



The Annual Report
of the

**MENTAL HYGIENE
ADMINISTRATION**

FISCAL YEAR 2006

***TRANSFORMING MENTAL HEALTH CARE
TOGETHER***

***COLLABORATION: A CATALYST FOR
TRANSFORMATION***

Martin O'Malley, Governor

Anthony G. Brown, Lieutenant Governor

John M. Colmers, Secretary, Department of Health and Mental Hygiene

Michelle Gourdine, M.D., Deputy Secretary, Public Health Services

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

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

**MENTAL HYGIENE
ADMINISTRATION**

ANNUAL REPORT

FISCAL YEAR 2006

**BRIAN HEPBURN, M.D.
EXECUTIVE DIRECTOR
MENTAL HYGIENE ADMINISTRATION**

MENTAL HYGIENE ADMINISTRATION

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.

MHA's website address is: WWW.DHMH.STATE.MD.US/MHA/

MESSAGE FROM THE EXECUTIVE DIRECTOR'S OFFICE

I am pleased to present the Mental Hygiene Administration's (MHA) FY 2006 Annual Report, which highlights MHA's programmatic and fiscal accomplishments for the year. During FY 2006, the Public Mental Health System (PMHS) has been successful in preserving access, improving quality, and encouraging and enhancing peer and family support programs in both the adult and child systems.

Maryland's PMHS continues to emphasize a consumer-focused service system in which the individualized needs of children, adolescents, and adults with mental illness can be met. Achieving a system which is fully recovery and resiliency oriented is the goal. Local Core Service Agencies (CSAs) assist MHA through local planning, management, and coordination of supports and services. The strong, well-developed network of consumer, family, advocacy, and provider participation continues to play an essential role in the ongoing success of the PMHS. Recognizing that individuals with mental illness often require services that are provided by other state departments and administrations, MHA maintains partnerships with these agencies. These partnerships have contributed greatly to our successes in supported employment, early childhood mental health, housing, jail mental health, and services for high-risk youth in many settings.

Maryland was one of seven states to receive a federal Mental Health Transformation State Incentive Grant. This five year, \$13.5 million planning and infrastructure development grant is designed to assist states in creating changes across systems so that the multiple health and life needs of individuals with mental illness can be more effectively and efficiently met. Through this grant, existing interagency collaborations and public-private partnerships will be solidified and new ones will be formed to further build the infrastructure to coordinate care and improve service systems. A Transformation Working Group, composed of consumers, family members, and state agency representatives, will oversee this effort.

The FY 2007 budget provides resources to further promote providers' use of evidence-based practice models in supported employment, assertive community treatment, and family psychoeducation. Rate increases will assist providers in their ongoing efforts to best meet the needs of those they serve. The budget also includes funding to further existing initiatives in early childhood mental health consultation, wraparound services, and other intensive, in-home treatment services and supports. State hospitals will continue to focus efforts on treatment and supports that enable an individual's successful return to the community.

Maryland's vision for the PMHS closely parallels the goals and recommendations of the President's New Freedom Commission on Mental Health. MHA will continue to monitor its service efficiency and effectiveness, and make adjustments to improve the full spectrum of services. Through various quality improvement efforts, including consumer satisfaction and outcomes surveys, consumer quality teams, and the implementation of the outcomes measurement system, the PMHS will continue to measure and improve its consumer and family focus. MHA and its partners will continue to promote recovery and resilience, improve hospital-based supports, further the implementation of community-based services, and cultivate a consumer and family driven, culturally competent mental health system.

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Mission

The mission of the Mental Hygiene Administration is to create and manage a coordinated, comprehensive, accessible, culturally sensitive, and age appropriate system of publicly funded services and supports for individuals who have psychiatric disorders and, in conjunction with stakeholders, provide treatment and rehabilitation in order to promote resiliency, health, and recovery.

Vision

There will be a comprehensive accessible array of public and private services. These services will help individuals empower themselves to achieve the highest level of participation in community life.

