

# Achieving Wellness Together

**Annual Report • Fiscal Year 2010**  
**With Selected Highlights from 2009**

Maryland Mental Hygiene Administration



*Martin O'Malley, Governor*

*Anthony G. Brown, Lieutenant Governor*

*Joshua M. Sharfstein, M.D., Secretary, Department of Health and Mental Hygiene*

*Renata J. Henry, Deputy Secretary, DHMH, Behavioral Health and Disabilities*

*Brian Hepburn, M.D., Executive Director, Mental Hygiene Administration*

# Tonier's Story of Recovery

I'm a forty-three year old African-American mental health consumer who has been in and out of prison multiple times. I have been in so many substance abuse programs, I can't even name them all. No matter where I was, I was always treated like a hopeless case. All they could see was the way I looked or react to the way I smelled. No one ever asked, "What happened to you?" It was always, "What's wrong with you?"

I was told that I would spend the rest of my life in prison or die in the streets like a stray dog.

Now after 19 years of drug addiction, alcoholism, homelessness, incarceration (I was arrested 83 times and convicted 66 times), living in mental institutions and undergoing substance abuse programs, I finally feel safe, I feel free, I feel hope!

This is my story:

As a young child I created a belief system that I was nothing and that I would never amount to anything.

I thought the men that my mother entertained, who would end up touching and hurting me, did it because something was wrong with me and I deserved it. I thought that my mother abused me and didn't love me because I was a bad child. I thought my eight brothers and sisters needed me to protect them. I had to keep the men from hurting them, like they hurt me; I only wished my mother loved me enough to protect me.

During those long years, I tried to get help. Every time I went into the jail or prison, I asked for help, but I was told, "This is a jail, not rehab."

When I would leave they would say "See you when you come back, we will hold your cell for you." No one ever said, "I hope you make it this time."

When I was admitted to the Mental Health Unit, I was told that I had several diagnoses and I would always ask "How do you know, I've been smoking crack for seven days, and you can't do an evaluation with crack in your system."

***"I was told that I would spend the rest of my life in prison or die in the streets like a stray dog."***

I went to many substance abuse programs. In one of them, I was raped by a counselor. Others used the "tear down and build back up" model for substance abuse, but I was broken down enough already and that didn't work.

I am a victim of neglect and abandonment, and many times I was put into seclusion. I can tell you, one of the worst things you can do to someone that suffers from neglect and abandonment, is to put them in an isolated room, padded or not. When that door shuts, the flashbacks of my mother's abuse begin, so when that nice tray of food would come, I'd be so upset I

***"No one ever asked, 'What happened to you?' It was always, 'What's wrong with you?'"***

### Mission

**T**he Department of Health and Mental Hygiene's Office of Behavioral Health and Disabilities will develop an integrated process for planning, policy, and services to ensure a coordinated quality system of care is available to individuals with behavioral health conditions and developmental disabilities. The Mental Hygiene Administration will, through publicly funded services and supports, promote recovery, resiliency, and health for individuals who have emotional or psychiatric disorders.

### Vision

**T**he vision of our public mental health system is drawn from fundamental core commitments:

- Coordinated, quality system of care
- A full range of services available
- Seamless linkages to services for the consumer delivered through a system of integrated care
- Recognition that co-occurring and co-morbid conditions are the norm
- Focus on treatment, behavioral health, support, recovery, and resilience
- Services developed in collaboration with culturally competent stakeholders in an environment that is culturally sensitive
- Improved health, wellness, and quality of life for consumers

### Our Partners

**M**HA's mission could not be accomplished without its partnerships with consumers, families, youth, advocates, academic institutions, and federal, state and local agencies.

# Letter from the Deputy Secretary



One of the many pleasures I have as Deputy Secretary for Behavioral Health and Disabilities is the opportunity to review the wonderful work done by those who work in this arena. A great example can be found in the following pages of this annual report. While you read about the work conducted by the Mental Hygiene Administration and its partners, please remember that it reflects only a portion of the effort put forth by this administration.

While I am extremely pleased with all of the activities chronicled in this report, I am even more excited about the activities occurring within Behavioral Health and Disabilities at DHMH.

We are moving forward with implementation of health care reform, an initiative which holds great promise for extending insurance coverage to uninsured people, including those with mental illness. Yet in order to be consistent with health care reform, we need to do a better job of integrating mental health and substance abuse services – and ensuring that somatic medical care is a part of the equation. This “treat the whole person” philosophy is a key recommendation of the Maryland Health Care Reform Coordinating Council and is one that will ultimately result in a better life for Maryland’s consumers.

In addition, there needs to be a review of how services are funded to capitalize on new opportunities for federal funding, including Medicaid coverage for health home services and the demonstration program for emergency psychiatric stabilization services for non-aged adults delivered through private psychiatric hospitals.

There is going to be an increased demand for behavioral health services, yet only limited opportunities in the short-term for increasing the behavioral health work force. Some of the demand may be accommodated by increased use of health information technology and changing from fee-for-service reimbursement of face-to-face services to more creative ways of providing and funding services.

One cutting-edge initiative that merits mention is Mental Health First Aid® (MHFA). Maryland was the first state to introduce this Australian-based concept to the United States. Through a collaborative effort between MHA, the Missouri Department of Mental Health and the National Council for Behavioral Healthcare, the Australian protocol was adapted for use in this country. The MHFA Manual and Instructor Teaching Notes were published in October 2009 and are now available in print for a nominal fee through funding provided by the Substance Abuse and Mental Health Services Administration and the three U.S. partners. More than 18,000 copies of the manual and 500 instructor teaching kits have been produced and distributed nationally.

Today, MHA, in collaboration with the Mental Health Association of Maryland and On Our Own of Maryland, educates the general public to recognize signs of an emerging mental illness or a mental health crisis through this program. More than 2,500 Marylanders have been trained by a corps of more than 80 certified instructors. The program is offered across Maryland in a variety of settings, including schools and universities.

Mental Health First Aid® is just one of the many shining programs that brings national respect and recognition to the Mental Hygiene Administration. Enjoy reading about many of the others in this report!

A handwritten signature in blue ink that reads "Renata J. Henry".

Renata J. Henry  
Deputy Secretary, DHMH, Behavioral Health and Disabilities

# Letter from the Executive Director



I am pleased to share with you this report for the Mental Hygiene Administration (MHA) and the state's Public Mental Health System (PMHS).

To paraphrase a noted British author, these are the best of times – and the worst of times. Perhaps worst is a little harsh, yet we certainly have been living in austere times that show few signs of an immediate turn-around.

While society is quite different from when Charles Dickens penned *A Tale of Two Cities*, I draw this parallel because MHA has been able to do so well with so little. We have been able to expand some of our exciting initiatives – the best of times – while closing state-run facilities and reducing allocations – the worst of times.

This report focuses on the “best” of these times.

We have received more than \$21 million through several grants from the federal Substance Abuse and Mental Health Services Administration. The Maryland CARES grant allows us to improve mental health services for children and youth served by the foster care system in Baltimore City. The Rural CARES grant enables an expansion of programs to meet the mental health needs of children living on Maryland's Eastern Shore. A *Linkages to Life* grant enhances the development of local partnerships in suicide prevention and intervention. The Healthy Transitions Initiative, a demonstration project in Frederick and Washington counties, focuses on transition-age youth.

We have launched our Recovery Centers of Excellence program and continue to move forward with WRAP – our Wellness Recovery Action Plans. MHA leads the way in incorporating Evidence-Based Practices within its service system. One of the many highlights among the EBP initiatives is the provider People Encouraging People, which received a SAMHSA Science and Service Award for exemplary contributions.

Meanwhile, Maryland's PMHS continues to promote consumer, youth and family involvement. We promote partnerships to increase services for our older adult population. And we continue to focus on initiatives to eliminate disparities, promote affordable housing and focus on the needs of our nation's veterans who live in Maryland.

You will find more information on these and other important initiatives in this report. We really have been able to accomplish so much while having to tighten the purse strings. Our goal is to continue to develop and deliver state-of-the-art mental health services while remaining fiscally and clinically responsible.

Needless to say, none of this would have been possible without our partners. Thank you so much to all who have helped to make Maryland one of the top states in the delivery of mental health services. Your tireless efforts have made all of the difference.

A handwritten signature in blue ink that reads "Brian Hepburn". The signature is fluid and cursive.

Brian Hepburn, M.D.

Executive Director, Mental Hygiene Administration



# Key Facts About Maryland's Public Mental Health System (PMHS)

- The Mental Hygiene Administration (MHA) is the agency within the Department of Health and Mental Hygiene (DHMH) responsible for the delivery of public mental health services.
- The majority of these services are delivered under the fee-for-service system, a system that allows providers to serve eligible individuals and then bill the state for those services. Most of these services (89 percent) are funded by Medicaid, with a 50 percent federal match for most expenditures.
- MHA operates five inpatient psychiatric facilities and two residential treatment centers for children and adolescents.
- MHA also funds services to individuals who are not eligible for Medicaid, but because of the severity of their illness and their financial need, are qualified to receive state-subsidized services.
- MHA, in collaboration with local mental health authorities known as Core Service Agencies (CSAs), manages the Public Mental Health System (PMHS). MHA and the CSAs are assisted in managing the PMHS by an Administrative Services Organization (ASO), which authorizes services, makes payments and manages data collection and reporting.

