year 2008, approximately 180 persons were served under this program.

The Harbel -Psychogeriatric Outreach Out-patient Mental Health program offers services to older adults with mental illnesses in the Harford/Belair Road catchment area of Baltimore City.

- Baltimore County:
The Peers program offered peer support for older adults with mental illnesses and served approximately 60 persons in 2008. Services include “face-to-face” visits and telephone support.
- Garrett County:
The Older Adult Transition Service (OATS) provides outreach services, counseling services, information and referral services to persons transitioning from adult to older adult status. Approximately 90 persons were served in the year 2008.

Partnership for Optimal Aging is an interagency committee on aging and health planning that includes representatives of key agencies in Garrett County which serve older adults with mental illnesses.

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- Howard County:
In Howard County, the CSA will implement Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors), a national model.
- Worcester County:
Maryland Access Point is a single-point-of-entry program available to all older adults in the county which provides information, referral and access to all countywide services. It is jointly sponsored by the CSA and the local Area on Aging.

Statewide Pre-Admission Screening/Resident Review Program (PASRR).

The statewide PASRR Program is a federally mandated pre-admission screening process for nursing home candidates who are diagnosed with major mental illnesses and whose symptoms have required in-patient psychiatric hospital services within the last two years. The law requires that these individuals be evaluated by an independent review team to ascertain that medical necessity criteria for nursing facility placement is present, that the individual's continued psychiatric needs can be adequately met outside of an in-patient setting, and that the nursing facility is the least-restrictive and most appropriate program to address the individual's medical needs.

Since the inception of the PASRR program in the 1980's, Maryland continues to see a decrease in the numbers of Level II evaluations submitted to the MHA for review and signature. This is due, in part, to a process that allows for potential PASRR candidates to be evaluated for appropriateness of admission to less restrictive settings at the time of referral for a Level II screen. Additionally, quarterly trainings are provided to nursing facility staff and hospital staff by the PASRR reviewers regarding the criteria necessary for a person to require a Level II evaluation. Intense efforts are made to divert persons from nursing home placement and toward alternative settings. There is no data collected by MHA regarding the number of persons who are diverted from requiring Level II evaluations, as the "Level I "ID screens" are not submitted to MHA. MHA becomes involved at the point when the "Level II "ID screens" are submitted to MHA for review and final sign-off.

MHA maintains a yearly information base for PASRR candidates regarding dispositions. For calendar year 2008, a total of 600 Level II PASRR evaluations were completed and reviewed by the MHA. Of that number, 15 persons were found to not meet the criteria for Level II screens and were therefore, exempted from continuation of the process, and five records remained incomplete in that additional information requested to continue the process was not produced. Statistics for calendar year 2008 show that approximately 70 persons required from two-six PASRR evaluations, while 510 persons received only one PASRR evaluation for the year. Of the remaining persons evaluated, 419 were persons over the age of 55, with all persons meeting the definition for eligibility for nursing facility services found in the recently revised Maryland COMAR 10.09.11 "Nursing Facility Services" regulation and the federal PASRR regulations. Maryland's "Medical Necessity Criteria for Nursing Facility Services" was modified as of July 1, 2008, due to a class action suit filed by the Maryland Legal Aid

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Bureau and the Legal Division of the American Association of Retired Persons (AARP). As a result of these legal changes, additional persons are eligible for admission to nursing facilities. However, some persons were diverted to Medicaid waivers for community alternatives. The remaining persons over age 55 were found to not meet medical necessity criteria and were recommended for community placement.

In FY 2010 training will focus on collaborations and partnerships among MHA, MDoA, DDA, and “DHR, as well as the local counterpart to these administrations. In FY 2009, MHA conducted a survey regarding the complexity and extent of somatic conditions facing consumers residing in psychiatric residential treatment programs within the Public Mental Health System. MHTO’s geriatric consultant continues to meet with a group of stakeholders to address the extent of issues facing residents in residential rehabilitation programs (RRPs) who are “aging in place”. Future plans call for a report identifying the extent of these issues and recommendations.

Finally, Maryland’s DHMH received a Money Follows the Person Rebalancing demonstration Grant (MFP) from the Centers of Medicare and Medicaid Services (CMS). As part of the implementation of this project to rebalance delivery of long term care services from institutions to the community, and develop transition services, MHA and the Transformation Office are addressing the mental health needs of individuals who will transition out of nursing homes into the community and identifying and proposing resources within existing Medicaid State Plan services and Medicaid waivers to meet the needs of individuals aged 65 and older in Institutions for Mental Disease (IMD). DHMH, MHA and the Transformation Office are integrating plans through a Behavioral Health Committee composed of stakeholders from long term care, mental health, traumatic brain injury, and aging communities.

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SFY 2010 OBJECTIVES FOR CRITERION 4:

SERVICES FOR ADULTS

TARGETED SERVICES TO OLDER ADULTS

- In collaboration with the Committee on “Aging in Place” develop an integrated care model for consumers age 50 years and over with behavioral and somatic health needs in PMHS residential programs.
MHA Monitor: James Chambers, MHA Office of Adult Services
- Develop and implement statewide activities for adult and older adult suicide prevention, intervention, and postvention.
MHA Monitor: James Chambers and Marge Mulcare, MHA Office of Adult Services
- Continue to support CSAs in their ongoing efforts to develop mechanisms to address prevention and early intervention services for older adults.
MHA Monitor: James Chambers, and Marge Mulcare, MHA Office of Adult Service

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ADULT & CHILD PLAN

CRITERION #5: Management Systems

This Criterion applies to both adult and children and adolescents. It is not duplicated in the Child Plan section.

Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.

FUNDING FOR MENTAL HEALTH SERVICES

The MHA budget currently contains funding (federal Medical Assistance and State general funds) for specialty (or non-primary) mental health services. This includes funding for services traditionally offered by the PMHS such as outpatient clinics and psychiatric rehabilitation, as well as inpatient psychiatric hospitalization, residential treatment center placement, services rendered by individual practitioners, mental health-related Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services, and mental health related laboratory services. Funding for the pharmacy benefit was formally transferred back to the Medical Assistance budget in FY 2001. This change promotes better coordination of care by utilizing the same pharmacy benefits manager for all prescription drugs. [NFC 4]

In FY 2010 a total of \$978.5 million has been appropriated for the MHA. Of this amount, \$679.2 million (\$556.5 million MA service funds) is for community services, \$290.9 million for State-operated institutions and \$8.2 million for program administration. (Sixty-nine point four percent (69.4%) of the FY 2010 funds are targeted for community services). In addition, several local jurisdictions contribute mental health funding, which is not included in these budget numbers. In addition, MHA continues to contract directly with CSAs to support those programs that provide specialized services that are either not included in the standard benefit package or do not lend themselves to payment through the fee-for-service system. This consists of approximately \$57 million in State general funds and \$25.3 million in federal funds. Federal grants include: this block grant, PATH, Shelter Plus Care, emergency response capacity, Data Infrastructure Grant (DIG), the Mental Health Transformation-State Incentive Grant, the new multi-year System of Care grant for children and other CMHS and CMS grants.

Vendors are reimbursed for pre-authorized services using a fee-for-service system based on a mental health benefits package. This package is the same for MA 1115 Waiver Medicaid recipients, for non-waiver Medicaid eligible recipients, and for those individuals who, because of the severity of their illness and their financial need, qualify for State subsidized services. Medicaid is the most significant insurance coverage type for consumers in the public mental health system. Medicaid covers 80% of all consumers receiving fee-for-service reimbursement. In recent years Maryland has worked to expand Medicaid eligibility through a number of special initiatives.

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Eligibility requirements for uninsured/MA ineligible individuals to qualify for State subsidized services in the fee-for-service system include uninsured consumers that have received services in the prior two years. Individuals discharged from psychiatric facilities or released from incarceration within the prior three months, on conditional release from a State hospital, who receive SSDI due to psychiatric impairment, or who are homeless do not have to meet these eligibility requirements. In addition, individuals presenting with an urgent need may obtain services upon approval of the appropriate CSA. Many previously uninsured individuals were enrolled in the Primary Adult Care waiver and now have Medical Assistance coverage for most mental health care (excluding hospital emergency, inpatient and outpatient hospital-based services).

With the upcoming closure of Walter P. Carter Center in October, 2009, Maryland will now operate six State psychiatric hospitals that provide intermediate and long-term care for adults. One of these facilities has inpatient units for adolescents, and one offers services for individuals who are deaf and hard of hearing. In addition, MHA operates one psychiatric forensic facility and two residential treatment facilities for youth. The Administration also collaborates with the Maryland Psychiatric Research Center, which is operated by the University of Maryland and is located on the grounds of a major State hospital. This facility coordinates with State facilities and community hospitals to provide innovative research in new medications and treatments for individuals whose mental health symptoms have not been relieved by traditional medication regimens. The Center also conducts physiological research regarding schizophrenia and other psychoses. [NFC 5]

In recent years, reimbursement for care for the uninsured has been policy concern raised by MHA at the budget hearings. Maryland made progress in addressing access to health care for the uninsured. As a result of legislation, medical coverage is being expanded to more than 100,000 uninsured Marylanders. This Medicaid expansion is one of several measures that assist the State to improve access and “put a dent” in the number of uninsured.

As noted earlier, in FY 2008 and 2009, Maryland’s Governor directed state Cabinet Secretaries to reduce state spending as an initial step in closing the deficit that the state faces. In FY 2010, the state is faced with a projected budget shortfall of more than \$700 million. Within MHA, strategic decisions will be reached to take its share of the budget reduction. Community –based services will be further challenged to meet the needs in the community and reduce hospital utilization. MHA, in collaboration with CSAs, will work to strengthen and support community-based services including diversion initiatives

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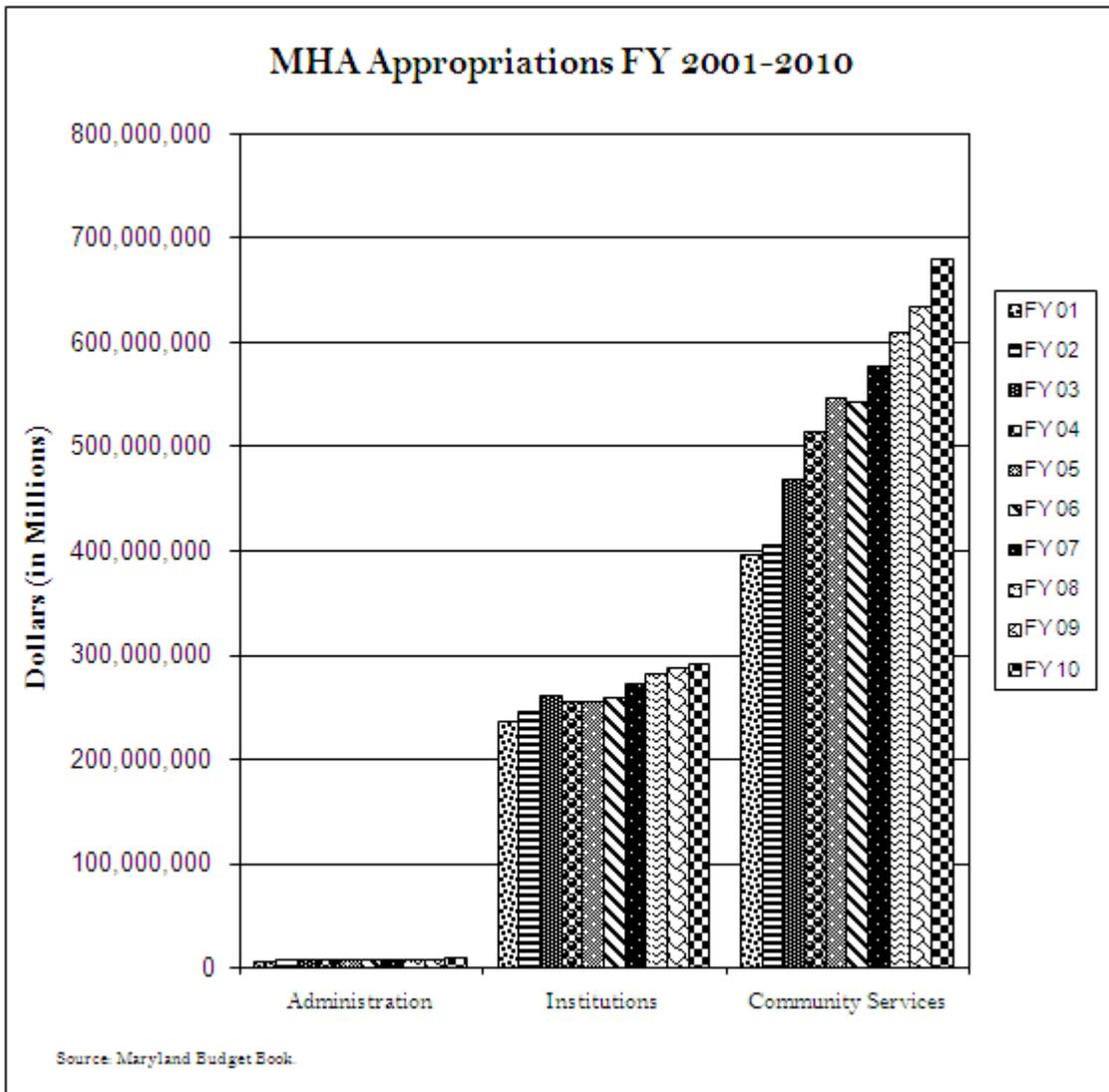
FINANCIAL DATA

The MHA contracts an administrative services organization (ASO) to assist in the operation of the PMHS. The ASO authorizes services based on medical necessity, processes claims payments, and provides management information services. Data are provided to the MHA, local CSAs, service providers, and the Maryland Medical Assistance program.

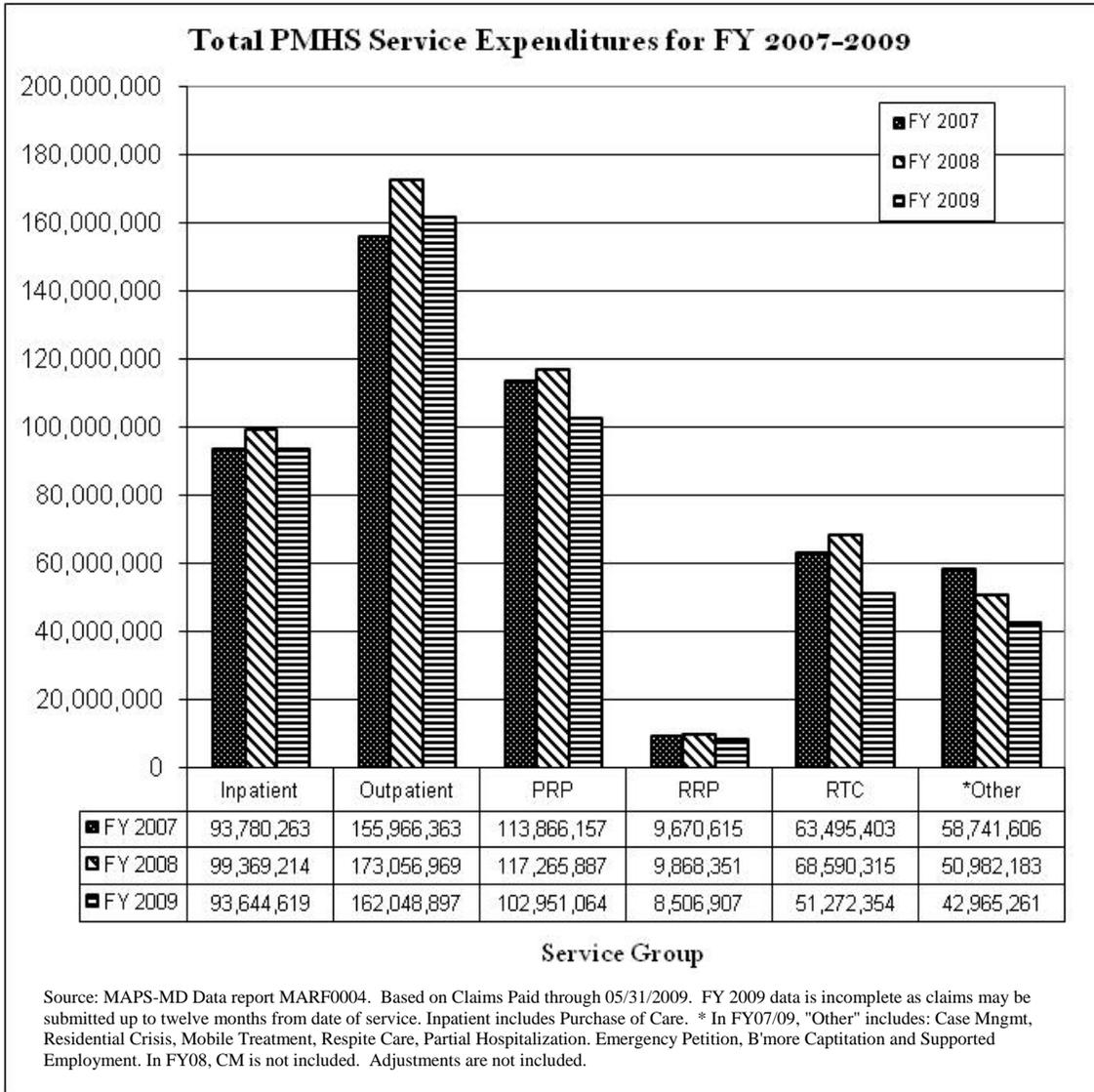
Data available from ASO are the source for the community-based fee-for-service information. Data sets are not routinely compiled for those non fee-for-service services that are funded through contracts. Other unavailable data are statistics on services provided to Medicare-only recipients and on Medicare-only reimbursed services. Medicare-eligible services are not subject to authorization and are processed through a federal intermediary, not through the ASO information on individuals that are both Medicare and Medicaid eligible was previously captured by the PMHS. Beginning July 1, 2003, claims for individuals who are qualified for federally matched MA and have Medicare began to be processed by Medical Assistance and the data are no longer in the ASO data system.

The MHA relies on the data from the ASO to monitor the expenditures and federal Medicaid attainments of the PMHS. MHA further analyzes the data for trends in service delivery and/or spending. This information is used to develop strategies for managing the budget, amending current MHA policies as needed, development/implementation of new services, and correcting any problems that may be identified. In addition, the information is used to prepare budgets and budget presentations; to track the number of services and expenditures by consumer age, diagnostic and eligibility categories; and to set rates in subsequent years.

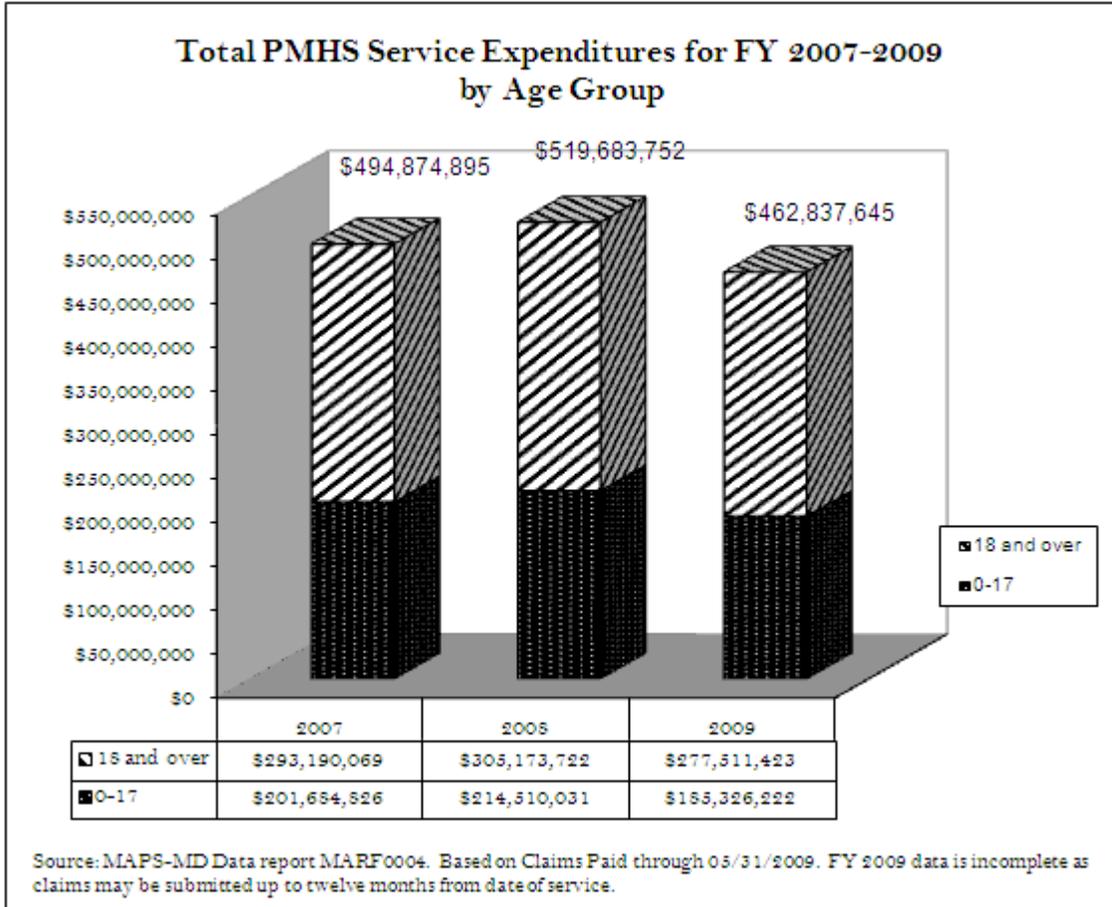
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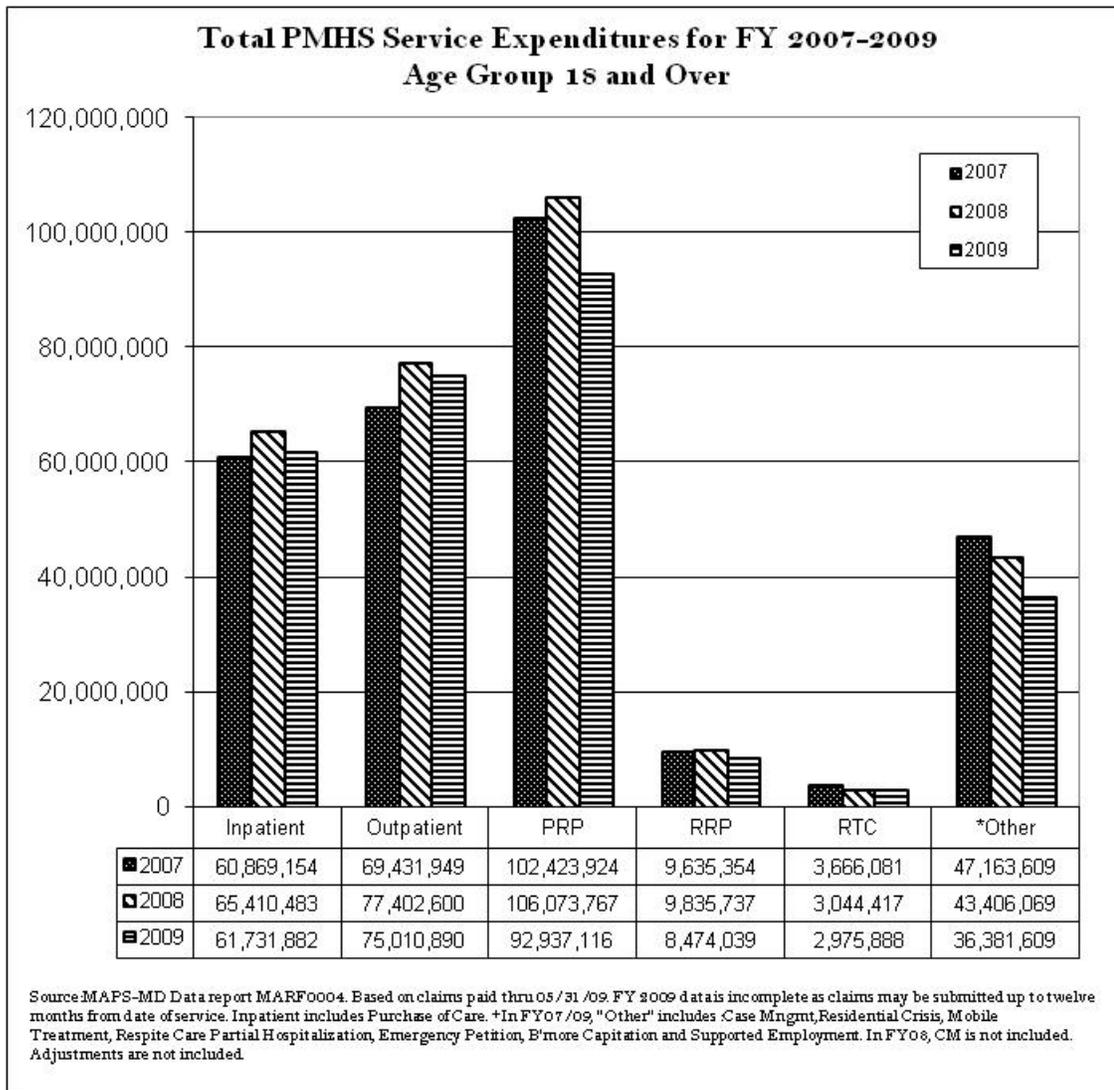
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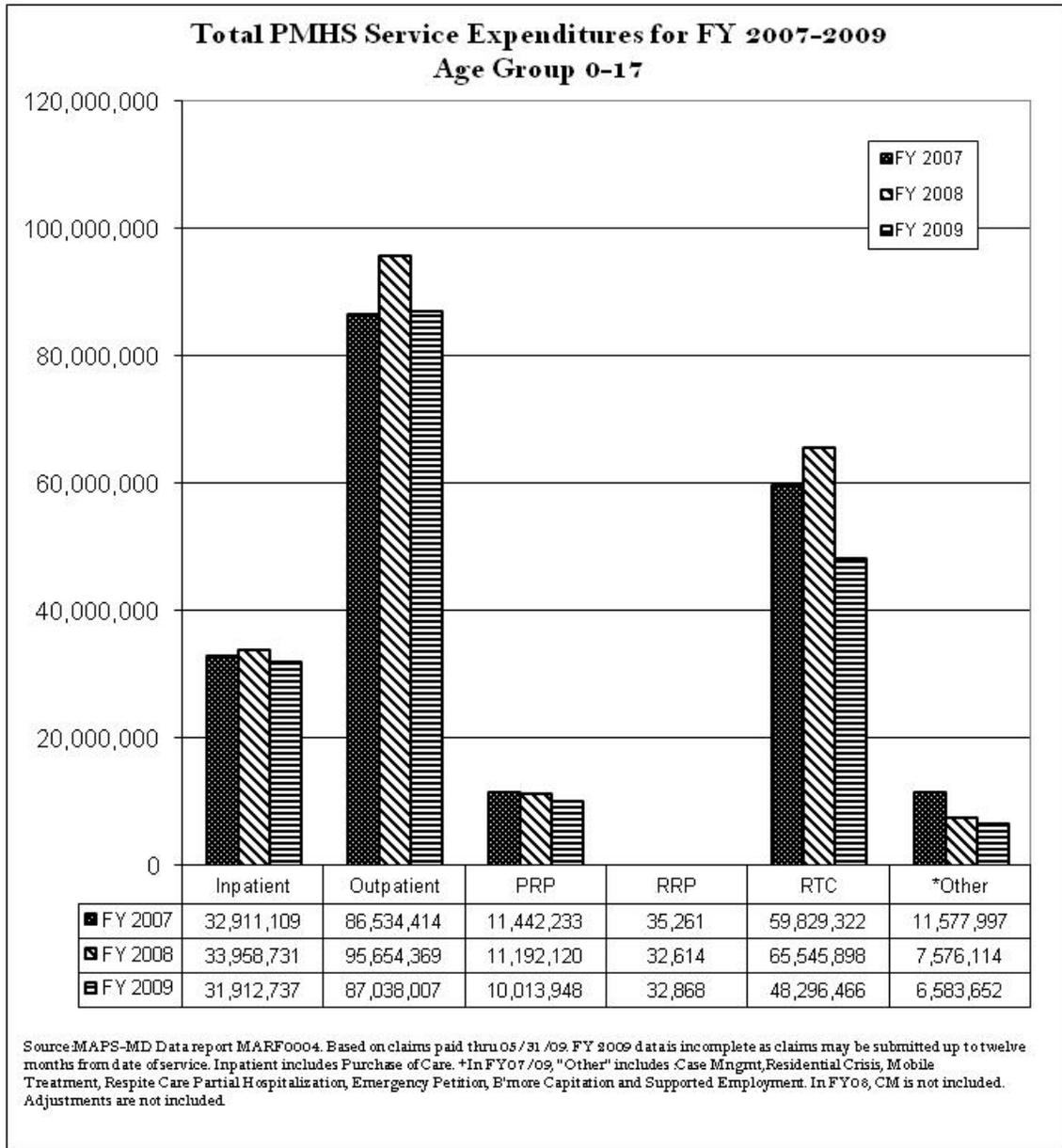
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Total Expenditure By County for FY 2007- 2009

County	FY 2007	FY 2008	FY 2009
ALLEGANY	\$8,431,432	\$8,619,931	\$7,598,988
ANNE ARUNDEL	\$28,344,417	\$30,952,420	\$26,957,346
BALTIMORE CITY	\$173,553,964	\$180,738,191	\$163,249,911
BALTIMORE COUNTY	\$76,554,793	\$77,488,023	\$70,445,381
CALVERT	\$5,142,367	\$4,005,568	\$3,475,746
CARROLL	\$10,406,893	\$10,453,856	\$8,558,639
CECIL	\$8,674,867	\$9,239,579	\$8,041,967
CHARLES	\$5,400,346	\$5,373,245	\$5,025,089
FREDERICK	\$16,099,781	\$17,388,959	\$15,417,385
GARRETT	\$3,782,936	\$2,964,087	\$2,718,728
HARFORD	\$13,994,308	\$14,843,182	\$13,519,338
HOWARD	\$10,144,392	\$10,925,448	\$9,361,975
*MIDSHORE	\$16,194,861	\$18,401,388	\$16,248,888
MONTGOMERY	\$40,793,843	\$44,750,306	\$36,810,896
PRINCE GEORGES	\$43,440,216	\$45,593,285	\$39,878,546
SOMERSET	\$3,293,785	\$3,460,936	\$3,267,315
ST. MARY	\$5,784,399	\$5,652,604	\$4,503,080
WASHINGTON	\$10,651,630	\$11,197,327	\$10,123,485
WICOMICO	\$9,861,941	\$11,316,596	\$10,279,670
WORCESTER	\$3,273,029	\$3,924,856	\$2,883,733
OUT OF STATE			
Total	\$493,824,200	\$517,289,787	\$458,366,106

*Midshore includes: Caroline, Dorchester, Kent, Queen Anne, and Talbot counties.

Source: MAPS-MD Data report MARF0004

Based on Claims Data Through 05/31/2009.

Note: FY 2009 data is incomplete as claims may be submitted up to twelve months from date of service.

Expenditures for Out of State consumers not included, therefore, totals will not equal overall State total expenditures in other charts.