Fundamental Values

The vision of our public mental health system is drawn from a statement of fundamental values. The values underpinning this system are:

- (1) ***BASIC PERSONAL RIGHTS***
Persons with psychiatric disabilities have the same rights and obligations as other citizens of the State. Consumers have the right to choice, to retain the fullest possible control over their own lives, and to have opportunities to be involved in their communities.
- (2) ***RESPONSIVE SYSTEM***
Mental health care must be responsive to the people it serves, coherently organized, and accessible to those needing mental health care. Information must be readily available for individuals to enter and proceed through the system in a more appropriate and timely manner and the system must be linked to allow for continuity of care. The hospital is one part of the community-based mental health system. The mental health system must collaborate with other public and private human health services systems in order to facilitate support with all activities of life.
- (3) ***EMPOWERMENT***
Consumers and families will be involved in decision-making processes, individually at the treatment level and collectively in the planning and operation of the mental health system. An array of services and programs must be available to allow for consumer choice in obtaining and using necessary services. Programs and services relevant to and recognizing varying cultural, ethnic, and racial needs are imperative.
- (4) ***FAMILY AND COMMUNITY SUPPORT***
We must provide families with the assistance they need in order to maintain or enhance the support they give to their family members. We will strive to provide services to persons within their communities with the availability of natural/family supports. A goal of our system is to support care in the community and to encourage communities to manage the care of their residents.
- (5) ***LEAST RESTRICTIVE SETTING***
Services should be provided in the least restrictive, most normative, and most appropriate setting. An array of services will be available throughout the State to meet a variety of consumer needs.
- (6) ***WORKING COLLABORATIVELY***
Collaboration at the State and local level will promote a consistently acceptable level of mental health services. Collaborations with other agencies will be fostered so that support to consumers is inclusive of all activities of life.

- (7) ***EFFECTIVE MANAGEMENT AND ACCOUNTABILITY***
We seek a well-managed mental health system, which provides services economically. Accountability is essential to consistently provide an acceptable level of mental health services. Essential management functions include monitoring and self-evaluation, rapidly responding to identified weaknesses in the system, adapting to changing needs, and improving technology. We must put the highest priority on measuring consumer satisfaction with the services they receive. Outcome measures will be a key component for evaluating program effectiveness.
- (8) ***LOCAL GOVERNANCE***
Local management of resources resulting from the implementation of Core Service Agencies will improve continuity of care, provide needed services in a timelier manner, improve the congruence of services and resources to needs, and increase economic efficiency due to the closer proximity of the services delivery level.
- (9) ***STAFF RESOURCES***
The presence of a competent and committed staff is essential for the provision of an acceptable level of mental health services. Staff must be provided with adequate support systems and incentives to enable them to focus their efforts on the individuals who receive care from them. Opportunities must be provided for skill enhancement training or retraining as changes in the service system take place.
- (10) ***COMMUNITY EDUCATION***
Early identification and prevention activities for risk groups of all ages, public education, and efforts that support families and communities must be incorporated into our service system. Increased acceptance and support for mental health services can only come from increased awareness and understanding of psychiatric disorders and treatment options.

MENTAL HYGIENE ADMINISTRATION

Annual Report – Fiscal Year 2006

THE PUBLIC MENTAL HEALTH SYSTEM

INTRODUCTION

This annual report offers a synopsis of the administrative, programmatic, and clinical accomplishments of the Mental Hygiene Administration (MHA). FY 2006 was a year of continued planning for system enhancements and ongoing transformation. Maryland's public mental health system's strengths were recognized this past year with the selection of Maryland as one of seven states to receive a Mental Health Transformation State Incentive Grant which will augment existing activities while planning and implementing new structures among many state agencies to better meet the needs of individuals with mental illnesses across the systems. Activities under the grant will build upon a foundation of mutual working relationships and service projects developed in partnership with the other agencies. Many joint services and support projects have been developed in the areas of education, corrections, human resources, and juvenile services. Innovations in housing, school-based mental health, wraparound services, screening and access, trauma-related services, prevention and early intervention supports, and other services are the result of these strong relationships. MHA has been collaboratively engaged in pilot projects, which disseminate and implement evidence-based practice models in supported employment, family psychoeducation, assertive community treatment, and co-occurring mental health and substance use disorders. Many lessons have been learned this year as we focus on promoting statewide implementation of these models.