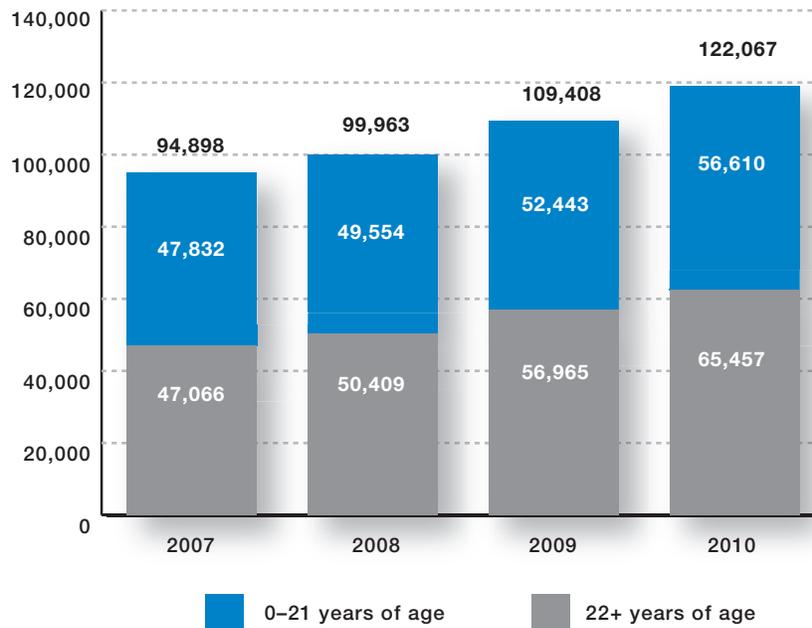
“I don't want to be too dramatic, but in brief our son would not be alive if it was not for Villa Maria Continuum. During a very challenging time six years ago, our son was hospitalized psychiatrically five times in 62 days; he was in the hospital 49 out of those 62 days. With the help of Villa Maria staff and support from other family members we knew through the Villa Maria support groups, we were able to get our son admitted on an emergency basis to the Villa Maria Residential Treatment Center. If the service was not available, something serious would have happened to our son, to someone in our family or to someone in the community. Safety was the most important reason he entered residential care, but the difference for our family was the consistent quality care offered across the service continuum... can't imagine not having Villa Maria in our corner when we really need them.”

# Marylanders Served by the Public Mental Health System

The number of individuals served in the fee-for-service PMHS has increased from 94,898 in FY 2007 to 122,067 in FY 2010, a 29 percent increase. This is nearly identical to the 28 percent growth in Medical Assistance eligibility from July 2006 to June 2010. The numbers served increased by 12 percent from FY 2009 to FY 2010, while the comparable increase in all Medical Assistance-eligible individuals grew by 26 percent during this period. Child and adolescents aged 0-21 grew over 18 percent while adults 22 and older experienced the largest growth, increasing the numbers served by 39 percent over the same time period between FY 2007-2010. From FY 2009 to FY 2010, the growth was eight percent and 15 percent respectively. Many of these increases result from preparing for implementation or implementing some of the components of the Affordable Care Act, which provided funding allowing states to cover more people on Medicaid.

The expansion of Medicaid, especially the extension of Medicaid to the parents of children in Maryland Children’s Health Program (MCHP), improved access to health care and services. It is estimated that an additional 25,000 Marylanders will be eligible for Medicaid and 15-17 percent of that population will penetrate the PMHS within the coming fiscal years.

**Number of Consumers by Age Group**



Source: Value Options-MD Data report #MARF0004 based on claims paid through 11/30/2010

# Demographics of Consumers Served in the Fee- For- Service System in 2010

FY 2010 saw a shift in the composition of males to females in the PMHS population. Historically, more males have been served than females. In 2009, males represented 51 percent of the total served in the PMHS. FY 2010 saw a decrease of three percent in males and a gain of three percent in the number of females served. In FY 2010, 54 percent of the people served were adults, 46 percent were children. In the past, the percentage of females in the child and adolescent population served in the PMHS has been lower than the percentage of males served, while the percentage of adult females has been greater than the percentage of males served. This shift in the percentages of consumers served by gender may be reflective of the increasing number of adults served in the PMHS and the increasing number of young mothers eligible for Medical Assistance because of the MCHP expansion to parents.

The racial distribution of the PMHS served population has changed as well. African American individuals in the PMHS increased by two percent, Caucasian individuals increased by four percent and Other individuals dipped down by six percent.

SEX	RACE	AGE
Male 48%	African American 48%	0-21 46%
Female 52%	Caucasian 44%	22 and Over 54%
	Other* 8%	

*\*Other includes Asian, Native American, Hispanic and Unknown.  
Source Value Options-MD Data Repository*

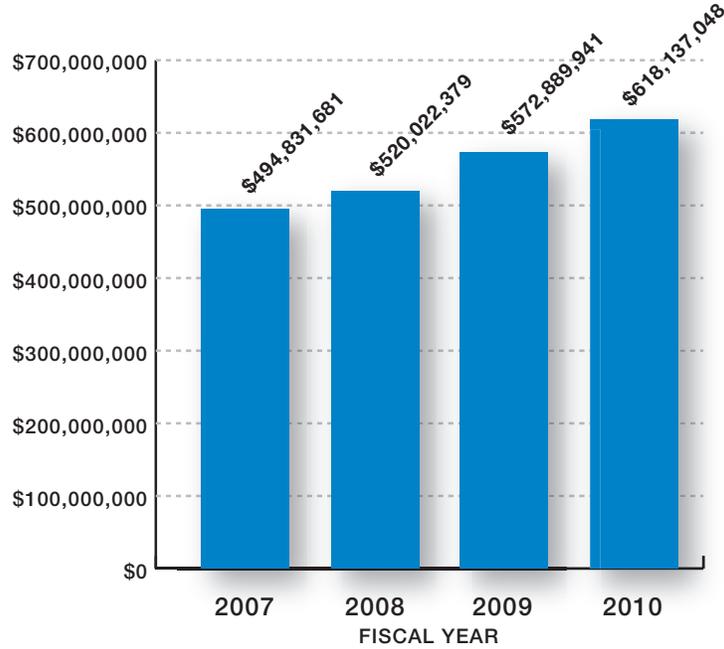
# Expenditures and Funding Sources for Marylanders in the Public Mental Health System

Increasing access to mental health services has been a key reason for the redesigned fee-for-service PMHS under the Medicaid 1115 Waiver. Fueled by the growth in Medicaid-eligible individuals, increasing numbers have received services (growth of 12 percent in the number served from FY 2009 to FY 2010). Associated expenditures have increased by eight percent from FY 2009 to 2010.

Increased service utilization reviews and cost containment efforts contributed to MHA's capacity to serve a larger number of individuals more efficiently. In response to budget demands, MHA, in FY 2010, instituted stricter service utilization and service eligibility guidelines. Medical necessity criteria for Intensive Outpatient, Partial Hospitalization and Residential Treatment services were narrowed. Case Management services delivered in the prior fiscal year under contract, using state grant funding, were reinstated for reimbursement in the Fee-For-Service (FFS) system. As a result of budgetary constraints,

MHA has required individuals to be at 200 percent of the federal poverty level or below and satisfy the other eligibility requirements to qualify for uninsured services in the PMHS. The new ASO, Value Options Maryland, has been able to closely manage eligibility criteria for the uninsured, resulting in a reduction in the number of uninsured served and the corresponding expenditure.

### Fee-For-Services Expenditures



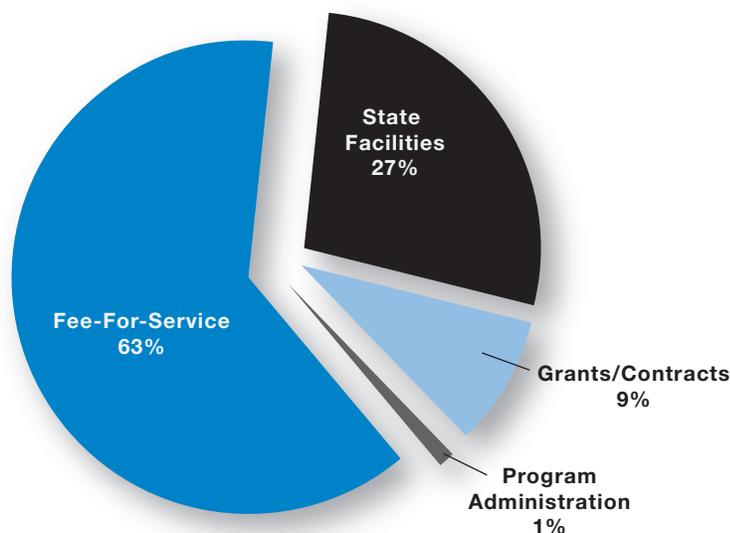
Source: Value Options-MD Data Report #MARF0004 based on claims paid through 11/30/2010.

# Community and State Facilities Expenditures Compared

In FY 2010, 72 percent of total expenditures were for community-based services (including those in the fee-for-service system and in grants and contracts). A total of \$936.8 million was appropriated for MHA -- \$675.7 million (\$586.8 million from Medicaid) for community services, \$261.1 million for state-operated institutions, and \$7.9 million for program administration.

The majority of expenditures in the fee-for-service PMHS are for services reimbursed by Medicaid. Federally matched Medicaid expenditures represent 87-90 percent of total expenditures. Non-Medicaid expenditures include those for Medicaid-ineligible recipients, non-Medicaid reimbursable services provided to Medicaid recipients, and for services for individuals within state-only Medicaid eligibility categories.

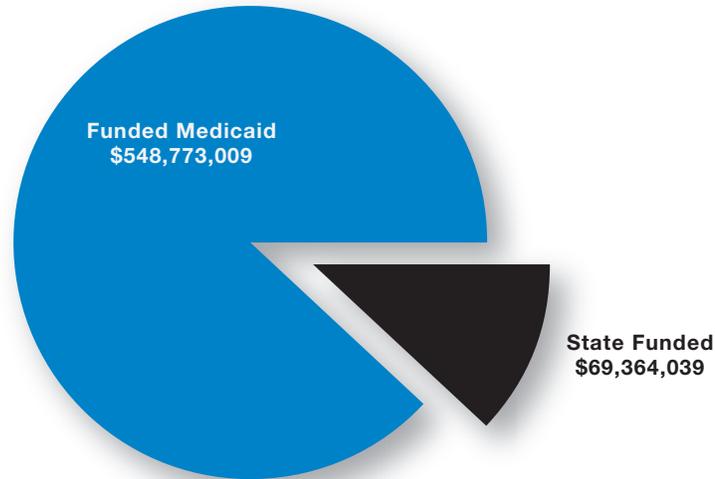
## Total Community and State Facility Expenditures - FY 2010



*Note: Expenditures for MHA Headquarters and Medicaid Community Pharmacy expenditures are not included. Source: FY 2010 Maryland Budget.*

In an effort to maximize all Medicaid federally matched funds, MHA continued its practice of converting eligible individuals to the Primary Adult Care (PAC) waiver. PAC is a statewide program which covers the fees of outpatient clinic and pharmacy services. In FY 2010, the number of uninsured individuals receiving services in the PMHS decreased by 48 percent from 2009 while the number of Medicaid-eligible individuals receiving services increased by 15 percent during the same time period. These changes result from PAC expansion and an effort to extend Medicaid benefits to parents of MCHP participants.