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**Total Expenditure By County for FY 2007-2009
for Age Group 18 and Over**

County	FY 2007	FY 2008	FY 2009
ALLEGANY	\$5,676,920	\$5,943,551	\$5,197,194
ANNE ARUNDEL	\$18,692,525	\$20,387,686	\$17,312,530
BALTIMORE CITY	\$103,850,546	\$108,413,037	\$98,795,836
BALTIMORE COUNTY	\$39,670,395	\$37,570,672	\$37,501,248
CALVERT	\$3,452,374	\$2,606,834	\$2,181,106
CARROLL	\$6,954,597	\$7,051,574	\$6,220,117
CECIL	\$4,191,406	\$4,244,551	\$3,980,589
CHARLES	\$3,776,901	\$2,687,959	\$2,889,091
FREDERICK	\$9,564,767	\$10,216,519	\$9,499,991
GARRETT	\$2,022,140	\$1,694,782	\$1,815,159
HARFORD	\$8,313,500	\$8,488,497	\$7,939,091
HOWARD	\$7,129,474	\$7,378,500	\$6,834,176
*MIDSHORE	\$7,558,358	\$7,167,996	\$7,003,040
MONTGOMERY	\$26,588,827	\$30,062,089	\$25,371,254
PRINCE GEORGES	\$27,893,646	\$30,013,904	\$25,851,493
SOMERSET	\$1,198,846	\$1,294,086	\$1,252,245
ST. MARY	\$3,978,117	\$3,723,516	\$3,212,388
WASHINGTON	\$5,097,989	\$5,637,221	\$5,580,921
WICOMICO	\$5,797,981	\$5,970,034	\$5,766,111
WORCESTER	\$1,580,199	\$1,425,247	\$1,033,751
Total	\$292,989,508	\$301,978,255	\$275,237,331

*Midshore includes: Caroline, Dorchester, Kent, Queen Anne, and Talbot counties.

Source: MAPS-MD Data report MARF0004

Based on Claims Data Through 05/31/2009.

Note: FY 2009 is incomplete as claims may be submitted up to twelve months from date of service.

Expenditures for Out of State consumers not included, therefore, totals will not equal overall State total expenditures in other charts.

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**Total Expenditure By County for FY 2007 -2009
for Age Group Under 18**

County	FY 2007	FY 2008	FY 2009
ALLEGANY	\$2,754,512	\$2,676,380	\$2,401,794
ANNE ARUNDEL	\$9,651,892	\$10,564,734	\$9,644,817
BALTIMORE CITY	\$69,703,418	\$72,325,154	\$64,454,075
BALTIMORE COUNTY	\$36,884,398	\$39,917,351	\$32,944,133
CALVERT	\$1,689,993	\$1,398,734	\$1,294,640
CARROLL	\$3,452,296	\$3,402,282	\$2,338,522
CECIL	\$4,483,461	\$4,995,028	\$4,061,378
CHARLES	\$1,623,445	\$2,685,286	\$2,135,998
FREDERICK	\$6,535,014	\$7,172,440	\$5,917,394
GARRETT	\$1,760,796	\$1,269,305	\$903,569
HARFORD	\$5,680,808	\$6,354,685	\$5,580,247
HOWARD	\$3,014,918	\$3,546,948	\$2,527,799
*MIDSHORE	\$8,636,503	\$11,233,392	\$9,245,848
MONTGOMERY	\$14,205,016	\$14,688,217	\$11,439,642
PRINCE GEORGES	\$15,546,570	\$15,579,381	\$14,027,053
SOMERSET	\$2,094,939	\$2,166,850	\$2,015,070
ST. MARY	\$1,806,282	\$1,929,088	\$1,290,692
WASHINGTON	\$5,553,641	\$5,560,106	\$4,542,564
WICOMICO	\$4,063,960	\$5,346,562	\$4,513,559
WORCESTER	\$1,692,830	\$2,499,609	\$1,849,982
Total	\$200,834,692	\$215,311,532	\$183,128,776

*Midshore includes: Caroline, Dorchester, Kent, Queen Anne, and Talbot counties.

Source: MAPS-MD Data report MARF0004

Based on Claims Data Through 05/31/2009.

Note: FY 2009 data is incomplete as claims may be submitted up to twelve months from date of service.

Expenditures for Out of State consumers not included, therefore, totals will not equal overall State total expenditures in other charts.

EVALUATION SERVICES

Several major Evaluation Services endeavors are discussed in this section, including MHA's Outcomes Measurement System (OMS); the Consumer Quality Team (CQT), which is funded in large part through this FBG; the annual Consumer Perception of Care Survey; and evaluation projects and activities conducted through MHA's contract with the University of Maryland Systems Evaluation Center (SEC), which is also funded through this FBG.

Maryland's Outcomes Measurement System (OMS), in operation since September 2006, is the result of a collaborative relationship among MHA, the University of Maryland Systems Evaluation Center (SEC), and MHA's Administrative Services Organization (ASO). The OMS was developed to collect information on individuals, ages 6-64, who are receiving outpatient mental health treatment services from outpatient mental health centers (OMHCs), Federally Qualified Health Centers (FQHCs), and hospital-based mental health centers. The OMS questions cover several life domains, including living situation, employment, school attendance, substance use, legal system involvement, symptoms, functioning, etc. The information is collected in order to understand more about the individuals who are receiving services from the PMHS and to begin to understand the outcomes of those services. Information is collected at the beginning of treatment and approximately every 6 months while receiving treatment. In FY 2009, there were two major accomplishments related to OMS: 1) the launch of an OMS data mart and 2) continued development of analytical structures to begin to report client outcomes.

In mid-September 2008, MHA launched the initial phase of the OMS data mart, accessed through the ASO's Web site. This initial phase of the OMS data mart provided statewide summary information about the individuals who are receiving services, based on the individual's most recent OMS questionnaire. Demographic information (e.g., age, race, gender), as well as information regarding several of the life domains listed above (e.g., living situation, employment, school attendance, substance use), was available. The system also allowed both the Core Service Agencies (CSAs, local mental health management entities) and providers to access the same OMS summary information for individuals in their jurisdictions and/or programs. The aggregate information in the data mart, updated monthly, was displayed in several different formats, including pie charts, bar graphs, or tables, depending on the items selected. For FY 2009, OMS information on more than 33,700 adults (unduplicated, ages 18-64) and more than 27,400 children and adolescents (unduplicated, ages 6-17) was available. With the change in MHA's ASO vendor, effective September 1, 2009, plans for re-configuring the OMS data mart will be developed.

In addition to the OMS data mart, analyses were continued on OMS data for individuals, both adults and children/adolescents, who had completed the OMS questionnaire two or more times with the same provider. This involved the continued development and refinement of analytical structures for comparing individual consumer

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progress over time (e.g., definitions for increase, decrease, and maintenance of scores have been developed). At the individual consumer level, responses from the first OMS interview are compared to responses from the most recent OMS interview and change-over-time scores are calculated. Data is then aggregated to the State level. Statewide and CSA-level OMS change-over-time analyses were distributed to CSAs at the end of FY 2009 for feedback on the format and utility of the outcome information presented. Provider-level outcome information was also distributed to several pilot providers for their feedback.

The Consumer Quality Team (CQT) initiative, funded in large part through this block grant and launched in FY 2007 through the Maryland Mental Health Association, was another significant evaluation project that was continued in FY 2009. During FY 2009, the CQT conducted 151 site visits to Psychiatric Rehabilitation Programs within ten jurisdictions, interviewing more than 625 consumers. The purpose of the interviews is to identify and address specific concerns of individual consumers. At the conclusion of all interviews within a program, the team gives a brief verbal report to the program director, resulting in the immediate resolution of many of the identified individual concerns. Monthly feedback meetings are then held with representatives from the appropriate local Core Service Agencies, provider organizations, and MHA. The CQT also conducted a total of 19 visits in five of the State-operated facilities. Feedback from these visits is provided to the CEO of the facility at the time of the visit and to the senior management of MHA on a quarterly basis. While there will be no additional expansion of the CQT project in FY 2010 (due to fiscal constraints), the ultimate goal is offer this initiative in all 24 jurisdictions and the remaining State-operated facilities.

In addition to the two major initiatives described above, MHA, through its contract with the ASO, continues to conduct annual Consumer Perception of Care Surveys via telephone interviews. As with previous survey efforts, the survey tools are based on the most recent versions of the Mental Health Statistics Improvement Project (MHSIP) consumer survey tools for both adults and children and adolescents and their families. The Perception of Care Surveys were administered in Winter/Spring 2008 with individuals who received outpatient mental health services in 2007 and the analyses of results were completed. An Executive Summary Report and tri-fold pamphlets detailing the results of the survey were prepared and widely disseminated. In order to continue to comply with annual federal URS requirements, the Consumer Perception of Care Surveys were conducted again in the third quarter of FY 2009. Through this most recent survey, Maryland has continued to incorporate the new federal reporting requirements for functioning, social connectedness, criminal/juvenile justice involvement, and school performance (i.e., attendance and suspensions/expulsions). Analyses of the current survey results will be completed in FY 2010, and reports and tri-fold brochures will again be generated and distributed. (Information from the Consumer Perception of Care Surveys is used to address several MHBG indicators).

Finally, MHA continued to contract during FY 2009 with the Systems Evaluation Center (SEC) within the University of Maryland, School of Medicine, Department of Psychiatry, Center for Mental Health Services Research, Mental Health Systems

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Improvement Collaborative (MHSIC) for a variety of PMHS evaluation projects and activities. This Center is funded through this block grant. The SEC, now in its eighth year of operation, began its work in August 2001 (FY 2002), and is one of three centers within the MHSIC. The others are the Training Center and the Evidence-Based Practice (EBP) Center. The SEC was created to increase MHA's capacity for a methodical and systematic approach to measuring PMHS performance. Overall goals of the SEC are to design systems/program evaluation questions, methods, and studies; develop analytic structures for more advanced analysis of existing PMHS data; and identify cost-effective practices with positive outcomes for consumers. In doing so, MHA obtains information that greatly enhances its ability to plan, manage, monitor, and evaluate PMHS efficiency and effectiveness, including the ability to develop realistic performance measures and indicators for the PMHS and programs.

Highlights of SEC projects and activities during FY 2009 included:

- participating in the ongoing OMS activities as described above, particularly with respect to development and refinement of analyses of change-over-time data and development of report format prototypes;
- finalizing and implementing a protocol to collect feedback from consumers, caregivers, and providers using the OMS, including conducting consumer, caregiver, and provider focus groups and developing and implementing an on-line provider survey;
- conducting reliability analyses on the psychiatric symptom scales for the youth and adult OMS questionnaires and planning for an OMS data validation study;
- participating in the development of recommendations for modifying/revising OMS questionnaires, documents, procedures, etc. in preparation for the ASO transition;
- designing and conducting a process evaluation of the CQT initiative described above, including conducting consumer and CQT staff focus groups, developing and implementing an on-line provider survey, developing a database system for analyzing qualitative data, and developing a report format; and continuing to participate in an oversight workgroup that is responsible for providing guidance to the implementation of the CQT initiative;
- continuing to implement the Data Infrastructure Project (DIP)/PMHS Data Analysis Project, including assisting MHA to complete all basic and developmental Uniform Reporting System (URS) tables, providing significant input for Maryland's DIG application, providing strong support in the OMS change-over-time analyses, calculating the fiscal impact of a proposed rate increase on MHA expenditures, preparing analyses of the FFP expenditures for a CMS audit, and providing analyses of PMHS data in support of several other MHA projects;
- continuing to provide supervision, support, technical assistance and consultation for the evaluation component of the Mental Health Transformation State Incentive Grant (MHT SIG), including providing supervision for all MHT SIG evaluation activities, performing management and administrative functions for the MHT SIG contract, recruiting and training new staff members for the MHT SIG evaluation, developing the protocol for the Adult Proof of Concept study, coordinating with

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- the Trainers/Consultants for the MHT SIG-sponsored cultural and linguistic competence initiative, participating in monthly national conference calls and SAMSHA site visit, and providing supervision for development, submission, and ongoing communication regarding IRB protocols (multiple separate IRBs) for the required cross-site evaluation and the local evaluation; and
- completing the evaluation component of a SAMHSA-funded State project on implementation of the Assertive Community Treatment (ACT) EBP, including finalizing and disseminating statewide and program-specific reports for the Consumer Outcomes and Consumer Satisfaction data and meeting with providers regarding evaluation reports as requested.

During FY 2010, the SEC will be involved with the following evaluation projects and activities:

- Outcomes Management System (OMS) – collaborating with MHA and completing the tasks necessary to ensure a successful implementation of OMS during the ASO transition (e.g., revision of OMS questionnaires, OMS Interview Guide, and other documents and the development of training information, etc.); continuing to collaborate to identify analysis protocols and report formats for statewide aggregate, CSA-level, and provider-specific OMS outcomes data; completing the data analysis activities for the OMS feedback project and preparing a written report of results; finalizing and beginning to implement an OMS Validation Study protocol; and collaborating with MHA and the ASO regarding the development of a new iteration of the OMS data mart;
- Mental Health Transformation State Infrastructure Grant (MHT SIG) – continuing to provide support to the MHT SIG evaluator in implementing the national Proof of Concept studies and local evaluation activities; continuing to collaborate with MHT SIG staff to identify relevant GPRAs for the September 2009 Comprehensive Mental Health Plan (CMHP); continuing to revise and update Transformation Tracker as needed; and continuing to provide formative evaluations of the TWG meetings;
- Evidence-Based Practice (EBP) Projects – continuing to collaborate with the Evidence-Based Practice Center and MHA to provide technical assistance and support related to the evaluation of EBPs;
- Data Infrastructure Project (DIP)/PMHS Data Analysis Project – providing any necessary support required for successful transition to a new ASO; reviewing the 2010 MHA State Plan and determining how the PMHS data relate to the strategies and objectives; continuing to respond to data analysis requests; initiating analyses of PMHS population dynamics; continuing the training of PMHS staff members in data utilization; completing a comparison of DSM IV-TR Axis 3 data (Somatic Conditions) from PMHS authorization data and Medicaid data; planning a minimum of three Data Seminars for PMHS stakeholders; and continuing to conduct analyses and provide data-related technical assistance as requested by MHA;

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- Consumer Quality Team (CQT) Initiative – continuing to participate in meetings in a consultative capacity; and completing data analyses for the CQT process evaluation and preparing the report; and
- Integrated Care Initiative – developing a project evaluating the integration of somatic and mental health service provision within the PMHS.

AVAILABILITY OF HUMAN RESOURCES

MHA recognizes that well-trained staff is a critical component of providing mental health services. Currently, there are 120 outpatient mental health programs and 123 psychiatric rehabilitation programs, many in multiple locations that are not included in this count. In FY 2008, there were 3,250 state hospital and residential treatment center full-time equivalent employees and 84 employees in MHA headquarters. In FY 2009, there were 3,090 budgeted positions in the facilities and 84 in headquarters. In FY 2010, there are 3,055 budgeted positions in facilities and 84 in headquarters.

WORKFORCE DEVELOPMENT

Training and Workforce Development Activities

Training continues to be a priority and primary responsibility of MHA, directly and indirectly through collaborative agreements with the University of Maryland Mental Health Systems Improvement Collaborative (MHSIC) Training Center and the Maryland Child and Adolescent Mental Health Institute. During the past year, training across systems issues, was presented in large and small group settings and through teleconferences targeted at specific populations or providers. Training included: services to specific age and special needs populations and support of the implementation of a variety of initiatives (e.g. early childhood interventions, older adult issues, trauma sensitive care, etc.). MHA's annual conference, held in May 2009, was titled "Body, Mind and Spirit: Promoting Health and Wellness over the Life-Span". This year's keynote was Lisa Dixon, M.D who spoke on "Pursuing Somatic Wellness in Recovery: Benefits and Barriers". Twenty workshops focused on various aspects of health and wellness for individuals with mental health conditions across the life span.

Cultural and Linguistic Competence Initiative. In collaboration with the Mental Health Transformation Office (MHTO), MHA's Coordinator for Multicultural Services has continued efforts to ensure cultural and linguistic competence throughout the public mental health system. As a result of legislation (HB 524) in FY 2008, and in partnership with DHMH's Office of Minority Health and Health Disparities, the Office of Health Workforce, and the Health Occupations Boards and Commissions, a report was issued to the legislature addressing issues related to the cultural competence of the mental health workforce. As the culture of Maryland changes, the adaptation of policies and regulations regarding cultural competency must target persons of different ethnic and racial descent. The report has recommended the development of training for foreign-born and foreign-trained mental health professionals. Other recommendations include mentoring foreign-born and foreign-trained practitioners who are seeking licensure in

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Maryland as well as establishing a program whereby licensed mental health practitioners can receive CEUs in exchange for mentoring college students enrolled in mental health programs and individuals including those in middle school interested in pursuing a mental health profession.

In another approach to advance the Cultural and Linguistic Competence Initiative, MHA and the MHTO, have developed and implemented the Cultural and Linguistic Competence Leadership Academy. This Academy is designed to assist organizations in Maryland with the incorporation of cultural and linguistic competence as an integral aspect in their organizational structure and operation. Implemented as a pilot project, this initiative involves the recruitment and training of individuals who will become “leaders” of change within their specific organizations. The “leadership team” includes management and direct care staff representatives and two consumers from each site. The early phases of this project toward eliminating mental health disparities includes a five day training taking place from June to September that will target organizational change within the ten programs and the collection of data to assess the impact of the training on consumer and program staff perception of cultural competence and the process of consumer recovery. The data analysis, along with the actual training and technical assistance, will support the development of an action plan to be utilized by the participating programs to move services and treatment toward cultural competence.

Other activities that are being provided and are consistent with the training initiative include:

- Technical assistance to organizations throughout the state,
- Workshops and conferences to raise awareness of cultural competence, and
- Utilization of an assessment tool to evaluate consumer and staff perception of cultural competence of providers/programs.

Additionally, the Recovery Initiative is a major statewide project intended to introduce mental health providers to the concepts of recovery and help agencies to become recovery-oriented. The MHTO is funding this activity. On Our Own of Maryland (OOOMD), a statewide consumer organization, is developing and implementing a Recovery Training Institute in FY 2010. A Request for Expression of Interest will be used to select four agencies for a yearlong participation in the Recovery Project. Activities will be provided by OOOMD and outside consultants. Training, consultation, and technical assistance will move these agencies through a culture change toward program-wide competency in delivering recovery-oriented services. The agencies will then serve as Centers of Excellence in Recovery, and will mentor additional agencies.

In Maryland, activities related to the workforce development break into several areas with clusters of activities focused on adults with mental illnesses and other activities directed towards children and adolescents with serious emotional disturbance (SED). In this Criterion 5, we will discuss sub-areas of workforce and training issues including each target group separately as appropriate.

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Workforce Development and Education, and Other Workforce issues such as Recruitment, Retention and Compensation – Adult, Child and Adolescent

Maryland residents with mental illness will benefit from services from a strengthened mental health workforce, with the ongoing mission of eliminating stigma. Through the creation of a workgroup charged with developing a state plan to address mental health workforce needs, issues such as recruitment, training, retention, and diversity will be addressed. Maryland's Mental Health Transformation Office (MHTO) is working with the Governor's Workforce Investment Board to produce a study in FY 2010 with recommendations to make effective and permanent changes in this area.

MHA also funds the Maxie Collier Scholars Program (MCSP) in which minority undergraduate students are provided with stipends and mentoring to encourage them to pursue graduate education towards a career in mental health. The undergraduate disciplines participating include nursing, natural sciences (pre-med), psychology, and social work. During academic year 2008-2009, eight students were enrolled as scholars in the MCSP. The program sponsors a mental health seminar entitled: "Emerging Issues in Mental Health and Well-being," which meets a general education requirement and is open to all students. Other program elements include: an internship in a mental health setting; access to a network of career placement resources; general academic advisement; individualized graduate school preparation and support plan for each scholar; and enrichment activities, i.e. mental health seminars, workshops, and conferences.

In an effort to address the increasing need for qualified professionals and paraprofessionals to serve children with mental health needs and their families, DHMH in collaboration with the Maryland State Department of Education (MSDE) convened the Maryland's Child and Adolescent Mental Health Workforce Development Steering Committee. It is comprised of 38 members and includes consumers, families, trainees, state and local agencies, representatives of higher education, public and nonpublic schools, and providers of services. MHA's Director of the Office of Child and Adolescent Services co-chairs the committee with the Deputy State Superintendent for Special Education of MSDE. The committee strives to assist in the development of core competencies, strategies and recommendations to assure the efforts to address recruitment and retention issues, quality training of children's mental health workforce, a uniformity of Maryland standards across equivalent training programs, and effective credentialing of children's mental health providers in the State. A set of core competencies in child and adolescent mental health have been developed to be utilized in Web-based curricula and in the classrooms of Maryland colleges and universities. These curricula are also being used for continuing education and in-service training for the existing workforce. A number of specialized curricula have been developed and will be offered in Web-based formats in undergraduate and graduate programs and for continuing education units in upcoming years.

An interesting example is the Maryland Early Childhood Certificate program. This program is a series of Web based and seminar-related coursework, open to post-masters degree students, offering a concentration in Early Childhood Mental Health.

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This certificate program is offered by the Center for Infant Study at the University of Maryland through the Maryland Child and Adolescent Mental Health Institute. At the end of the most recent academic year, a total of 96 child-serving professionals had received a certificate in early childhood mental health since the inception of the program several years ago, greatly assisting in the process of expanding early childhood mental health programs in day care and early childhood education settings as described in other criteria.

Similarly, MHA has partnered with the Maryland Association of Resources for Youth (MARFY), the state's child services provider association, to create a certificate program at the associate degree level for paraprofessional child care services in conjunction with community colleges around the state. The Child and Youth Care Certificate Program (CYCP) is an eight course, twenty-five credit program which began enrolling students during the fall 2007 semester. Enrollment at four different course locations, two satellite locations, and in one on-line course since inception of the program has numbered at least 79 (possible duplicate count of actual students). To further statewide applicability the program will submit a request for "statewide" designation that will allow students residing in all of Maryland's jurisdictions to benefit from in-county tuition rates. Tuition from the courses will sustain this project. Eventually, all residential child care facilities in the state will require credentialed staff with this or equivalent training.

Maryland through the Center on the Social Emotional Foundations for Early Learning (CSEFEL) is participating in a training and technical assistance project to foster the professional development of the early care and education workforce. The Maryland State Department of Education and the MHA are jointly sponsoring this project. CSEFEL will work with Maryland to accomplish the following goals: convene a collaborative workgroup to develop policies that sustain the model; train trainers and coaches to build the capacity of the workforce and support local implementation; identify 3 to 4 local programs to serve as demonstration sites; and evaluate outcomes.

Training in Maryland is facilitated by strong public-academic partnerships. Executive staff at MHA and university leaders collaborate regularly on system and program development. Since the 1970's, the Maryland Plan, a program for training and recruitment of psychiatrists into the public sector, has been in place between MHA and the University of Maryland School of Medicine. Other professional schools (nursing, social work, psychology, and rehabilitation) at the university campuses have been involved as well. Additionally, a collaborative program for training child psychiatrists is in place between MHA and Georgetown University. The University of Maryland and Johns Hopkins Department of Psychiatry and the Georgetown University are partners with MHA in the planning and development of child and adolescent services, providing regular technical assistance and consultation.

EVIDENCE BASED PRACTICES

Adult

The mental health field has benefited from a substantial body of research about practices that can improve the lives of many people who experience mental illness. The Mental Health Systems Improvement Collaborative (MHSIC) was created in 2001 as a joint venture between the Mental Hygiene Administration (MHA) and the University of Maryland, Baltimore (UMB). MHSIC is located in the Division of Services Research, which is a unit of the School of Medicine's Department of Psychiatry. MHSIC is made up of the Mental Health Services Training Center, the Evidence-Based Practice Center (EBPC) and the Systems Evaluation Center (SEC). Through the block grant, MHA funds the EBPC and the SEC at the MHSIC. These three Centers work in partnership, with MHA to foster and support the continued development of the Public Mental Health System (PMHS). The combination of Centers provides an opportunity to initiate changes in system management, policy development, and service delivery while assessing and analyzing system performance.

The EBPC is in the seventh year of active implementation of evidence-based practices (EBPs) for adults in the areas of Supported Employment (SE), Assertive Community Treatment (ACT), and Family Psychoeducation (FPE), a treatment model involving family participation. Fidelity is assessed by MHA annually to determine the EBP reimbursement rate. Sites must score a minimum of 4.0 on the fidelity measurement tool, taken from the SAMHSA toolkit, in order to bill at an enhanced rate. Following is a discussion of the EBP's current year's activities.

There are currently 30 Evidence-based Practice Supported Employment (EBP SE) programs. There is a new initiative to address sustaining activities for Supported Employment. Ongoing training opportunities are now offered every other month to trained EBP programs. Attendance and feedback from the trainings have been very positive and well received. Additionally, on-site technical assistance is offered to each program 30 days prior to their scheduled fidelity assessment. After the assessment, a trainer assists with a Fidelity Action Plan to address identified areas which may need improvement. A new initiative based on a tool created by the New Hampshire-Dartmouth Psychiatric Research Center requires the trainer and the program leader, after each program's fidelity assessment, to develop a Fidelity Action Plan on how to address the program's needs and improve practice. Another new initiative has been collaboration with the ACT teams to train them in supported employment. Finally, the trainer has been invited to participate in the Psychiatric Addictions Rehabilitation Group (PARG) in the Division of Rehabilitation Services (DORS). The objective of this group is to bring together counselors from DORS, Addictions and Mental Health for networking, training, problem solving, and general discussion. These meetings take place on a quarterly basis.

A new training was developed to address the barriers and issues for clinicians collaborating with vocational staff. *The Benefits of Evidence-Based Practice Supported*

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Employment and Mental Health Collaboration was successfully presented to two regions of the state with positive feedback on the evaluations. The training included information about the seven principles of EBP SE, entitlements, myths about employment for individuals with mental illness, and benefits of employment for consumers, clinicians, agencies and the community.

Maryland currently has 8 Assertive Community Treatment (ACT) teams, serving over 1600 consumers. These ACT teams provide intensive, mobile, assertive mental health treatment for people for whom traditional mental health services do not work, and they do so with a model of strong evidence of effectiveness. The ACT trainer organized multiple focus groups for all teams to establish the needs around substance abuse interventions and vocational issues. The trainer then helped to establish a training program for all sites with assistance from the trainers for supported employment and co-occurring disorders.

Family Psychoeducation is actively being followed in six agencies. Several sites are networking with the state FPE coordinator in Kansas, sharing support and tips for successful implementation. Strategies for outreach and practical suggestions for difficult clinical situations that arise are often the focus of the technical assistance calls creating peer supervision and informal problem solving across sites.

Additionally, Maryland continues efforts in the implementation of practices related to co-occurring disorders, within the public mental health system (PMHS). Activities are underway in eight (8) Core Service Agencies (CSAs) involving a total of 12 jurisdictions. The co-occurring disorders trainer provides consultation and technical assistance on system change models such as the Comprehensive, Continuous, Integrated System of Care (CCISC) model, developed by Ken Minkoff, PH.D and Christie Cline. Each jurisdiction is unique, and requires specialized consultation geared to its progress in implementing a system change effort. The counties remain in various stages of implementation. The COD trainer is working with two agencies in Maryland on the implementation of the Integrated Dual Disorders Treatment (IDDT) model. He works with agency leaders and a consultant from the New Hampshire-Dartmouth Psychiatric Research Center to provide technical assistance and establish resources for the programs. The trainer also participates in a MHA/DDA/ADAA workgroup to establish state competencies for co-occurring disorders (CODs), develop a curriculum, and to set up a statewide training process for supervisors.

Additionally, the trainer, in collaboration with ACT and SE trainers, has designed training to enhance workforce development for substance abuse and employment specialists within ACT teams. Focus groups were conducted to determine additional training needs in the ACT programs, and plans are underway to design training to address these needs.

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Child & Adolescent

The Maryland Child and Adolescent Mental Health Institute/ Innovations Institute—known as the Institute, has been described at length in earlier criteria and serves as the principal training arm of the child and adolescent mental health system. Now funded by both MHA and the Children’s Cabinet, the Institute provides training on system of care principles and on the delivery of high fidelity Wraparound services. In addition, the Institute provides training that certifies providers of family to family and youth to youth peer support under the 1915 (c) waiver. The System of Care Training Institutes are held annually in July of each year.

The Institute is in the initial stages of rolling out a grant on Trauma Informed Cognitive Behavioral Therapy. In addition, in conjunction with the Children’s Cabinet, the Institute is overseeing the implementation fidelity of Multi-systemic Therapy, and Functional Family Therapy funded by other agency partners in selected locations in Maryland. The Institute is also involved in a program to develop increased evidence of the effectiveness of the state’s respite care program.

In addition, MHA is funding a number of known evidence-based practices in the area of youth suicide prevention with support from a statewide Garret Lee Smith Suicide Prevention grant from SAMHSA. Local grants will be awarded during the coming year to entities such as the CSAs and local school systems based on a competitive review of proposals that emphasize the implementation of suicide prevention evidence-based practices.

COMBINED ADULT AND CHILD TRAINING ACTIVITIES

First Responders

MHA, in collaboration with law enforcement agencies, offers training for officers, other public safety officials and community providers regarding the management of crises involving persons who appear to have a mental disorder and who may or may not have committed an offense. Training is provided through the MHA Office of Forensic Services, as well as by the local crisis response systems. Presentations include use of emergency petitions, approaching persons with mental disorders, the field interview of the person with a mental disorder, dealing with the suicidal individual, coverage of post traumatic stress disorder (PTSD) and treatment resources for active duty personnel and veterans. These presentations concentrate on the practical decisions that police officers have to make in the field, and are in plain, non-technical language. MHA will continue to participate in meetings with stakeholders regarding availability of mental health services for individuals with criminal justice involvement and on current or new programs and services provided by MHA's Office of Forensic Services such as diversion, services for inmates with mental illness, and discharge planning for pre/post release inmates. The Office will continue to provide training to MHA facilities and community forensic evaluators on the new reporting requirements for individuals committed as Incompetent to Stand Trial.

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In collaboration with DHR, MHA through the CSAs have participated in the implementation of the Mental Health Mobile Crisis and Stabilization Service Initiative. This initiative provides community-based, 24-hour intensive in-home services to respond to crisis issues in foster/kin homes where DSS has placed children or for children who continue to reside with their families as a result of family team meeting intervention. This service is slated for a two-year implementation and is currently in place in 16 jurisdictions. Each jurisdiction has a team consisting of trained mental health professionals. The service is available 24/7 and in most jurisdictions relies on a warm-line for triage assistance. In most jurisdictions this service is supported through briefings to law enforcement and dispatcher training. DSS staff also provide training about foster/kinship care to mobile crisis providers, often in conjunction with foster care/kinship provider trainings.

Implementation of the Mental Health First Aid (MHFA) Program

Under DHMH Secretary's direction, Maryland became one of three national partners in bringing Mental Health First Aid to the USA and is currently a national leader, along with Missouri Transformation and the National Council for Community Behavioral Health, in sustaining this effort. MHA through the Mental Health Transformation –State Incentive Grant (MHT-SIG) is developing the capacity to respond to individuals experiencing psychiatric emergencies. Significant progress has been made over the past year in implementing the Mental Health First Aid (MHFA) initiative in Maryland and bringing the training certification program to individuals, organizations and communities throughout the State of Maryland. The corps of certified Instructors who are regionally distributed throughout the State has expanded to 42 individuals. Since the program's launch, 41 trainings have been held and over 800 Marylanders have been trained. Maryland's effort is led by four regional coordinators who are housed with local Mental Health Associations. These coordinators carry out marketing and community outreach functions and provide oversight and technical assistance to the 42 certified Instructors. On Our Own of Maryland, Inc. contracted with seven nationally known consumer leaders, from seven different states, to provide feedback and input on the MHFA manual. The MHFA Manual and Instructor Teaching Notes were scheduled to be released in late FY 2009. More than 2,500 draft manuals and 300 Instructor Training Kits have been produced and distributed for trainings conducted in Maryland and throughout the United States.

State Disaster Planning and Training Activities

The Director and Assistant Director of Behavioral Health Disaster Services have provided facilitation, support and technical assistance to enhance Maryland's ability to respond to the behavioral health needs that arise in the event of natural or man-made crises/disasters as well as enhance MHA, ADAA and Core Service Agencies (CSA) planning and preparedness. The Director and Assistant Director have reviewed and revised the All-Hazards Disaster Plans for ADAA and MHA and have conducted on-site review visits to each of Maryland's 20 CSAs focusing on All-Hazards Disaster Plan

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updates and improvements. MHA and ADAA drills and exercises have been scheduled and technical support to CSAs on plan drills and exercises has been offered.