MHA facilities continue to focus efforts on treatment and supports that enable an individual's successful return to the community. From the time of admission, facilities work collaboratively with Core Service Agencies, community providers, consumers, and families toward patient discharge.

MHA's partnerships also include those with consumer, family, advocacy, and provider groups. MHA continues to encourage and support consumer and family-directed projects such as drop-in centers, peer support specialists, and family to family support groups.

MHA monitors and evaluates the system through many vehicles, including compliance and audit activities, data analysis, and annual consumer satisfaction and outcomes surveys. In collaboration with consumers, family, advocacy groups, providers, academic organizations, and the administrative services organization, MHA has finalized development of a statewide outcomes measurement system which will be initiated in outpatient mental health programs in early FY 2007.

MHA values the partnerships that enhance our delivery of mental health services and which help us to evaluate and transform our system toward a recovery and resiliency orientation, expanded community supports, and empowerment of all people involved in the Public Mental Health System (PMHS).

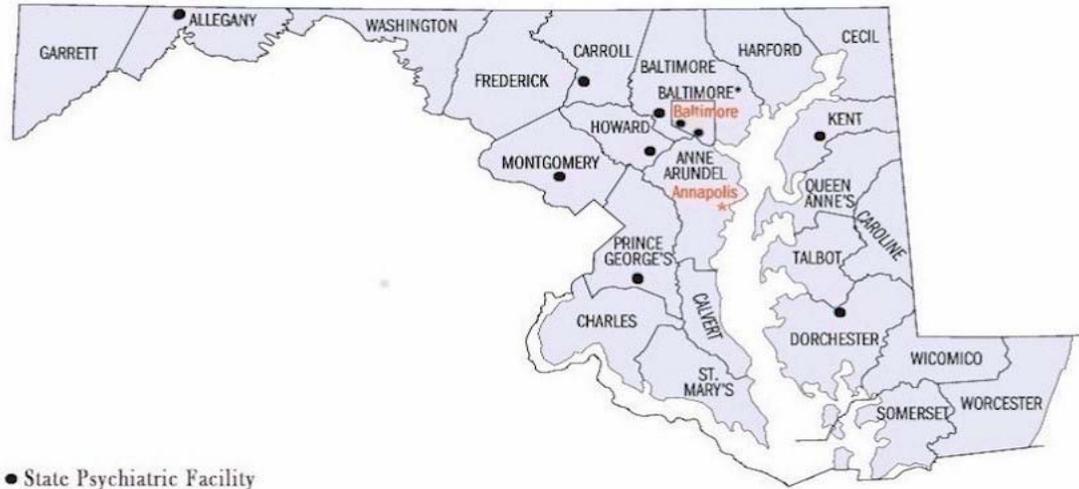
DESCRIPTION OF THE SYSTEM

MHA is the mental health authority for the State of Maryland, which is responsible for oversight of the delivery of public mental health services in Maryland. It is part of the Department of Health and Mental Hygiene (DHMH), a cabinet level secretariat. As a result of the 1997 implementation of the redesigned public mental health system under Maryland's 1115 Medicaid Waiver, MHA administers all state and federal, including Medicaid, funds related to mental health services. MHA's duties further include formulating a state mental health plan for needed services; working with Core Service Agencies to manage and develop their local community mental health systems; and creating monitoring mechanisms to ensure that services provided to consumers are medically necessary and appropriate, and meet required standards and/or contract deliverables.

MHA administrative headquarters has various offices and divisions which oversee the diverse components of the system. Headquarters staff support the operation of service delivery systems for individuals across all age groups from early childhood through older adulthood, in inpatient and community settings. Treatment and support services are coordinated for individuals who are involved in the criminal justice system, who are homeless, deaf or hard of hearing, who have traumatic brain injuries, or co-occurring disorders. MHA headquarters staff perform and oversee activities in compliance, planning, evaluation, training, governmental affairs, and consumer leadership, as well as specific efforts in emergency preparedness and suicide prevention activities. Additionally, headquarters offices monitor activities of the local Core Service Agencies, and manage system data, budget, and contracts. MHA offices and divisions have active liaisons with other state agencies, participate in multiple agency workgroups, and advocate for the availability of services offered in the broader system to persons with psychiatric disabilities. A Mental Health Transformation Office was established and housed at the Mental Hygiene Administration Headquarters to administer the Mental Health Transformation State Incentive Grant awarded to Maryland by the Substance Abuse and Mental Health Services Administration (SAMHSA). This proximity facilitates the coordination of transformation activities with the ongoing work of MHA.