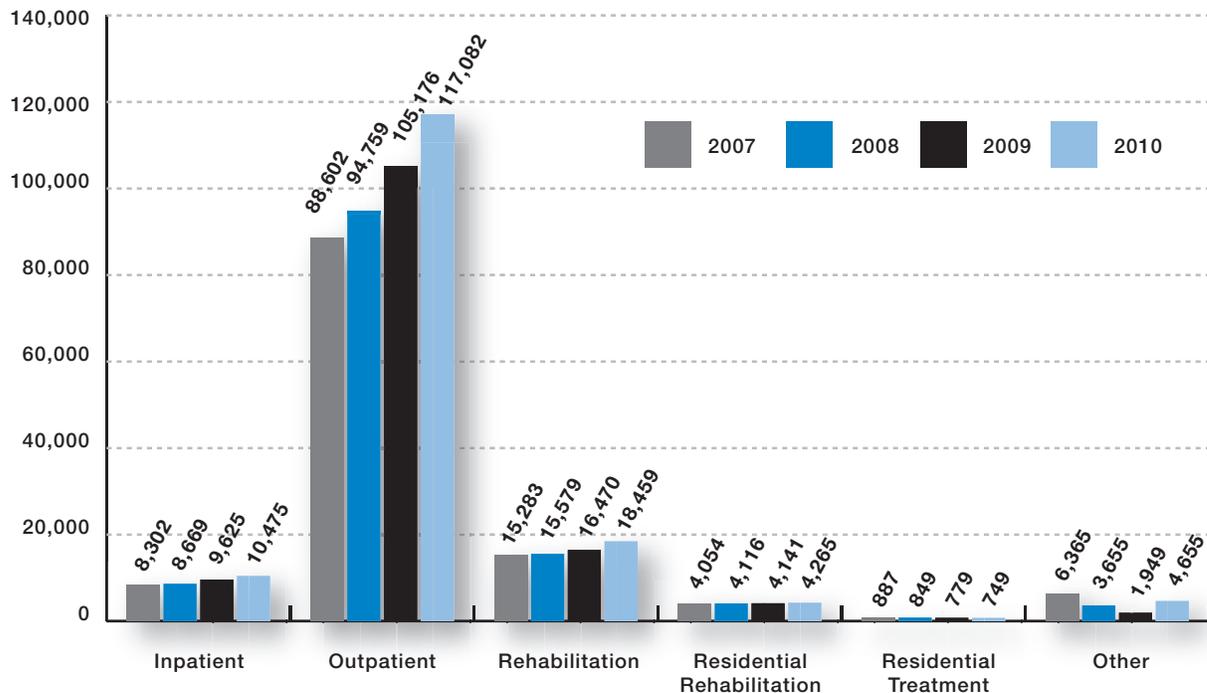
## FY 2010 Expenditures by Funding Source



Source: Value Options-MD Data Report #MARF0004 based on claims paid through 11/30/2010.

## Services Purchased and Provided through the Public Mental Health System

### Number of Consumers by Service Type



Note: Inpatient is inclusive of Inpatient and Purchase of Care. Outpatient is inclusive of Outpatient, Partial Hospitalization, Mobile Treatment, Baltimore Capitation and Emergency Petitions. Rehabilitation is inclusive of Psychiatric Rehabilitation and Supported Employment. Other includes Crisis, Respite and Case Management. In FY 2009, Case Management services were funded through CSA contracts. In FY 2010, CM was added back into the FFS system. Consumer counts may be duplicated across service categories, but unduplicated within service categories.

Source: Value Options-MD Data Report #MARF0004 based on claims paid through 11/30/2010.

There has been a 16 percent decrease in the number of individuals served in Residential Treatment Centers since FY 2007. This decrease can be attributed to the 1915 C RTC (Residential Treatment Center) Waiver which assists in diverting youth from RTC level care to community-based services and supports, which allows young people to remain living with their families and reduces the incidence of displacement from their community.

Case Management services delivered in the prior fiscal year under contract grant funding was reinstated for reimbursement in the Fee-For-Service (FFS) system. This system-wide change explains the 150 percent increase in number served.

## Inpatient Services in State Psychiatric Facilities

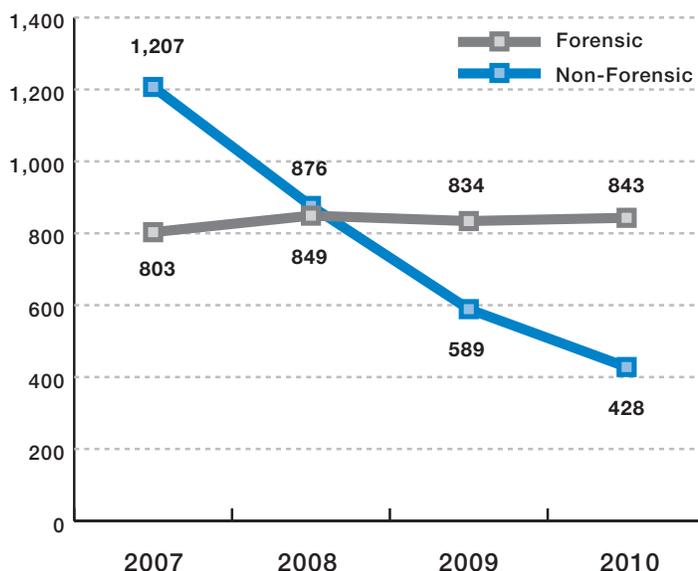
MHA continues to look for alternatives to hospitalization in state hospitals. There are three main reasons for this effort: people generally prefer treatment in their home community, the costs are lower than at state hospitals, and there is an increasing demand by the criminal justice system for services and beds in state hospitals for people involved in the criminal justice system.

One alternative to state hospitalization is the purchase of inpatient care from private psychiatric hospitals and general hospitals with excess capacity within their psychiatric units.

## State Hospital Admissions and Length of Stay

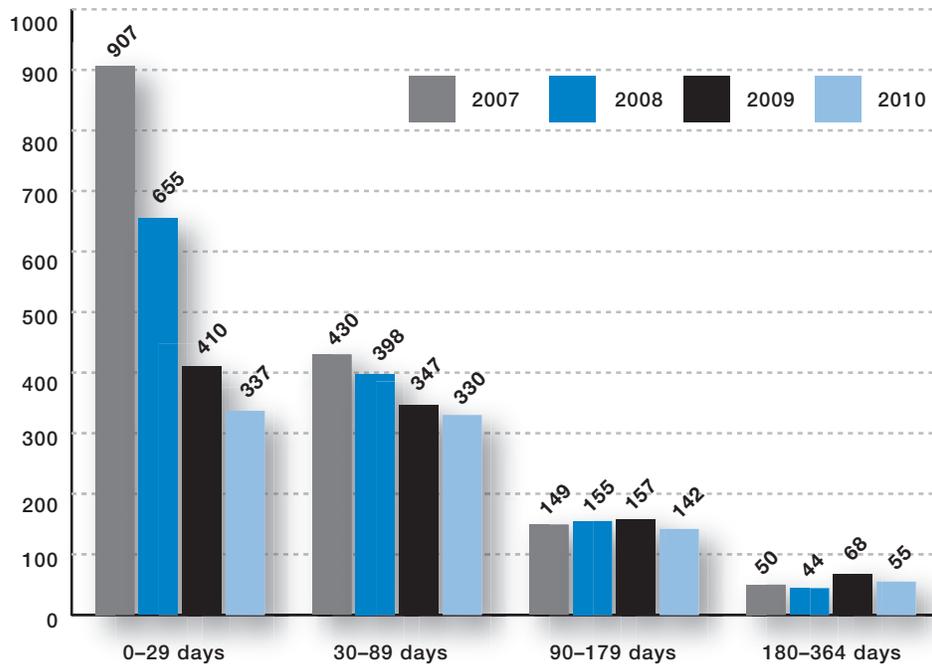
Total admissions to state psychiatric hospitals since FY 2007 have decreased by 37 percent. Non-forensic admissions have decreased by 65 percent over the last four fiscal years. However, forensic admissions to state facilities since FY 2007 have increased by five percent.

**Admissions to State Facilities by Legal Class**



Data excludes RICAs and Clifton T. Perkins Hospital. Source: State Hospital Management Information System (HMIS)

## State Psychiatric Facility Length of Stay\*



\*LOS calculated using admissions in the fiscal year, that were discharged within the same fiscal year. Data excludes RICAs and Clifton T. Perkins Hospital. Source: State Hospital Management Information System (HMIS)

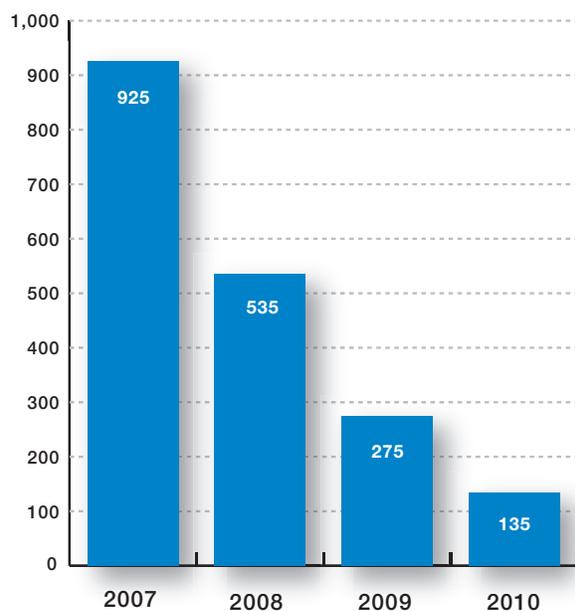
As the forensic population within state hospitals expands, the percentage of those individuals discharged within 30 days of admission continues to decline.