Behavioral Health Disaster Services staff have provided training to the Maryland Professional Volunteer Corps (MPVC) and assisted the MPVC in their recruitment of additional disaster behavioral health volunteers. In addition, the staff have facilitated disaster behavioral health training to numerous CSAs that wish to augment existing local disaster behavioral health volunteer teams. The Director and Assistant Director have coordinated NIMS training for MPVC and for MHA and have provided technical assistance in the maintenance of the MHA Incident Command System.

Behavioral Health Disaster Services (BHDS) staff also served at the State Emergency Operations Center during Tropical Storm Hanna; collaborated with Maryland Emergency Management Administration (MEMA), DHR and DHMH to provide behavioral health technical support and training running up to and during the Presidential Inauguration, and developed situational specific handouts for both the public and the professional response community. BHDS also was active during the H1N1 outbreak both at MEMA and with DHMH providing technical assistance and message support.

In response to a request from the Office of Consumer Affairs, BHDS has developed and will implement a train-the-trainers program for lead staff at Maryland's On Our Own Wellness and Recovery Centers incorporating disaster behavioral health and basic disaster preparedness concepts into the WRAP approach to health and well being for persons with mental health challenges.

Seclusion and Restraint

Following MHA's receipt of a SAMHSA grant in FY 2005 to reduce the use of seclusion and restraint in the child-serving mental health facilities, a project director was hired at the EBPC. The project director's role is to provide education and consultation regarding techniques and strategies to achieve the reduction of seclusions and restraints to the state mental health inpatient and residential treatment facilities. Since July 1, 2008, following the ending of federal grant support, which focused on child serving facilities, the Transformation State Incentive Grant (MHT-SIG) has funded the Seclusion & Restraint elimination effort,. Springfield Hospital Center was selected as the first adult facility to receive S&R reduction activities under the supervision of the S&R project director.

Activities of the project director include:

- Collaborating with the Johns Hopkins University researcher to develop a survey for staff working in the child and adolescent facilities to identify their impressions of the START manual, with the goal of identifying gaps in training and basic knowledge.
- Coordinating with NASMHPD experts who previously were enlisted to conduct additional training on "Trauma Informed Care".

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- Adapting the START manual for use in adult facilities. Each adult facility will be given an overview of the state's grant activities over the past three years, sharing strategies that have been successful in the child/adolescent facilities.
- Beginning expansion of technical assistance activities designed to reduce or eliminate Seclusion/Restraint to the public adult inpatient facilities, beginning with Springfield Hospital Center.

Leadership Training

In addition to the Family Leadership Institute described in a previous criterion, the Maryland Coalition of Families provides two specific training curricula to families, Navigating the Juvenile Justice System and Navigating the Transition Years. Both of these training courses are reimbursable under the Medicaid waiver for family members of waiver service recipients, but these trainings are also considered essential for family members working as Family Navigators and as Family Peer to Peer Specialists under the waiver.

MHA also supports training through its CSAs. Local/regional trainings are provided dependent on local needs. Consumer, family, and advocacy groups receive funding to provide community education and training which target adult consumers, minorities, family members, children's mental health, and stigma issues.

The following list includes training and technical assistance activities that have been approved by MHA, which will be coordinated through the University of Maryland Training Center in FY 2010. Training events include projects for children and adolescents, adults and elderly consumers, as well as a multitude of special populations.
[NFC 1] [NFC 5]

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DESCRIPTION OF MHA FY 2010 TRAINING

1. Annual MHA conference. This 2 day event brings together stakeholders from the Public Mental Health System (PMHS) to address issues related to the direction of the system and the delivery of mental health services in Maryland. Projected attendance: 450
2. CSA Training/Technical Assistance: Provides for training related to system management including such topics as planning, mental health finance systems, service development, consumer relations, emerging populations, Evidence-Based Practices, etc. Training and technical assistance is targeted to relevant CSA, MHA and ASO staff. Projected attendance: 3 training activities @ 100 per activity = 300 + technical assistance to individual CSA's as requested.
3. Interpreters: Provides funding for interpreter services at training events, to ensure ADA compliance.
4. The Training Center: Continuation of the relationship with the Department of Psychiatry at the University of Maryland School of Medicine to coordinate planning, development and evaluation of the herein described training projects.
5. Adult Services Rehabilitation/Recovery Conference: This is a first annual conference for Adult Services to combine thematic strands into a consolidated transdisciplinary conference. Workshops will address: older adults, transition age youth, traumatic brain injury, supported employment, housing and case management, rehabilitation and recovery and evidence-based practices. Projected attendance – 400.
6. Child and Adolescent: Center for Social and Emotional Foundations of Learning (CSEFEL) Training: Updated training and coaching for trainers. Projected attendance: 500
7. Child and Adolescent: Youth Suicide Prevention Conference. Annual conference on youth suicide, 2010 theme is "Inner Strength During Challenging Times." Projected attendance: 500
8. Child and Adolescent Annual Conference: A two day conference focused clinical updates on psychiatric disorders, psychopharmacology, use of the RTC system, and a focus on wellness and resiliency, featuring Maryland universities and providers. Projected attendance: 450
9. Office of Consumer Affairs (OCA) – Leadership, Advocacy and Empowerment Program (LEAP): Intensive four day training focused on consumer recovery, advocacy, resilience, evidence-based practices and outcome driven services. Projected attendance: 12
10. OCA – Wellness and Recovery Directors' Training Part 2: To train the Wellness and Recovery Center (WRC) and Core Service Agency (CSA) Directors on enhanced communication skills, updates for service delivery and utilization of resources. Projected attendance: 40
11. OCA – Boundaries in the Workplace: To train WRC and CSA Directors on how to set healthy boundaries for themselves, employees and members of the centers. Projected attendance: 40
12. OCA – Identification Management Seminar: Designed to assist and enhance the WRC's on identifying strengths and using them to enhance leadership qualities of their peers. Projected attendance: 40
13. Forensic Conference: 13th Annual Symposium on Mental Disability and the Law: Addresses issues concerning individuals with mental illness who are involved in the criminal justice system. Projected attendance: 175

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14. Cultural Competence Conference: “Eliminating Mental Health Disparities” conference to address the impact of consumer, family member and provider communication, mental health literacy, the importance of beliefs and values in diverse cultures, and the integration of culturally responsive psychiatric treatment and mental health services. Projected attendance: 100
15. Special Populations – Personal and Organizational Disaster Preparedness: Designed for WRC Directors to assist consumers in the event of a disaster. Projected attendance: 3 regional trainings, 25-30 each, Total 75-90
16. Special Populations – Trauma Informed Care for Justice Involved Veterans: Introduction to trauma and the connection to criminal activity, training law enforcement personnel on trauma informed care. Projected attendance: 75
17. Special Populations – SSI/DDSI Outreach, Access and Recovery Training (SOAR): Directed to case managers and providers working with individuals who are homeless and have a mental illness to assist in accessing resources. Projected attendance:
18. On Our Own Md. Recovery Project: Training and technical assistance on employment, recovery and wellness. Includes 30 hour a week providing individualized benefits counseling and benefits workshops; Discovering Your Recovery Muse workshops and Steps to Wellness workshops (24 total), and 5 hours/ week of staff time toward the pilot project, Recovery Centers of Excellence. Projected attendance: 1,000
19. On Our Own Md. Summer Conference: Annual statewide conference for consumers focusing on recovery , empowerment and wellness: Projected attendance: 400

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SFY 2010 OBJECTIVES FOR CRITERION 5:

SERVICES FOR ADULTS AND CHILDREN AND ADOLESCENTS:

- Continue the annual statewide client perception of care surveys of adults and parents/caretakers of children and youth regarding their experiences with PMHS services.
MHA Monitor: Sharon Ohlhaber, MHA Office of Quality Management and Community Programs
- Review and approve CSA mental health plans, budget documents, annual reports, and letters of review from local mental health advisory committees (LMHACs) and CSA advisory boards.
MHA Monitor: Cynthia Petion, MHA Office of Planning, Evaluation, and Training
- Monitor and collect documentation on each CSA's performance of activities, as outlined in the Memorandum of Understanding (MOU), on risk-based assessment of the CSA and specific MOU elements; and notify the appropriate MHA program director of exceptions that may require corrective action or additional technical assistance.
MHA Monitor: Alice Hegner, MHA Office of CSA Liaison
- In collaboration with the University of Maryland's Research, Education and Clinical Center and the Maryland Child and Adolescent Mental Health Institute, implement best practices in psychiatry to address reduction of negative side effects of medication, prevention of obesity, and reduction in morbidity and mortality rates for both adults and child and with serious mental illness or serious emotional disorder.
MHA Monitor: Gayle Jordan-Randolph, MHA Office of the Clinical Director and Al Zachik, MHA Office of Child and Adolescent Services
- Provide information, training, and technical assistance for MHA facility staff, CSAs, and community providers regarding services for individuals who have mental illnesses and are involved with the criminal or juvenile justice system.
MHA Monitor: Larry Fitch, MHA Office of Forensic Services
- MHA, in conjunction with the Mental Health Transformation Office (MHTO), will implement an assessment and cultural competence training project and utilize information on cultural competency training across the PMHS.
MHA Monitor: Iris Reeves, MHA Office of Planning, Evaluation, and Training
- MHA, in collaboration with the DHMH Office of the Deputy Secretary of Behavioral Health and Disabilities, will implement Maryland's Action Plan to Eliminate Disparities in Behavioral Health Care with a focus on culturally and linguistically appropriate services.

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Monitor: Iris Reeves, MHA Office of Planning, Evaluation, and Training

- MHA in collaboration with the University of Maryland will continue implementation of a training initiative for outpatient mental health clinics (OMHCs) to improve services at the local level to serve individuals with co-occurring disorders.

MHA Monitor: Carole Frank, Office of Planning, Evaluation, and Training

- Maintain and update disaster mental health response plans including MHA, Alcohol and Drug Abuse Administration (ADAA), and Core Service Agency (CSA) All-Hazards plans; provide disaster behavioral health and related disaster training for Department of Health and Mental Hygiene (DHMH) staff and for local volunteers; support the Maryland Professional Volunteers Corps Program through the provision of disaster behavioral health and National Incident Management System/Incident Command System (NIMS/ICS) training and technical assistance (TA); integrate disaster preparedness and behavioral health into the Wellness and Recovery Action Plan (WRAP) training for consumer-run Wellness and Recovery Centers statewide; provide TA to emergency management and public health on disaster behavioral health.

MHA Monitor: Laura Copland, MHA Office of Special Needs Populations

- Based on a requirement for DHMH as a federal grant receiving agency and on instructions from the Governor's Chief of Staff, MHA will have an all-hazards approach to emergency preparedness and response for MHA as an administration (including facilities) and for the mental health community at large.

MHA Monitor: Tom Franz, MHA Office of Special Needs Populations

- Collaborate with the Maryland Advisory Council for the Deaf and Hard of Hearing, the Governor's Office of Deaf and Hard of Hearing (ODHH), CSAs, advocates, other state and local agencies, and colleges and universities to provide support and technical assistance to promote statewide access to services that are culturally competent for individuals who are deaf or hard of hearing, which includes application of new communication and technology, i.e. video phone, telepsychiatry, and Web-based training.

MHA Monitor: Marian Bland, MHA Office of Special Needs Population

- Provide training designed for specific providers, consumers, family members, and other stakeholders to increase the effectiveness of service delivery within the PMHS.

MHA Monitor: Carole Frank, MHA Office of Planning, Evaluation, and Training

- Facilitate cross-training activities in cooperation with the three administrations under the DHMH Deputy Secretary for Behavioral Health and Disabilities: Alcohol and Drug Abuse, Developmental Disabilities, and Mental Hygiene.

MHA Monitor: Pat Miedusiewski, DHMH, State Program Administrator for Co-occurring Disorders

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- Review MHA's budget and PMHS expenditures and services; implement corrective actions, as needed, to maintain operations within allocation.
MHA Monitor: Brian Hepburn, MHA Office of the Executive Director and Randolph Price, MHA Office of Administration and Finance
- Continue the annual statewide client perception of care surveys of adults and parents/caretakers of children and youth regarding their experiences with PMHS services.
MHA Monitor: Sharon Ohlhaber, MHA Office of Quality Management and Community Programs
- Enhance capacity for stakeholders to utilize PMHS data to measure service effectiveness and outcomes.
MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis
- In collaboration with the Mental Health Transformation Office (MHTO) and the Maryland Consumer Leadership Coalition (MCLC), continue to further define "recovery-based mental health treatment" and establish guidelines for peer workforce development in the PMHS.
MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs
- The Child and Adolescent Mental Health Workforce Committee, chaired by MHA and MSDE, will develop a mental health training model for educators and continue development and delivery of curricula for training of staff in child mental health professions based on established core competencies.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

SERVICES FOR ADULTS

- Continue, in collaboration with the University of Maryland, CSAs and key stakeholders, statewide implementation of evidence-based practice (EBP) models in supported employment, assertive community treatment, and family psycho-education, and evaluate programs annually to determine eligibility for EBP rates.
MHA Monitor: James Chambers and Steve Reeder, MHA Office of Adult Services
- MHA, in collaboration with CSAs, will provide training for law enforcement officers, other public safety officials, and corrections personnel regarding the management of crises involving individuals who appear to have a mental disorder and are charged with offenses or suspected of criminal involvement or juvenile delinquency.
MHA Monitor: Larry Fitch, MHA Office of Forensic Services

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- In collaboration with the University of Maryland, the Johns Hopkins University, and the Maryland Coalition of Families for Children’s Mental Health, continue the efforts of the Maryland Child and Adolescent Mental Health Institute to explore and implement child and adolescent evidence-based practices (EBPs) and other promising practice based models.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

SERVICES FOR CHILDREN AND ADOLESCENTS

- In collaboration with the University of Maryland, the Johns Hopkins University, and the Maryland Coalition of Families for Children’s Mental Health, continue the efforts of the Maryland Child and Adolescent Mental Health Institute to explore and implement child and adolescent evidence-based practices (EBPs) and other promising practice based models.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services
- The Child and Adolescent Mental Health Workforce Committee, chaired by MHA and MSDE, will develop a mental health training model for educators and continue development and delivery of curricula for training of staff in child mental health professions based on established core competencies.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services
- In collaboration with Center for Medicare/Medicaid Services (CMS) and Maryland Medical Assistance (MA), continue implementation of the CMS-supported 1915(c) Psychiatric Residential Treatment Facility (PRTF) demonstration waiver to provide services to up to 80 children and youth and their families in four jurisdictions across the state.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services
- The Child and Adolescent Mental Health Workforce Committee, chaired by MHA and MSDE, will develop a mental health training model for educators and continue development and delivery of curricula for training of staff in child mental health professions based on established core competencies.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

SECTION III

PERFORMANCE GOALS AND ACTION PLAN

TO IMPROVE THE SERVICE SYSTEM

Children's Mental Health Plan

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CHILDRENS PLAN

CRITERION #1: Comprehensive Community–Based Mental Health Service System for Children and Adolescents

Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.

AVAILABLE SYSTEMS OF TREATMENT, REHABILITATION, AND SUPPORT SERVICES

Services Available

Community-based mental health services and supports that are included in the fee-for-service benefit package for children, youth and families include:

- Psychiatric hospitals
- Psychiatric units of acute care general hospitals
- Residential treatment centers (RTCs)
- Psychiatric day treatment (also called partial hospitalization)
- Outpatient mental health clinics (many of which provide school-based and after-school treatment programs)
- Psychiatric rehabilitation programs
- Mobile treatment services (MTS)
- Supported employment (SE) and vocational services (for transition-age youth [TAY] age 16 and above)
- Respite care
- Residential crisis services
- Therapeutic behavioral aides
- Mental health related laboratory services

In addition to the broad range of services provided in the fee-for-service PMHS, youth admitted to the psychiatric residential treatment facility (PRTF) waiver (further explained in the following section) will be eligible for additional waiver services in addition to the PMHS services these services include:

- High Fidelity Wraparound Care Management
- Family to Family Peer Support
- Youth to Youth Peer Support
- Family and Youth Training
- In Home Respite Care
- Out of Home Respite Care
- Crisis and Stabilization Services
- Expressive and Experiential Services (i.e. art, movement, and music therapies, and horticultural and equine assisted therapies)

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Additionally, MHA provides funds through contracts to programs that offer specialized services (e.g., mobile crisis, therapeutic nurseries, and therapeutic group homes) that do not fit the fee-for-service model. These programs are eligible to apply for funds for programs such as family support groups, protection and advocacy services, juvenile court evaluation programs, and early childhood mental health consultation. A wide array of other child mental health services are also provided by other agency partners, such as Wraparound, which is funded through the Governor's Office for Children. Case management is currently contracted through the core service agencies, with one or more case management programs that provide linkage services and resources that will assist the consumer in stabilizing into the community. However, in FY 2010, MHA worked with Medicaid to amend the Medicaid State Plan and regulations for case management. Once CMS approval is received, MHA in collaboration with the CSAs and the ASO will implement and monitor the transition from contracted case management services to the fee for service system (FFS) for Medicaid recipients and uninsured individuals. [NFC 2]

With regard to the MHA-operated Public Mental Health System (PMHS), any mental health provider who meets appropriate licensing, certification, accreditation, or other applicable standards is eligible to become a provider in the fee-for-service system. Eligible providers include facilities, programs, and individual practitioners. Individual practitioners include physicians, psychologists, nurse psychotherapists, clinical social workers, occupational therapists, and certified professional counselors who are allowed to practice independently under their Practice Acts. This increase in the provider community offers consumers an expanded choice of providers, including both approved mental health programs and individual licensed mental health practitioners. PRTF waiver services add Family Support Organizations to the mix of providers. Expressive and experiential therapies are provided by individual providers only.

In addition to the above services, coordinated service provision of a number of other service types is available within the child and adolescent system of care. Many of these are described below:

Employment Services - These services are primarily intended for transition-age youth (TAY) and, while they are funded as highly specialized TAY programs, the services of supported employment are similar to those described in the adult plan.

Housing Services - There are two primary housing concerns for children and youth with mental health needs: 1) out-of-home placement, and 2) affordable, adequate and safe housing for the family as a support to keep the child or adolescent in their community. Most housing, or "out-of-home placements", in the child and adolescent service system are provided by the child welfare and juvenile justice systems. An array of kinship care, foster care, treatment foster care, group homes, therapeutic group homes, childcare institutions and residential treatment centers are available. All residential service policy in Maryland is developed and promulgated in an interagency context by the Interagency Licensing Board, operated out of the Governor's Office for Children

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(GOC). MHA is currently involved with this group in a quality improvement effort regarding Therapeutic Group Homes, the only residential service option in the continuum of residential services that is regulated by MHA. A series of regular site visits and technical assistance designed to advance the programs' recovery and resilience orientations are planned for 2008. Family preservation is a key objective of the system along with keeping the child in the least restrictive environment possible. However, the full range of housing options is available to enable the most appropriate placement for each child. Mental health services, including outpatient, psychiatric rehabilitation, respite, and therapeutic behavioral aides are used to meet the mental health needs of children and adolescents in these out-of-home placements. In four jurisdictions, high fidelity wraparound services called Wrap-MD are available to assist in keeping children with their families. These services are funded through a combination of Medicaid and state funds administered by the GOC. The services made available through Wraparound will soon be provided under the aegis of a Medicaid Section 1915(c) waiver as a part of a CMS funded demonstration program. This new demonstration project is described in greater detail in Criterion 3. **[NFC 2]**

MHA and DHR work together in a number of venues focused on housing. The National Institute for Mental Health (NIMH) funded "Science to Service" evidence-based practice initiative focused on the implementation of treatment foster care. This is a service that falls into the nexus of mental health treatment and social services (or juvenile services) housing placement for youth unable to remain with their families. In FY 2006 MHA, in conjunction with DHR, the University of Maryland – Baltimore, and treatment foster care providers across the state completed Maryland's NIMH Science to Service grant assessing the use of evidence-based treatment foster care (TFC) in the state. Based on this work, a TFC Roundtable was convened in June 2007 to discuss approaches to promote the development and utilization of innovative treatment foster care in Maryland. Almost 50 participants representing a broad variety of stakeholders explored issues and developed a draft white paper with recommendations to be made that Maryland move TFC toward more evidence-based practice standards with identified funding and/or reimbursement. The work of the TFC roundtable will focus on moving implementation of TFC in the direction of more evidence based models statewide, an ambitious project that is being undertaken with the Maryland Child and Adolescent Mental Health Institute at the University of Maryland.

MHA's activities in the broader housing arena may affect families as well. Housing that is affordable, accessible, and integrated into the community is a major factor in enhancing the well-being and stability of children and adolescents and their families. MHA actively collaborates with both the Maryland Department of Housing and Community Development (DHCD) and the federal Department of Housing and Urban Development (HUD) to promote access and receipt of affordable housing through specialized government-supported housing opportunities. DHCD is represented on the Joint Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council. **[NFC 1]**

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MHA encourages the CSAs to work with local housing authorities and affordable housing developers to maintain awareness of opportunities in their regions. To access housing, many local mental health providers have helped consumers, successfully pursue HUD Housing Choice Voucher Programs and rental assistance services. One major implication of the mental health recovery movement is that consumers, particularly mothers, have increased opportunities to regain custody of their children and to live together as families. Several CSAs have also supported their local housing authorities in their applications for HUD Housing Choice Voucher Program vouchers for persons with disabilities and their families. Additionally, MHA has encouraged and provided some financial incentives to establish non-profit housing development entities. Many of these entities, as well as mental health provider organizations, have developed affordable housing through community bond grants through Maryland's DHMH's Administration-Sponsored Capital Program. MHA has identified housing as its priority for receipt of these bond monies. Projects have included development of affordable housing units for transition-age youth. Several of this year's Capital Program awards addressed this priority. [NFC 1]

In 1995, the U.S. Department of Housing and Urban Development (HUD) awarded MHA a five-year, \$5.5 million Shelter Plus Care grant to provide housing for individuals who are homeless with serious mental illness (SMI) (with or without accompanying substance abuse) and their dependents, who are being released from the detention center or are in the community on the intensive caseloads of parole and probation. Last year, the FY 2009 Shelter Plus Care Housing grant was renewed for \$3,862,442 due to increases in the Fair Market Rental Values determined by HUD. Additionally in 2009, MHA received \$592,916 through seven small grants targeted to specific jurisdictions. The jurisdictions awarded the five-year grants were Allegany, Anne Arundel, Baltimore, Cecil, Frederick, Harford, and Prince George's Counties. Effective July 1, 2010 (FY 2010), MHA was awarded funding in the total amount \$3,306,900 for 16 of the Shelter Plus Care renewal grants. Currently, MHA is serving a total 653 persons, 147 single individuals with mental illnesses and 172 families with 281 children and 53 other family members through all of the Shelter Plus Care programs. [NFC 1]

School Based Mental Health - MHA continues its extensive work with the Maryland State Department of Education (MSDE), both in regard to strengthening student support services for students in regular classrooms and in special education settings governed by the requirements of the Individuals with Disabilities Education Act (IDEA). MHA and MSDE collaborate to provide services to children and youth and to recruit qualified mental health providers for schools and the community. There has been a considerable increase in school-based mental health services over the past several years. For example, mental health services are available in 120 public schools in Baltimore City and in six schools in Baltimore County. There are currently 61 school-based health centers across the state, each of which provides somatic services. Approximately half of the centers also provide mental and behavioral health services. [NFC 1]

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The Blueprint School Mental health Committee (further explained in the following section) completed a statewide assessment of expanded school mental health availability in Maryland's 24 local jurisdictional school systems.

- **PBIS**-- Additionally, Maryland law requires elementary schools with suspension rates over 18% to implement the Positive Behavioral Interventions and Supports (PBIS), or an alternative behavioral modification program, to reduce suspensions. MSDE, in partnership with Sheppard Pratt Health System and Johns Hopkins University's Bloomberg School of Public Health, oversee and support the statewide implementation of PBIS in Maryland. The partnership, known as PBIS Maryland, is responsible for providing training and technical assistance to local school systems. Each summer, the PBIS Maryland hosts a Training Institute for new teams and local school systems host a number of local/regional Training Institutes for their implementing schools. -An increasing number of schools are choosing to use this program because of its success in improving school climate. The program has been successful in decreasing the number of suspensions and expulsions as well as behavioral referrals to special education. As of 2008, a total of 650 schools will be trained in PBIS and 568 schools actively implementing PBIS in Maryland.
- MHA's Work Force project undertaken with the MSDE is described in greater detail in Criterion 5.
- Specialized efforts with the Early Childhood Educational sector and, for transition-age youth, with the Division of Vocational Rehabilitation Services (DORS), housed within MSDE, are described in subsequent sections.

Early Childhood Mental Health - The goal of the Maryland Early Childhood Mental Health Initiative is to increase the numbers of children who enter kindergarten ready to learn. Maryland has moved to a statewide assessment of children who enter kindergarten - the Work Sampling System - which provides a status report at the school and county levels of children and their school readiness. According to the criteria employed, Work Sampling System scores represent percentages of students who consistently demonstrate skills, behaviors, and abilities, needed to meet kindergarten expectations successfully. The Work Sampling data are compiled in seven domains and also create a composite readiness score. Over time these scores represent the level of progress the state has made in achieving its goal of entering school ready to learn.

The strategy for early childhood mental health is to integrate mental health services into existing early childhood programs (children 0 to 5 years), to incorporate supports into existing early childhood programs, and to promote and support the integration of early childhood mental health services within other settings. The mental health component of the Maryland Infant and Toddler Program, which provides services for young children governed by IDEA, is strengthened by the activities of the Early Childhood Mental Health Initiative. Additionally, the Initiative supports the provision of mental health services in day care services as well as federally-funded Head Start programs. [NFC 4]

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The Maryland State Early Childhood Mental Health Steering Committee provides direction to the Initiative. The Steering Committee is composed of a wide variety of organizations including: MHA's Office of Child and Adolescent Services; Maryland Coalition of Families for Children's Mental Health; MSDE; Governor's Office for Children; DJS; Maryland Insurance Administration; Mental Health Association of Maryland; CSAs; Local Management Boards; University of Maryland Training Center; and, other child serving agencies. [NFC 4]

Findings from the recent evaluation of the pilot of early childhood mental health consultation with childcare providers indicated that that on-site consultation to child care programs delivered by interventionists who were knowledgeable about child development, individualized consultation for children at risk of being expelled from their child care programs, and consultation to providers about classroom-wide behavior management strategies had a number of positive effects. These effects included substantial decrease in expulsion for at-risk children, strong gains in social skills, reductions in children's problem behaviors, changes in teachers' behaviors, and improvement in the classroom environment. Based on the results of the pilot project and evaluation, support from agencies, providers and families, and the success of the FY 2007 expansion of early childhood mental health consultation MSDE received \$2.5 million for state FY 2008 to further early childhood mental health screening, prevention and intervention for preschool children at risk of developing emotional and mental health disorders. This will ensure that consultation is available in all jurisdictions. [NFC 4, 5]

Services for Transition-Age Youth - MHA has initiated a new committee to review in the upcoming year the status of approaches to transition-age youth and to develop a strategic plan with recommendations toward creating a better system of care for this age group. Earlier in this decade, MHA received funding to provide services for youth moving from the child to the adult system. MHA fully implemented competitively awarded grant-funded transition-age youth (TAY) projects in ten jurisdictions (Baltimore, Worcester, Washington, and Garrett Counties; Charles County—in a tri-county project involving St. Mary's and Calvert Counties; Prince George's, Anne Arundel, , Montgomery, and Howard Counties; and Baltimore City). No additional funding was appropriated for the last several years; however, MHA continues to support existing grantees through its system of core service agencies (CSAs). These projects are supported with state general funds provided through contracts to CSAs and with Medical Assistance (MA) through the fee-for-service system. These projects utilize different service approaches and target diverse and specialized populations (i.e. pregnant and parenting TAY with children; TAY transitioning from RTCs; supported education). MHA continues to review local CSA Plans for inclusion of services to TAY individuals and to identify diversionary strategies for supporting TAY in the community and preventing institutional placement. [NFC 2]

MHA plans to utilize input from focus groups conducted by the Maryland Coalition of Families for Children's Mental Health to identify best practices in the delivery of services for transition-age youth (TAY) and begin dissemination activities. Focus groups with parents and transition age youth were conducted by the Coalition and

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a report, identifying recommendations for best practices, was provided to MHA. For example, a major thrust of the current plans to improve service to transition-aged youth evolved from themes identified in the Coalition's study. These included: 1) the transition age (roughly 16 to 24 years) is an especially difficult time for youth with mental health needs and their families who may continue many of the roles they had assumed when the child was younger due to lack of services; 2) structure is no longer provided by school and a number of decisions must be made about housing, employment or college requiring learning about a set of agencies new to the families and in which youth did not wish to participate due to perceived stigma; 3) youth expressed a strong desire for independence and yet lacked the experience, skills or emotional stability to work, manage their own finances, and have a "normal" life; 4) youth had career aspirations but felt that work was a major issue; 5) there was a gap between the youth's cognitive development and social and emotional development which impeded their ability to meet their goals for independence; and, 6) families were frustrated that when their children turned 18, parents were legally no longer able to be involved in their child's treatment although they were always the ones called upon in time of crisis. **[NFC 1, 2]**

Employment services are considered a priority for the "school to work" transition efforts listed on students' Individual Treatment Plans (ITPs) required by IDEA. The desire for a job may be a motivating force for older teens and young adults to keep them involved in their overall plan of care and movement toward self-determination. Outpatient and psychiatric rehabilitation mental health service providers, including school-based mental health services, can support the activities of the schools in transitioning students with mental health needs into the world of further training, education, or work. Many of MHA's TAY initiative projects focus on assisting youth to obtain and maintain employment. Supported employment services, as described under Criterion #1 of the adult plan, are available for older adolescents as well. MHA and the Department of Rehabilitation Services (DORS) collaborate on employment activities for adults with mental illnesses and their efforts to increase vocational counselors' understanding of the needs of individuals with psychiatric disabilities. This effort has fostered an increased understanding of the needs of youth with psychiatric disorders as well. **[NFC 1, 5]**

For older youth requiring ongoing mental health services in the adult services sector, access and linkage to educational services are primarily managed through psychiatric rehabilitation programs (PRPs). The rehabilitation assessment includes review of the individual's strengths, skills, and needs for education and vocational training. Based upon the assessment, the individual rehabilitation plan includes a description of needed and desired program services and interventions and identification of, recommendations for, and collaboration with other services to support the individual's rehabilitation, as appropriate. Some PRPs offer GED programs within their own service continuum, while others refer consumers to classes offered elsewhere. Community colleges and local universities in many counties provide opportunities for higher education with special supports for students with disabilities. A spectrum of low cost/ subsidized programs (both federal and state subsidies) is available to individuals with

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disabilities. Many PRPs utilize a “supported education” model, supporting the consumer in his/her choice and pursuit of education in the community at large. [NFC 1, 5]

MHA also collaborates with other agencies to address services to the TAY target group. MHA participates through the Governor’s Interagency Transition Council (ITC) for Youth with Disabilities, in working with designated state agencies to coordinate cross-training and integration of initiatives that may impinge on systems reform for TAY-serving agencies. In FY 2007, MHA jointly sponsored an annual statewide conference on TAY with the Interagency Transition Council for Youth with Disabilities (ITC). MHA continues to collaborate with the Maryland Department of Disabilities (MDOD) and with the ITC in the development and implementation of a cross-agency, multi-year strategic plan based on a recently completed statewide resource mapping process. This process identified existing and needed services and resources to improve post-school outcomes for Maryland youth, ages 16-25, with disabilities. The goal is: 1) to align and coordinate existing TAY services across state agencies and to identify new services to develop, enhance, and sustain TAY outcomes; 2) to enhance coordination and collaboration among stakeholders with relevant services; and, 3) to develop new policies and legislation to better meet goals and objectives. [NFC 5]

Substance Abuse Services - Since DHMH is the agency responsible for mental health, substance abuse, developmental disabilities, AIDS, child and maternal health, and all the programs offered through the State Medical Assistance Plan, there is an ongoing need for coordinating mechanisms within the Department itself in order for DHMH to fulfill its role as an interagency partner with the other Departments of the Children’s Cabinet. The coordination of services for substance abuse, as well as developmental disabilities, with services offered to children and youth for mental health problems, is a critical issue within the DHMH coordination process. These needs all fall under the category of youth with special health care needs, and the primary systemic coordinating effort is the Special Needs Advisory Committee. Staff coordinators from MHA and ADAA work with the special needs coordinator from the child’s HealthChoice MCO when a child with co-occurring diagnoses requires enhanced coordination efforts. Efforts to support initiatives at the county level to implement the Integrated Systems of Care for Consumers with Co-Occurring Mental Health and Substance Use Disorders model of best and evidence-based practices and the state’s involvement in the SAMHSA National Policy Academy are discussed under the adult section of Criterion 1. [NFC 4]

Medical and Dental Services. Medicaid is the joint federal and state program that provides health and long term care coverage to low-income children, families, and individuals with disabilities. The main low-income populations covered under Medicaid include children and their parents, pregnant women, older adults, and individuals with disabilities. Medicaid also covers Medicare cost-sharing for certain low-income Medicare enrollees.