MHA currently operates six hospitals that provide acute, intermediate, and long-term care for adults. Springfield Hospital continues to offer inpatient care for individuals who are deaf or hard of hearing. In addition, MHA operates one psychiatric forensic facility and three residential treatment facilities for youth known as Regional Institutes for Children and Adolescents (RICAs). The locations of the seven hospitals and the three RICAs are indicated on the following map:

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Over the years, Maryland has configured its state hospital system so that it only maintains a small safety net of two hospital units for adolescents - Thomas B. Finan and Spring Grove Hospital Centers - each with a bed capacity of 18. Hospital-level services for children under the age of 12 are only available through the private sector, with the state purchasing care as needed. In FY 2005, responsibility and funding for the Maryland Psychiatric Research Center (MPRC) was transferred from MHA to the University of Maryland. MPRC and the University of Maryland School of Medicine, in collaboration with Spring Grove Hospital Center, through a grant from the National Institutes of Health's National Institute on Drug Abuse (NIDA), are establishing a research program on the treatment of people with serious mental illnesses who also have substance abuse disorders.

To better manage the ongoing demand for state inpatient services, MHA implemented in FY 2003, a centralized admission and referral center (CARC) to assist emergency rooms in locating and accessing state hospital beds. CARC is operated by the Walter P. Carter Center staff and receives referrals 24 hours per day, 7 days per week, on uninsured individuals with mental illnesses who require inpatient services. CARC also provides consultation to the emergency rooms regarding alternative resources when hospitalization is not appropriate. MHA has initiated a pilot for FY 2007 that will support specific jurisdictions to evaluate individuals who are uninsured in the referring emergency room, divert as many consumers as possible to currently available community-based resources, and authorize and purchase hospitalization, when appropriate.

MHA, in collaboration with the Core Service Agencies (CSAs), manages the Public Mental Health System (PMHS). Currently, there are 20 CSAs serving all of Maryland's 24 jurisdictions. CSAs may be county departments, quasi-government bodies, or private non-profit corporations. They vary in size, needs, budgets, and budget sources. CSAs are the administrative, program, and fiscal authorities which, in collaboration with MHA, are responsible for assessing local service needs and planning the implementation of a comprehensive mental health delivery system that meets the needs of eligible individuals of all ages. The CSA planning role is critical to confirm that services are congruent with the preferences of consumers, reflect consumers' ethnic and cultural backgrounds, and are "user friendly". Active community and interagency linkages help CSAs create

coordinated, comprehensive systems of care in their communities. Each CSA has an active role in the implementation of quality management activities. Together with MHA, CSAs determine the criteria for utilization management, establish performance standards, and evaluate appropriateness and effectiveness of services. CSAs are important points of contact for both consumers and providers in the PMHS. They have defined responsibilities in the complaints, grievances, and appeals processes.

MHA and the CSAs are assisted in their responsibility to manage the PMHS by an administrative services organization (ASO). As of October 1, 2004, MAPS-MD has been under contract with MHA as the ASO. MAPS-MD provides access to services, utilization management, management information services, claims processing, and evaluation services. MAPS-MD also assists MHA in monitoring quality. This includes analyzing consumer service utilization, expenditures data, conducting consumer satisfaction and outcomes surveys, provider satisfaction surveys, and audits of providers. This information enhances MHA's ability to develop strategies for managing the budget, guide planning for service development and improvement, set rates for subsequent years, and correct any problems identified. MHA, through its compliance office, the CSAs, and the ASO, has intensified its review of claims payments and documentation of services provided. The review includes whether documentation has been provided to ensure that services are clinically necessary and have been provided by appropriately credentialed staff.