In FY 2007, 60 percent of those admitted were discharged with a length of stay less than 30 days. In FY 2010, that percentage dropped to 39 percent. Most individuals who need inpatient treatment now receive that level of care in the community near the individual's home.

## Crisis Response for People with Mental Illness

Crisis Response systems have provided a continuum of community-based crisis emergency services, including urgent care and outpatient clinics, mobile crisis, respite options, crisis residential services, referrals to addiction treatment, and residential or crisis support services for children and adolescents. These projects provide mobile crisis evaluation, triage, and referral to minimize the need for emergency treatment and hospitalization. Of those uninsured individuals who need inpatient care, MHA purchases the less costly alternative of private psychiatric purchase of care beds, thereby diverting these individuals from state hospitals to inpatient care from private psychiatric hospitals and general hospital psychiatric units.

### State Psychiatric Facility Non-Forensic Admissions Originating from Emergency Department



Source: Hospital Management Information System (HMIS)

“I entered Mobile Crisis Stabilization Services (MCSS) in May 2009. I was referred to the program through DSS (Department of Social Services) because my family felt they had no choice other than to request a voluntary placement. At that time, I displayed unmanageable behaviors such as violence toward family members, running away from home. I even refused to eat, complete daily hygiene skills, or take my much-needed medications... The entire family was in a sense of panic so the parents called DSS requesting that I be placed in a residential treatment center.

MCSS began working with the family and was able to advocate for the family to enroll me into the eighth grade at a private day school. I am so happy now and the teachers say that I am thriving in the school, and demonstrating a positive attitude and making new friends. MCSS worked with my family to develop the skills needed to maintain me in the home. I graduated from MCSS and I now have support services from Integrative Therapeutic Family Services (ITFS).”

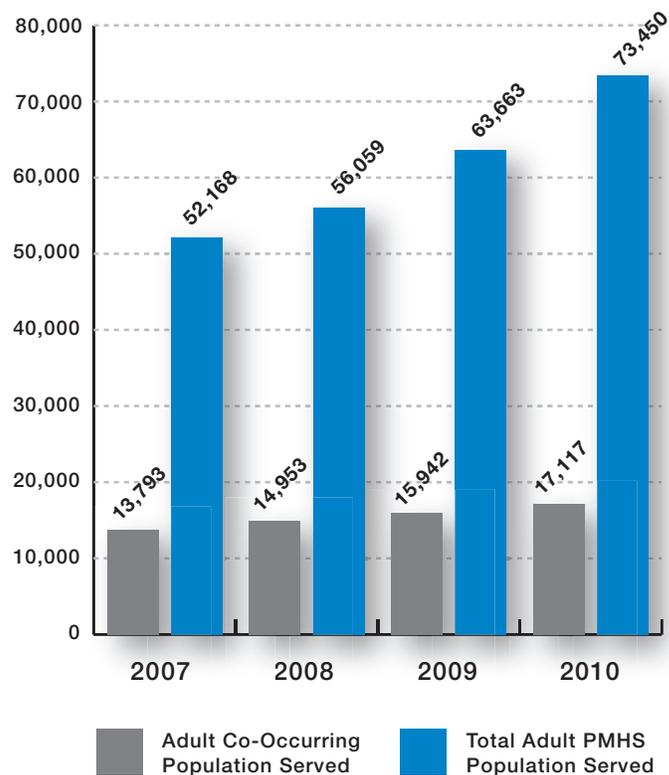
## Purchase of Care Beds in Private Sector

Purchase of care admissions to private hospitals have expanded access to community-based inpatient services for Public Mental Health System clients. From FY 2007-2010, MHA facilities statewide experienced an 85 percent decrease in non-forensic admissions originating from emergency departments. At the same time, purchase of care admissions increased by 43 percent, where room and board charges were paid. This confirms that MHA continues to treat those in need of hospital level of care in a manner that is not only more cost effective, but that also promotes the mission of serving individuals in community settings.

## Consumers with Co-Occurring Mental Health and Substance Abuse Disorders

A significant number of individuals in the fee-for-service PMHS have co-occurring disorders of mental illness and substance abuse. This number grew from almost 14,000 adults in FY 2007 to more than 17,000 in FY 2010, a 24 percent increase.

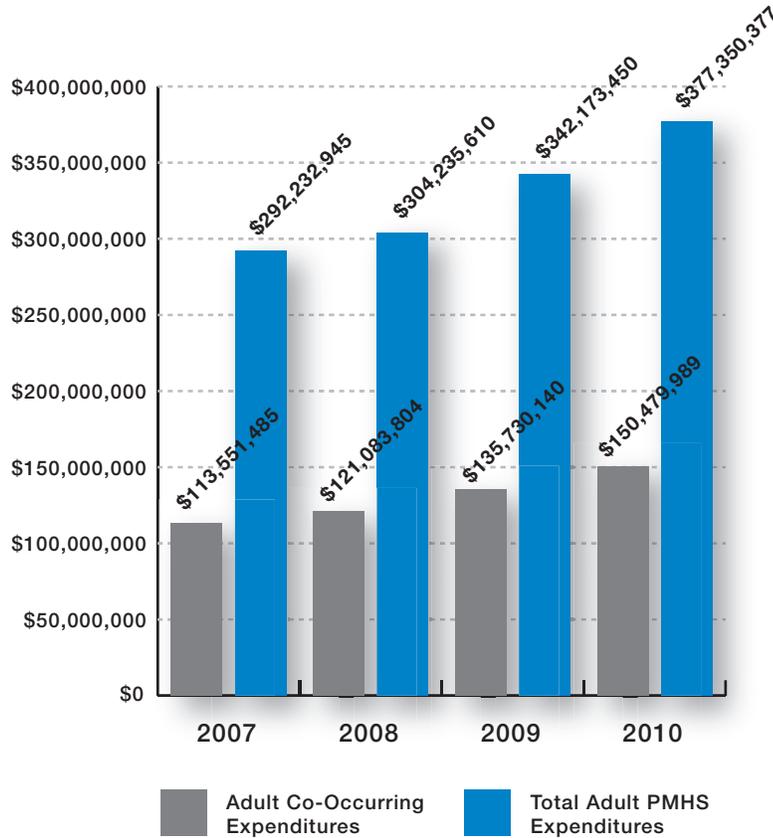
**Number of Adult Consumers with Co-Occurring Disorders\* Served in the PMHS by Fiscal Year**



\*An individual with a diagnosis of substance abuse and mental illness.  
 Source: Value Options-MD Data Repository based on claims paid through 11/30/2010.

Working with CSAs, the state Alcohol and Drug Abuse Administration, and other stakeholders, MHA is strengthening coordination and integration of services to improve access for consumers with co-occurring disorders. This collaborative approach is designed to ensure clinically sound services for this population.

### PMHS Expenditures for Adults with Co-Occurring Disorders\* by Fiscal Year

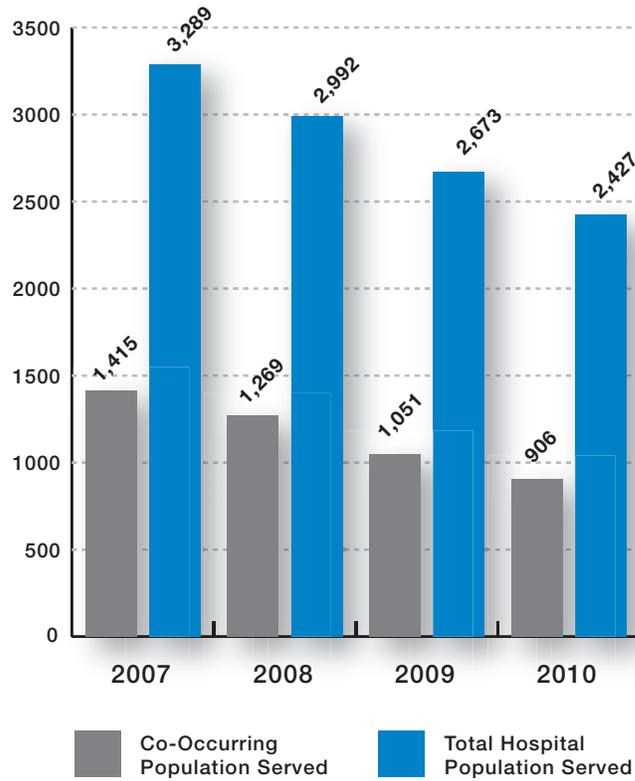


\*An individual with a diagnosis of substance abuse and mental illness.  
 Source: Value Options-MD Data Repository based on claims paid through 11/30/2010.

As illustrated on page 14, adults who have co-occurring mental illness and substance abuse disorders represent 23 percent of adults served in the fee-for-service PMHS in FY 2010. The chart above shows expenditures for these individuals in the same fiscal year represent 40 percent of the total adult services expenditures for the PMHS.

Over the past four fiscal years, the co-occurring population within state psychiatric facilities has decreased from 43 percent in FY 2007 to 37 percent in FY 2010. This reflects the change from a civil population with high co-occurring mental health and substance abuse disorders to a predominately forensic population.

### Co-Occurring Population\* Served in State Psychiatric Facilities



\*Excludes Regional Institute for Children and Adolescents (RICAs) data.  
 Source: State Hospital Management Information System (HMIS).

# Major MHA Accomplishments in 2009-2010

## Millions in Grants and Awards Support Services

Four grants totaling more than \$21 million have been received to support activities of the Public Mental Health System. They are:

- A six-year, \$8.6 million grant called Maryland CARES awarded by SAMHSA, the federal Substance Abuse and Mental Health Services Administration. This is intended to improve mental health outcomes for children and youth served by the foster care system in Baltimore City. This program will serve up to 40 young people at one time, each for an average of 15 months.
- A six-year, \$9 million grant called Rural CARES awarded by SAMHSA. This expands programs to meet children's mental health needs in the state's nine Eastern Shore counties. The grant serves children in, or at risk of entering, Maryland's foster care system and expands and supports "wraparound" services that provide a comprehensive array of home and community-based services to maximize the strengths of families, natural support systems and community resources.
- A three-year, \$1.5 million grant called *Linkages to Life*, awarded by SAMHSA. This grant enhances the development of local partnerships in suicide prevention and intervention. Sub-awards were granted to 19 counties and community organizations across Maryland for suicide prevention training, outreach, and awareness.