Federal Medicaid requires coverage of the following services: inpatient and outpatient hospital; physician, nurse midwife and certified nurse practitioner; laboratory and x-ray; nursing home and home health care; rural health and federally qualified health

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centers; and early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21. EPSDT requires coverage of all medically necessary services, including dental services, for children under age 21. The dental benefits offered typically include cleanings, fillings, and extractions. Maryland Medicaid also covers “optional” services, such as drugs, therapies, medical day care, and personal care.

On July 1, 2008 Maryland’s Medical Assistance benefits expanded to include comprehensive health care coverage for many more parents and other family members caring for children. Eligibility depends on family size and income. The income limit is about \$21,000 annually for a family of three. Funding was increased for Medicaid dental services over the next three years. The state has also set aside additional funds in a grant program for Maryland’s 24 jurisdictions to help local governments and non-profits to create new or expanded sources of dental care services that will increase the number of Maryland residents with access to a comprehensive and continual source of dental care. Additionally, the DHMH’s office of Oral Health is charged with developing statewide oral health prevention and educational strategies to decrease oral disease, conducting oral health survey of the State’s school Children, and providing grant monies for the establishment of local oral health programs targeted to populations at risk for oral disease.

In Maryland, about 80% of Medicaid beneficiaries, including almost all children with mental health needs who do not reside in a Psychiatric Residential Treatment Facility (PRTF), are in HealthChoice, Maryland Medicaid’s mandatory managed care program. Families choose or are assigned a primary care provider (PCP) and enroll in one of seven HealthChoice managed care organizations (MCOs). Special provisions are provided for children who are in the care and custody of the state with regard to how they are enrolled and services are provided. MCOs provide almost all Medicaid benefits, except for certain “carved-out” services that are provided on a fee-for-service basis. Specialty mental health is a key carve-out service. HealthChoice regulations require that MCOs provide medically necessary and appropriate dental services to enrollees who are younger than 21 years old. As noted in DHMH’s Maryland Medicaid eHealth statistic’s, 793,305 individuals were enrolled with Medical Assistance on May 2009. Of that number, 102,595 children were enrolled in Maryland’s Children’s Health Program (MCHP). Their benefit package and care is provided through MCOs as well. **[NFC 1, 5]**

In FY 2008, 24,798 children under age 13 and a total of 41,547 children and adolescents from age 0-18 were served through the mental health fee-for-service system. The needs of the child and adolescent population with co-occurring mental illness and substance abuse are a special concern for the system. Special efforts to coordinate care when these young people are encountered by the system are made by MHA, Alcohol and Drug Abuse Administration (ADAA), Developmental Disabilities Administration (DDA), and the special needs coordinators of the various MCOs. In particular, the juvenile justice population has a high rate of co-occurring disorders and efforts to integrate mental health treatment within the juvenile justice system places a high premium on the integration of mental health and substance abuse treatment approaches. **[NFC 1]**

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DHMH promotes coordination of MCO and fee-for-service specialty mental health services. Enrollees can self-refer to the Specialty Mental Health System, and Medicaid regulations state that an MCO or an MCO PCP shall refer an enrollee to the Specialty Mental Health System when the MCO PCP cannot meet the enrollee's needs. The regulations also state that a MCO shall cooperate with the Specialty Mental Health System in developing referral procedures and protocols. The requirement that MCOs provide primary mental health care provides a clear linkage between a child's pediatric medical care and mental health treatment plan. The mental health benefits provided under the Early and Periodic Screening Diagnostic and Treatment (EPSDT) program are managed by the PMHS. Carving out this mental health benefit has facilitated identification and access to care for children and youth, particularly young children in the early stages of a problem. [NFC 1, 5]

Meetings among Medicaid and MHA staff, MCO medical directors, and the ASO's medical directors promote coordination. Special needs coordinators at the MCOS currently have access to identified care managers at the ASO, who are specifically commissioned to fulfill this coordinating function. In addition, information on pharmacy utilization is shared across systems. Medicaid receives real-time information on MCO and fee-for-service pharmacy claims in order to prevent drug contraindications at the point of sale. On a monthly basis, Medicaid sends reports to each MCO of their enrollees' fee-for-service mental health drug use, so MCOs and PCPs have information on the mental health drugs their enrollees are taking.

Pharmacy Services. In ongoing efforts to manage pharmacy costs, Medical Assistance (MA) developed a Preferred Drug List (PDL) to make better use of less expensive, but equally effective medications. Cooperating drug manufacturers have offered the state additional revenue in the form of supplemental rebates for purchasing some of the brand name drugs. Fifty-three classes of drugs currently fall under the preferred drug list. According to PDL regulations, for each therapeutic class where there are three or fewer drugs, the PDL may be limited to only one drug; for each therapeutic class in which there are four or more drugs, at least two drugs must be included on the PDL. Prescribing of non-preferred drugs requires a preauthorization. The PDL affects all fee-for-service recipients and those HealthChoice and Primary Adult Care (PAC) recipients who take certain mental health drugs. Preauthorization phone numbers and fax are available for prescribers who prefer to use non-PDL drugs. Preauthorizations for non-preferred drugs are granted upon request and require no justification or criteria at this time. There is also a hotline for recipients to use if they feel they are having difficulty getting their medications

A new initiative planned for the upcoming year is to study the use of psychopharmacological drugs in the foster care population in order to determine current practice and assure appropriate prescribing patterns. Because this population is disproportionately more likely to be served in the mental health system and is known to experience higher levels of residential instability than the general population, the issue of

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continuity of care and follow-up for children in foster care is a key question to be examined.

The Maryland General Assembly established the Maryland Health Insurance Plan under the Health Insurance Safety Act of 2002. A Board of Directors governs the plan, which operates as an independent unit of Maryland Insurance Administration. Individuals who are not eligible for group health coverage, COBRA, government – sponsored health insurance programs and some other special categories, may be eligible. The MHIP includes in its benefits coverage for mental health services. MHIP also has a Prescription Drug program which provides coverage at different levels and includes a deductible. [NFC 5]

Educational services (including those provided by local schools and the Individuals with Disabilities Education Act (IDEA) - MHA continues its extensive work with the Maryland State Department of Education (MSDE), both in regard to strengthening student support services for students in regular classrooms and in special education settings governed by the requirements of the Individuals with Disabilities Education Act (IDEA). MHA and MSDE collaborate to provide services to children and youth and to recruit qualified mental health providers for schools and the community. An extensive array of school-based mental health services are available for students enrolled in regular education and in special education. There has been a considerable increase in school-based mental health services over the past several years. For example, mental health services are available in 120 public schools in Baltimore City and in six schools in Baltimore County. There are currently 61 school-based health centers (SBHCs) across the state, each of which provides somatic services. Approximately half of the SBHCs also provide mental and behavioral health services. [NFC 1]

Maryland law requires elementary schools with suspension rates over 18% to implement the Positive Behavioral Interventions and Supports (PBIS) program or an alternative behavioral modification program to reduce suspensions. MSDE, in partnership with Sheppard Pratt Health System and Johns Hopkins University's Bloomberg School of Public Health, oversee and support the statewide implementation of PBIS in Maryland. The partnership, known as PBIS Maryland, is responsible for providing training and technical assistance to local school systems. Each summer, the PBIS Maryland hosts a Training Institute for new teams and local school systems host a number of local/regional Training Institutes for their implementing schools. As of 2008, a total of 648 schools will be trained in PBIS and 568 schools actively implementing PBIS in Maryland. Additionally, an increasing number of schools are choosing to use this program because of its success in improving school climate. The program has been successful in decreasing the number of suspensions and expulsions as well as behavioral referrals to special education. [NFC 1]

A major new project for 2009 in the arena of special education policy has evolved from a partnership of the Maryland State Department of Education (MSDE), the Coalition of Families for Children's Mental Health, and the MHA which will focus on outcomes for students identified with emotional disturbance in Maryland's school

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systems. This process directly addresses the specific needs of the most highly involved youth identified under the entitlement provisions of the Individuals with Disabilities Education Act (IDEA). A highly successful series of forums was held in the spring of 2008, which highlighted some of the challenges faced by this group of students. MSDE tracks a number of key data elements on students identified under IDEA with emotional disturbance. These data elements include the drop out rates, suspension/expulsion rates, and preliminary data on high school academic performance in English and Algebra. These data reveal troubling trends for all the students, particularly the transition-age youth with mental health needs. More than 49 percent of nearly 9,000 students identified with emotional disturbance dropped out of Maryland schools in 2006, capping a rising trend of more than six percent across the past four school years. Prior to dropping out of school, students with emotional disturbance experience a disproportionately greater number of suspensions and expulsions than do other students with disabilities. Although students with emotional disturbance comprise slightly over eight percent of all students in special education, they account for 52 percent of all suspension/expulsion related disciplinary actions for special education students. This factor is all the more staggering when one considers that so many drop out of school prematurely. Academic proficiency testing in Algebra and English II reveals students scoring in the low 30 percent proficiency range compared to all Maryland high school students, whose aggregate scores are twice as high, registering over 60 percent proficiency on these assessments. To compound an already troubling picture, it must be noted that African American students are disproportionately much more likely to be identified as emotionally disturbed in Maryland schools. African Americans constituted over 56% of all students identified with emotional disturbance in 2006 while representing only 33% of the school-aged population (MSDE PowerPoint- "Meeting the Needs of Students with Emotional Disturbance in Schools"--April 28th, 2008).

The work of this task group will continue into FY 2010, resulting in a series of recommendations for improvements of outcomes for these students. It should be noted that the Children's Cabinet tracks the dropout rate of students with emotional disturbance as a well being indicator. MSDE will offer more than one million new dollars to local school systems in the upcoming year for projects designed to improve the education of students with emotional disturbance.

Case Management Services

In FY 2007, a decision was made to change the financing for mental health case management due to new requirements from the Centers for Medicare and Medicaid Services (CMS) on rate setting methodology. Rather than use Maryland's Medicaid state plan option and protocol for case management, MHA contracted with the CSAs, who in turn, contracted with approved case management providers for the service. Case management programs are operated in 24 jurisdictions throughout the state. In FY 2010, MHA will work with Medicaid to amend the Medicaid State Plan and regulations for case management. As of September 1, 2009, approved case management providers will be funded by the fee-for-service system and receive the federal match through MA. Information for authorizations will be reported to the ASO and payment will be based on

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the level of care that the individual needs in the community. Several counties have also provided case management through the PATH program, Shelter Plus Care community outreach programs, or special jail-based programs. [NFC 4]

Additionally, the FY 2008 MHA's Annual Child and Adolescent Services Conference focused on trauma and trauma informed care in the child and adolescent sector in an effort to increase provider base knowledge about this important focus and delivery of effective case management services. [NFC 1, 5]

Substance Abuse Services including co-occurring disorders - DHMH is the agency responsible for mental health, substance abuse, developmental disabilities, AIDS, maternal and child health, and all the programs offered through the State Medical Assistance Plan. There is an ongoing need for coordinating mechanisms within the Department itself in order for DHMH to fulfill its role as an interagency partner with the other Departments of the Children's Cabinet. The coordination of services for substance abuse, as well as developmental disabilities, with services offered to children and youth for mental health problems, is a critical issue within the DHMH coordination process. These needs all fall under the category of youth with special health care needs, and the primary systemic coordinating effort is the Special Needs Advisory Committee. [NFC 5]

In the past, Maryland has emphasized cross training of staff and coordination of services as a means of providing access to services by individuals needing both mental health and substance abuse services. A number of existing mental health treatment and rehabilitation programs, as well as programs established through the DHMH Alcohol and Drug Abuse Administration (ADAA), have developed dual diagnosis capability and are able to offer substance abuse treatment services to individuals with mental illnesses. [NFC 4, 5]

MHA continues to address the challenge of how to implement evidence-based practices to improve services for children and adolescents, with co-occurring disorders of mental illness and substance abuse. In FY 2008, MHA continued multiple collaborations with ADAA to promote integrated treatment for consumers with co-occurring disorders at the local level. Currently representatives from MHA and ADAA regularly meet with county leaders to provide assistance and support for regional initiatives. This approach includes initiatives at the county level to implement the Comprehensive, Continuous, and Integrated Systems of Care (CCISC) for Consumers with Co-occurring Mental Health and Substance Use Disorders model. Worcester, Montgomery, Anne Arundel, Baltimore, Prince George's, and St. Mary's Counties are currently involved in strategic planning processes. In FY 2009 MHA will assist up to eight jurisdictions to initiate or complete consensus documents, local action plans and train local staff in implementing CCISC. [NFC 5]

The Secretary of the Department of Health and Mental Hygiene (DHMH) has also demonstrated commitment to co-occurring disorders by appointing an administrative officer from his office to work with MHA and ADAA. As a result of coordination through this newly formed position, a state-level leadership team has been convened to

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provide leadership toward enhanced service coordination across systems. There is now a State Charter, reflecting the state's ongoing development toward service integration across the systems. Additionally, within DHMH, new legislation established the Office of the Deputy Secretary for Behavioral Health and Disabilities. This Office includes responsibilities for developing a system of services for individuals with co-occurring disorders, to address systems change and to identify and implement specified treatment and supports.

The majority of the women with co-occurring disorders in the justice system have children and a smaller population is pregnant while incarcerated. MHA was instrumental in developing and implementing the TAMAR's Children Program to address the needs of these women and their children. This program, for pregnant women who were incarcerated or at risk of incarceration in local detention centers and the Maryland Correctional Institute for Women (MCIW), was initially funded through a SAMHSA Targeted Capacity Expansion grant program known as Building Healthy Communities, the Department of Housing and Urban Development (HUD) program (additional Shelter Plus Care), a Department of Justice Residential Substance Abuse Treatment grant, local and state in-kind service commitments, and private foundation funding. The program provided services during the period of incarceration, in a community rehabilitation setting, and re-entry to community with housing and case management services. The program as originally constructed ceased operation near the close of FY 2006. [NFC 2, 3]

In 2007, MHA collaboratively worked with the Department of Public Safety and Correctional Services, the Administrative Office of the Courts, the Alcohol and Drug Abuse Administration, the Family Health Administration, Baltimore Mental Health Systems, Inc. and the Archdiocese of Baltimore to create a new statewide diagnostic and transitional program for pregnant women who are at least 18 years of age who might otherwise be incarcerated. As a result of this collaborative partnership, a new program, the Chrysalis House Healthy Start Program, was created. This program, funded through state general funds, consists of a 16-bed diagnostic and transitional facility (in the former location of the Tamar's Children Program) and serves pregnant and post-partum women and their babies. [NFC 2]

After the newborn's birth, the mother and baby remain in the residential facility and receive a comprehensive array of services. Services include: medical care through contract with a health care organization; mental health treatment which includes trauma and attachment-based treatment interventions; substance abuse treatment and co-occurring treatment services; legal services; parenting and childcare services which include involvement from the Healthy Start and Family Tree Programs; housing; after hours residential support; health education; and other support services. [NFC 2]

Pregnant women may be referred by the courts, the state, Defense Attorney, or DHMH. A comprehensive assessment is conducted by a licensed clinician and an individualized treatment plan is developed between each woman and the treatment team.

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Also in FY 2008, MHA continued to offer and/or provide consultation to state and local agencies serving pregnant and post-partum women and their children on mental health and trauma. MHA continues to fund outreach, case management, and housing assistance to graduates of the Chrysalis House Healthy Start Program through funding provided to Prisoner's Aid Association. [NFC 2]

Activities to Reduce Hospitalization

MHA has directed efforts toward reducing the numbers and length of inpatient admissions, both in hospitals and in residential treatment centers (RTCs) for children and adolescents.

Hospitals: Under the Lisa L. et al Settlement Agreement, the State continues to address the requirements for the timeliness of discharges for youth who are clinically ready to leave the hospital setting. At the end of FY 2004 Crownsville Hospital Center was closed, although bed capacity was maintained within the system. The adolescent unit located at Crownsville was relocated to Spring Grove Hospital Center. Four million dollars from the closure of the hospital was reallocated for community-based services in the five counties largely affected by the closure. These counties have developed a variety of services, focusing on diversion from and alternatives to State hospitalization. Assertive community treatment teams, in-home intervention programs for adults and children and adolescents, and services in the jails are examples of the types of services developed. MHA's process for managing hospital admissions and interface with emergency departments is described in Criterion 1 of the Adult plan and these processes also operate when a child or adolescent is in need of a hospital admission.

The ongoing impetus of the Lisa L. et al Settlement Agreement continues the reduced inpatient utilization of MHA-operated hospital units for adolescents. The ADP this year for the adolescent unit at Spring Grove Hospital Center was 12. In FY 2009, as a result of budget reductions and cost containment actions, several changes occurred: Finan Center closed its adolescent unit and open an assisted living unit for adults. MHA has not operated beds for children under age 12 since FY 1994. Beds are purchased from the private sector, when necessary. [NFC 2, 5]

Residential Treatment Centers: A major development during the past year has been the closure of one of three state operated Regional Institutes for Children and Adolescents (RICAs) As a result of the State's fiscal situation and the under utilization of the program in Cheltenham, Maryland, the Maryland General Assembly acted to close the program by June 30, 2008. This closure has been smoothly and effectively completed and all youth residing in the facility have been transferred to community care or other private facilities. The closure is highly consistent with the goals of the community mental health block grant, resulting in part from the ongoing creation over the years of community alternatives to intensive residential programs. Each of the remaining RICAs will be reduced by eight beds. As these community alternatives have developed, increased pressure was placed on State and private sector residential program for admissions. As a consequence, the situation evolved to the point where budget analysts

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for the General Assembly advised that existing private programs were adequate to the need. We expect as the CMS funded Residential Treatment Facility Demonstration program begins to serve increasing numbers of youth that this trend may continue over the next several years. [NFC 2, 5]

An issue of concern within the hospital system is the number of children and adolescents who are in acute inpatient beds, ready for discharge, without adequate insurance coverage and whose parents, without additional supports, are unable to care for them. In many instances, the child's insurance will cover acute inpatient care, but not the range of community-based services that the child requires to successfully return home or to an interim placement. Often, a recommendation is made for more restrictive RTC placement in order to access MA eligibility as a "family of one" the eligibility deeming rules which allow the State to disregard the family's assets and income in making the determination. The new section 1915(c) waiver is expected to provide families with access to more community services when this is the case and help to offset the problem of forced or voluntary custody relinquishment,. [NFC 2]

In December 2006 Maryland was awarded one of 10 CMS demonstration projects for alternatives to psychiatric residential treatment facilities (PRTF) allowing the designated states to apply for a 1915(c) Medicaid Home and Community-Based Services waiver to serve children and youth at risk of out-of-home placement in the community. This project will serve children who meet the medical necessity criteria for PRTF admission, who are not eligible for MA Home and Community-Based services, for whom MD-Wrap is an appropriate alternative treatment, and who live in a jurisdiction with MD-Wrap available (currently four jurisdictions). There will be up to 80 children enrolled per year by the end of the project in 2011. [NFC 5]

DEVELOPMENT OF AN INTEGRATED COMMUNITY-BASED SYSTEM OF CARE FOR CHILDREN'S BEHAVIORAL HEALTH SERVICES

As described briefly in Section II, the Children's Cabinet is Maryland's state level interagency body charged with development and implementation of an integrated interagency system of care for children, youth and families. Maryland was among the first states in the nation to legislatively create an interagency coordination body with the passage of Chapter 426 of the Acts of 1978. Subsequently, the General Assembly formalized the creation of the Subcabinet for Children Youth and Families in 1990. The existence of such an enduring interagency structure creates a highly effective venue for interagency policy development and implementation. The Children's Cabinet is composed of the Secretaries of all the major executive departments that directly provide or finance service delivery to youth and their families. These agencies include: Maryland State Department of Education (MSDE), Department of Health and Mental Hygiene (DHMH), Department of Juvenile Services (DJS), Department of Human Resources (DHR), Department of Disabilities (MDOD), and Department of Budget Management (DBM). The Governor's Office for Children (GOC) provides staffing and coordination functions for the Children's Cabinet. The Children's Cabinet collaborates to promote the vision of the state for a stable, safe and healthy environment for children and

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families. The Cabinet also assesses need, establishes budget priorities, and develops interagency initiatives to address these specific priority needs.

The Children's Cabinet set forth its first Interagency Strategic Plan in July 2008 to accomplish these ends. The plan is organized under a number of broad cross agency themes that include the following: {1} Family and Youth Partnerships; {2} Interagency Structures; {3} Workforce Development and Training; {4} Information Sharing; {5} Improving Access to Opportunities and Care; {6} Financing; and {7} Education. A number of recommendations and specific strategies are articulated across a multi-year span within this interagency planning framework. Correlations with the statutory requirements of the Block Grant are clear.

Prior to the articulation of the Interagency plan, work of the Children's Cabinet was based in the methodology of Results Accountability, a strategic planning approach that produced over a decade of trend data for an established set of results and indicators reflecting on the broad well-being of children and families in Maryland. The new State Interagency plan narrowed the focus of these results and indicators to four principal areas as priorities for Maryland, while maintaining a strong Results Accountability approach. The four areas are: {1} Rates of out of home placement for youth under 18; {2 & 3} Educational indicators for two different points along the developmental spectrum, including 3rd grade reading proficiency and educational attainment (i.e. diploma, GED, some college vocational training etc.) for young adults 18 to 24 years of age; and {4} Juvenile arrest rates (both violent and non-violent offenses) for youth 15-17. Data on these four indicators follows from the Interagency Plan:

Out-of-Home Placement

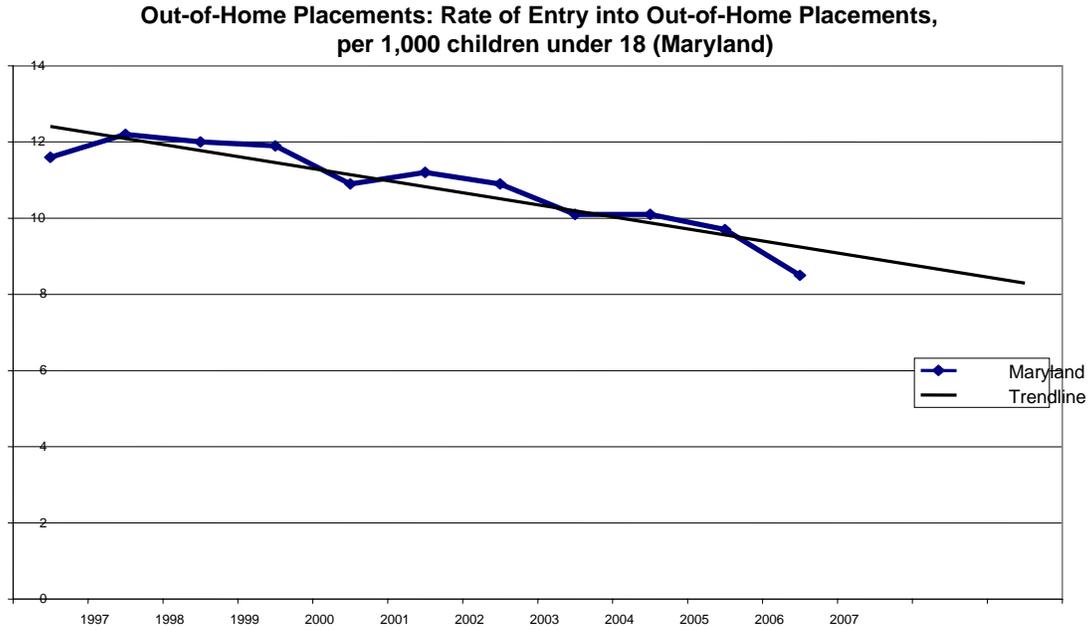
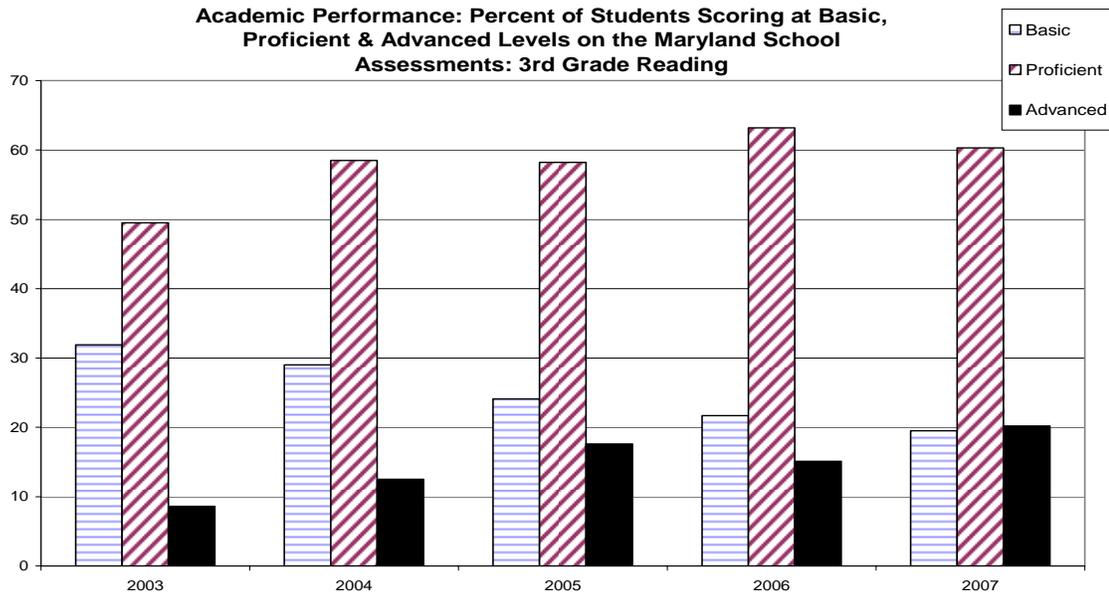


Figure 1: Rate of Entry into Out-of-Home Placements (Source: Governor’s Office for Children, 2008).

As can be seen from this graph, the rate of entry into all out-of-home placements in FY07 was the lowest in ten years, at 8.5 per 1,000 children under 18 years old. FY07 also marked the lowest number of entries into out-of-home placement in at least ten years, with 12,920 entries. Despite the downward trend in the rate of out-of-home placements, the cost for these placements continues to rise; the cost was \$765 million in FY07 compared to \$720 million in FY06. While the majority of out-of-home placements are from DHR (54%), this percentage has been declining over the past several years. DJS had the second largest percentage of children in out-of-home placements (37%), with DHMH and MSDE-funded placements representing the remainder (Governor’s Office for Children, 2008b).

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3rd Grade Reading



Source: Maryland State Department of Education, 2007.

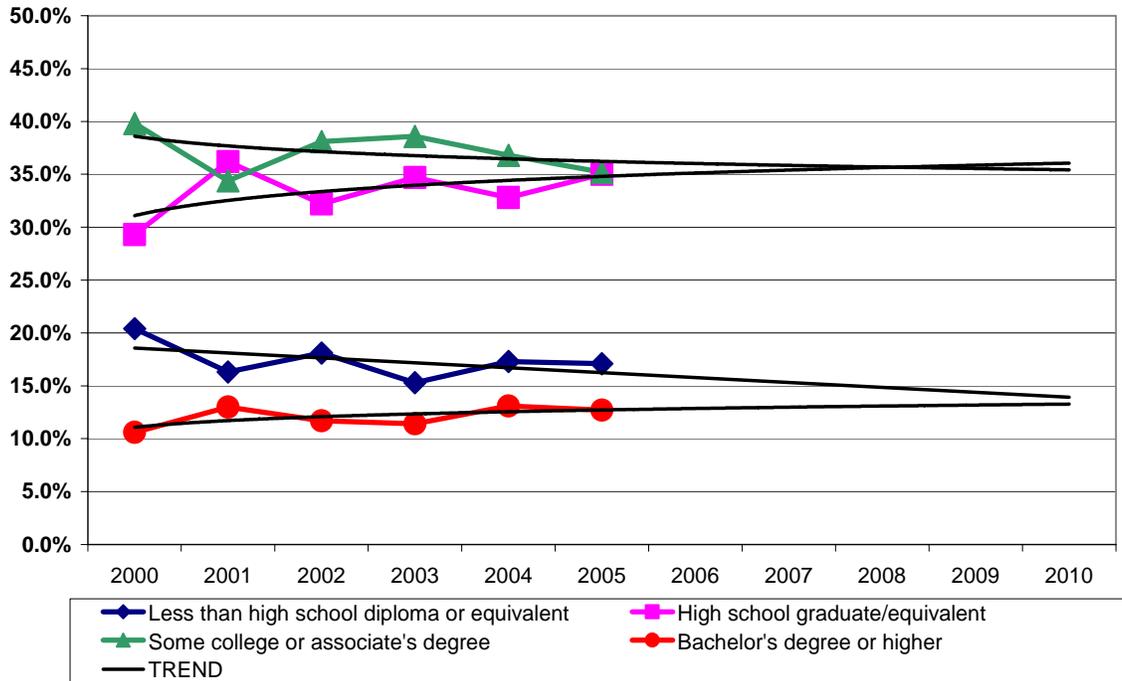
Figure 2: 3rd Grade Reading

As Figure 2 illustrates, the percentage of third grade students in Maryland who are scoring at basic levels on the reading component of the Maryland State Assessment has been in steady decline over the past four years. The percentage of students who scored at the advanced level was the largest since 2003, which is indicative of the trend heading in the right direction. However, there is a need to accelerate this trend, as almost 20% of third grade students still do not score at least at the proficient level.