In FY 2006, MHA continued to rely upon the strong and well developed system of consumer, family, advocacy, and provider organizations to obtain input into federal, state and local planning, policy, and decision making. Groups such as On Our Own of Maryland Inc., the National Alliance for Mental Illness-Maryland, the Mental Health Association of Maryland, the Maryland Coalition of Families for Children's Mental Health, the Maryland Association of Resources for Families and Youth, and the Community Behavioral Health Association of Maryland, continued to play an integral role in the ongoing operations of the PMHS. Consumers, family members of persons with psychiatric disorders, mental health professionals, providers, representatives of other state agencies, and citizens interested in the PMHS served on many work groups and committees set up by MHA, the CSAs, and the ASO.

The Maryland Advisory Council on Mental Hygiene and the Public Law 102-321 Planning Council, which meet jointly and are often referred to as the Joint Council, work with MHA to monitor the PMHS and to advise MHA on the provision of statewide services to citizens with mental illnesses. Joint Council members serve on numerous work groups and task forces, including planning committees, which help shape MHA's annual planning efforts. Local mental health advisory committees and CSA Boards have the opportunity and responsibility to advise CSAs regarding the PMHS and to participate in the development of local mental health plans and budgets.

SERVICES WITHIN THE PMHS

Since 1997, mental health care has been provided on a fee-for-service basis, through the PMHS. 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. Over the years, large numbers of new providers, particularly individual practitioners, outpatient mental health programs, and psychiatric rehabilitation programs, have entered the system, creating increased choice, diversity, and accessibility. The array of services available through the fee-for-service system include:

- Psychiatric hospitals (Institutions for Mental Diseases (IMDs) – being phased out)
- Psychiatric units of acute care general hospitals
- Residential treatment centers (children and adolescents only)
- Psychiatric day treatment (also called partial hospitalization)
- Outpatient mental health clinics (including some school-based and after-school treatment programs)
- Individual practitioner services
- Psychiatric rehabilitation programs
- Residential rehabilitation programs
- Mobile treatment services
- Supported living programs
- Supported employment and vocational services
- Mental health case management
- Respite care services
- Residential crisis services
- Mental health services related to Early and Periodic Screening, Diagnosis, and Treatment (Therapeutic Behavioral Aides)
- Mental health related laboratory services

In addition, MHA continues to contract directly with providers and with CSAs to support those programs that provide specialized services which are either not included in the standard benefits package or do not lend themselves to payment through the fee-for-service system. Approximately \$35.8 million in state general funds and \$16 million in federal dollars are awarded through such contracts. Federal grants include the Community Mental Health Services Block Grant, Projects for Assistance in Transition from Homelessness (PATH), Shelter Plus Care, emergency response capacity, the Data Infrastructure Grant, the Mental Health Transformation Grant, and the Evidence-Based Practice Training and Evaluation grant.