“I was committed to Crownsville State Hospital due to persistent psychiatric instability. With the closure of Crownsville, I had to be discharged, but community placements could not provide the additional supports I needed to maintain my psychiatric stability. With minimal funding (\$8,620 annually) through the Crownsville Hospital Project, I am now able to live independently. I attend a psychiatric rehabilitation program five days a week and receive all of my psychiatric services at a single location. I believe that I have made significant progress living independently in the community and I have recently started attending classes at the local community college.”

- A five-year, \$2.4 million grant called Healthy Transitions Initiative awarded by SAMHSA. This implements a demonstration project in Washington and Frederick counties to develop integrated home and community-based services and supports for transition-age youth.

MHA has collaborated with other partners on two grant awards that total \$12.8 million:

- A five-year, \$1.8 million grant awarded to the Department of Human Resources by the federal Administration on Children, Youth and Families for Project KEEP (KEEPing foster and kinship parents trained and supported). This initiative strengthens the network of foster care families, decreases placement disruptions and increases permanency for foster care children. It supports foster parents' ability to address and cope with youth who have mental health needs.
- A five-year grant totaling \$11 million, funded by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The money will help states implement and evaluate provider performance measures and utilize health information technologies such as pediatric electronic health records and other quality improvement initiatives. The grants are federally funded and are designed to help establish a national quality system for children's health care through Medicaid and CHIP. These awards will help create the foundation for a more responsive and effective national system of high quality health care for children. Maryland partnered with Georgia and Wyoming on this grant.

## Actions that Empower Stakeholders and Promote Systems Change

### Anti-Stigma Project Works to Change Attitudes on Mental Illness

---

Stigma continues to be one of the biggest impediments to recovery from mental illness. The Anti-Stigma Project (ASP) offers workshops that challenge participants to examine the impact of stigma on both their professional and personal lives. In FY 2010, the Anti-Stigma Project reached more than 3,000 people through 61 workshops held across the state. In addition, ASP designed and launched a new workshop on internalized stigma titled, *An Inside Look at Stigma*, in 2009. To date, 150 consumers have participated in this workshop and learned to identify and create possible solutions to internalized stigma. Another workshop on creating non-stigmatizing environments and policies is being developed and should be ready to pilot by the end of fiscal year 2011. ASP is currently using resources from the Maryland Transformation Grant to collaborate with researchers to evaluate the quantitative impact of this training project and its possibilities as a best or promising evidence-based tool.

## MHA Moves Forward with WRAP®

---

MHA, in collaboration with On Our Own of Maryland (OOOMD) and the Maryland Transformation Grant, continues to provide changes to the mental health system that assist consumers in the recovery process through Wellness Recovery Action Plans (WRAP®). This widely accepted evidence-supported recovery tool is tailored to meet individuals' unique needs. Currently 90 facilitators have been trained statewide and more than 2,700 people have received WRAP® introduction/orientation training.

WRAP® facilitators are located at Eastern Shore, Thomas B. Finan, and Springfield Hospitals and WRAP® is incorporated into all consumer-run Wellness and Recovery Centers as a model for peer support. In concert with the implementation of recovery regulations, WRAP® training has helped change the way providers of mental health services think about recovery.

## Consumers Maintain Disability Benefits While Employed

---

The Maryland version of the Ticket to Work program, which allows individuals to work while maintaining benefits, was implemented in March 2009. This is a collaborative effort of MHA, Maryland State Department of Education's Division of Rehabilitation Services (MSDE-DORS) and Core Service Agencies (CSAs) in Harford and Anne Arundel counties and Baltimore City. The three CSAs and their respective supported employment programs formed a single employment network to provide coordination and delivery of employment, vocational rehabilitation, and other support services to eligible beneficiaries. The Ticket to Work program is the next step in the evolution of the Maryland Evidence-Based Practice in Supported Employment initiative.

“I am a 33-year-old woman who had been hospitalized several times, and entered the Self Directed Care (SDC) program when it first began in FY 2008. Just 18 months earlier, I had witnessed my husband being killed and only went out of the house for mental health appointments. I was seeing my therapist at least weekly, sometimes twice a week, and seeing the doctor every month. I was referred to the SDC program by my therapist. . .Funds were requested for clothing to attend school and workout clothes for the YMCA. And I went back to college, and am so proud that I earned straight A's. . .In June 2009 I graduated from the SDC program and began working in the program as a Peer Support Advocate. I was able to stand up in front of several hundred consumers and professionals at the On Our Own of Maryland summer conference and tell my story. I still see my therapist but only once every two or three weeks. I see the doctor once every three months, and have been able to stop several of my meds.”

## Suicide Prevention Efforts Focus on All Ages

---

The Governor's Commission on Suicide Prevention, established in October of 2009, consists of 21 members that represent the state, mental health advisory councils, Core Service Agencies, organizations for older adults, and a number of advocacy and survivor groups. It is charged with developing a two-year, comprehensive and coordinated strategic plan to target suicide prevention, intervention, and post-intervention for individuals and families across the state. The federal Youth Suicide Prevention Grant, *Linkages to Life*, enhances this effort as it develops local partnerships and targets funding toward Maryland's 24 school districts, high risk jurisdictions, and specified communities for youth suicide prevention. Special focus is placed on enhanced efforts in rural counties where mortality rates are highest in the state. The grant is a partnership of state and local government agencies, the Medical Schools at Johns Hopkins University and the University of Maryland, and numerous private sector agencies.

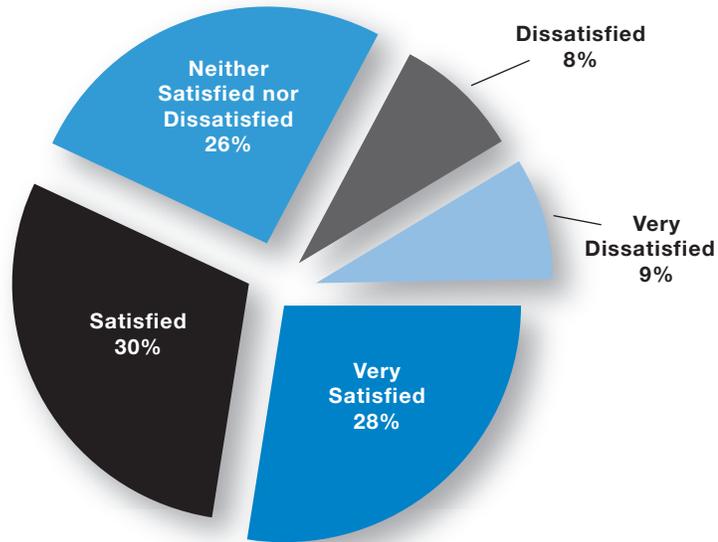
## Maryland's Outcome Measurement System

---

The Outcome Measurement System (OMS), implemented statewide in FY 2007, was developed to collect information on several life domains (including symptoms, functioning, living situation, employment, school performance, alcohol and substance use, legal system involvement, and somatic health) from individuals, ages 6-64, who are receiving mental health services in outpatient settings from Maryland's fee-for-service system. OMS information, gathered directly through interviews between the clinician and consumer, is collected at the beginning of treatment and approximately every six months thereafter while an individual is receiving treatment.

OMS data was collected from 34,034 adults receiving services in the PMHS in 2010. As demonstrated in the following chart, respondents were asked "Overall, how satisfied are you with your recovery?"

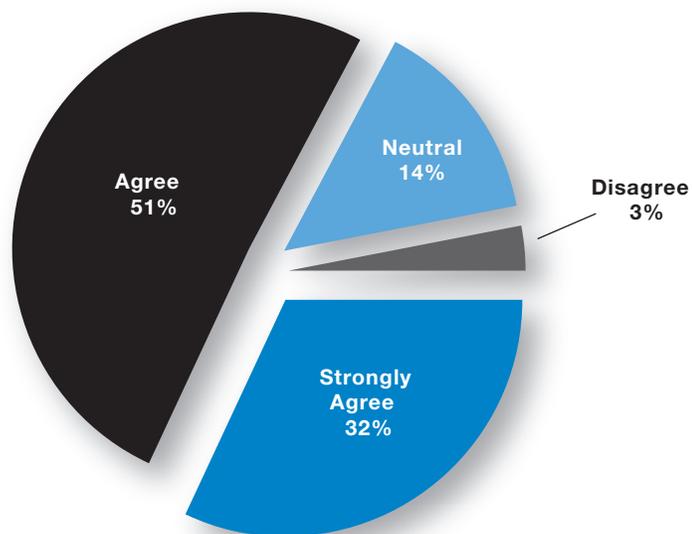
## Adult Satisfaction with Recovery



Based on OMS responses of adults from 12/01/2009 to 11/30/2010  
Note: Because of rounding, total adds to 101 percent.

OMS data was collected from 13,948 young people receiving services in the PMHS. As demonstrated in the following chart, respondents were asked whether or not they agreed with the statement “I am hopeful about my future.”