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Educational Attainment

**Percentage of Youth 18-24 by Highest Educational Attainment, Maryland
2000 - 2005 (Trend through 2010)**

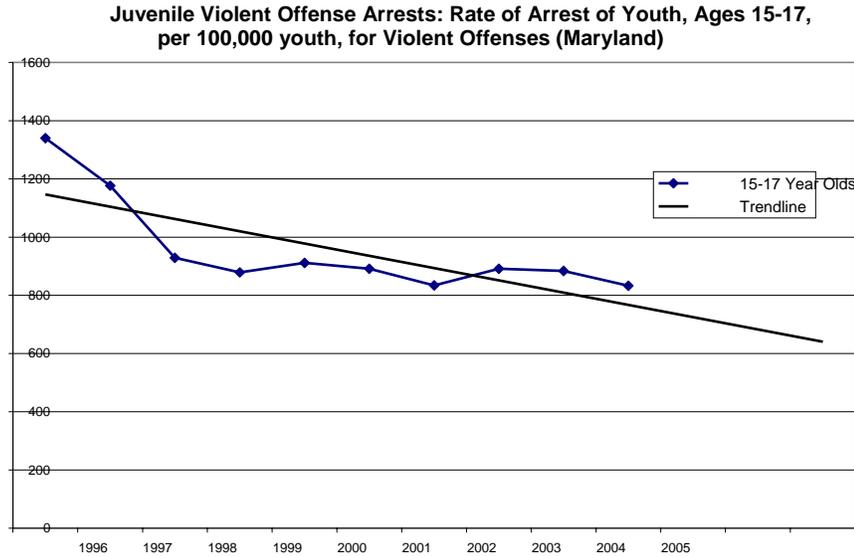


Source: Census 2000 Summary File 3, Table PCT25 (calculated); Supplementary Survey (U.S. Census) 2001, Table PCT033 (calculated); American Community Survey (ACS) 2002, 2003, Table PCT033 (calculated); ACS 2004, 2005, Table S1501

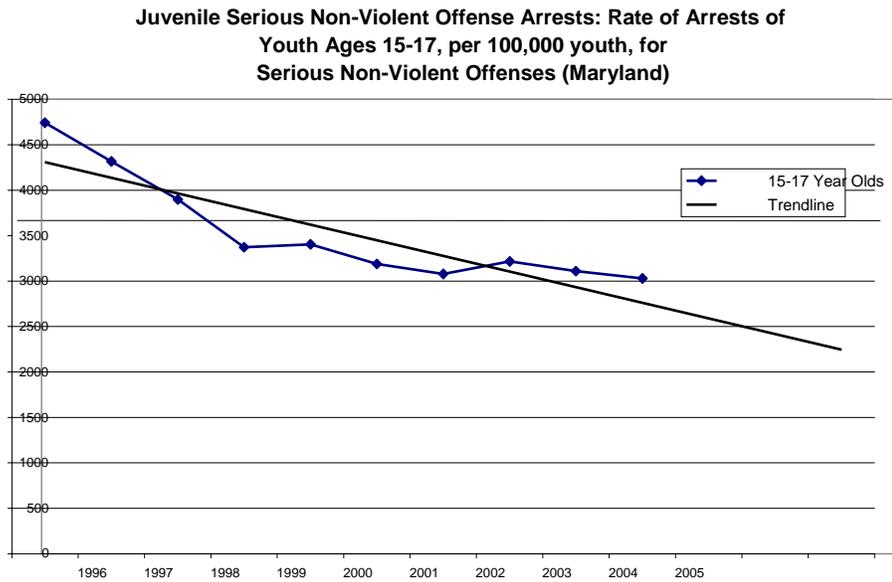
Figure 3: Educational Attainment

In 2005, 17% of Maryland youth ages 18-24 had less than a high school diploma or equivalent and 35% of youth had some college or an associate’s degree. As the *Ready by 21: An Action Agenda for Maryland* report notes, this is “not good enough” (Governor’s Office for Children, 2007c, p.10). Median earnings for males over 24 with at least a bachelor’s degree are \$35,802 greater than males without at least a high school diploma. For females, the difference is \$25,715 between individuals with at least a bachelor’s degree and those without a high school diploma. Even those individuals with a high school diploma have median earnings that are considerably less than their peers with a bachelor’s degree (U.S. Census Bureau, 2007). Educational attainment is important not only because of its direct relation to economic independence but also because it serves as a proxy measure for access to opportunities, both during childhood and in the future.

Juvenile Offense Arrest Rates



Source: Maryland State Police Uniform Crime Report, as published in Results for Child Well-Being (Governor's Office for Children, 2007a).



Source: Maryland State Police Uniform Crime Report, as published in Results for Child Well-Being (Governor's Office for Children, 2007a).

Figures 4&5 The data displayed in figures 4 and 5 are for the offense arrest rates for 15-17 year olds in Maryland for violent offenses (murder, forcible rape, robbery, and aggravated assault) and serious non-violent offenses (breaking and entering, larceny/theft, and motor vehicle theft). Both of these graphs show the trends moving in the right direction, with declines in the rate of arrests. The rate of violent offense arrests has declined by 37.8% since 1995, and the rate of serious non-violent offense arrests has declined by 26.1% during that same time. It is, however, a priority of the Children's

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Cabinet to accelerate these declines to both improve public safety and produce better outcomes for children and youth.

Role of MHA in the Interagency Strategic Plan - It is clear that mental health services and supports across the child and adolescent developmental spectrum are a vital component of addressing outcomes in all four of the major outcome areas targeted by the Children's Cabinet. Speaking more specifically, as noted in Section II, a major focus of activity for MHA under the Interagency Plan is taking the lead in implementation of the Centers for Medicare and Medicaid (CMS) funded Psychiatric Residential Treatment Facility (PRTF) Demonstration Waiver. This initiative will contribute both to the reduction of out of home placements at RTF level of care and also in maintaining family preservation whenever possible. The waiver will also improve coordination of care and advance educational attainments for older youth and help reduce arrests for adolescents when they enter the transitional years.

Center for Medicaid/ Medicare Services PRTF Waiver - Maryland has been granted a Section 1915(c) Medicaid waiver for home and community-based services for children and youth at the Psychiatric Residential Treatment Facility (PRTF) level of care. Often referred to as the RTC (residential treatment center) Waiver, this effort is based on two high Fidelity Wraparound pilots begun in January 2006. State funding was received through the GOC to expand the program in FY 2007 to an additional two jurisdictions that are able to provide high-fidelity services. Maryland is one of ten states selected to participate in the Centers for Medicare and Medicaid (CMS) sponsored PRTF demonstration which is based on using section 1915(c) federal Medicaid demonstration waivers to divert youth from psychiatric residential treatment and provide them with community-based services. The target population for the waiver is children, youth, and their families who meet the medical necessity criteria for psychiatric residential treatment facility (PRTF) admission, who live in Montgomery, St. Mary's and Wicomico Counties and Baltimore City. Regulations have been developed to govern the waiver and its operations and provider recruitment is in full swing. The demonstration project will serve up to 80 children and youth per year phased-in over the duration of the project. Fidelity monitoring of the four sites will be conducted at least three times per year. Children may remain in the waiver for up to 24 months with annual review. [NFC 2, 5]

A major component of the implementation of the waiver includes the development of Interagency Care Management Entities (CMEs) statewide. Proposals from private vendors to deliver this service statewide are currently being reviewed. This effort is strongly integrative of the agency efforts in Maryland as it will provide care management in addition to the PRTF waiver, also for youth placed at the group home level by both DHR and DJS and the new System of Care grant for youth in child welfare in Baltimore City. However, due to fiscal constraints, there were no new youth enrolled into the CMEs. 1915C PRTF Waiver will be implemented during the first quarter of FY 2010, requiring allocations of the children's cabinet funds to cover the costs of Public Mental Health System services for youth who are not community Medicaid eligible.

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Clearly, Maryland has a long track record in creating extensive interagency infrastructure and interagency mechanisms for sustaining and improving an integrated system of care for children, youth, and families under the broad aegis of the Children's Cabinet. Much of our success in interagency planning is based on the next element of the narrative, Maryland's commitment to youth and family involvement.

Youth & Family Involvement - The value placed on youth and family member participation and involvement continues as a major priority of the Child and Adolescent Mental Health System. This value also appears as the first element of the Interagency Strategic Plan. MHA and its partners encourage the input of youth, family members, and adult consumers across the board. A concerted effort is made to include all in the planning, development, and monitoring of the PMHS. In FY 2009, MHA will continue to fund the Maryland Coalition of Families for Children's Mental Health, a statewide child and family advocacy group, to develop local family support activities with a mission to inform families of children and adolescents about policy, to teach them about becoming participants in the policy and decision-making process, and to provide feedback about the operations of the Public Mental Health System. The Coalition participates on more than 22 state and local policy shaping committees. At the current time, over 50 family members are employed by the Coalition, its local counterparts, or in local child serving systems as providers of peer-to-peer support and assistance to families in navigating the system. We expect to see future increases in these numbers when the section 1915(c) Medicaid waiver becomes operational and provides reimbursement for family-to-family peer support services, youth-to-youth peer support services, and family and youth training delivered by peers. The new services delivered under the waiver are described in greater detail in the section on available services and supports.

A major new project of the Coalition of Families, jointly with the Maryland Mental Health Association, is the "Children's Mental Health Matters" public awareness campaign. This project is a significant social marketing effort designed to: improve public information, reduce the stigmatization of youth with mental health conditions, and garner public support for innovative system development through a major public awareness campaign. This effort may in some ways be one of this year's plan's greatest strengths because it goes beyond limited mandates for service improvement while addressing deeper contextual issues required for lasting system change and better results. The campaign features a media partnership with both FOX and ABC networks, and involves Maryland's First Lady, Katie O'Malley as Honorary Chair, and Debbie Phelps, mother of Maryland's celebrated Olympic swimmer, Michael Phelps, as media spokeswoman. A major media blitz occurred during Children's Mental Health Week, May 3-9, 2009, and will be continued in the upcoming year.

The Coalition has conducted extensive research over the years, including studies using focus group design, of parents involved with custody relinquishment, the juvenile justice system, transition-age youth (TAY) and families of young children engaged with the early childhood education system. These studies have been described in past years' plans and they provide an excellent and highly effective basis to support advocacy and policy initiatives designed to improve the child and adolescent system of care. In

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addition, in FY 2004, the Coalition established a Family Leadership Institute (FLI) which has continued producing new advocates every year since. FLI provides a six-month training program for families in navigating the child and adolescent mental health services system in Maryland and in becoming advocates in their communities and the state. Twenty families participated in the first Institute. The fifth Family Leadership Institute was held this year with 20 graduates, increasing the total number of trained family advocates to 115 over the five years of the Institute implementation.

Youth MOVE - In June 2007, Maryland initiated its Youth MOVE (Youth Motivating Others through Voices of Experience) program which provides training for youth to be active participants and leaders in seeking services for themselves and for the community of youth. Maryland's effort is based on the national model (<http://www.tapartnership.org/youth/YouthMOVE.asp>). [NFC 2]

Last year, MHT-SIG established Youth MOVE Maryland by hiring a statewide coordinator housed within the Innovations Institute (described in a following section). Youth MOVE has been implemented in 13 of the state's 24 jurisdictions. The further statewide roll-out and continued efforts will be sustained through the new Systems of Care (SOC) grant award. Accomplishments include the following: creation of a Youth MOVE Myspace page and brochure; several meetings with senior state officials; and a number of county specific social marketing activities.

In 2008 the 13 jurisdictions implementing Youth MOVE Maryland held between 2-5 trainings that were open and available for the youth leaders to attend. The Innovations Institute also hosted and provided training to youth leaders at the three Systems of Care Training Institutes (SOCTI) during 2008. There are currently a total of 65 youth involved in this initiative within the 13 jurisdictions implementing Youth MOVE.

The Child and Adolescent Division of MHA also works, when appropriate, with On Our Own of Maryland (OOOMD), the statewide mental health consumer network. Areas include efforts to fight stigma within the mental health system through the Anti-Stigma Project (ASP) which is described more fully in the adult plan. Exploration of utilization Of Wellness Recovery Action Planning (WRAP) for TAY and other transition-age youth issues. [NFC 2]

Maryland's Blue Print Committee - A major outgrowth of Maryland's family involvement philosophy was the development of the Maryland Blue print for Children's Mental Health. This ongoing strategic planning effort was developed at the request of our statewide family organization, originally in 2003, and the Blueprint was updated this year in the spring of 2009. It is a five-year strategic plan which extends the work of the 2003 Blueprint to address the mental health needs of children, youth and their families. The guiding philosophy of care found in the Public Health Model, with its emphasis on the health of an entire population beginning with health promotion, prevention and early intervention, is central to this 2009 update. The revised vision and mission as well as the

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recommendations and suggested strategies, themselves, are rooted in the broader public health approach to mental health.

Six major themes emerged which became the basis for recommendations and suggested strategies. Within each theme, the recommendations were prioritized. The six themes and the most highly prioritized recommendation in each are listed below.

- Mental Health Promotion, Prevention and Early Intervention
 - Increase and coordinate mental health promotion efforts, increasing protective factors and decreasing risk factors through individual and community education for all age groups across all jurisdictions
- Family and Youth Partnership
 - Ensure that Family and Youth are equal partners at every level of statewide and local decision making throughout each phase of policy, program, and evaluation in all jurisdictions
- Infrastructure Development
 - Develop sustainability for core levels of services, supports, and opportunities in each jurisdiction (as proposed in Continuum of Services and Supports below)
- Workforce Development
 - Strengthen services by providing adequate pre-service and in-service training, resources, and leadership to all those who provide direct care to children, youth and their families across disciplines and populations
- Access to Care and Opportunities
 - Provide consistency in policy, practice, and funding across agencies and throughout local jurisdictions
- Continuum of Services and Supports
 - Define and develop an accessible baseline, or foundation of services and supports, in every jurisdiction in Maryland

The Maryland Child and Adolescent Mental Health Institute - A major outgrowth of the original Blue print Committee process was the development of the Maryland Child and Adolescent Mental Health Institute. The Institute is a joint project of Johns Hopkins and the University of Maryland (UM) Schools of Medicine. A number of key related projects run by the Institute include: {1} a SAMHSA-funded effort to reduce seclusion and restraint in state-operated child and adolescent mental health facilities; {2} a SAMHSA-funded Child Trauma Center; and {3} a project focused on implementation of Treatment Foster Care implementation, a process begun under the National Institute of Mental Health (NIMH)-SAMHSA Science to Service grant. In addition, a special focus has been placed in partnership with DHR and the UM School of Social Work on development of trauma-informed care and evidence based Cognitive Behavioral Therapy for children and youth in the foster care system. Funding from the MHT-SIG has been

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provided through the Institute to the UM Center for School Mental Health Assistance, one of only two national centers on school mental health funded by the federal government, to study the educational needs of children in child welfare.

- In addition to the above, the Maryland Child and Adolescent Innovations Institute, of the University of Maryland Division of Child and Adolescent Psychiatry, was initiated in 2005 to assist the State of Maryland, the Children's Cabinet, the Governor's Office for Children (GOC), Maryland jurisdictions, and the state's child-serving agencies to support efforts in improving access, services and outcomes for families of children with intensive needs. Innovations Institute seeks to assist the state of Maryland and local jurisdictions with obtaining skills, interpreting new knowledge, and adapting policy and practice to ensure that Maryland's children, youth, and families achieve wellness through family-driven, youth-guided, culturally and linguistically competent, and individualized quality care within a system of care. The Innovations Institute is funded by the Governors Office for Children (GOC).
- The Johns Hopkins University School of Medicine offers a broad range of research, educational and clinical resources. The Department of Psychiatry and Behavioral Sciences has over 200 full-time faculty members and an extensive program of research supported by multiple funding sources, including over \$38 million annually in NIH grants. The Division of Child and Adolescent Psychiatry consists of 40 full-time faculty members who are located in diverse clinical settings. The faculty are committed to training clinical researchers in the following areas of interventions research with children and adolescents: 1) efficacy studies evaluating new or available but un-validated medication and/or psychosocial treatments, 2) effectiveness studies of empirically supported treatments applied in diverse populations and settings, 3) safety and adverse effects of psychotropic medications, particularly during long-term treatment and 4) methodological approaches and techniques that inform the specificity of treatment to identify which treatments work best for which individuals. The research environment in the Division of Child and Adolescent Psychiatry is very collaborative in nature, offering many opportunities and resources.

Social Services - The social service sector in Maryland is primarily housed in the Department of Human Resources (DHR). For child and adolescent planning purposes, the majority of social services are administratively located in the Social Services Administration. (SSA) The principal functions of SSA are child welfare focused, including child protection, kinship care, formal custodial placement of children in a variety of out of home placements, family reunification, and adoption/post adoption services. It is important to note that the juvenile court plays a significant a role in interfacing with the social service sector through its dependent youth docket, in addition to the role it plays in the juvenile delinquency sector. Both juvenile and social services will be discussed again in the subsequent section on housing. Collaboration with social service providers is particularly important given the high prevalence of mental health disorders among children who are in state custody of the state's child welfare system. Local social service agencies in each jurisdiction are called Departments of Social

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Services (DSS). MHA tracks the percentage of selected categories of youth in the child welfare systems who receive services via the PMHS as a performance indicator.

- **“Place Matters”**--A current major priority of DHR is the “Place Matters” campaign. The agency joined with the Annie E. Casey Foundation’s Casey Strategic Consulting Group to reform foster care in the state. DHR is spearheading a three-year effort to bolster 1,000 new foster family homes by 2010 so that children live in closer proximity to their family members and their communities. Specific recruitment goals for each region of the state are guiding the outreach. Key Performance Measures for Place Matters include: {1} reducing the number of children in out-of-home care; {2} reducing the number of children in group homes; {3} increasing the number of children placed in their home jurisdiction; {4} increasing the number of children who reunite with their family; and {5} increasing the number of adoptions.
- **“Other DHR”** - Other DHR social services that are housed outside of child welfare, which also come into play in planning and delivery, include homeless services, domestic violence services, victim services, adult services, and Medicaid eligibility services, (notably for Medicaid waivers). It is important to note that child care services, typically considered a social service, are administratively housed in Maryland within the Department of Education. As a result, these services will be discussed subsequently in conjunction with early childhood education. For those youth and young adults in the transitional youth age range, the full array of adult oriented social services also become a part of the overall system of integrated services required.
- **“MD CARES”** – Funded through a SAMHSA system of care grant, the Maryland Crisis and At Risk for Escalation diversion Services for children (MD CARES) project is key child welfare collaboration. It will develop a cross-agency partnership that blends family-driven, evidence-based practices within mental health and child welfare to better serve this high risk population. In Maryland there are approximately 10,100 children in foster care, of which approximately 6,100 are from Baltimore City. Service dollars awarded under the grant will be targeted to the neighborhoods in the City, where the majority of the youth and families in foster care reside. To most effectively leverage the systems change in the City and adapt the model for statewide implementation, MD CARES also incorporates statewide infrastructure and sustainability strategies which include: crisis response and stabilization; completion of the statewide rollout of Youth MOVE; and cross-agency fiscal and policy analysis. The service focus of this initiative is the care management and treatment of youth in the Baltimore City foster care system at the point of initial diagnosis of serious emotional disturbance (SED), in order to prevent out-of-home placement or disruption in first placement when the disability is expected to last in excess of one year. Grant funds will be used to expand and support “wraparound” services to foster children in their communities. Wraparound services provide a comprehensive array of home and community-based services to maximize the strengths of families, natural support systems and community resources. These services are different from traditional "one size fits all" programs and expensive residential care. MD CARES will

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serve up to 40 youth at a time for an average of 15 months with a projected total of 340 youth throughout the project.

- **Crisis Stabilization and Response** - A related joint venture with DHR that first appeared in last year's plan, is the creation of a mental health crisis response and stabilization system designed to help respond to children in foster care placements and intervene in the home setting so that psychiatric crises and resulting hospitalization do not result in the disruption of the child's residential placement. This initiative was funded in the Governor's budget and approved by the General Assembly to commence in FY 2009. Program start-up began in selected jurisdictions in September 2008. Nine service provision areas covering 16 counties have been initiated. These include the Lower Shore region; Mid-Shore region; Allegany, Garrett, Washington, Baltimore, and Anne Arundel Counties; and Baltimore City. During the upcoming year jurisdictions plan to hold extensive trainings of local first responders, police and EMS staff, about the special needs of foster families. Harford, and Prince George's Counties originally planned for statewide implementation. However, further expansion of this project has unfortunately been curtailed due to budget limitations.
- **School Mental Health Foster Care Project**-- This special project has made a number of accomplishments. It is believed to be the first project in the United States to explicitly connect school mental health outreach and services for youth in foster care. The project has established a diverse and influential advisory board of 40 systems leaders and stakeholders from over 20 organizations. In addition, ten modules for training child welfare, education, and mental health systems staff, with strong youth and family involvement, were completed and a partnership with Maryland's Child Welfare Academy was established with the first full-day training held in December 2008. A School Mental Health and Foster Care Issue Brief was disseminated broadly within Maryland and is available for national and international dissemination at <http://csmh.umaryland.edu>. MHA and the Maryland Child and Adolescent Mental Health Institute are completing a special project on the use of psycho pharmacological treatments with foster care children, described in subsequent section.

Juvenile Services - There are a number of continuing activities underway to enhance the linkages and accessibility to behavioral health care for youth in Maryland's juvenile justice system.

The MHA budget includes funds for a mental health component for juvenile justice aftercare services. These are services offered to youth released from the Department of Juvenile Services (DJS) commitment facilities. In FY 2008, approximately \$1.6 million was transferred to MHA through an interagency memorandum of understanding to continue implementation of the mental health component for youth discharged from state juvenile correctional facilities. Mental health professionals, called Family Intervention Specialists (FIS), participated in 26 specialized DJS Intensive Aftercare Teams to conduct assessments, make referrals for treatment, and facilitate groups. In FY 2007, the Family Intervention Specialists provided mental health services to over 376 youth who came in contact with the juvenile justice system and were

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in need of services. In order to meet each jurisdiction's needs, the FIS worked in collaboration with DJS area directors and supervisors and participated in meetings and trainings. The CSAs have been designated lead agencies at the local level, assuring coordination with other mental health services.

The MHA Child and Adolescent staff provide training for DJS direct care staff on an as needed basis, but at least four times annually. In addition, one of the staff will be assisting the DJS Director of Professional Development and Training to create training for DJS direct care staff, which will be offered on an ongoing basis. If requested, MHA will assist in conducting this training.

In addition, mental health services provided in juvenile justice detention centers continue to operate as in years past. The program now focuses on the needs of juvenile offenders in six detention centers prior to adjudication and disposition by the juvenile court (J. DeWeese Carter Youth Center, Alfred D. Noyes Children's Center, Cheltenham Youth Detention facility, Thomas J. S. Waxter Children's Center, Western Maryland Children's Center, and the Baltimore City Juvenile Justice Center). DJS, with newly appropriated mental health funding, continued to build upon these existing services in FY 2008. The provision of additional funds for mental health in juvenile justice last year resulted in Maryland absorbing a block grant reduction from the federal government in this cost center, thus resulting in an uninterrupted service delivery as described in more detail in our block grant spending plan. **[NFC 4, 5]**

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SFY 2010 OBJECTIVES FOR CRITERION 1:

SERVICES FOR CHILDREN AND ADOLESCENTS

- MHA in collaboration with CSAs, will continue to provide support, funding, and ongoing consultation to Maryland's mental health advocacy groups to promote and implement a series of public education and training activities to increase awareness of mental illness; mental health issues; and recovery and resiliency among children, youth, and adults.

MHA Monitor: John Hammond, MHA Office of Public Relations; Al Zachik, MHA Office of Child and Adolescent Services and Cynthia Petion, MHA Office of Planning Evaluation and Training

- Provide resources to continue to implement leadership activities and trainings through the Maryland Coalition of Families for Children's Mental Health Leadership Institute for parents of children with emotional disorders; the Youth MOVE (Motivating Others through Voices of Experience) peer leadership program; and the Leadership Empowerment and Advocacy Project (LEAP) for adult consumers.

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services; Clarissa Netter, MHA Office of Consumer Affairs

- In collaboration with Center for Medicare/Medicaid Services (CMS) and Maryland Medical Assistance (MA), continue implementation of the CMS-supported 1915(c) Psychiatric Residential Treatment Facility (PRTF) demonstration waiver to provide services to up to 80 children and youth and their families in four jurisdictions across the state.

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

- Implement a diverse range of innovative statewide and local youth suicide prevention activities with support of the SAMHSA Statewide Youth Suicide Prevention and Early Intervention grant "Maryland's Linkages to Life."

MHA Monitor: Henry Westray, MHA Office of Child and Adolescent Services

- Design, develop and implement a pilot benefits counseling initiative, in collaboration with On Our Own of Maryland, as a means to promote and actively support consumer recovery and economic self-sufficiency through the use of work incentives, individualized benefits counseling, and work supports, to include the Employed Individuals with Disabilities (EID) Program.

MHA Monitor: Steve Reeder, MHA Office of Adult Services

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- Based on a 1987 Lisa L. Program class action lawsuit (which requires timely discharge from hospitals to appropriate placements) track and monitor children and youth in state custody in designated psychiatric hospitals as identified under COMAR 14.31.03.

MHA Monitor: Marcia Andersen and Musu Fofana, MHA Office of Child and Adolescent Services

- MHA and Medicaid will develop state plan, amend regulations, and notify the public on plans to implement Medicaid-reimbursed case management. Once CMS approval is received, MHA in collaboration with CSAs and the ASO, will implement and monitor the transition from contracted case management services to the fee-for-service system (FFS) for Medicaid recipients and uninsured individuals.

MHA Monitor: Lissa Abrams, MHA Office of the Deputy Director for Community Programs and Managed Care and Alice Hegner, MHA Office of CSA Liaison

- MHA, in collaboration with the Department of Health and Mental Hygiene (DHMH), the Mental Health Transformation Office (MHTO), and local and national advocacy organizations, will adapt the Mental Health First Aid (MHFA) curriculum to further implementation of the MHFA initiative for adults in Maryland.

MHA Monitor: Brian Hepburn, MHA Office of the Executive Director, Daryl Plevy, MHTO

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CHILDREN'S PLAN

CRITERION #2: Child Mental Health System Data Epidemiology

Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.

PMHS DATA SYSTEM

The primary PMHS data system is currently managed by an Administrative Services Organization (ASO). Effective September 1, 2009, a new vendor, ValueOptions Inc. has been selected to contract as the new ASO for the PMHS. Historical data from the previous vendor will be transferred to ValueOptions. Historical data have also been placed at the University of Maryland Systems Evaluation Center (SEC). The SEC provides enhanced capacity for analysis of the data, particularly in relation to evaluation and outcome efforts.

The data system collects information on those who receive services in the fee-for-service system. The system is driven by a combination of authorizations and claims for mental health services. Inherent in the implementation of the PMHS is a series of extremely comprehensive data sets. Data sets on clients' service authorization and events and the provider community are available. Client information is accumulated through either the Medical Assistance (MA) eligibility file or the subsidized client data forms. Unduplicated counts are calculated by using MA numbers, Social Security numbers, and/or unique identifiers. Authorizations are made on-line and added to available data. Provider data come from provider enrollment files, which are used both for referral and for payment of claims. Finally, event and cost data are derived from claims files.

[NFC 5]

The ASO is contracted to support mental health services access, utilization review, and care coordination tasks. The PMHS data are collected and displayed by demographic, clinical service, provider, and outcome information relative to an episode of care, and also link multiple consumer records into useful "episodes of care." The PMHS data system through a series of interrelated databases and software routines can report over 200 elements for both inpatient and outpatient care. Also included among the numerous data fields, care management elements, and outcome indicators are:

- service authorizations and referrals;
- services utilized by level of care and service;
- treatment service lengths and number of units provided; and
- site visits, including record reviews and second opinion (peer) reviews of authorization.

All stored data can be retrieved and reported either in standard form, using an automated reporting system by way of custom programming, or ad hoc reports. The data may be formatted to produce monthly, quarterly, or fiscal reports. Maryland operates on

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a July-June fiscal year. Currently over 50 standard reports are generated to assist in general planning, policy, and decision making. The data may also be accessed to produce an unlimited range of reports via ad hoc requests. Data are currently shared with the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council.

Implemented in July 2007, information on Medicaid (MA) drug prescriptions filled by consumers in the PMHS will become available through the ASO. These prescriptions are for all medications other than HIV medications regardless of prescriber. This information is accessible to providers of mental health services. It is available to those providers with existing open authorizations to treat the consumer. The pharmacy is refreshed monthly and includes prescriptions filled during the 12 months prior to the refresh date. Information is now made available to Managed Care Organizations (MCOs), who can then communicate it to their primary care physicians. The availability of this new module has enhanced service quality and provided a rich resource to enhance data analysis efforts. [NFC 6]

An unanticipated problem resulting from PMHS implementation contributes to an undercount of persons with mental illness. The ASO Management Information System (MIS) does not capture data for individuals who receive services not reimbursed by MA and have Medicare as their only payer source. These Medicare reimbursed services cannot be subject to authorization and claims are not paid by the ASO, the two mechanisms for capturing data. Additionally, beginning July 1, 2003, claims for individuals who are qualified for federally matched MA, and have Medicare, began to be processed by Medical Assistance and the data on their utilization of Medicare reimbursed services is no longer in the ASO data system. Therefore, the data on those served in the PMHS represents an undercount.

Tables on the following pages provide data on consumers served by age and number of consumers accessing care in FY 2008 (the last full fiscal year for which claims have been processed). However, FY 2009 data, based on claims paid through 5/31/09, shows that thus far, 99,159 individuals had claims submitted for mental health services through the fee-for-service system, with forty two percent (42%) of the total, 41,504 being children. Seventy four percent (74%) of children treated met the diagnostic categories selected for Serious Emotional Disorders (SED). The treated prevalence of SED from the State indicator is projected to be twenty percent (20%).

Access to services is critical for any mental health system. In recent years and as an ongoing strategy in the FY 2010 State Plan, MHA “continues to monitor the system for growth maintaining an appropriate level of care for at least the same number of individuals”. Data relevant to this national indicator on access to services continue to support the achievement of this target.

The ASO MIS was utilized to produce most of the data included as performance indicators in this application. Data for FY 2007, 2008, and 2009 are based on claims paid through May 31, 2009. For FY 2007 and 2008 this produces reliable numbers. Since claims can be submitted up to twelve months following the date of service, the data for

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FY 2009 is still incomplete. Full year projections were not made for FY 2009. Specific diagnoses were used to define SED. An individual was categorized as SED if, at any time during the fiscal year, a diagnosis in the specific categories was submitted on a claim.

MHA submitted its application to SAMHSA/CMHS for a third round of the Data Infrastructure Grant in June 2008. The required Basic and Developmental Tables were submitted in December 2008. All tables will be submitted this year, including developmental tables based on new consumer survey items. Data for these come from three sources. Community data are obtained from data that results from claims, authorizations, and the Outcomes Measurement System (OMS) which are within the ASO system. Some data, such as employment status and residential status, along with detailed racial and ethnicity data, are not available from either standard claims or MA eligibility data sets. Efforts are made to obtain this information in the ASO system through requirements for registration and authorization by providers for services. The ASO information is supplemented by an annual Consumer Satisfaction and Outcomes Survey for many National Outcome Measures (NOMs), though the newly implemented OMS may allow MHA to move to client level reporting for some of these measures. Data from state operated inpatient facilities are obtained from a Hospital Management Information System (HMIS). Currently, information is abstracted from the HMIS and integrated into data from the community system to complete all required Uniform Reporting System (URS) and NOMs reporting. While this system does not use the same consumer identifiers at the ASO data system, there are elements common to both which MHA has used to establish a nearly unique identifier based on demographic variables. This identifier has been used to link data from the two systems. This system, which has been in place since 1986, is scheduled for replacement. Data for those tables reporting on individuals served and services provided are collected and reported at the person level. **[NFC 5]**

In addition to the ASO, MHA contracts with the Systems Evaluation Center (SEC), a component of the Mental Health Services Improvement Collaborative of the University of Maryland School of Medicine, Department of Psychiatry, Division of Services Research to assist with evaluation and data infrastructure activities. As MHA's strategic partner, SEC maintains a copy of the community services' data repository which extends back to 1999. The University of Maryland SEC has accepted responsibility for the oversight of the effort to collect the data necessary to complete the URS tables required to be included with Maryland's Mental Health Block Grant application. The SEC, ASO, and MHA are working jointly to further develop the OMS, described more fully in Criterion 5. In this coming year the SEC will continue to collaborate with MHA and key stakeholders to identify areas of interest related to the PMHS that could be analyzed using multiple databases. These databases include claims, authorization, the consumer satisfaction and outcomes survey, the OMS, the HMIS, Medicaid, and other state databases, as available.

Additionally, through Maryland's StateStat, MHA is also responsible for providing information on agency performance and priority initiatives. StateStat is a

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performance measurement and management tool implemented by the Governor to make our state government more accountable and more efficient.

INCIDENCE AND PREVALENCE FOR CHILDREN AND ADOLESCENTS

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For children and adolescents, the recalculated Maryland poverty level changed the prevalence rates to be used in calculating number of children and adolescents with serious emotional disturbance (SED). Two estimates were used based upon the most recent information available. The estimates utilized were tied to the child poverty rate and the lowest and most upper limits of levels of functioning in the federal calculation. This translates from 5% up to 11% of the population under 18. The performance indicator under this criterion provides data for both the 5% and 11% prevalence rates. The population under 18 for each county was multiplied by the two rates cited in the federal definition.