SYSTEMS PERFORMANCE OVERVIEW

THE FEE-FOR-SERVICE SYSTEM

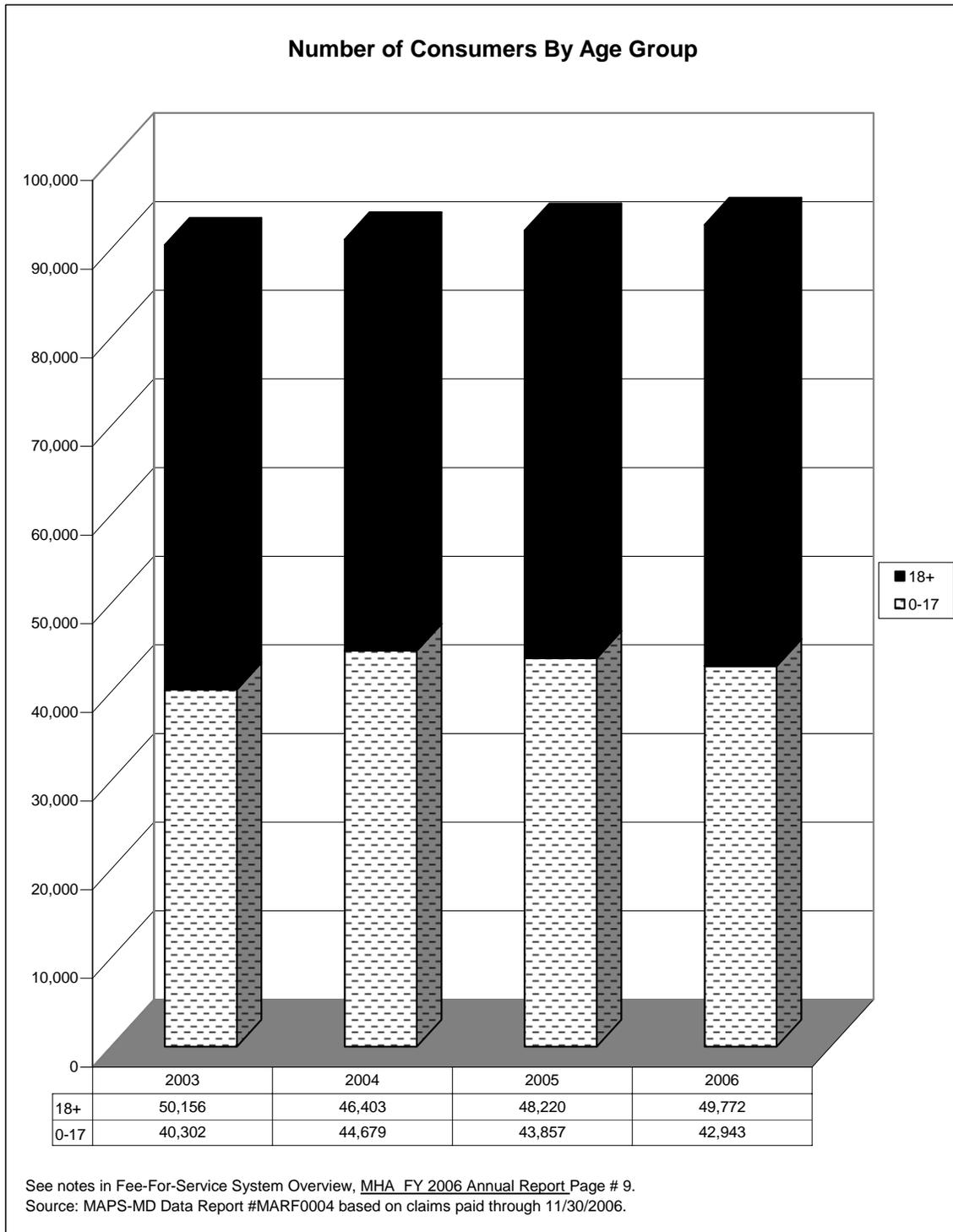
MAPS-MD's authorization and claims-based reporting system collects information on consumers receiving services in the fee-for-service system. In the following section, information on consumer characteristics, service utilization, and expenditures is presented. The data presented is derived from claims paid through November 30, 2006. Since claims may be submitted up to nine months from the date of service, data for FY 2006 may change over time. Over the years, many system changes have been made, which in turn affect data availability and information reported. When reviewing data in this section, it is important to note:

- Psychiatric and residential rehabilitation services for Medical Assistance (MA) ineligible individuals were paid through contracts in FY 2003 and information on their consumer characteristics, service utilization, and expenditures is not included for that year. Funding moved back to the fee-for-service system in FY 2004.
- Beginning in FY 2004, MA assumed responsibility for payment of MA reimbursable claims for individuals who are dually eligible for federally matched MA and Medicare. This primarily affects data on adults. Data from these claims does not appear in the following charts.
- In February 2004, the payments for rehabilitation services were changed to a monthly case rate.
- In FY 2006, the case rates for intensive psychiatric rehabilitation services (adult) and for child and adolescent psychiatric rehabilitation services increased and are reflected in the service expenditure charts.
- This data set does not include information on services funded through contracts.