## Youth Hopeful about Future

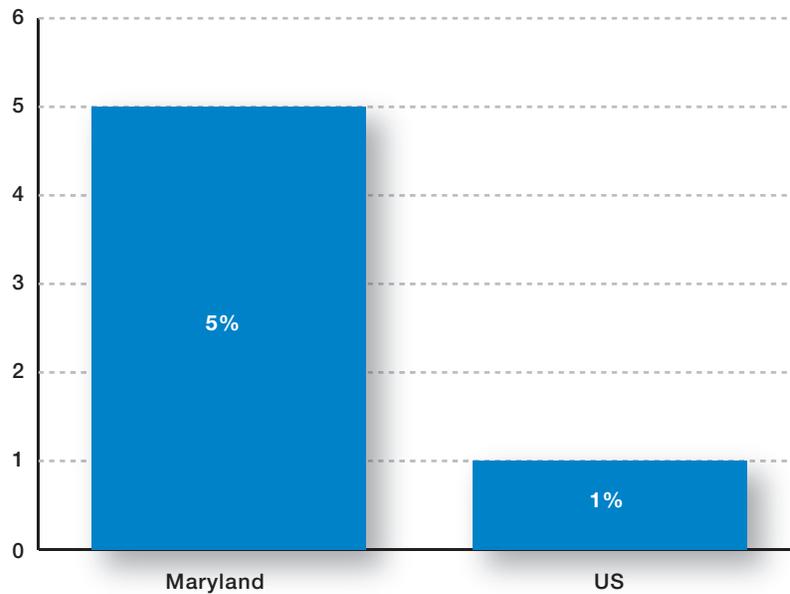


Based on OMS responses of children and adolescents ages 12 to 18 from 12/01/2009 to 11/30/2010  
Note: The number of respondents who strongly disagreed was negligible.

Value Options is developing an OMS datamart that will have the ability to perform analysis and create reports to be available to MHA, providers, CSAs, and the general public. The target date for completion of the datamart is the beginning of FY 2012.

Another tool used to assess recovery and resiliency is the National Outcomes Measures (NOMs). The NOMs were developed in 2004 by SAMHSA and the states to create a simple, performance-based, outcome-driven measurement system for SAMHSA's block grant programs. The Community Mental Health block grant requires NOMs information to be gathered on all consumers served by the PMHS. Maryland NOMs data indicate that the state's consumers are reporting more positive outcomes and social connectedness when compared with consumers across the country.

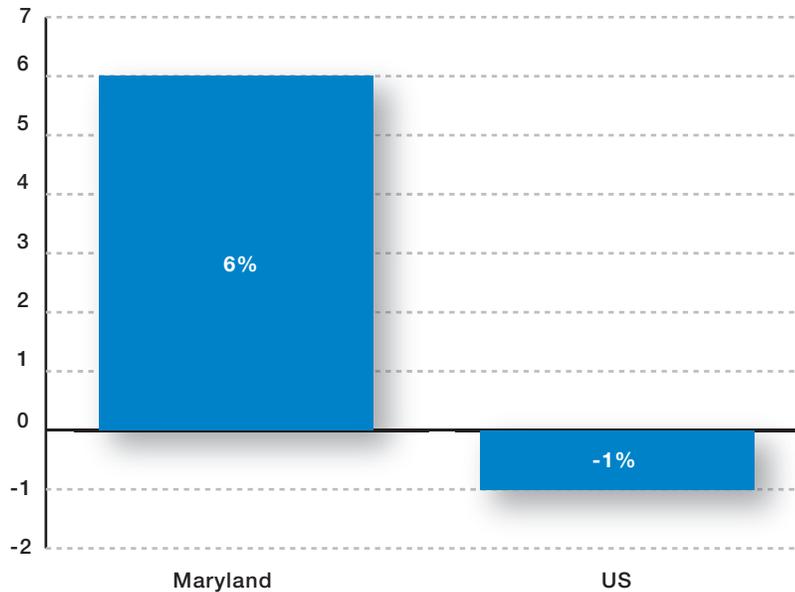
### **Percentage Change in Adult Consumers Reporting Positive Outcomes in 2009 relative to 2004**



*Source: SAMHSA/CMHS Mental Health Block Grant/National Outcomes Measurement System*

From 2004 through 2009, Maryland reported a five percent increase in positive outcomes for adult consumers compared to a national increase of one percent.

### Percentage Change in Adult Consumers Reporting Increased Social Support/Connectedness in 2009 relative to 2006



Source: SAMHSA/CMHS Mental Health Block Grant/National Outcomes Measurement System

From 2004 through 2009, Maryland reported a six percent increase in social support/connectedness for adult consumers compared to a national decrease of one percent.

### Spotlight on the Recovery Centers of Excellence

Maryland is continuing to work as a national leader by promoting recovery in all aspects of the behavioral health care system. With the promulgation of new recovery regulations completed in 2008, Maryland is now addressing in-depth program change within community mental health programs through the Recovery Centers of Excellence project. On Our Own of Maryland's Recovery Training Institute, in collaboration with the Mental Hygiene Administration's Transformation Office, the Howard County Mental Health Authority, and the University of Maryland's Systems Evaluation Center, developed a training and technical assistance program for the project.

The goal of this project was to create a paradigm shift and cultural change at selected provider agencies. Through a highly competitive process, agencies from around the state vied for spots in this program, which officially started in October 2009. The four selected agencies were: Alliance, Inc., Arundel Lodge, Humanim, and Johns Hopkins Bayview. Each provider committed to work toward an agency-wide culture of recovery and pledged to disseminate the philosophy and practice of recovery to other service providers. Each organization also agreed to reach out to additional stakeholders such as family members, the local Core Service Agency, members of their respective boards, and spiritual leaders in their communities.

On Our Own of Maryland (OOOMD) worked with the four agencies to provide education, tools, and support as each group moved toward its vision of a values-based, recovery-oriented, transformed organization. OOOMD developed an 11 module curriculum covering the following topics: Creating a Recovery Culture, Stigma, Stages of Change, Trauma-Informed Care, Creating and Sustaining a Welcoming Environment, Person Centered Planning, Utilizing Alternative and Complementary Strategies for Recovery, Employing Wellness Strategies, Utilizing Peer Support/Consumers as Providers, Spirituality and an agency-specific wrap-up.

OOOMD also provided intensive technical assistance and consultation to bridge the gap between gathering knowledge and skills and implementing them. At the same time, an evaluation of the program is being conducted to assess progress at all levels of the project.

On February 17, 2011, On Our Own of Maryland hosted a Closing Ceremony for the four participating agencies. During the ceremony, the agency CEOs were presented with certificates designating them as Transformation Recovery Centers of Excellence. These agencies will now serve as mentors to other agencies wishing to implement the program.

## MHA Continues to Promote Consumer, Youth and Family-Driven System

---

Maryland's Public Mental Health System prides itself on its consumer, youth and family driven, recovery-focused service system. MHA supports a number of initiatives that promote consumer, youth and family involvement.

- MHA and Maryland consumers recently created the Maryland Consumer Leadership Coalition which brings together leaders in the consumer movement from diverse cultural and organizational backgrounds. This group focuses on system improvements and effective consumer advocacy.
- The Consumer Quality Team of Maryland (CQT) allows consumers and family members to play a direct role in improvement of mental health services by recording and addressing individual consumers' satisfaction with the services received. Since implementation of the program in FY 2007,

the CQT has conducted 468 site visits and interviewed more than 2,650 consumers in either psychiatric rehabilitation programs or state facilities to identify needed changes. In FY 2010, the CQT conducted 180 site visits to 51 PRPs (Psychiatric Rehabilitation Programs) and five facilities, and they interviewed 1,080 consumers. They also conducted 21 feedback meetings with local and state agencies which offered valuable comments to providers. Additionally, the CQT was asked by DHMH to develop and implement a plan to track 63 consumers relocated due to the closing of Upper Shore Community Mental Health Center to ensure that hospital consumers were receiving services in the community.

- The MHA Office of Consumer Affairs held its annual Leadership, Empowerment, and Advocacy Program (LEAP) Retreat to train consumers in leadership and advocacy activities. This program, which produced 13 graduates in 2009 and 12 graduates in 2010, has produced a cadre of advocates since its 1991 inception. Most participants were affiliated with OOOMD (On Our Own of Maryland), NAMI MD (National Alliance on Mental Illness of Maryland), and other organizations in the consumer network. In addition to several consumers, presenters included a member of the Maryland legislature and staff from SAMHSA (Substance Abuse and Mental Health Services Administration) and CMS (Centers for Medicare and Medicaid). This marks the first time LEAP training included federal level partners.
- Youth MOVE (Motivating Others through Voices of Experience), an organization designed to ensure youth participation and feedback in the development of systems and services for youth, is active in 14 of the state's 24 jurisdictions. Maryland was the first state to implement Youth MOVE and membership has increased to 90 participants. The Transformation grant provided funds for a statewide coordinator housed within the Maryland Child and Adolescent Innovations Institute. Two Children's Mental Health Initiative grants, one for Baltimore City (Maryland CARES) and the other for Maryland's Eastern Shore (Rural CARES), support MHA's continued efforts to expand Youth MOVE across the state.

**“I was placed with a Therapeutic Foster Care (TFC) home through the Department of Social Services when I was a young teenager. I had lots of problems. For example I displayed anti-social behaviors, setting fires and sexually inappropriate actions. In addition, I exhibited self absorption and lack of care or concern for others. But, through therapy, life and social skills training, and peer group outings, I was able to make significant progress. I got a part time job during high school and graduated with success. I am now employed full-time and live on my own. I now have a girlfriend who I love a great deal. As a result of my recovery, the TFC program asked me to serve as a role model to mentor other children who struggle with mental illness and assist them in their journey to wellness and recovery.”**

## MHA Promotes Initiatives to Eliminate Disparities

---

Maryland is doing cutting edge work to ensure cultural and linguistic competence throughout the Public Mental Health System. The purpose of this work is to ensure meaningful access to mental health services, regardless of race or ethnicity. This year a number of initiatives were implemented to address mental health care disparities.

- Maryland was selected as one of six states to participate in the SAMHSA (Substance Abuse and Mental Health Services Administration) National Policy Summit on the Elimination of Disparities in Mental Health Care. This summit addressed the high morbidity and mortality among mental health consumers and provided states with the opportunity to develop new plans and policies to address these issues. This recognition illustrates that Maryland is increasingly known as a model state for the elimination of health disparities.
- MHA's Cultural Competency Committee adopted an assessment tool and conducted an analysis of mental health providers participating in the Cultural and Linguistic Competence Training program. The training initiative is expected to help eliminate mental health disparities by increasing the extent to which consumers served by these programs demographically and culturally reflect the surrounding community.
- MHA's Office of Special Needs Populations collaborated with Mid-Shore Mental Health Systems and Gallaudet University, an institution of higher education for students who are deaf and hard of hearing, to create a series of trainings to increase cultural awareness and sensitivity to the needs of people who are deaf and hard of hearing. These trainings were provided live and also via Webcast in closed captioning.