Estimates of treated prevalence; however, were of necessity based upon a somewhat stricter definition of SED. Specific Axis I and II diagnoses codes were selected to identify the SED treated in the system. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. Slight modifications were made this year to the list of diagnoses included under the SED category. Specific pervasive developmental disorder and learning disorder diagnoses were further restricted. All data have been updated to reflect this change. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

"Priority population" means those children and adolescents, for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared priority for publicly-funded services. MHA's priority population includes a child or adolescent, younger than 18 years old, with SED which is a condition that is:

- Diagnosed with a mental health diagnosis, according to a current diagnostic and statistical manual of the American Psychiatric Association (with the exception of the "V" codes, substance use, and developmental disorders unless they co-exist with another diagnosable psychiatric disorder); and
- Characterized by a functional impairment that substantially interferes with or limits the child's role or functioning in the family, school, or community activities.

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities.

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**Mental Hygiene Administration
Prevalence Estimates for Serious Emotional Disorder (SED) by County
Child and Adolescent Population**

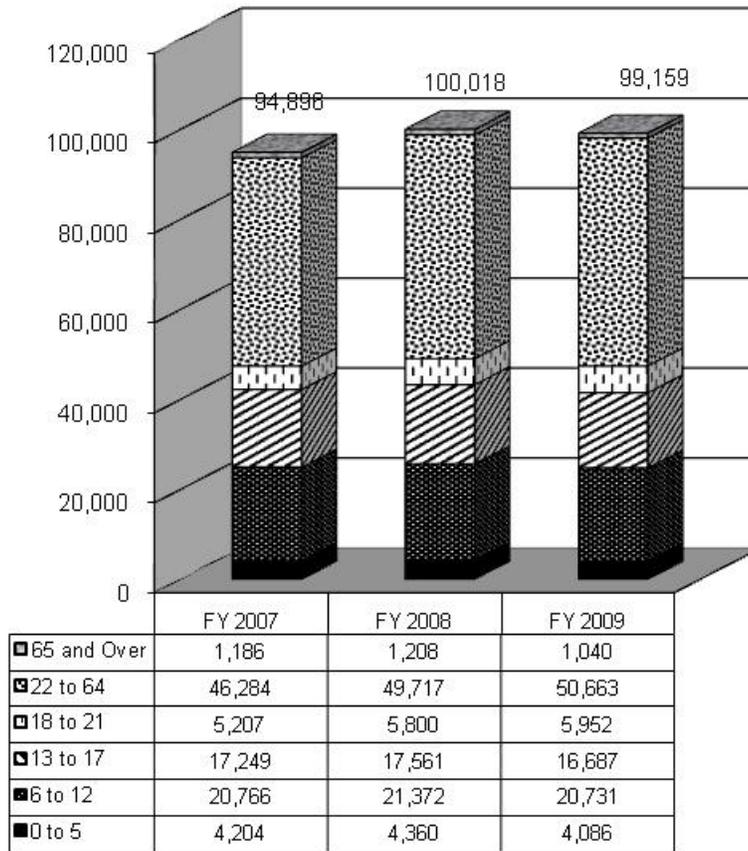
County	Under 18 Population	Low Prevalence 5%	High Prevalence 11%
Allegany	13,584	679	1,494
Anne Arundel	123,597	6,180	13,596
Baltimore County	177,547	8,877	19,530
Calvert	22,342	1,117	2,458
Caroline	8,096	405	891
Carroll	41,481	2,074	4,563
Cecil	24,729	1,236	2,720
Charles	37,625	1,881	4,139
Dorchester	6,872	344	756
Frederick	58,380	2,919	6,422
Garrett	6,536	327	719
Harford	60,620	3,031	6,668
Howard	69,991	3,500	7,699
Kent	3,737	187	411
Montgomery	226,246	11,312	24,887
Prince George's	208,468	10,423	22,931
Queen Anne's	10,929	546	1,202
St. Mary's	26,159	1,308	2,877
Somerset	4,697	235	517
Talbot	7,195	360	791
Washington	33,189	1,659	3,651
Wicomico	21,877	1,094	2,406
Worcester	9,385	469	1,032
Baltimore City	155,155	7,758	17,067
Statewide Total	1,358,437	67,922	149,428

Data Source:

July 1, 2007 Estimated Maryland Total Population by Age Group, Region and Political Subdivision

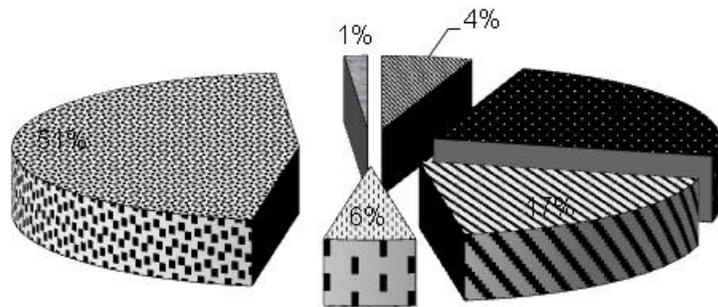
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Total PMHS Consumer Counts for FY 2007-2009 by Age Groups



Source: MAPS-MD Data report MARF0004. Based on Claims Paid through 05/31/2009. FY 2009 data is incomplete as claims may be submitted up to nine months from date of service.

Percentage of PMHS Consumer Counts for FY 2008 by Age Groups

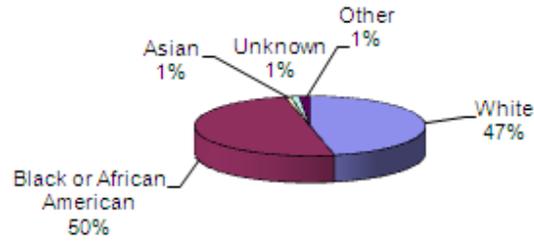


Early Child 0-5	Child 6-12	Adolescent 13-17
Transitional 18-21	Adult 22-64	Geriatric 65 and over

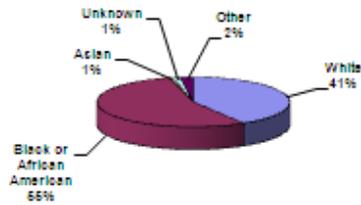
Source: MAPS-MD Data report MARF0004. Based on Claims Paid through 05/31/2009. FY 2009 data is incomplete as claims may be submitted up to nine months from date of service.

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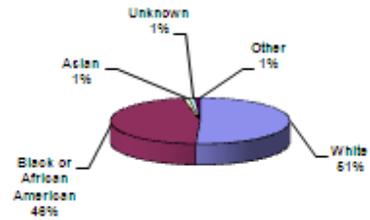
**Total Consumer Served in
in FY 2008 by Race and Age Group**



Age 0-17



Age 18 and over

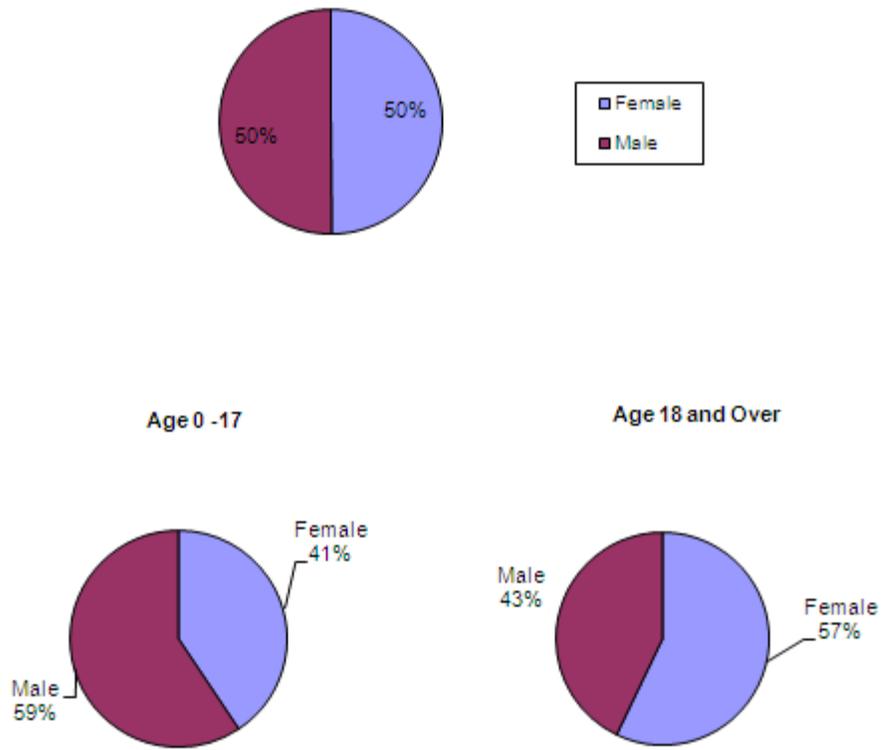


Source: FY 2008 URS Table 2A

Note: Other includes : American Indian,Native Hawaiian, Pacific Islander and those consumers with more than one race.

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**Total Consumer Served
in FY 2008
by Gender and Age Group**



Source :FY 2008 URS Table 2A

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SFY 2010 OBJECTIVES FOR CRITERION 2:

SERVICES FOR CHILDREN AND ADOLESCENTS

- During the transition of the ASO and thereafter, continue to monitor the system for growth and expenditures, identify problems (including high-cost users), and implement corrective actions as needed, maintaining an appropriate level of care for at least the same number of individuals.
MHA Monitor: Lissa Abrams, MHA Office of the Deputy Director for Community Programs and Managed Care
- In collaboration with the Maryland Child and Adolescent Mental Health Institute, Maryland State Department of Education, the Center for Maternal and Child Health, the Maryland Blueprint Committee, and other stakeholders, continue to build infrastructure and deliver training to improve quality of mental health screening assessment and intervention for young children.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services
- MHA will work in conjunction with Department of Human Resources (DHR) and other stakeholders to improve screening, assessment, and service delivery for children and youth in foster care.
MHA Monitor: Al Zachik and Cyntrice Bellamy, MHA Office of Child and Adolescent Services
- MHA will work in conjunction with MSDE, local school systems, and a wide range of other interested stakeholders to develop recommendations to improve access to and quality of school mental health services provided to school-aged children.
MHA Monitor: Cyntrice Bellamy, MHA Office of Child and Adolescent Services
- In collaboration with Center for Medicare/Medicaid Services (CMS) and Maryland Medical Assistance (MA), continue implementation of the CMS-supported 1915(c) Psychiatric Residential Treatment Facility (PRTF) demonstration waiver to provide services to up to 80 children and youth and their families in four jurisdictions across the state.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services
- MHA in collaboration with CSAs, will continue to provide support, funding, and ongoing consultation to Maryland's mental health advocacy groups to promote and implement a series of public education and training activities to increase awareness of mental illness; mental health issues; and recovery and resiliency among children, youth, and adults.
MHA Monitor: John Hammond, MHA Office of Public Relations; Al Zachik, MHA Office of Child and Adolescent Services and Cynthia Petion, MHA Office of Planning Evaluation and Training

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- Enhance PMHS data collection and monitoring through continued activities to develop and/or refine management information systems.
MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

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CHILDRENS PLAN

CRITERION #3: Integration of Children's Services

Many of the items in this section appear in Criterion #1. They are repeated here to meet the Block Grant instructions. Please refer to Criterion 1 for greater details.

Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.

DEVELOPMENT OF AN INTEGRATED SYSTEM OF CARE FOR CHILDREN'S MENTAL HEALTH SERVICES

As described briefly in Section II, The Children's Cabinet is Maryland's state level interagency body charged with development and implementation of an integrated interagency system of care for children, youth and families. Maryland was among the first states in the nation to legislatively create an interagency coordination body with the passage of Chapter 426 of the Acts of 1978. Subsequently, the General Assembly formalized the creation of the Subcabinet for Children Youth and Families in 1990. The existence of such an enduring interagency structure creates a highly effective venue for interagency policy development and implementation. The Children's Cabinet is composed of the Secretaries of all the major executive departments that directly provide or finance service delivery to youth and their families. These agencies include: Maryland State Department of Education (MSDE), Department of Health and Mental Hygiene (DHMH), Department of Juvenile Services (DJS), Department of Human Resources (DHR), Department of Disabilities (MDOD), and Department of Budget Management (DBM). The Governor's Office for Children (GOC) provides staffing and coordination functions for the Children's Cabinet. A working subgroup of the Children's Cabinet, the Children's Cabinet Results Team (CCRT), meets more frequently to move the work of the Cabinet forward. The CCRT membership includes Deputy Secretaries and other key members from the same agencies as the Cabinet. The director of MHA's Child and Adolescent Services is a major participant in the CCRT's work, providing staff support to the Secretary of Health and Mental Hygiene in his role on the Children's Cabinet and representing DHMH on CCRT. As a result, mental health is well represented with major input into all policy decisions and programs. The Children's Cabinet collaborates to promote the vision of the state for a stable, safe and healthy environment for children and families. The Children's Cabinet also assesses need, establishes budget priorities, and develops interagency initiatives to address these specific priority needs.

SPECIAL MECHANISMS FOR STATEWIDE COORDINATION OF INTEGRATED CHILDREN'S SYSTEM OF CARE

Center for Medicaid/ Medicare Services PRTF Waiver - Maryland has been granted a Section 1915(c) Medicaid waiver for home and community-based services for children and youth at the Psychiatric Residential Treatment Facility (PRTF) level of care. Often referred to as the RTC (residential treatment center) Waiver, this effort is based on two high Fidelity Wraparound pilots begun in January 2006. State funding was received

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through the GOC to expand the program in FY 2007 to an additional two jurisdictions that are able to provide high-fidelity services. Maryland is one of ten states selected to participate in the Centers for Medicare and Medicaid (CMS) sponsored PRTF demonstration which is based on using section 1915(c) federal Medicaid demonstration waivers to divert youth from psychiatric residential treatment and provide them with community-based services. The target population for the waiver is children, youth, and their families who meet the medical necessity criteria for psychiatric residential treatment facility (PRTF) admission, who live in Montgomery, St. Mary's and Wicomico Counties and Baltimore City. Regulations have been developed to govern the waiver and its operations and provider recruitment is in full swing. The demonstration project will serve up to 80 children and youth per year phased-in over the duration of the project. Fidelity monitoring of the four sites will be conducted at least three times per year. Children may remain in the waiver for up to 24 months with annual review. [NFC 2, 5]

A major component of the implementation of the waiver includes the development of Interagency Care Management Entities (CMEs) statewide. Proposals from private vendors to deliver this service statewide are currently being reviewed. This effort is strongly integrative of the agency efforts in Maryland as it will provide care management in addition to the PRTF waiver, also for youth placed at the group home level by both DHR and DJS and the new System of Care grant for youth in child welfare in Baltimore City.

Clearly, Maryland has a long track record in creating extensive interagency infrastructure and interagency mechanisms for sustaining and improving an integrated system of care for children, youth, and families under the broad aegis of the Children's Cabinet. Much of our success in interagency planning is based on the next element of the narrative, Maryland's commitment to youth and family involvement.

Youth & Family Involvement - The value placed on youth and family member participation and involvement continues as a major priority of the Child and Adolescent Mental Health System. This value also appears as the first element of the Interagency Strategic Plan. MHA and its partners encourage the input of youth, family members, and adult consumers across the board. A concerted effort is made to include all in the planning, development, and monitoring of the PMHS. In FY 2009, MHA will continue to fund the Maryland Coalition of Families for Children's Mental Health, a statewide child and family advocacy group, to develop local family support activities with a mission to inform families of children and adolescents about policy, to teach them about becoming participants in the policy and decision-making process, and to provide feedback about the operations of the Public Mental Health System. The Coalition participates on more than 22 state and local policy shaping committees. At the current time, over 50 family members are employed by the Coalition, its local counterparts, or in local child serving systems as providers of peer-to-peer support and assistance to families in navigating the system. We expect to see future increases in these numbers when the section 1915(c) Medicaid waiver becomes operational and provides reimbursement for family-to-family peer support services, youth-to-youth peer support services, and family

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and youth training delivered by peers. The new services delivered under the waiver are described in greater detail in the section on available services and supports.

A major new project of the Coalition of Families, jointly with the Maryland Mental Health Association, is the “Children’s Mental Health Matters” public awareness campaign. This project is a significant social marketing effort designed to: improve public information, reduce the stigmatization of youth with mental health conditions, and garner public support for innovative system development through a major public awareness campaign. This effort may in some ways be one of this year’s plan’s greatest strengths because it goes beyond limited mandates for service improvement while addressing deeper contextual issues required for lasting system change and better results. The campaign features a media partnership with both FOX and ABC networks, and involves Maryland’s First Lady, Katie O’Malley as Honorary Chair, and Debbie Phelps, mother of Maryland’s celebrated Olympic swimmer, Michael Phelps, as media spokeswoman. A major media blitz occurred during Children’s Mental Health Week, May 3-9, 2009, and will be continued in the upcoming year.

The Coalition has conducted extensive research over the years, including studies using focus group design, of parents involved with custody relinquishment, the juvenile justice system, transition-age youth (TAY) and families of young children engaged with the early childhood education system. These studies have been described in past year’s plans and they provide an excellent and highly effective basis to support advocacy and policy initiatives designed to improve the child and adolescent system of care. In addition, in FY 2004, the Coalition established a Family Leadership Institute (FLI) which has continued producing new advocates every year since. FLI provides a six-month training program for families in becoming advocates in their communities and the state. Twenty families participated in the first Institute. The fifth Family Leadership Institute was held this year with 20 graduates, increasing the total number of trained family advocates to 115 over the five years of the Institute implementation.

Youth MOVE - In June 2007, Maryland initiated its Youth MOVE (Youth Motivating Others through Voices of Experience) program which provides training for youth to be active participants and leaders in seeking services for themselves and for the community of youth. Maryland’s effort is based on the national model (<http://www.tapartnership.org/youth/YouthMOVE.asp>). [NFC 2]

Last year, MHT-SIG established Youth MOVE Maryland by hiring a statewide coordinator housed within the Innovations Institute (described in a following section). Youth MOVE has been implemented in 13 of the state’s 24 jurisdictions. The further statewide roll-out and continued efforts will be sustained through the new Systems of Care (SOC) grant award. Accomplishments include the following: creation of a Youth MOVE Myspace page and brochure; several meetings with senior state officials; and a number of county specific social marketing activities.

In 2008 the 13 jurisdictions implementing Youth MOVE Maryland held between 2-5 trainings that were open and available for the youth leaders to attend. The Innovations Institute also hosted and provided training to youth leaders at the three

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Systems of Care Training Institutes (SOCTI) during 2008. There are currently a total of 65 youth involved in this initiative within the 13 jurisdictions implementing Youth MOVE.

The Child and Adolescent Division of MHA also work, when appropriate, with On Our Own of Maryland (OOOMD), the statewide mental health consumer network. Areas include efforts to fight stigma within the mental health system through the Anti-Stigma Project (ASP) which is described more fully in the adult plan. Exploration of utilization Of Wellness Recovery Action Planning (WRAP) for TAY and other transition-age youth issues. [NFC 2]

Maryland's Blue Print Committee - A major outgrowth of Maryland's family involvement philosophy was the development of the Maryland Blue print for Children's Mental Health. This ongoing strategic planning effort was developed at the request of our statewide family organization, originally in 2003, and the Blueprint was updated this year in the spring of 2009. It is a five-year strategic plan which extends the work of the 2003 Blueprint to address the mental health needs of children, youth and their families. The guiding philosophy of care found in the Public Health Model, with its emphasis on the health of an entire population beginning with health promotion, prevention and early intervention, is central to this 2009 update. The revised vision and mission as well as the recommendations and suggested strategies, themselves, are rooted in the broader public health approach to mental health.

Six major themes emerged which became the basis for recommendations and suggested strategies. Within each theme, the recommendations were prioritized. The six themes and the most highly prioritized recommendation in each are listed below.

- **Mental Health Promotion, Prevention and Early Intervention**
-Increase and coordinate mental health promotion efforts, increasing protective factors and decreasing risk factors through individual and community education for all age groups across all jurisdictions
- **Family and Youth Partnership**
-Ensure that Family and Youth are equal partners at every level of statewide and local decision making throughout each phase of policy, program, and evaluation in all jurisdictions
- **Infrastructure Development**
-Develop sustainability for core levels of services, supports, and opportunities in each jurisdiction (as proposed in Continuum of Services and Supports below)
- **Workforce Development**
-Strengthen services by providing adequate pre-service and in-service training, resources, and leadership to all those who provide direct care to children, youth and their families across disciplines and populations
- **Access to Care and Opportunities**
-Provide consistency in policy, practice, and funding across agencies and throughout local jurisdictions
- **Continuum of Services and Supports**

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-Define and develop an accessible baseline, or foundation of services and supports, in every jurisdiction in Maryland

The Maryland Child and Adolescent Mental Health Institute - A major outgrowth of the original Blue print Committee process was the development of the Maryland Child and Adolescent Mental Health Institute. The Institute is a joint project of Johns Hopkins and the University of Maryland (UM) Schools of Medicine. A number of key related projects run by the Institute include: {1} a SAMHSA-funded effort to reduce seclusion and restraint in state-operated child and adolescent mental health facilities; {2} a SAMHSA-funded Child Trauma Center; and {3} a project focused on implementation of Treatment Foster Care implementation, a process begun under the National Institute of Mental Health (NIMH)-SAMHSA Science to Service grant. In addition, a special focus has been placed in partnership with DHR and the UM School of Social Work on development of trauma-informed care and evidence based Cognitive Behavioral Therapy for children and youth in the foster care system. Funding from the MHT-SIG has been provided through the Institute to the UM Center for School Mental Health Assistance, one of only two national centers on school mental health funded by the federal government, to study the educational needs of children in child welfare.

- In addition to the above, the Maryland Child and Adolescent Innovations Institute, of the University of Maryland Division of Child and Adolescent Psychiatry, was initiated in 2005 to assist the State of Maryland, the Children's Cabinet, the Governor's Office for Children (GOC), Maryland jurisdictions, and the state's child-serving agencies to support efforts in improving access, services and outcomes for families of children with intensive needs. Innovations Institute seeks to assist the state of Maryland and local jurisdictions with obtaining skills, interpreting new knowledge, and adapting policy and practice to ensure that Maryland's children, youth, and families achieve wellness through family-driven, youth-guided, culturally and linguistically competent, and individualized quality care within a system of care. The Innovations Institute is funded by the Governors Office for Children (GOC).
- The Johns Hopkins University School of Medicine offers a broad range of research, educational and clinical resources. The Department of Psychiatry and Behavioral Sciences has over 200 full-time faculty members and an extensive program of research supported by multiple funding sources, including over \$38 million annually in NIH grants. The Division of Child and Adolescent Psychiatry consists of 40 full-time faculty members who are located in diverse clinical settings. The faculty are committed to training clinical researchers in the following areas of interventions research with children and adolescents: 1) efficacy studies evaluating new or available but un-validated medication and/or psychosocial treatments, 2) effectiveness studies of empirically supported treatments applied in diverse populations and settings, 3) safety and adverse effects of psychotropic medications, particularly during long-term treatment and 4) methodological approaches and techniques that inform the specificity of treatment to identify which treatments work best for which individuals. The research environment in the Division of Child and Adolescent Psychiatry is very collaborative in nature, offering many opportunities and resources.

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INTEGRATION OF MENTAL HEALTH WITH SOCIAL SERVICES, STATE AND LOCAL EDUCATIONAL SYSTEMS, JUVENILE JUSTICE AND SUBSTANCE ABUSE SERVICES

Details of the more specific interagency initiatives are presented below. The service sectors identified in Criterion 3 specifically for integration with mental health include: {1} social services; {2} education (including, but not limited to, special education); {3} juvenile justice; and {4} substance abuse services. These are discussed in the order they appear in the federal statute.

Social Services - The social service sector in Maryland is primarily housed in the Department of Human Resources (DHR). For child and adolescent planning purposes, the majority of social services are administratively located in the Social Services Administration (SSA). The principal functions of SSA are child welfare focused, including child protection, kinship care, formal custodial placement of children in a variety of out of home placements, family reunification, and adoption/post adoption services. It is important to note that the juvenile court plays a significant role in interfacing with the social service sector through its dependent youth docket, in addition to the role it plays in the juvenile delinquency sector. Both juvenile and social services will be discussed again in the subsequent section on housing. Collaboration with social service providers is particularly important given the high prevalence of mental health disorders among children who are in state custody of the state's child welfare system. Local social service agencies in each jurisdiction are called Departments of Social Services (DSS). MHA tracks the percentage of selected categories of youth in the child welfare systems who receive services via the PMHS as a performance indicator.

- **“Place Matters”**--A current major priority of DHR is the “Place Matters” campaign. The agency joined with the Annie E. Casey Foundation's Casey Strategic Consulting Group to reform foster care in the state. DHR is spearheading a three-year effort to bolster 1,000 new foster family homes by 2010 so that children live in closer proximity to their family members and their communities. Specific recruitment goals for each region of the state are guiding the outreach. Key Performance Measures for Place Matters include: {1} reducing the number of children in out-of-home care; {2} reducing the number of children in group homes; {3} increasing the number of children placed in their home jurisdiction; {4} increasing the number of children who reunite with their family; and {5} increasing the number of adoptions.
- **“Other DHR”** - Other DHR social services that are housed outside of child welfare, which also come into play in planning and delivery, include homeless services, domestic violence services, victim services, adult services, and Medicaid eligibility services, (notably for Medicaid waivers). It is important to note that child care services, typically considered a social service, are administratively housed in Maryland within the Department of Education. As a result, these services will be discussed subsequently in conjunction with early childhood education. For those youth and young adults in the transitional youth

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age range, the full array of adult oriented social services also become a part of the overall system of integrated services required.

- **“MD CARES”** – Funded through a SAMHSA system of care grant, the Maryland Crisis and At Risk for Escalation diversion Services for children (MD CARES) project is key child welfare collaboration. It will develop a cross-agency partnership that blends family-driven, evidence-based practices within mental health and child welfare to better serve this high risk population. In Maryland there are approximately 10,100 children in foster care, of which approximately 6,100 are from Baltimore City. Service dollars awarded under the grant will be targeted to the neighborhoods in the City, where the majority of the youth and families in foster care reside. To most effectively leverage the systems change in the City and adapt the model for statewide implementation, MD CARES also incorporates statewide infrastructure and sustainability strategies which include: crisis response and stabilization; completion of the statewide rollout of Youth MOVE; and cross-agency fiscal and policy analysis. The service focus of this initiative is the care management and treatment of youth in the Baltimore City foster care system at the point of initial diagnosis of serious emotional disturbance (SED), in order to prevent out-of-home placement or disruption in first placement when the disability is expected to last in excess of one year. Grant funds will be used to expand and support “wraparound” services to foster children in their communities. Wraparound services provide a comprehensive array of home and community-based services to maximize the strengths of families, natural support systems and community resources. These services are different from traditional "one size fits all" programs and expensive residential care. MD CARES will serve up to 40 youth at a time for an average of 15 months with a projected total of 340 youth throughout the project.
- **Crisis Stabilization and Response** - A related joint venture with DHR that first appeared in last year’s plan, is the creation of a mental health crisis response and stabilization system designed to help respond to children in foster care placements and intervene in the home setting so that psychiatric crises and resulting hospitalization do not result in the disruption of the child’s residential placement. This initiative was funded in the Governor’s budget and approved by the General Assembly to commence in FY 2009. Program start-up began in selected jurisdictions in September 2008. Nine service provision areas covering 16 counties have been initiated. These include the Lower Shore region; Mid-Shore region; Allegany, Garrett, Washington, Baltimore, and Anne Arundel Counties; and Baltimore City. During the upcoming year jurisdictions plan to hold extensive trainings of local first responders, police and EMS staff, about the special needs of foster families. Harford and Prince George’s Counties originally planned for statewide implementation. However, further expansion of this project has unfortunately been curtailed due to budget limitations.
- **School Mental Health Foster Care Project--** This special project has made a number of accomplishments. It is believed to be the first project in the United States to explicitly connect school mental health outreach and services for youth in foster care. The project has established a diverse and influential advisory board of 40 systems leaders and stakeholders from over 20 organizations. In addition,

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ten modules for training child welfare, education, and mental health systems staff, with strong youth and family involvement, were completed and a partnership with Maryland's Child Welfare Academy was established with the first full-day training held in December 2008. A School Mental Health and Foster Care Issue Brief was disseminated broadly within Maryland and is available for national and international dissemination at <http://csmh.umaryland.edu>.

MHA and the Maryland Child and Adolescent Mental Health Institute are completing a special project on the use of psycho pharmacological treatments with foster care children, described in subsequent section.

Educational Services, including Services provided under the Individuals with Disabilities Education Act (IDEA) - A major new project for 2009 in the arena of special education policy has evolved from a partnership of the Maryland State Department of Education (MSDE), the Coalition of Families for Children's Mental Health, and the Mental Hygiene Administration which will focus on outcomes for students identified with emotional disturbance in Maryland's school systems. This process directly addresses the specific needs of the most highly involved youth identified under the entitlement provisions of the Individuals with Disabilities Education Act (IDEA). A highly successful series of forums was held in the spring of 2008, which highlighted some of the challenges faced by this group of students. The Maryland State Department of Education (MSDE) tracks a number of key data elements on students identified under IDEA with emotional disturbance. These data elements include the drop out rates, suspension/expulsion rates, and preliminary data on high school academic performance in English and Algebra. These data reveal troubling trends for all the students, particularly the transition aged youth with mental health needs. Over 49 percent of nearly 9,000 students identified with emotional disturbance dropped out of Maryland schools in 2006, capping a rising trend of over six percent across the past four school years. Prior to dropping out of school, students with emotional disturbance experience a disproportionately greater number of suspensions and expulsions than do other students with disabilities. Although students with emotional disturbance comprise slightly over eight percent of all students in special education, they account for 52 percent of all suspension/expulsion related disciplinary actions for special education students, a factor that is all the more staggering when one considers that so many drop out of school prematurely. Academic proficiency testing in Algebra and English II reveals students scoring in the low 30 percent proficiency range compared to all Maryland high school students, whose aggregate scores are twice as high, registering over 60 percent proficiency on these assessments. To compound an already troubling picture, it must be noted that African American students are disproportionately much more likely to be identified as emotionally disturbed in Maryland schools. African Americans constituted over 56% of all students identified with emotional disturbance in 2006 while representing only 33% of the school-aged population (MSDE PowerPoint- "Meeting the Needs of Students with Emotional Disturbance in Schools"--April 28th, 2008).

The work of this task group will continue into FY 2010, resulting in a series of recommendations for improvements of outcomes for these students. It should be noted that the Children's Cabinet tracks the dropout rate of students with emotional disturbance

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as a well being indicator. MSDE will offer more than one million new dollars to local school systems in the upcoming year for projects designed to improve the education of students with emotional disturbance.

Early Childhood Mental Health - The goal of the Maryland Early Childhood Mental Health Initiative is to increase the numbers of children who enter kindergarten ready to learn. Maryland has moved to a statewide assessment of children who enter kindergarten - the Work Sampling System - which provides a status report at the school and county levels of children and their school readiness. According to the criteria employed, Work Sampling System scores represent percentages of students who consistently demonstrate skills, behaviors, and abilities, needed to meet kindergarten expectations successfully. The Work Sampling data are compiled in seven domains and also create a composite readiness score. Over time these scores represent the level of progress the state has made in achieving its goal of entering school ready to learn.