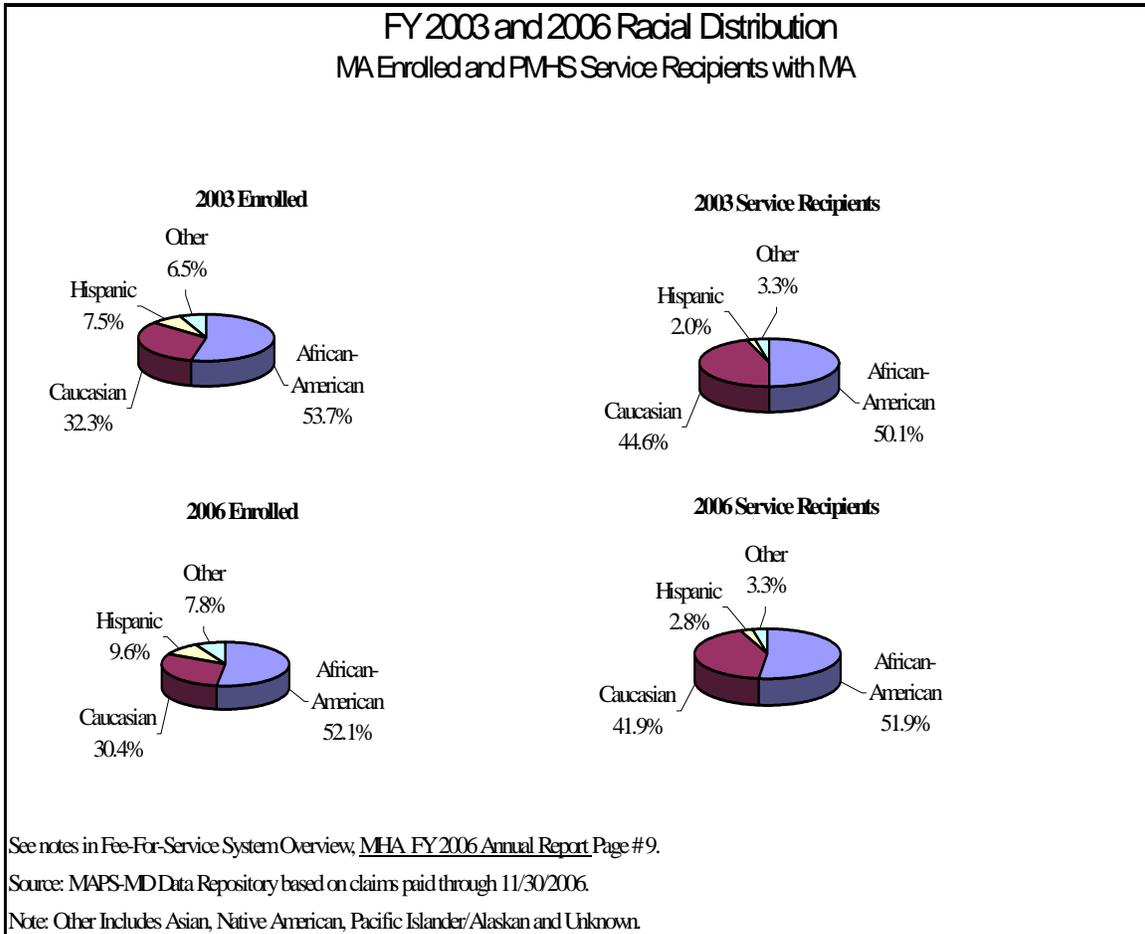
Population Served

The number of individuals served in the PMHS has increased from 90,458 in FY 2003 to 92,715 in FY 2006. An almost equal number of males and females received services in the PMHS. In FY 2006, 54% of the people served were adults, 46% were children.