# Community Services – Adults

## Award-Winning Evidence-Based Practices

---

MHA leads the way in incorporating Evidence-Based Practices (EBP) within its service system. For instance, in FY 2010 it

- Provided outreach to 970 adults through nine mobile treatment programs meeting fidelity standards for Assertive Community Treatment (ACT).
- Delivered high fidelity Supported Employment services to 1,782 individuals through a unique collaboration between MHA and the Division of Rehabilitation Services.
- Served 41 consumers and their families through four programs that met Family Psycho Education (FPE) fidelity standards. FPE is an effective treatment model involving family participation.
- Launched an evidence-based practice based on interventions that have been shown to prevent and/or treat co-occurring mental illness and substance abuse disorders.
- In addition, one of Maryland's EBP providers, People Encouraging People, received a 2009 SAMHSA (Substance Abuse and Mental Health Services Administration) Science and Service Award for its exemplary contributions to the field for its five Assertive Community Treatment Teams across Maryland.

## MHA Promotes Affordable Housing

---

Independent, permanent affordable housing is essential to consumer recovery and self-sufficiency in the community. MHA has collaborated with the Technical Assistance Collaborative, the DHMH Office of Capital Planning, Budgeting and Engineering Services, the Maryland Departments of Disabilities and Housing and Community Development (DCHD), local housing authorities, and community providers to examine housing options for persons with disabilities.

“I have had panic attacks and depression ever since I was a teenager. When I was young I would sit down and think lots of times about suicide. In fact I took pills three times...My life has been difficult. My daughter was diagnosed with OCD (obsessive compulsive disorder), but my deepest sadness was about my son. He had been sick almost since the day he was born. He was in mental health facilities from the time he was eight until he died by hanging himself at the age of 19. I still suffer from depression and panic attacks, but I don't see a psychiatrist regularly now, although I do see a counselor from time to time and I take Zoloft. I can honestly say, however, that the thing that helps me the most is being able to talk to somebody...It helps me to work with other consumers and try to find answers to all of our problems.”

“In 2007 I found myself standing on a highway about to jump in front of oncoming traffic. I had been on an alcohol and drug binge for two years, severely depressed and could not function as a “normal” person. I always wondered why I did the things I did, hurt the people I hurt, and isolated myself from society. Instead of ending my life, somehow I found the strength to call the police and ask for help...I was diagnosed with bipolar and the disease of addiction...About a year into my recovery I was diagnosed with ADHD (Attention Deficit Hyperactivity Disorder). This explained a lot of why I couldn't focus and had difficulty at work. I am currently in college pursuing my degree in the mental health field...I not only learned about mental illness, I found that I was not alone... I finally feel a part of something, comfortable sharing my feelings and being there to help others.”

- MHA conducted an assessment of current state housing programs and funding resources. A central purpose was to determine use of existing funding; identify new and reconfigured funding sources to expand affordable, safe, and integrated housing opportunities; and address the important nexus between community mental health and subsidized housing programs. This work has given particular attention to promotion of recovery and self-sufficiency. The Technical Assistance Collaborative has provided key technical assistance in this collaborative effort.
- MHA increased the number of individuals who obtain affordable housing each year by using funds from DCHD and the federal Department of Housing and Urban Development. In addition, the Maryland General Assembly approved a total of \$6,167,000 to serve individuals with mental health needs, by providing new housing options under the Community Bond Program. In previous years, the Community Bond program provided funding toward housing for more than 525 individuals.
- MHA received \$3,897,846 from the Department of Housing and Urban Development's Rental Assistance Program for Non-Elderly Persons with Disabilities Program for a total of 372 Category 1 and Category 2 vouchers.
- MHA received \$1,586,369 from the Department of Housing and Urban Development's Veterans Affairs Supportive Housing (VASH) program. VASH combines Housing Choice Voucher rental assistance for homeless veterans with case management and clinical services provided by the Veterans Affairs (VA) at its medical centers and in the community. A total of 140 vouchers are available with this funding.

## Medicaid Enrollment Program Benefits Homeless Individuals

---

In April 2008, MHA implemented the state's SSI/SSDI (Social Security Insurance/Social Security Disability Insurance) Outreach, Access and Recovery (SOAR) Initiative and the project has seen much growth since then. SOAR is a strategy that helps states increase access to mainstream benefits for individuals with a mental illness who are homeless or at risk of homelessness through training, technical assistance and strategic planning. Outreach coordinators worked with

case managers to assist more than 100 consumers with applications for SSI/SSDI benefits. SOAR is currently operating in Baltimore City, and Anne Arundel, Prince George's, Somerset, Wicomico and Worcester counties. Carroll, Howard, and Montgomery counties have developed SOAR workgroups and will be implementing SOAR in 2011. Frederick County is in the process of establishing a workgroup. A statewide planning group developed a strategic plan to enable SOAR to be implemented effectively across the state. The work has been supported by SOAR Outreach Coordinators in Prince George's County and Baltimore City and a parttime evaluation and data consultant. In FY 2010, more than 60 applications were formally submitted using the SOAR process; 88 percent were approved. Baltimore City has a 100 percent approval rate for initial claims, in an average of 61 days.

## MHA is the Lead State Agency for Traumatic Brain Injury

---

MHA is the lead agency for Traumatic Brain Injury (TBI) in Maryland and is responsible for guiding the state's plans and initiatives for this population. As the result of Maryland's *Money Follows the Person* policy, there is currently no cap on the number of TBI waiver slots available to individuals with a brain injury transitioning from certain Maryland institutional settings such as CARF (Commission on Accreditation of Rehabilitative Facilities) accredited hospitals dealing with chronic illnesses. MHA is in the process of recruiting new providers and expanding the capacity of existing providers to meet increasing demand for this program.

## Partnership Efforts Recognized for Work in the Criminal Justice System

---

MHA has been involved in a number of activities to improve outcomes for individuals with mental illnesses who come in contact with the criminal justice system.

- 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 serious mental illness in detention centers. In FY 2010, the MCCJTP operated in 22 Maryland counties, identified 8,000 inmates and provided services to 6,700 individuals.
- In October 2008, a process to refer inmates with serious mental illness being released from the Department of Corrections to Outpatient Mental Health Clinics was established. The intent is to enable community case managers to work with inmates who are within three months of release to link them to medically necessary community mental health services and supports.
- A Memorandum of Understanding (MOU) was signed by the Department of Public Safety and Correctional Services (DPSCS) and DHMH in May 2009 to permit data sharing between the two agencies for the purpose of quickly restoring Medicaid benefits to individuals upon release from incarceration.
- During the 2010 legislative session, the partnership achieved a significant victory in advancing efforts to improve community reentry through the passage of SB 761/HB 1335. This new law

requires local detention centers (jails) to provide access to a 30-day supply of psychiatric medication upon release to inmates who were sentenced to a term of at least 60 days and have been diagnosed with a mental illness. State prisons and the Baltimore City jail were already required to provide medication support.

## Website Focuses on Veterans' Needs for Community Success

---

In 2009 Maryland became the first state in the country to add a comprehensive veterans' portal to the state's Network of Care site. This unique initiative helps service men and women with behavioral health needs obtain access to services. Staff from MHA and the Anne Arundel County Mental Health Agency worked closely with the Department of Veterans Affairs to develop the new Website, which builds on the state's previously-launched Network of Care, a state of the art informational resource designed to meet the needs of anyone who has a behavioral health need. The veterans' portal recorded almost 60,000 sessions from its launch in March 2009 through June 2010.

## MHA Initiates Telemental Health Programs in Rural Areas

---

In May 2008, the federal Health Resources and Services Administration awarded MHA a three-year grant to purchase telemental health equipment to support further development of the mental health system in rural areas. Seven jurisdictions – Garrett, St. Mary's, Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties-- implemented this on-line service in FY 2009. In addition, the Wicomico County Health Department's Behavioral Health Clinic entered into a partnership with the Sheppard Pratt Health System to provide telemental health services to children and adolescents, and Queen Anne's County opened an in-county facility with capacity for the necessary telemental health equipment. The technology is used by Correctional Mental Health Services in several detention centers and in several key state correctional facilities to enhance long distance training and referral processes.

## MHA Promotes Partnerships to Increase Services for Older Adults

---

MHA, in collaboration with the Maryland Mental Health Transformation Office (MHTO) and the University of Maryland, held two conferences in 2009 that emphasized the importance of partnerships and service integration for older adults. A policy forum, *Building the Partnership: Collaboration Between the Maryland Mental Health and Aging Network*, brought together more than 100 representatives from the Mental Health Association of Maryland, local Core Service Agencies, and the Aging Network. A cross-section of 115 representatives from mental health, aging, human resources and health departments from throughout the state met in June 2009 for *Achieving Transformation Through Systems Integration and Service Coordination*. Transformation's geriatric consultant continues to meet with a group of stakeholders to address "aging in place" issues that face individuals in residential rehabilitation programs.

# Community Services – Children and Adolescents

## New Program Helps Children Live in the Community, not in Residential Facilities

---

Maryland is one of 10 states selected to participate in the Centers for Medicare and Medicaid-sponsored Psychiatric Residential Treatment Facilities demonstration project to divert youth from these facilities and provide them with community-based services. This program focuses on strength-based service planning, and offers community-based alternatives to costly residential and hospital care for children with multi-agency needs.

To implement this demonstration program, in November 2009, the Governor's Office for Children, on behalf of the Children's Cabinet, awarded contracts establishing three regional Care Management Entities to provide intake, intensive care management and development of home and community-based services for children and youth with complex needs as alternatives to residential care. The three regional contracts provide statewide capacity for this service.

## Increase in Skills of Early Childhood Mental Health Professionals

---

Since 2007, more than 150 master-level clinicians have graduated from the Early Childhood Mental Health Certificate Program. This program offers specialized training in core knowledge, skills, and attitudes necessary for practicing in the field of early childhood mental health.