The strategy for early childhood mental health is to integrate mental health services into existing early childhood programs (children 0 to 5 years), to incorporate supports into existing early childhood programs, and to promote and support the integration of early childhood mental health services within other settings. The mental health component of the Maryland Infant and Toddler Program, which provides services for young children governed by IDEA, is strengthened by the activities of the Early Childhood Mental Health Initiative. Additionally, the Initiative supports the provision of mental health services in day care services as well as federally-funded Head Start programs. [NFC 4]

The Maryland State Early Childhood Mental Health Steering Committee provides direction to the Initiative. The Steering Committee is composed of a wide variety of organizations including: MHA's Office of Child and Adolescent Services; Maryland Coalition of Families for Children's Mental Health; MSDE; Governor's Office for Children; DJS; Maryland Insurance Administration; Mental Health Association of Maryland; CSAs; Local Management Boards; University of Maryland Training Center; and, other child serving agencies. [NFC 4]

Findings from the recent evaluation of the pilot of early childhood mental health consultation with childcare providers indicated that that on-site consultation to child care programs delivered by interventionists who were knowledgeable about child development, individualized consultation for children at risk of being expelled from their child care programs, and consultation to providers about classroom-wide behavior management strategies had a number of positive effects. These effects included substantial decrease in expulsion for at-risk children, strong gains in social skills, reductions in children's problem behaviors, changes in teachers' behaviors, and improvement in the classroom environment. Based on the results of the pilot project and evaluation, support from agencies, providers and families, and the success of the FY 2007 expansion of early childhood mental health consultation MSDE received \$2.5 million for state FY 2008 to further early childhood mental health screening, prevention and intervention for preschool children at risk of developing emotional and mental health disorders. This will ensure that consultation is available in all jurisdictions. [NFC 4, 5]

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School Based Mental Health - MHA continues its extensive work with the Maryland State Department of Education (MSDE), both in regard to strengthening student support services for students in regular classrooms and in special education settings governed by the requirements of the Individuals with Disabilities Education Act (IDEA). MHA and MSDE collaborate to provide services to children and youth and to recruit qualified mental health providers for schools and the community. There has been a considerable increase in school-based mental health services over the past several years. For example, mental health services are available in 120 public schools in Baltimore City and in six schools in Baltimore County. There are currently 61 school-based health centers across the state, each of which provides somatic services. Approximately half of the centers also provide mental and behavioral health services. [NFC 1]

The Blueprint School Mental health Committee completed a statewide assessment of expanded school mental health availability in Maryland's 24 local jurisdictional school systems.

- **PBIS**-- Additionally, Maryland law requires elementary schools with suspension rates over 18% to implement the Positive Behavioral Interventions and Supports (PBIS), or an alternative behavioral modification program, to reduce suspensions. MSDE, in partnership with Sheppard Pratt Health System and Johns Hopkins University's Bloomberg School of Public Health, oversee and support the statewide implementation of PBIS in Maryland. The partnership, known as PBIS Maryland, is responsible for providing training and technical assistance to local school systems. Each summer, the PBIS Maryland hosts a Training Institute for new teams and local school systems host a number of local/regional Training Institutes for their implementing schools. -An increasing number of schools are choosing to use this program because of its success in improving school climate. The program has been successful in decreasing the number of suspensions and expulsions as well as behavioral referrals to special education. As of 2009, a total of 648 schools will be trained in PBIS and 568 schools actively implementing PBIS in Maryland
- MHA's Work Force project undertaken with the MSDE is described in greater detail in Criterion 5.
- Specialized efforts with the Early Childhood Educational sector and, for transition-age youth, with the Division of Vocational Rehabilitation Services (DORS), housed within MSDE, are described in subsequent sections.

Juvenile Services - There are a number of continuing activities underway to enhance the linkages and accessibility to behavioral health care for youth in Maryland's juvenile justice system.

The MHA budget includes funds for a mental health component for juvenile justice aftercare services. These are services offered to youth released from the Department of Juvenile Services (DJS) commitment facilities. In FY 2008, approximately \$1.6 million was transferred to MHA through an interagency

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memorandum of understanding to continue implementation of the mental health component for youth discharged from state juvenile correctional facilities. Mental health professionals, called Family Intervention Specialists (FIS), participated in 26 specialized DJS Intensive Aftercare Teams to conduct assessments, make referrals for treatment, and facilitate groups. In FY 2007, the Family Intervention Specialists provided mental health services to over 376 youth who came in contact with the juvenile justice system and were in need of services. In order to meet each jurisdiction's needs, the FIS work in collaboration with DJS area directors and supervisors and participate in meetings and trainings. The CSAs have been designated lead agencies at the local level, assuring coordination with other mental health services.

The MHA Child and Adolescent staff provide training for DJS direct care staff on an as needed basis, but at least four times annually. In addition, one of the staff will be assisting the DJS Director of Professional Development and Training to create training for DJS direct care staff, which will be offered on an ongoing basis. If requested, MHA will assist in conducting this training.

In addition, mental health services provided in juvenile justice detention centers continue to operate as in years past. The program now focuses on the needs of juvenile offenders in six detention centers prior to adjudication and disposition by the juvenile court (J. DeWeese Carter Youth Center, Alfred D. Noyes Children's Center, Cheltenham Youth Detention facility, Thomas J. S. Waxter Children's Center, Western Maryland Children's Center, and the Baltimore City Juvenile Justice Center). DJS, with newly appropriated mental health funding, continued to build upon these existing services in FY 2008. The provision of additional funds for mental health in juvenile justice last year resulted in Maryland absorbing a block grant reduction from the federal government in this cost center, thus resulting in an uninterrupted service delivery as described in more detail in our block grant spending plan. [NFC 4, 5]

Substance Abuse Services including co-occurring disorders - DHMH is the agency responsible for mental health, substance abuse, developmental disabilities, AIDS, maternal and child health, and all the programs offered through the State Medical Assistance Plan. There is an ongoing need for coordinating mechanisms within the Department itself in order for DHMH to fulfill its role as an interagency partner with the other Departments of the Children's Cabinet. The coordination of services for substance abuse, as well as developmental disabilities, with services offered to children and youth for mental health problems, is a critical issue within the DHMH coordination process. These needs all fall under the category of youth with special health care needs, and the primary systemic coordinating effort is the Special Needs Advisory Committee. [NFC 5]

In the past, Maryland has emphasized cross training of staff and coordination of services as a means of providing access to services by individuals needing both mental health and substance abuse services. Staff coordinators from MHA and ADAA work with the special needs coordinator from the child's HealthChoice MCO when a child with co-occurring diagnoses requires enhanced coordination efforts. A number of existing mental health treatment and rehabilitation programs, as well as programs established through the DHMH Alcohol and Drug Abuse Administration (ADAA), have developed

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dual diagnosis capability and are able to offer substance abuse treatment services to individuals with mental illnesses. [NFC 4, 5]

MHA continues to address the challenge of how to implement evidence-based practices to improve services for children and adolescents, with co-occurring disorders of mental illness and substance abuse. In FY 2008, MHA continued multiple collaborations with ADAA to promote integrated treatment for consumers with co-occurring disorders at the local level. Currently representatives from MHA and ADAA regularly meet with county leaders to provide assistance and support for regional initiatives. This approach includes initiatives at the county level to implement the Comprehensive, Continuous, and Integrated Systems of Care (CCISC) for Consumers with Co-occurring Mental Health and Substance Use Disorders model. Worcester, Montgomery, Anne Arundel, Baltimore, Prince George's, and St. Mary's Counties are currently involved in strategic planning processes. In FY 2009 MHA will assist up to eight jurisdictions to initiate or complete consensus documents, local action plans and train local staff in implementing CCISC. [NFC 5]

The Secretary of the Department of Health and Mental Hygiene (DHMH) has also demonstrated commitment to co-occurring disorders by appointing an administrative officer from his office to work with MHA and ADAA. As a result of coordination through this newly formed position, a state-level leadership team has been convened to provide leadership toward enhanced service coordination across systems. There is now a State Charter, reflecting the state's ongoing development toward service integration across the systems. Additionally, within DHMH, new legislation established the Office of the Deputy Secretary for Behavioral Health and Disabilities. This Office includes responsibilities for developing a system of services for individuals with co-occurring disorders, to address systems change and to identify and implement specified treatment and supports.

The majority of the women with co-occurring disorders in the justice system have children and a smaller population is pregnant while incarcerated. MHA was instrumental in development and implementation of the TAMAR's Children Program which addressed the needs of the women and their children. In 2007, MHA collaboratively worked with the Department of Public Safety and Correctional Services, the Administrative Office of the Courts, the Alcohol and Drug Abuse Administration, the Family Health Administration, Baltimore Mental Health Systems, Inc. and the Archdiocese of Baltimore to create a new statewide diagnostic and transitional program for pregnant women who are at least 18 years of age who might otherwise be incarcerated. As a result of this collaborative partnership, a new program, the Chrysalis House Healthy Start Program, was created. This program, funded through state general funds, consists of a 16-bed diagnostic and transitional facility (in the former location of the Tamar's Children Program) and serves pregnant and post-partum women and their babies. [NFC 2]

After the newborn's birth, the mother and baby remain in the residential facility and receive a comprehensive array of services. Services include: medical care through contract with a health care organization; mental health treatment which includes trauma

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and attachment-based treatment interventions; substance abuse treatment and co-occurring treatment services; legal services; parenting and childcare services which include involvement from the Healthy Start and Family Tree Programs; housing; after hours residential support; health education; and other support services. [NFC 2]

Pregnant women may be referred by the courts, the state, Defense Attorney, or DHMH. A comprehensive assessment is conducted by a licensed clinician and an individualized treatment plan is developed between each woman and the treatment team.

Also in FY 2008, MHA continued to offer and/or provide consultation to state and local agencies serving pregnant and post-partum women and their children on mental health and trauma. MHA continues to fund outreach, case management, and housing assistance to graduates of the Chrysalis House Healthy Start Program through funding provided to Prisoner's Aid Association. [NFC 2]

Health and Mental Health Services

Since DHMH is the agency responsible for mental health, substance abuse, developmental disabilities, AIDS, child and maternal health, and all the programs offered through the State Medical Assistance Plan, there is an ongoing need for coordinating mechanisms within the Department itself in order for DHMH to fulfill its role as an interagency partner with the other Departments of the Children's Cabinet. The coordination of services for substance abuse, as well as developmental disabilities, with services offered to children and youth for mental health problems, is a critical issue within the DHMH coordination process. These needs all fall under the category of youth with special health care needs, and the primary systemic coordinating effort is the Special Needs Advisory Committee. Staff coordinators from MHA and ADAA work with the special needs coordinator from the child's HealthChoice MCO when a child with co-occurring diagnoses requires enhanced coordination efforts. Efforts to support initiatives at the county level to implement the Integrated Systems of Care for Consumers with Co-Occurring Mental Health and Substance Use Disorders model of best and evidence-based practices and the State's involvement in the SAMHSA National Policy Academy are discussed under Criterion 1. [NFC 4]

DEFINED GEOGRAPHIC AREAS FOR PROVISION OF CHILD SERVICES

At the jurisdictional or local level, Local Management Boards (LMBs) have been created in each of the 24 jurisdictions with the responsibility for coordinating a wide variety of services provided to children, youth, and families. These entities operate in ways similar to the CSA function described under Section I, Regional/Sub-State Programs. In many jurisdictions the LMB has a member on the CSA and vice versa, resulting in the integration of the efforts of LMBs and CSAs, who are responsible for mental health which is an essential component of the child and adolescent service system in Maryland.

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The following discussion of AVAILABLE SYSTEMS OF TREATMENT, REHABILITATION, AND SUPPORT SERVICES is also included in Criterion 1 of both the Adult and Child Plans.

Services Available

Community-based mental health services and supports that are included in the fee-for-service benefit package for children, youth and families include:

- Psychiatric hospitals
- Psychiatric units of acute care general hospitals
- Residential treatment centers (RTCs)
- Psychiatric day treatment (also called partial hospitalization)
- Outpatient mental health clinics (many of which provide school-based and after-school treatment programs)
- Psychiatric rehabilitation programs
- Mobile treatment services (MTS)
- Supported employment (SE) and vocational services (for transition-age youth [TAY] age 16 and above)
- Respite care
- Residential crisis services
- Therapeutic behavioral aides
- Mental health related laboratory services

In addition to the broad range of services provided in the fee-for-service PMHS, youth admitted to the PRTF waiver will be eligible for additional waiver services in addition to the PMHS services these services include:

- High Fidelity Wraparound Care Management
- Family to Family Peer Support
- Youth to Youth Peer Support
- Family and Youth Training
- In Home Respite Care
- Out of Home Respite Care
- Crisis and Stabilization Services
- Expressive and Experiential Services (i.e. art, movement, and music therapies, and horticultural and equine assisted therapies)

Additionally, MHA provides funds through contracts to programs that offer specialized services (e.g., mobile crisis, therapeutic nurseries, and therapeutic group homes) that do not fit the fee-for-service model. These programs are eligible to apply for funds for programs such as family support groups, protection and advocacy services, juvenile court evaluation programs, and early childhood mental health consultation. A wide array of other child mental health services are also provided by other agency partners, such as Wraparound, which is funded through the Governor's Office for Children. Case management is contracted through the core service agencies, with one or

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more case management programs that provide linkage services and resources that will assist the consumer in stabilizing into the community. [NFC 2]

With regard to the MHA-operated Public Mental Health System (PMHS), any mental health provider who meets appropriate licensing, certification, accreditation, or other applicable standards is eligible to become a provider in the fee-for-service system. Eligible providers include facilities, programs, and individual practitioners. Individual practitioners include physicians, psychologists, nurse psychotherapists, clinical social workers, occupational therapists, and certified professional counselors who are allowed to practice independently under their Practice Acts. This increase in the provider community offers consumers an expanded choice of providers, including both approved mental health programs and individual licensed mental health practitioners. PRTF waiver services add Family Support Organizations to the mix of providers. Expressive and experiential therapies are provided by individual providers only.

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SFY 2010 OBJECTIVES FOR CRITERION 3:

INTEGRATION OF CHILDREN'S SERVICES

- MHA will work in conjunction with Department of Human Resources (DHR) and other stakeholders to improve screening, assessment, and service delivery for children and youth in foster care.
MHA Monitor: Al Zachik and Cyntrice Bellamy, MHA Office of Child and Adolescent Services
- Utilize the principles and values of the Transition to Independence (TIP) program, a best practice approach to improve the quality of services for transition-age youth (TAY), to conduct a comprehensive quality improvement initiative for MHA funded programs servicing this age group.
MHA Monitor: Tom Merrick, MHA Office of Child and Adolescent Services, and Steve Reeder, MHA Office of Adult Services
- In collaboration with the Maryland Child and Adolescent Mental Health Institute, Maryland State Department of Education, the Center for Maternal and Child Health, the Maryland Blueprint Committee, and other stakeholders, continue to build infrastructure and deliver training to improve quality of mental health screening assessment and intervention for young children.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services
- Provide resources to continue to implement leadership activities and trainings through the Maryland Coalition of Families for Children's Mental Health Leadership Institute for parents of children with emotional disorders; the Youth MOVE (Motivating Others through Voices of Experience) peer leadership program; and the Leadership Empowerment and Advocacy Project (LEAP) for adult consumers.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services; Clarissa Netter, MHA Office of Consumer Affairs
- In collaboration with Center for Medicare/Medicaid Services (CMS) and Maryland Medical Assistance (MA), continue implementation of the CMS-supported 1915(c) Psychiatric Residential Treatment Facility (PRTF) demonstration waiver to provide services to up to 80 children and youth and their families in four jurisdictions across the state.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services
- Implement a diverse range of innovative statewide and local youth suicide prevention activities with support of the SAMHSA Statewide Youth Suicide Prevention and Early Intervention grant "Maryland's Linkages to Life."
MHA Monitor: Henry Westray, MHA Office of Child and Adolescent Services

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CHILDRENS PLAN

CRITERION #4: Rural Populations and Services to the Homeless

Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.

TARGETED SERVICES FOR RURAL POPULATIONS

Definition of Rural Areas

Rural counties have historically been defined in Maryland as those with a population of 35,000 or less. Six counties continue to meet this criterion. Source: U.S. Census Bureau, Estimated Maryland Total Population by Political Subdivision, July 1, 2007 - Maryland Vital Statistics Annual Report 2007.

Maryland's definition was reviewed relative to the more complicated definitions of rural used by the U.S. Census Bureau. For Census 2000, the Census Bureau's classification of "rural" consists of all territory, population, and housing units located outside of urbanized areas (UAs) and urban clusters (UCs). The Census Bureau also looks at the population density with core census blocks of at least 1,000 people per square mile or surrounding census blocks with an overall density of at least 500 people per square mile. Many counties and metropolitan areas are split with UAs and UCs, often mixed with more rural areas. Based on population density alone, several other counties in Maryland, beyond the six, might be considered rural. However, other factors, including growth rate and proximity to major metropolitan areas (emerging bedroom communities), make these counties appear less rural. Based upon this, the six counties with populations under 35,000 will remain Maryland's defined rural areas for purposes of this application, while recognizing that pockets of "rural" areas exist in other counties.

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Of the six Maryland counties that qualify under this definition, one rural county—Garrett—is the western-most jurisdiction in the state, and the other five—Caroline, Dorchester, Kent, Somerset, and Talbot Counties—are on the Eastern Shore. In recent years, several Eastern Shore counties have developed past the 35,000 threshold. Typically, as a rural county develops beyond the 35,000 threshold, it experiences growth in housing, commerce, and average household income that makes it more similar to the rest of the State. (**Talbot County, with 36,196 slightly exceeds this threshold. Please see discussion of Talbot County on following page.)

Rural County Population
Caroline 32,910
Dorchester 31,846
Kent 19,987
Somerset 26,016
Talbot** 36,193
Garrett 29,627

Source: U.S. Census Bureau, Estimated Maryland Total Population by Political Subdivision, July 1, 2006 and July 1, 2007
Maryland Vital Statistics Annual Report 2007

While the Mental Hygiene Administration will continue to utilize the foregoing definition of rural counties for purposes of this Mental Health Block Grant Application, the Office of Health Policy and Planning of the Maryland Department of Health and Mental Hygiene in June 2007 published *The Maryland Rural Health Plan* which provides a broader discussion of rural health issues in Maryland. The following are excerpts from that plan to assist us in identifying and addressing rural mental health issues in this analysis.

“The challenges to providing quality health care services and delivery to rural Maryland largely result from their geographic isolation and lack of the critical population mass necessary to sustain a variety of primary and specialty services. Efforts to address health care disparities in rural areas are often made difficult by struggling economies and limited financial and human resources.”

“Compared with the state overall, Maryland’s rural communities tend to have fewer health care organizations and professionals, higher rates of chronic disease and mortality, and larger Medicare and Medicaid populations. Evidence indicates that rural populations fare worse in many health and economic indicators, and do not receive the same quality, effective, and equitable care as their suburban counterparts. Rural populations tend to be older and exhibit poorer health behaviors and experience increased

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health risk factors such as higher rates of smoking and obesity, relative to the State, although there is variability in health behaviors among rural communities.”

The DHMH Office of Rural Health convened a steering committee to create the Maryland Rural Health Plan. Among the top priority areas for rural health in Maryland identified by the Steering Committee were behavioral health (mental health and substance abuse) and improvement in behaviors leading to a healthier lifestyle.

For purposes of data analysis and comparison, all Maryland jurisdictions where at least two-thirds of the census tracts are classified as rural by the federal Office of Rural Health Policy (ORHP) are included in the “federally designated rural” group. These jurisdictions tend to fare worse in the health and economic status because they are generally more isolated and have smaller and older populations than the other jurisdictions. The ORHP classifies the following three additional counties in addition to the previously identified six jurisdictions as rural: Allegany County (with 72,831 population); St. Mary’s County (with 98,853 population); and Worcester County, home of Maryland’s major ocean front resort, (with 48,866 population-year round in the non summer months). It is worthwhile to note that rural issues apply to other areas beyond the six most rural counties discussed in this rural section of Maryland’s mental health block grant analysis.

**Talbot County is an excellent example of a county that is in the process of transforming from a rural to non-rural area. On July 1, 2003 the population was 34,670. On July 1, 2007, the last year in which official age specific population was available, the number increased to 36,193 exceeding Maryland’s self defined “rural” threshold of 35,000 by 1,193. Projections indicate that the population of Talbot County continued to increase approximately 0.4% in 2007. For purposes of this year’s block grant application we will continue to include Talbot County among the six rural counties. (Utilization data from all six counties are used in the block grant performance indicator.) Talbot County now has an average per capita personal income of \$56,775, up from \$46,144 in 2005. (Department of Business and Economic Development <http://www.choosemaryland.org/factsandfigures/demographics/incomedata.html>)

The five Eastern Shore rural counties have personal per capita incomes ranging from a low of \$24,053 in Somerset County to the high of \$56,775 in Talbot County, compared to a statewide average per capita personal income of \$48,091. The demographics of Somerset County and most of the Shore counties also reflect issues affecting rural areas. As the second smallest county in the state, Somerset County’s population actually increased slightly by 242 individuals after a decline in the previous year according to the July 1, 2007 DHMH Vital Statistics estimates. Somerset County’s 2004 household median income was one of the lowest in the State at \$33,700. Statewide household median income was \$68,080. Over the past five years, the number of Medical Assistance Program enrollees has risen. (Economic updates from Maryland Manual 2005 estimate printed 6/24/08)

Garrett County, in western Maryland, provides a useful example of how rural

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communities differ from jurisdictions in more rapidly developing areas of the State. Garrett County has one of the lowest per capita incomes (\$29,820) of the State's 24 subdivisions. The 2010-2011 Core Service Agency (CSA) Plan notes that Garrett County has 819 families, or 9.8% (same) of the 8,354 families who live in poverty. In 2007, the median household income was \$40,115 (Maryland Department of Business and Economic Development). Garrett County ranks 21st out of 24 counties in the state, for total personal income. Unemployment rates in Garrett County are almost double that of the State of Maryland. According to the July 2007 Maryland Department of Labor statistics, the annual average unemployment rate ranged from 4.5%-4.8% in one year. Current data for April 2009 estimates a 7.3% unemployment rate in Garrett County compared to a 6.6% statewide rate. (Source US Department of Labor) In Garrett County, of the adults in the age group 25 and over, 7% have less than a ninth grade education or no diploma; 79.2% have a high school or higher education. (Statewide Web-based data indicate that in March 2009 a total of 6,345 out of the total county population of 29,627 were Medicaid eligible.) The current plan indicates 18.6% of the county residents, among the highest of Maryland jurisdictions, are enrolled in Medical Assistance. In its FY 2009 CSA Plan Update, Garrett County is described as a, rural, mountainous county in the northwestern most corner of Maryland. This area of the Appalachian Mountains has higher elevations with more demanding winter conditions. The average yearly snowfall is over seven feet. The majority of roads are winding, the nearest large city with mental health services is Cumberland, Maryland, located in Allegany County. Limitations, typical of rural areas, exist in availability of transportation, access to healthcare and health information for a number of socioeconomic, geographic, educational, and cultural reasons. Low education levels create a barrier to seeking and understanding health information. However, in April 2009 access to primary health care services was improved when a new permanent Federally Qualified Health Center (FQHC) opened on property adjacent to the Garrett County Health Department and a major mental health outpatient clinic (OMHC). There was a 6.5% increase for persons served in the OMHC from 2007 to 2008. The plan notes that some of the OMHC increases resulted from more children 6-12 being served.

Use of Technology

Perhaps the best example of the use of Technology in Maryland is the recent statewide launch of The Network of Care. The Network of Care is an information Website cited as a "best practice" for the use of technology in the President's New Freedom Commission Report on Mental Health. The site contains a listing of services; a library of mental health articles; a list of support and advocacy organizations; legislation; and a personal folder/advance directive/Wellness Recovery Action Plan (WRAP) feature. The goal is to provide simple and fast access to information for persons with mental illnesses, caregivers, and service providers. The Website was first piloted in Worcester and Anne Arundel Counties. The official statewide launch was held at the annual summer conference of On Our Own of Maryland, Inc. (OOOMD) in June 2008. Phase II of the Network of Care initiative reached out to consumers in all of Maryland's 24 jurisdictions who now have access to information and resources in their communities.

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The Maryland Network of Care for Behavioral Health has recorded 104,279 visits from its May 30, 2008 launch date through Feb. 12, 2009.

Also added to the Network of Care site is a comprehensive Veteran's portal to help service men and women returning from Iraq and Afghanistan with behavioral obtain access to services. This public service is an attempt to bring together critical information for all components of the veterans' community, including veterans, family members, active-duty personnel, reservists, members of the National Guard, employers, service providers, and the community at large.

In FY 2010 MHA plans collaboration with Mental Health Transformation Office (MHTO) and CSAs, to improve implementation and provide training on Network of Care. Improved outcomes will include: Web-based platform purchased and installed throughout Maryland, utilization of site tracked, improved user friendliness, mental health community informed regarding availability of Web system, consumers trained in the utilization of personal health record features, and training in use of individual advance directives.

A child and adolescent best practices project funded by MHA, in collaboration with the directors of the departments of child and adolescent psychiatry at the University of Maryland and the Johns Hopkins Hospital, involves seminars held once per month and video-conferenced to seven sites across the state. The goal is to provide state-of-the-art information (best practices) to child practitioners in Maryland on child psychiatry, psychopharmacology, and treatment. It is a live, interactive seminar that offers slide presentations, didactic material, and interactive discussion. This project keeps state providers informed of the latest developments in their field without the need to travel many hours and/or accumulate high costs. **[NFC 3, 6]**

In 2003, Sheppard Pratt Hospital Systems was awarded a grant from the U.S. Department of Agriculture (USDA) to install and furnish telemedicine equipment at several public and private mental health facilities in the State to improve access to care, using IP lines to improve real time interactions between psychiatrists and patients. Three units were set up in Worcester County in conjunction with the grant. Worcester County Health Department Core Service Agency, with funding from the Mental Hygiene Administration, contracted with Sheppard Pratt to provide telepsychiatry services to clients who were homeless with mental illnesses and substance abuse problems. The Worcester County Core Services Agency has since expanded on these services by funding mental health treatment to children and adolescents. Additionally, a population of pregnant and post-partum women at the Center for Clean Start in Salisbury are served under the USDA grant. Sheppard Pratt was also awarded a grant in 2006 by the Health Resources Services Administration (HRSA) to purchase equipment, train providers, and establish a telepsychiatry disaster network at several general hospitals and community mental health clinics in Maryland.

Sheppard Pratt has also completed a telepsychiatry inpatient attending physician demonstration project, one of the first in the country, with a general hospital on the

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Eastern Shore. The general hospital was in need of psychiatric coverage during a time of staff turnover, a common problem for rural general hospitals in Maryland as well as most other states. The hospital funded the professional fees portion of the pilot project as a demonstration of inpatient telepsychiatry utilization. Finally, a twice-monthly mental health grand rounds professional education program is provided via interactive video-conferencing to a number of hospitals and mental health clinics in Maryland.

Correctional Mental Health Services began utilizing telepsychiatry in 2004 at the St. Mary County Detention Center as part of a comprehensive program to provide mental health services to incarcerated individuals. This program currently provides telepsychiatry services at the St. Mary's, Charles, and Wicomico County Detention Centers. Through this program, both live and telepsychiatry services are provided to all sites which utilize telepsychiatry. Additionally, in FY 2010, Sheppard Pratt will begin providing telemedicine services to children and adolescents at the Behavioral Health Clinic, an outpatient facility in Wicomico County.

MHA, in collaboration with CSAs, is now working to develop parameters for telemedicine, including its use to address access issues for remote locations, specialty services, and special needs groups. The Maryland Association of Core Service Agencies (MACSA) applied for grants, (USDA and HRSA) to obtain funding for the purchase of equipment and has partnered in this grantsmanship effort with the Mental Hygiene Administration and the University of Maryland Department of Psychiatry. In May 2008 HRSA approved the grant for telemental health equipment in rural areas. The grant is for three years with a two-year renewal possibility. The University of Maryland Department of Psychiatry has 90 psychiatrists, many board certified, who will implement the telemental health project with Medical Assistance (MA) patients from these rural areas. MHA is providing funding for the psychiatrists services which will eventually be reimbursed by MA. Telemental health has been piloted in 26 other states. [NFC 6]

MHA chairs the mental health subcommittee meetings on telemental health. MHA has also met with Springfield Hospital Center (SHC), along with MHTO, and the University of Maryland to explore the possibility of installing equipment at a SHC unit to implement telemental health services for individuals who are deaf or hard of hearing.

Additionally, MHA partnered with the University of Maryland's Department of Psychiatry to submit a grant application on March 6, 2009, for the federal Health Resources and Services Administration (HRSA) funding in order to develop a Center of Excellence on Telemental health for Special Need Populations. If funded, the Center of Excellence on Telemental Health will improve access to culturally competent services for the deaf and hard of hearing population. In rural communities, MHA's Office of Special Needs Populations in collaboration with Mid-Shore Mental Health Systems and Gallaudet University, will promote a series of trainings, as well as explore the use of the Web to increase cultural awareness and sensitivity to the needs of individuals who are deaf or hard of hearing. This includes application of new communication and technology, i.e. video phone, telepsychiatry, and Web-based training.

Available Services

At present, the range of mental health and support services in rural counties is similar to those that are available in urban and suburban jurisdictions. Some services in contiguous counties are provided by programs that provide services at multiple sites throughout the area served. Mental health providers in rural areas have a history of cooperation and coordination as well as a history of sharing resources, with each other and with other service related agencies, to address the service needs of specific populations. Through this cooperation, providers have developed innovative services that are tailored to the unique needs of their areas. [NFC 3]

The maintenance of effective core service agencies (CSAs) is a key statewide strategy to meet rural needs. The Mid-Shore Mental Health Systems, Inc. (MSMHS) is the CSA responsible for public mental health services in Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties, located on Maryland's Eastern Shore. MSMHS is currently the only regional CSA in Maryland. Of these five MSMHS counties, Queen Anne's County, despite its location in the eastern side of the five mile long Chesapeake Bay Bridge, separating it from the Baltimore Washington metro area was added to the Baltimore-Washington metropolitan region after the 2000 Census. It is no longer considered a rural county.

In its Community Mental Health Fiscal Year 2010 Plan Update, MSMHS discussed the rural nature of counties in the region. Population per square mile ranges from 55.4 persons per square mile in Dorchester County to 130.1 per square mile in Talbot County, with a regional average of 89.9. The Plan emphasizes that in "planning processes to improve the system of care to assure consumer focus and one (system) that is recovery oriented, it is apparent that the unique needs of the rural jurisdictions must be given a priority." "In absence of a number of valuable mental health services that are difficult to replicate in rural communities, the CSA uses the spirit of cooperation to break down barriers to access and choice whenever possible".

In its FY 2010 updated Community Mental Health Plan, the MSMHS reported special initiatives and collaborative efforts targeted towards specific populations which include individuals with mental illnesses who are homeless, dually-diagnosed (mental illness and developmental disabilities), have co-occurring disorders (mental illness and a substance addiction), are deaf or hard of hearing, returning military veterans, transition-age youth and individuals whose mental health needs are coupled with a forensic background.

In FY 2010 updated Plan, the MSMHS reported on the following accomplishments:

- Forensic Mental Health Coordinator: MSMHS has partnered with the Circuit and District Court judges to create two regional positions that will offer the criminal justice system in each jurisdiction an opportunity to provide consumers with mental illnesses voluntary, community-based assessment and treatment

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- alternatives to traditional methods of criminal behavior punishment through: 1) access to a licensed mental health professional who understands systems management and resources in the region and can recommend and monitor those alternatives which improve outcomes to people historically poorly-served by detention centers. Monitoring of offenders in court ordered evaluation, recommendations regarding community-based treatment, and facilitation of ongoing communication and collaboration where criminal justice, mental health, substance abuse, and related systems intersect. (This new initiative is supported by a reallocation of community mental health block grant resources. Success will be measured by the program's ability to lead individuals to effective community treatment and break the cycle of recidivism in the courts and detention facilities.)
- Telepsychiatry Network Program: This new program puts tele-video equipment in clinics and other provider locales in seven rural Maryland counties; including all five on the Mid-Shore. These rural sites will be able to: link to psychiatric specialists identified as not present in the region or operating with excessive waiting lists due to a chronic supply/demand imbalance in rural communities. Service commenced during December 2008, and will continue for two and a half years.
 - MSMHS has taken the role of the lead agency for the HUD Continuum of Care (CoC), and was successful in the development of 35 Shelter Plus Care permanent housing units, 17 permanent supportive housing units, and a regional Homeless Management Information System. Increased availability of affordable housing/homeless shelters was one of three prioritized regional needs identified by stakeholders. The CoC has engaged three faith-based groups that have volunteered to operate shelters in the region. **[NFC 3]**
 - MSMHS and its providers promote a long-term recovery model for consumers with serious mental illness (SMI) and have developed outcome measures for PMHS community – based services. MSMHS collaborated with local providers to develop outcome measures for contractually funded services, as well as for selected services within the fee-for-service system, including adult psychiatric rehabilitation programs, residential rehabilitation programs, and supported employment.
 - MSMHS continues to participate on the Governor's Office of Deaf and Hard of Hearing Mental Health sub-committee, supporting the development of a statewide needs assessment and inventory of mental health services available to individuals who are deaf or hard of hearing and will develop a state proposal to include recruitment and training of culturally competent mental health professionals. Many representatives are active on the local and state mental health advisory council.
 - Chesapeake Rural Network (the region's peer support network) has been developing stability, resulting in an improved operations plan that will benefit all consumers in the region.