“Everyone says that I was a very quiet and shy 23-year-old young man when I entered the Self-Directed Care program (SDC) in 2008. I had always lived at home with my mother and never really went out unless it was with her or to doctor appointments. I was referred to the program by my case worker... My first goal was that I decided that I wanted to go back to school and get my GED so that I could go to college and learn a skill to be independent. Another goal was to find my own apartment and live on my own and make friends. Ten months after starting the program I entered school, completed the classes and received my GED... The SDC consumer funds paid for classes, clothing, books, some furniture and household items that I needed but could not afford... I still see a therapist and had to be hospitalized on two occasions due to anxiety. But now, I am better and I have just started my second semester of college and very rarely stay home.”

# Community Services: Public-Private Partnerships

## MHA Introduces Mental Health First Aid® to the U.S.

---

MHA, in collaboration with the Mental Health Association of Maryland and On Our Own of Maryland, educates the general public to recognize signs of an emerging mental illness or a mental health crisis through the Mental Health First Aid® (MHFA) program. More than 2,500 Marylanders have been trained by a corps of more than 80 certified instructors. The program is offered across Maryland in a variety of settings, including schools and universities. The Australian-based program was adapted for use in the United States through a collaborative effort among MHA, the Missouri Department of Mental Health and the National Council for Behavioral Healthcare. The MHFA Manual and Instructor Teaching Notes were published in October 2009 and are available in print for a nominal fee through funding provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the three US partners. More than 18,000 copies of the manual and 500 instructor teaching kits have been produced and distributed nationally. The collaborative is also developing certification standards.

## Public and Private Partners Unite to Promote Children's Mental Health

---

- MHA partnered with the Maryland Coalition of Families for Children's Mental Health and the Mental Health Association of Maryland to create the highly successful *Children's Mental Health Matters!* Awareness Campaign, a statewide media campaign to increase awareness of children's mental health issues. A total of 30 public and private partner agencies contributed to the campaign, including those in mental health, state government, hospital and healthcare associations, education organizations, and provider and advocacy groups. ABC2 and Fox 45 were media partners. Maryland First Lady Katie O'Malley and Debbie Phelps, mother of Olympic champion Michael Phelps, were

featured in Public Service Announcements that aired in May 2009 (Mental Health Awareness Month). In 2010 this campaign was selected as the recipient of a Gold Plaque during the national Georgetown Training Institutes Excellence in Community Communications and Outreach (ECCO) Recognition ceremony. The awards event was sponsored by Substance Abuse and Mental Health Services Administration's (SAMHSA) *Caring for Every Child's Mental Health Campaign* which highlights outstanding social marketing and communications achievements in communities across the country. The campaign was recognized for creative and innovative approaches in promoting children's mental health. The campaign received a Silver Plaque for media outreach for an interview that Dr. Al Zachik conducted with First Lady Katie O'Malley on Fox 45 News and a webcast that the Maryland Coalition of Families for Children's Mental Health conducted with Dr. Gloria Reeves of the University of Maryland. The Teacher Resource Toolkits and brochure produced by the Mental Health Association of Maryland also received a Bronze Plaque.

## Mental Health Disaster Preparedness & Response

---

MHA 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. Each state facility developed a General and Pandemic Continuity of Operations Plan (COOP) which guides actions to be taken in the event of a disaster. All personnel on the MHA Incident Command System have been trained according to the Federal Emergency Management Administration (FEMA) requirements.

Also, MHA developed a train-the-trainers program for lead staff at On Our Own of Maryland's Wellness and Recovery Centers. This incorporates disaster behavioral health and basic disaster preparedness concepts into WRAP® training.



# Inpatient Services

## Services for Community Re-entry of Long-Term Care Individuals

---

- *Transitions*, the first unit for Maryland individuals with co-occurring disorders of mental illness, developmental disability, and/or substance abuse, opened in July 2009. Sixteen individuals have been admitted to this unique 20-bed unit located at the Potomac Center in Hagerstown. The individuals receive treatment to prepare them for community reintegration. Services include community day programs as well as opportunities for supported employment. The initiative is a collaborative effort between MHA and the Alcohol and Drug Abuse and Developmental Disabilities Administrations. In FY 2010, three consumers were discharged to community placements.
- MHA discharged 52 long-stay hospital residents from state hospitals through the support of Assertive Community Treatment (ACT) teams in Prince George's and Anne Arundel counties. MHA continues to use reallocated dollars from the closure of Crownsville Hospital Center for housing subsidies to support community living for individuals who once lived in state hospitals. MHA uses a Housing First model because recent research shows that a stable home is essential for effective treatment. Once a stable home is established, evidence-based Assertive Community Treatment teams provide necessary support in the homes.

## Special Unit for Court-Involved Individuals Awaiting Discharge

---

The SPEF unit, a 22-bed assisted living/step-down unit located on the campus of the Spring Grove Hospital Center in Catonsville opened in July of 2009. Known as the Secure Post Evaluation Forensic (SPEF) unit,

“Until the age of 11, I had a typical childhood. I had a ton of friends, was on several sports teams, and played in the school band. I was incredibly outgoing and in general just a very happy kid. Once I got into middle school however, things started to change...I started to get extremely depressed... until finally I tried to kill myself. I missed the last two weeks of my eighth grade year because I was in the hospital...I started to get better... I worked as hard as I could on getting better, using a lot of what I learned from Dialectical Behavioral Therapy... I currently work at the Maryland Coalition of Families as their youth coordinator, have many friends, and started back at community college this semester. I have not been on any kind of medication for two years and am doing great emotionally.”

this newly renovated facility serves court-involved individuals who have completed treatment, are deemed competent, and are awaiting court hearings. A Memorandum of Understanding with the DHMH Office of Health Care Quality recognizes the operation of this unique unit. The SPEF unit is working closely with the legal system to promote the continued recovery of its residents, and to secure court-approved community placements. As of December 2, 2010 there have been 151 court-involved individuals discharged through the program. The cost per SPEF-operated bed is substantially less than the cost of inpatient (hospital-level) beds.

## Actions Taken to Reduce Use of Seclusion and Restraint

---

Since July 2008, following the end of a SAMHSA grant that focused on reduction of seclusion and restraint in child serving facilities, the Transformation grant has funded expansion of technical assistance designed to reduce or eliminate seclusion and restraint in public adult inpatient facilities. Activities include training staff on the skills needed to use de-escalating and prevention tools, making the most appropriate and effective use of the peer support specialists on their teams, and regularly reviewing data and current trends on seclusion and restraint.

would push the tray away from me. A couple of times when I got upset somebody might have gotten hit with the tray, so then they would restrain me. They restrained a rape victim!

It took such a long time before someone finally asked, "What happened to you?" instead of "What's wrong with you?" At that time, I was in prison and also pregnant, and I was terrified that I was about to lose another child. I had already had four kids taken from me, and I could not survive losing another child. I was told about a program that could help me heal from my trauma. I didn't know what trauma was, but I knew I had it, and they said the program would help me recover from my addictions.

Well, I definitely wanted to be in that program -- they would treat my mental illness, and I could keep my baby. I didn't know how I was going to manage that, but I knew I had to give it a try. What did I have to lose?

The first thing my therapist said to me was, "Everything that happened to you as a child, happened to you, you didn't do to yourself." I believed her, because her tone was gentle and not judgmental; then we began the work. I had to remember and talk about every time I was touched and assaulted as a child. I remember the smell, the faces of the men, and I cried. I began to heal because they were no longer hurting me. I also talked about my issues with my mother -- how she never loved me, never believed in me, and never protected me. I began to heal because I am an adult now and my mother's lack of love for me is who she is, it's not who I am.

Then my therapist told me that we had to start talking about the loss of my children, and I shut down. I asked, "How do you talk about something that gives you so much pain and suffering everyday of your life, how do you heal when you have four kids walking the earth and you don't know how they are doing, what they look like or who they are? How do you heal from that?"

She said, "You do, you just don't do it by yourself." For years I had numbed out their existence with drugs and alcohol, because it was too painful to remember them. So I had to do what my therapist told me, but she was there with me. It took weeks of crying and rocking, but I began to heal and allowed myself to remember them, and to grieve for them.

While I was going through this trauma therapy, I felt so safe. Throughout the building, the walls had pictures and positive quotes on them. We had our own rooms with colors; no one was screaming "medication." I was asked every day, "How are you feeling today?" All the staff were trained in trauma, which meant I could talk to any staff member at any time and they would listen. For the first time in my life I felt like a person, a human being rather than the monster I was treated like in the past. I felt hope.

It was just a little over four years ago that I took a hit of crack, was in a mental institution and in and out of prison. I was told I would spend the rest of my life going in and out of prisons and mental institutions or I was going to die in the street.

Where there's breath there's hope, and it began with Trauma Treatment.

*“Where  
there's breath  
there's hope, and  
it began with  
Trauma  
Treatment.”*

# MHA Values

## We value:

- 1 **Basic Personal Rights**
- 2 **A System Responsive to the People It Serves**
- 3 **Empowerment**
- 4 **Family and Community Support**
- 5 **Least Restrictive Setting**
- 6 **Working Collaboratively**
- 7 **Effective Management and Accountability**
- 8 **Local Governance to Increase Efficiency, Congruence, and Continuity of Services**
- 9 **Staff Resources**
- 10 **Community Education**

The services and facilities of the Maryland State Department of Health and Mental Hygiene (DHMH) are operated on a non-discriminatory basis. This policy prohibits discrimination on the basis of race, color, sex, or national origin and applies to the provisions of employment and granting of advantages, privileges, and accommodations.

The Department, in compliance with the Americans with Disabilities Act, ensures that qualified individuals with disabilities are given an opportunity to participate in and benefit from DHMH services, programs, benefits, and employment opportunities.



## Maryland Mental Hygiene Administration

Spring Grove Hospital Center • 55 Wade Avenue • Dix Building  
Catonsville, Maryland 21228

410.402.8300 • FAX 410.402.8309 • MD Relay 1.800.735.2258

[www.dhmh.state.md.us/mha/](http://www.dhmh.state.md.us/mha/)