After several years of moderate expansion, Somerset County CSA (SCCSA) has worked to maintain the array and number of services available. As the second smallest county in the state, Somerset County's population actually increased slightly by 242 individuals after a decline in the previous year, according to the July 1, 2007 DHMH

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Vital Statistics estimates. Somerset County has only seen a 5.6% growth in population in the past 10 years, with little of that growth in recent years, and has one of the lowest median income rates in the state. These factors make it important to avoid duplication of effort and to acknowledge the need for collaboration with both in-county and tri-county (Somerset, Worcester, and Wicomico) stakeholders on planning, service expansion, and coordination of activities and efforts. The Tri-County Provider Forum continues to meet to discuss issues regarding the PMHS and to increase provider knowledge.

In the FY 2010-FY2011 Plan, the Somerset County Core Service Agency reported on the following accomplishments:

- Collaborated with Department of Human Resources to implement regional Mental Health Mobile Crises and Stabilization Services to Department of Social Services (DSS) foster care involved youth and families in the three lower counties of Somerset, Wicomico, and Worcester.
- Partnered with the Family Services Division of the Circuit Court to update and re-distribute the county resource guide;
- Support increased participation in Lower Shore Friends developing plans in FY 2009 to implement the Wellness and Recovery Action Plan (WRAP);
- Participated in the statewide effort to launch a mental health and human services Website called Network of Care (NOC) to assist individuals, families, and agencies concerned with behavioral health;
- Continued to coordinate the Somerset County Adult Multi-disciplinary Team;
- Continued working in partnership with the two other CSAs on the lower shore and received a HUD grant to provide housing in the tri-county region to address permanent housing; and
- Partnered with Seton Center, a local affiliate of Catholic Charities, to provide mental health educational information in the Spanish language. [NFC 3]

The Fiscal Year 2010-11 Plan for the Garrett County Core Service Agency (GCCSA) included recent accomplishments. Highlights included:

- Extensive collaboration and partnerships to improve services to children, youth, and adults in areas related to school mental health, peer support, addictions services, trauma and jail services, suicide prevention, and disaster planning.
- A statewide initiative for service coordination for veterans began in FY 2009. Two outpatient mental health programs in Garrett County have participated and the Western Region Resources Coordinator presented information to the community on the program at the Local Mental Health Advisory Committee (LMHAC) meeting.
- GCCSA continued the Adventure Sports Institute (ASI) of Garrett College, which operates the Transition-Age Youth (TAY) project. TAY graduates now act as mentors to incoming TAY participants. The Garrett County Commissioners and Garrett College have agreed to provide support for the third year of this successful project.

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- Consumer-run Wellness and Recovery Center (Harvey House) will have hours of operation expanded during FY 2010.
- Garrett County Sunrise Support Group for Survivors of Suicide will continue to meet with the GCCSA providing assistance and public awareness activities
- The Federally Qualified Health Center (FQHC) provided access to primary health care services on property adjacent to the Garrett County Health Department. There was a 6.5% increase for persons served in the outpatient mental health clinic (OMHC) from 2007 to 2008. The plan notes that part of the OMHC increases resulted from more children 6-12 (one of the identified targeted population) being served.

The following table provides an overview of the six rural counties and the major programs available. Not included in the table is the broad array of individual providers in these rural communities.

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CONTINUUM OF MENTAL HEALTH SERVICES	Mid-Shore Mental Health Systems	Somerset County CSA	Garrett County CSA
Advocacy- Adult and Child	X	X	X
Community Support Funds(pharmacy, lab, transportation, other needs)	X	X	X
Detention-Based Mental Health Services	X	X	X
Inpatient Services Adult Adolescents Child	X X X	X (youth and family services in Crisfield)	Emergency Room only
Intensive Outpatient Services	X		X
Intensive In-Home Services	X	X	X
Outpatient Mental Health Adult Child and Adolescent	X X	X X	X X
Peer Support Services	X	X	X
Psychiatric Rehabilitation Program Adult Child and Adolescent	X X	X X	X X
Respite Care Adult Child	X X	X X	X
Supported Employment Services	X	X	X
Transition Age Youth Programs	X	Go-Getters provided six residential slots	X
Targeted Case Management Adult Child and Adolescent	X X	X X	X

Service Needs

In order to best assess local service needs and implement services to meet those needs, MHA strongly supported the development of CSAs in rural counties. As noted previously, all rural counties in Maryland are served by CSAs. The rural CSAs are challenged to plan, both independently and collectively, for their residents' needs and the most efficacious use of resources. All CSAs are required to include a description of their needs assessment process and findings, including gaps in services, in their local mental health planning documents. The consistent and recurring service needs identified are: adequate number and mix of providers, need for specialty service providers, transportation, crisis treatment services, and efforts to address the needs of individuals with co-occurring disorders.

One of the major challenges for a rural area is the recruitment, retention, and ongoing training of mental health professionals. The number of qualified professionals in the Mid - Shore area has increased over time and this may be attributed to the growing nature of some of the Mid-Shore counties. Conversely, in its FY 2009 Plan Update, the Garrett County Core Service Agency reports that there is only 1.6 full-time equivalent of psychiatrist time available in the county. The need for psychiatric care for the child and adolescent population is acute. Garrett County and Kent County (as well as a number of very urban census tracts in Baltimore City with special needs related to the homeless population) are designated by the federal Department of Health and Human Services, Bureau of Primary Health Care as mental health professional shortage areas (MHPSA). MHPSA designation may provide needed assistance in the recruitment of physicians.

In FY 2010-11 Plan, the Somerset County Core Service Agency identifies the development of services in rural areas as presenting multiple challenges. Accessing services is difficult, especially with limited transportation services. Available resources are scarce compared to urban areas. There are severe shortages of specialized mental health professionals and providers. Additionally, stigma continues to be an issue.

Like many rural areas, Somerset County providers are having problems attracting and keeping behavioral health professionals, particularly psychiatrists and therapists. Additionally, psychiatrist availability can be limited. One clinic in Somerset County closed new intakes for approximately one year due to having limited psychiatrist time. In the FY 2010-2011 Plan, the Somerset County Core Service Agency identified the following areas of need to continue to address:

- Maintaining collaborative initiatives locally, regionally and statewide;
- Increasing awareness and public knowledge about mental illness and mental health resources;
- Developing strategies that address ending chronic homelessness among individuals with mental illnesses;
- Addressing the need for integrated services for individuals with mental illnesses, substance abuse, and developmental delays; and

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- Developing and implementing outcomes management objectives for all contractual obligations.

CSAs, in both rural Western Maryland and rural Eastern Shore, have identified the need to travel to adjacent counties for some services as a significant rural issue. Transportation to and from services has been a barrier not only for appointments but for consumers attempting employment and increasing involvement in their local communities. Due to the lower population density and greater distances to all types of services, rural mental health programs have acquired and operate vehicles to link individuals to services, both through mobile services and by transporting consumers to needed services. Local health departments and community action agencies also provide some publicly-supported transportation in rural counties. Additionally, CSAs have some funding in their budgets for transportation services for eligible individuals. Stigma also plays a significant role as a barrier to accessing mental health services, particularly in rural settings. The CSAs on the Eastern Shore and Lower Shore Counties work collaboratively with stakeholders to address stigma through workshops and public awareness activities.

In Mid-Shore Mental Health Systems, Inc.'s (MSMHS's) Community Mental Health Plan for Fiscal Year 2009 and 2010, a good discussion is provided of the local needs assessment process and results. The Plan discusses disproportionate representation of ethnic groups in the lower income range and the impact of the search for affordable housing as suburban counties see rapid increases in housing costs. In a chart designed to show the Mid-Shore region's continuum of care for public mental health, clear gaps in crisis services are shown. (A same day appointment service has been successfully used as a stop-gap measure.) Also the plan identifies another critical gap with regard to jail mental health delivery in the region's detention centers.

MSMHS, in collaboration with other community programs, recognizes the need for mental health services for Hispanic consumers that are uninsured. The Mid-Shore Council on Family Violence has two bilingual client advocates. For All Seasons, an OMHC, applied for a grant to obtain funding for a bilingual interpreter and MSMHS will provide the cost of the therapist, and limited psychiatrist time. **[NFC 3]**

The Garrett County Core Serve Agency's (GCCSA's) 2010-2011 Mental Health Plan focuses on solidifying and enhancing existing programs. Efforts will focus on:

- Coordination and collaboration with consumers, family members, providers and other county and state stakeholders to assure accessibility to quality mental health services;
- Implementation of Telepsychiatry services at the Garrett County Community Mental Health Center to improve consumer access to skilled mental health professionals;
- Strengthening the consumer-run center and fostering a more cohesive consumer movement for quality-based mental health services;
- Expansion of geriatric mental health services;

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- Development of a continuum of community- based housing services for individuals who have severe mental illness;
- Continuation of suicide prevention activities;
- Ongoing development of services for the co-occurring population;
- Identification of funds and programs which are targeted to increasing evidence-based practices mental health services for children and adolescents and their families;
- More supported employment opportunities/work sites for those individuals who want to work;
- Increased availability of child psychiatry services- the health department hired a part-time psychiatrist leading to a decrease in the wait time for initial medication evaluation appointment for new mental health consumers; and
- Continued availability of outpatient and psychiatric rehabilitation program providers - in March 2009 the Mental Health Center of Western Maryland, which had been providing outpatient mental health and psychiatric rehabilitation program services to children, adolescents, and adults, closed.

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SFY 2010 OBJECTIVES FOR CRITERION 4:

SERVICES FOR CHILDREN AND ADOLESCENTS

TARGETED SERVICES FOR RURAL POPULATIONS

- In collaboration with the CSAs, improve implementation and provide training for consumers at the county-level on Network of Care, a Web-based platform, which provides information, resource directories, and on-line availability of personal health record information, including advance directives.
MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis
- Collaborate with the Maryland Advisory Council for the Deaf and Hard of Hearing, the Governor's Office of Deaf and Hard of Hearing (ODHH), CSAs, advocates, other state and local agencies, and colleges and universities to provide support and technical assistance to promote statewide access to services that are culturally competent for individuals who are deaf or hard of hearing, which includes application of new communication and technology, i.e. video phone, telepsychiatry, and Web-based training.
MHA Monitor: Marian Bland, MHA Office of Special Needs Population
- Promote use of Web-based resources to educate the public and extend and improve training resources for consumers, family members, mental health professionals, and other stakeholders.
MHA Monitor: Carole Frank, MHA Office of Planning, Evaluation, and Training

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CHILDRENS PLAN CRITERION #4

TARGETED SERVICES TO THE HOMELESS

The exact number of children and youth in Maryland who are homeless and who have mental health problems is unknown. MHA has been participating in the efforts of the Maryland Department of Human Resources (DHR) and local communities to implement the Homeless Management Information System statewide. All of the Maryland counties have established a system and most of the counties have trained shelters' staff and providers on utilizing the Homeless Management Information System. Some counties are still working to resolve issues regarding providers' resistance to using the Homeless Management Information System due to concerns about client confidentiality. Data are not broken out by age as a part of the survey. Efforts are also underway to develop a statewide data warehouse so that local homeless data may be accessed at the state level. [NFC 6]

DHR gathers and reports information only on people who have stayed in emergency shelters, transitional housing programs or who have received emergency motel placements. The data reflects the extent of shelter services provided to people who are homeless as reported by emergency shelter and transitional housing providers on a Homelessness Services Survey form. The data in DHR's report does not include an absolute count of the number of homeless people in Maryland.

DHR's FY 2008 Annual Homeless Report is unavailable at this time; therefore, MHA is using data from DHR's FY 2007 Annual Homelessness Report. Based on this report, there were 36,599 persons served in Maryland's homeless shelters in FY 2007, which represents a decrease - 834 less people served than in the prior year. There were 23,986 people served in emergency shelters, 7,248 served in transitional housing, 5,383 served through motel placements.

Another source of data that is available is Maryland's 2006 Homeless Assistance Programs Point in Time Survey which estimates 4,569 individual and family households were served in emergency or transitional housing, and 1,755 households were unsheltered. In terms of persons homeless, the Department of Housing and Urban Development (HUD) 2006 Continuum of Care (COC) estimates 6,656 persons in individual or family households were residing in emergency or transitional housing and 2,041 unsheltered persons were homeless. Also based on HUD COC Point in Time Survey in Maryland, there are 8,697 persons who are homeless. Of this number 30.7% are unsheltered and 21.1% have a serious mental illness.

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SSI/SSDI Outreach, Access, and Recovery (SOAR). Individuals who are homeless can benefit from Medicaid enrollment to obtain needed services. In FY 2010, MHA has a strategy to utilize an increase in PATH funding to provide support to hire a SSI/SSDI Outreach, Access, and Recovery (SOAR) outreach coordinator to re-launch the pilot initiative in Baltimore City and Prince George's County. Outreach coordinators will work with case managers in these jurisdictions to assist 105 consumers with applying for SSI/SSDI benefits through the SOAR process.

Services for Runaway and Homeless Youth. The unmet needs of youth that are homeless are extensive, particularly the needs of the runaway and homeless adolescents with serious emotional disturbance. A special project, for runaway and homeless youth, continues in Ocean City, Maryland, the state's major beach resort area. Located in Worcester County on the Eastern Shore, Ocean City increases from a relatively small year round resident community to a population of close to 400,000 in the summer, often more on weekends. Many runaway and homeless youth frequent the resort, some experiencing serious psychiatric disorders and many involved in drug and alcohol abuse in the party atmosphere of the beach. The agencies in the community have formed a successful collaborative consortium to coordinate shelter, primary health, substance abuse, mental health, and other human services for this population. The project serves youth from all areas of the rest of the Maryland and large numbers of youth from other surrounding states in the region. Federal community mental health block grant funds have been allocated for mobile crisis services in Worcester County. This project is intensively staffed. [NFC 5]

Services for Children in Homeless Families. MHA has funded and provided technical assistance to a project for young children who are homeless because their mothers and other family members live in family shelters throughout Baltimore City. The Parents and Children Together (PACT) program provides a therapeutic nursery at the YWCA shelter in Baltimore City, and extensive consultation at The Ark, a day care program that serves many of the children who reside in family shelters across the entire city. This population is reported to experience significant developmental delays, particularly in language acquisition.

Children and adolescents with serious emotional disturbance in families that are homeless can access Maryland's Projects for Assistance in Transition from Homelessness (PATH) and Shelter Plus Care programs for services. PATH funds are used for outreach, engagement, case management, screening and diagnostic services, consultation to shelters, training, housing assistance, supportive services in residential settings, and mental health and substance abuse services. PATH funded case managers are located in shelters, detention centers, and service agencies, facilitating outreach and access to services in a timely manner. PATH provides outreach and access in urban, suburban, and all rural areas in Maryland. These services also link individuals and families to the fee-for-service system. The PATH Program is targeted to homeless consumers who have serious mental illnesses or co-occurring substance use disorders, who are disconnected from the community and lack the necessary supports to obtain permanent housing.

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The PATH program provided services in 22 of 23 counties and Baltimore City in FY 2009. In FY 2008, the funding level was \$1,052,000. Local PATH supported agencies identified 3,847 homeless individuals with mental illnesses. Of these, 2,082 actually enrolled for PATH services. In FY 2009, the PATH funding level was decreased to \$1,032,000 due federal cuts in the PATH Program. The \$20,000 shortfall in FY 2009 was taken from Baltimore City's PATH award. In FY 2010, PATH was increased by \$140,000 which will fund SOAR Outreach Specialists in Baltimore City and Prince George's County. In FY 2010, PATH will be funded at \$1,172,000. PATH programs are projected to serve an estimated 2,238 individuals and families in FY 2010.

The following table presents a summary of the most current PATH program information:

SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2010 FUNDING	PROJ. # SERVD. SFY 2010	SERVICES PROVIDED UNDER PATH
Allegany County	Allegany County Mental Health Systems	\$54,955	40	ALLEGANY COUNTY MENTAL HEALTH SYSTEMS - Community outreach, case management, staff training, housing assistance, supportive services, referrals to primary health services, job training, educational and relevant housing.
Baltimore City	BMHS Baltimore Mental Health Systems, Inc.	\$268,856	340	BALTIMORE MENTAL HEALTH SYSTEMS-Position funded in BMHS to provide technical assistance in locating and developing affordable housing, room and board training, registry of house resources.
				UNIVERSITY OF MARYLAND MEDICAL SYSTEMS- SSI outreach, linkage to services and housing, case management, liaison to homeless outreach teams, outreach assessment.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2010 FUNDING	PROJ. # SERVD. SFY 2010	SERVICES PROVIDED UNDER PATH
				<p>HEALTH CARE FOR THE HOMELESS-Street outreach, SSI Presumptive Eligibility Project, mental health and addictions treatment, and case management. SOAR Outreach Specialist to develop and maintain relationships necessary to achieve more rapid SSI/SSDI application approvals, including relationships with SOAR partners, Disability Determination Services, Social Security Administration, Policy Research Associates, Mental Hygiene Administration and others. Provide technical assistance to case managers and other SOAR trained providers with outreach to homeless individuals and completing SSI/SSDI applications for benefits.</p>
				<p>PRISONER'S AID ASSOCIATION-Outreach, case management, linking women who have a history of mental illness and trauma to services and housing</p> <p>CHRYSALIS HOUSE HEALTHY START PROGRAM - 16 bed diagnostic and transitional facility for pregnant and post-partum women and their babies. The participants will be women who are incarcerated in local detention centers and have misdemeanor charges. Comprehensive assessment, outreach assessment, housing assistance, case management, access to appropriate treatment resources and services will be provided.</p> <p>STATEWIDE TRAINING</p>

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2010 FUNDING	PROJ. # SERVD. SFY 2010	SERVICES PROVIDED UNDER PATH
Baltimore County	Dept. of Health Bureau of Mental Health CSA	\$96,200	150	PROLOGUE, INC. – Outreach, screening and diagnostic services, training, case management, housing coordination and matching, security deposits, one-time rentals (eviction prevention), support and supervision in residential settings, staff training.
Calvert County	Calvert County CSA	\$30,380	120	CALVERT COUNTY MENTAL HEALTH CLINIC Outreach, screening, case management relevant housing services, referrals for primary health, community mental health services, substance abuse treatment, job training programs, educational services.
Carroll County	Carroll County CSA	\$37,000	50	KEYSTONE SERV.OF MD – Outreach, intensive case management, screening and diagnostic, assistance with linking to housing and services linking to training, support in residential settings.
Cecil County	Cecil Co CSA	\$5,000	8	CECIL COUNTY CORE SERVICE AGENCY -One - time only rental assistance, security deposits and training, contract with outreach and case management services.
Charles County	Charles County CSA	\$35,000	75	SOUTHERN MARYLAND DIVISION OF CATHOLIC COMMUNITY SERVICES – Outreach, referral to intensive case management, mental health, linkage to mental health services, screening and diagnostic treatment, assistance in planning for housing, technical assistance with housing, referrals to alcohol and drug treatment, medical care, pharmacy assistance, job training, educational legal assistance, and assistance with security deposits.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2010 FUNDING	PROJ. # SERVD. SFY 2010	SERVICES PROVIDED UNDER PATH
Frederick County	Frederick County CSA	\$77,400	300	FREDERICK COMMUNITY ACTION AGENCY – Outreach, case management, referrals for health care, job training, alcohol and substance abuse treatment, transportation, housing coordination, supportive and supervisory services, and the development of Med bank services to link PATH clients to free prescription medications made available through patient assistance programs.
Garrett County	Garrett County CSA.	\$24,500	27	GARRETT COUNTY CSA. - Screening, housing coordination, security deposits, one - time only rental assistance linkage to permanent housing, and referrals for mental health and other services.
Harford County	Harford Co CSA	\$71,524	95	CORE SERVICE AGENCY IN COLLABORATION WITH ALLIANCE, INC. – Outreach, case management, linkage to housing, assessments, and referrals, substance abuse and assertive treatment services, services to prevent re-incarceration and improve access to services upon release from incarceration.
Howard County	Howard County CSA	\$35,478	30	GRASS ROOTS CRISIS INTERVENTION CENTER – Case management, psychiatric services, referral, housing assistance, assistance with entitlements.
Mid-Shore (Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties)	Mid-Shore Mental Health Systems, Inc.	\$52,624	80	MIDSHORE MENTAL HEALTH SYSTEMS, INC. – Contracts with vendors to provide homeless outreach to all five counties, assessments, housing security deposits assistance, case management, conduct needs assessment, one - time only rental payments.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2010 FUNDING	PROJ. # SERVD. SFY 2010	SERVICES PROVIDED UNDER PATH
Montgomery County	Montgomery County CSA	\$115,588	300	MONTGOMERY COUNTY DETENTION CENTER- Outreach, engagement, linkage to mental health and co-occurring treatment services, case management, and housing assistance.
				VOLUNTEERS OF AMERICA- Outreach on streets, at emergency shelters, day programs, soup kitchens and to those on the psychiatric crisis intervention unit, case management and linkages to entitlements and services.
Prince George's County	Department of Family Services, Mental Health Authority Division	\$119,264	85	QUALITY CARE INTERNET BEHAVIORAL HEALTH – Outreach, screening, assessment, case management, supportive services in residential settings, housing assistance, referrals to mental health services, medical, housing, rehabilitation, and vocational training, one-time only rental assistance and security deposits. Prince George's County Department of Social Services or selected vendor will target Thirty (30) individuals and assist them with completing SSI/SSDI applications based on technical assistance and training provided by SOAR Outreach Specialist.
Somerset County	Somerset County CSA	\$10,000	8	SOMERSET COUNTY CORE SERVICE AGENCY-Outreach, housing services, i.e. one-time only rental assistance to prevent eviction, security deposits, planning of housing, and minor renovations to existing housing.
St. Mary's County	St. Mary's Department of Human Services	\$45,950	120	DETENTION CENTER MENTAL HEALTH - to serve homeless, detention center inmates with mental illness, screening, assessment, linkage to community resources. Two hours per week of telepsychiatry in a mental health clinic to assist with aftercare planning.
				THREE OAKS SHELTER – Outreach and case management services and aftercare which includes housing are its goals.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2010 FUNDING	PROJ. # SERVD. SFY 2010	SERVICES PROVIDED UNDER PATH
Washington County	Washington County CSA	\$37,000	320	TURNING POINT – Case management outreach, job training, supportive and supervisory services, screening and diagnostic services. 2 positions: homeless outreach worker and outreach assistance.
Wicomico County	Wicomico County CSA	\$22,000	40	WICOMICO COUNTY CSA- Assessment, service planning, linkage to mental health, housing, medical, employment, outreach, and case management.
Worcester County	Worcester County CSA	\$33,281	50	HEALTH DEPARTMENT – MENTAL HEALTH PROGRAM – Mobile assessments, assertive outreach, training one - time only rental payments, security deposits, minor renovation, expansion and repair of homes, mental health and case management.
TOTAL Maryland	23 Jurisdictions	\$1,172,000	2,238*	

In previous years, data on the number of persons served included those served through outreach and those receiving ongoing PATH services. Due to changes in definition, PATH consumers who are engaged through outreach are no longer included in the number of persons to be served. PATH providers are currently counting only those who are considered enrolled (client file opened and service plan developed) as the number served in FY 2009.

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Additional grants have also been used to support needed services. PATH supported services are linked with Shelter Plus Care, which provides tenant-based or sponsor-based rental assistance. MHA has adopted a strategy to target individuals for Shelter Plus Care who are homeless and being discharged from detention centers. However, several of the small Shelter Plus Care grants target those without criminal justice involvement. The success of the program is measured not only by enhancement in the quality of life to consumers but also by the reduction in readmission to detention centers and hospitals or the return to homelessness. During the past several years, recidivism across the system has been limited to 3 % - 7% to jails, 1% to hospitals, and 1% to homelessness. (Data does not include Baltimore City).

In 1995, the U.S. Department of Housing and Urban Development (HUD) first awarded MHA a five-year, \$5.5 million Shelter Plus Care grant to provide housing for individuals who are homeless with serious mental illnesses and their dependents who are being released from the detention center, or are in the community on intensive caseloads of parole and probation. Last year, the FY 2009 Shelter Plus Care Housing grant was renewed for \$3,862,442. The renewal grant was increased largely due to increases in the Fair Market Rental Values determined by HUD. Additionally, in FY 2009 MHA received \$592,916 through five small grants targeted to specific jurisdictions. The jurisdictions awarded new five-year grants over the past years through MHA included Allegany, Anne Arundel, Baltimore, Cecil, Frederick, Harford, and Prince George's counties. [NFC 2]

For FY 2010, MHA was awarded funding in the total amount of \$3,306,900 for 16 Shelter Plus Care renewal grants. Additionally in FY 2010, MHA received \$513,678 through five small grants targeted to the specific jurisdictions as mentioned. Currently, MHA is serving a total of 653 persons, 147 single individuals with mental illness, 172 families with 281 children and 53 other family members through all of the Shelter Plus Care grant programs.

Since 1995, the process for applying for funding through the U.S. Department of Housing and Urban Development (HUD) has changed. In 1996, HUD introduced to communities the Continuum of Care model to strategically address the problems of housing and homelessness in a more coordinated and comprehensive fashion. The model required local communities to develop a strategic plan to address the use of HUD resources and this also became the application process for obtaining HUD funding. As a result of this change, MHA lost its ability to directly apply for Shelter Plus Care Housing grant funds to HUD and to apply for funding using a single statewide application. The new process requires MHA and other state and local entities to apply for funding through the local Continuum of Care Planning group. In FY 2009, MHA submitted 16 renewal grants to thirteen Continuum of Care Planning groups as a part of their application for HUD funding. Each local Continuum of Care of Plan must incorporate MHA's Shelter Plus Care application into its local plan annually.

Advocates for the homeless and for housing for people with disabilities in Maryland have expressed concern with proposed changes in the Housing Choice Voucher

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Program. If fewer vouchers are available for individuals with disabilities, then it will be more difficult to advance consumers from Shelter Plus Care to other housing choice programs.

Individuals who are homeless are also served by traditional mental health treatment and support programs, including existing psychiatric rehabilitation programs, case management entities, crisis service providers, and mobile and on-site clinic services. In addition, outreach and eviction prevention services, as well as coordination with needed mental health services are provided to homeless individuals. In Baltimore City, Baltimore Mental Health Systems, Inc. obtained grant funds to provide case management and other services for homeless individuals with mental illnesses. State general funds and mental health block grant funds support additional services and programs for the homeless population.

People Encouraging People, a mental health provider and long a leader in mental health services and outreach to the homeless in Baltimore City, was awarded \$400,000 per year for five years to create a comprehensive dual diagnosis treatment program for persons who are homeless and have substance abuse and mental health problems in June 2005. During the last reporting period, January 1, 2009- March 31, 2009, 69 clients were engaged for services. Ten (10) clients consented to receive case management or intensive outpatient services and participate in a COD evaluation for medication and psychosocial assessment. Sixty-seven (67%) were housed within 60 days of initial agreement to receive services and 100% of consumers remained housed for 180 days. Twenty-seven (27%) of consumers not already receiving Temporary Cash Assistance (TCA) receive Transitional Emergency, Medical, and Housing Assistance (TEHMA), food stamps or other accessed benefits.

MHA provides state general funds to support statewide training for mental health providers, which includes providers of PATH services. In addition a portion of Baltimore Mental Health Systems PATH funding is targeted for statewide training for PATH providers and/or to send providers to national, state, and local trainings to enhance skills of staff delivering services to PATH eligible clients. Additionally, MHA has quarterly meetings with PATH providers to discuss clinical and programmatic issues and to provide an opportunity for information sharing between local providers. The following trainings or conferences were held in FY 2009:

- MHA's Office of Special Needs Populations in partnership with MHA's Office of Adult Services and the University of Maryland Mental Health Training Center had a two-day training on Motivational Interviewing for case managers and PATH providers that empowered them to address client motivation by "meeting the client where they are", reducing unrealistic expectations, strengthening and consolidating the client's commitment to change. A total of 25 people attended the training.
- MHA's Office of Special Needs Populations was also involved in the planning for MHA's Adult Services Annual Case Management Conference titled "A Stimulus Package for Case Management." The Director of Shelter Plus Care and PATH

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Programs presented along with a PATH provider a workshop entitled “Moving Individuals Along the Continuum of Care to Housing.” A total of 60 people attended the workshop and the overall attendance at the conference was 270.

- MHA’s Office of Special Needs Populations assumed leadership of the state’s SOAR initiative in April 2008 and MHA, over the past year, has provided technical assistance to two pilot sites (Baltimore City and Prince George’s County). In addition, MHA has met with Anne Arundel County, Baltimore County and Montgomery County to implement a SOAR initiative in their local jurisdictions. MHA’s Office of Special Needs Populations will continue to meet with other jurisdictions to expand SOAR statewide during FY 2010.
- Technical assistance and “Train the Trainer” activities on SOAR implementation was provided to the Maryland Department of Public Safety and Correctional Services Social Workers and to mental health case managers/benefits specialists. This training effort will continue in FY 2010.

In FY 2009 MHA continued to meet on a quarterly basis with community service providers that receive PATH funds. MHA staff also attends the Continuum of Care Planning group meetings on a regular basis. Since December 2004, MHA has been participating in the development of the state’s Interagency Council on Homelessness Ten-year Plan to End Homelessness in Maryland. This planning committee is chaired by the Department of Human Resources (DHR) and co-chaired by DHMH. MHA also participated on the State's SSI/SSDI, Outreach, Access and Recovery Technical Assistance Initiative, and work group which-provides training to case managers working with individuals who are homeless on strategies to expedite processing of SSI/SSDI applications. Additionally, MHA collaborates with other agencies and departments that provide services or have resources to meet the needs of individuals who are homeless with psychiatric disorders, including DHR, the Department of Housing and Community Development, the Department of Housing and Urban Development, the Department of Public Safety and Correctional Services, and the Department of Economic and Employment Development. Within DHMH itself, MHA collaborates with the Alcohol and Drug Abuse Administration, Family Health Administration, Medical Care Policy Administration, and the AIDS Administration. MHA encourages and provides technical assistance on request to encourage similar interaction at the local level to facilitate effective service provision for homeless individuals of all ages with psychiatric disorders.

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SFY 2010 OBJECTIVES FOR CRITERION 4:

SERVICES FOR CHILDREN AND ADULTS

TARGETED SERVICES TO THE HOMELESS

- Utilize increase in Projects for Assistance in Transition from Homelessness (PATH) funding to provide support to hire a SSI/SSDI Outreach, Access, and Recovery (SOAR) Outreach Coordinator to re-launch the pilot initiative in Baltimore City and Prince George's County and expand SOAR regionally.
MHA Monitor: Marian Bland, and Keenan Jones, MHA Office of Special Needs Populations
- Continue to provide funding for rental assistance to CSAs through the Shelter Plus Care grants from the federal Department of Housing and Urban Development (HUD).
MHA Monitor: Marian Bland, and Keenan Jones, MHA Office of Special Needs Populations

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ADULT & CHILD PLAN

CRITERION #5: Management Systems

This Criterion applies to both adult and children and adolescents. It is not duplicated in the Child Plan section.