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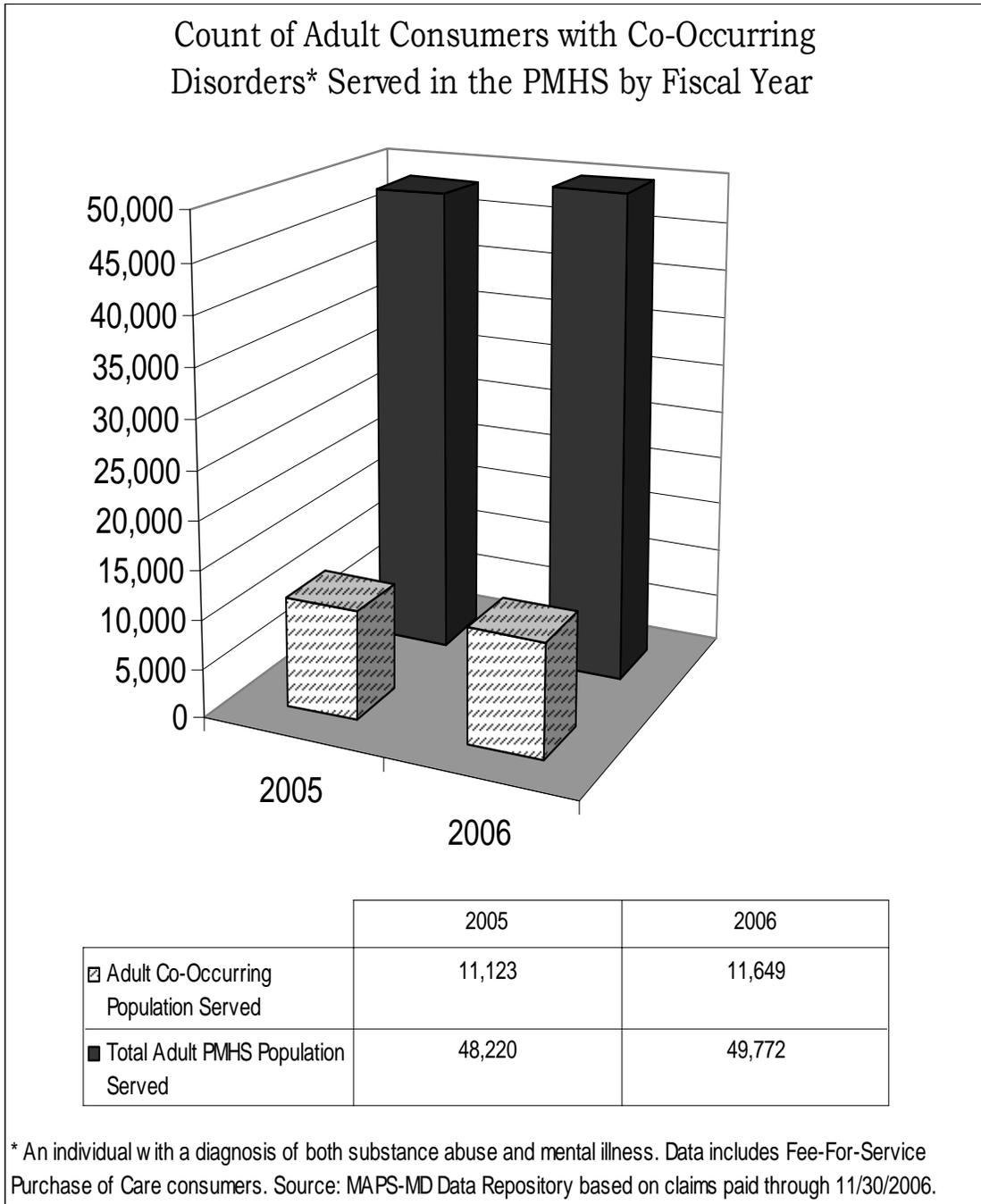
The racial distribution of the MA enrolled population has remained relatively constant since FY 2003, with the African-American population between 52 and 54% and Caucasians at 30-32%. The Hispanic population has risen from 7.5% in FY 2003 to 9.6% of the MA enrolled population in FY 2006. Of the MA population served in the PMHS in FY 2006, African Americans represent approximately 52%, Caucasians 42%, and Hispanic individuals approximately 3%.



The PMHS serves individuals with a range of psychiatric diagnoses. The three most common diagnostic groupings for children and adolescents are attention deficit disorders, adjustment disorders, and major depression. The most common for adults are major depression, bipolar disorders, followed by other nonpsychotic mental disorders and schizophrenia.

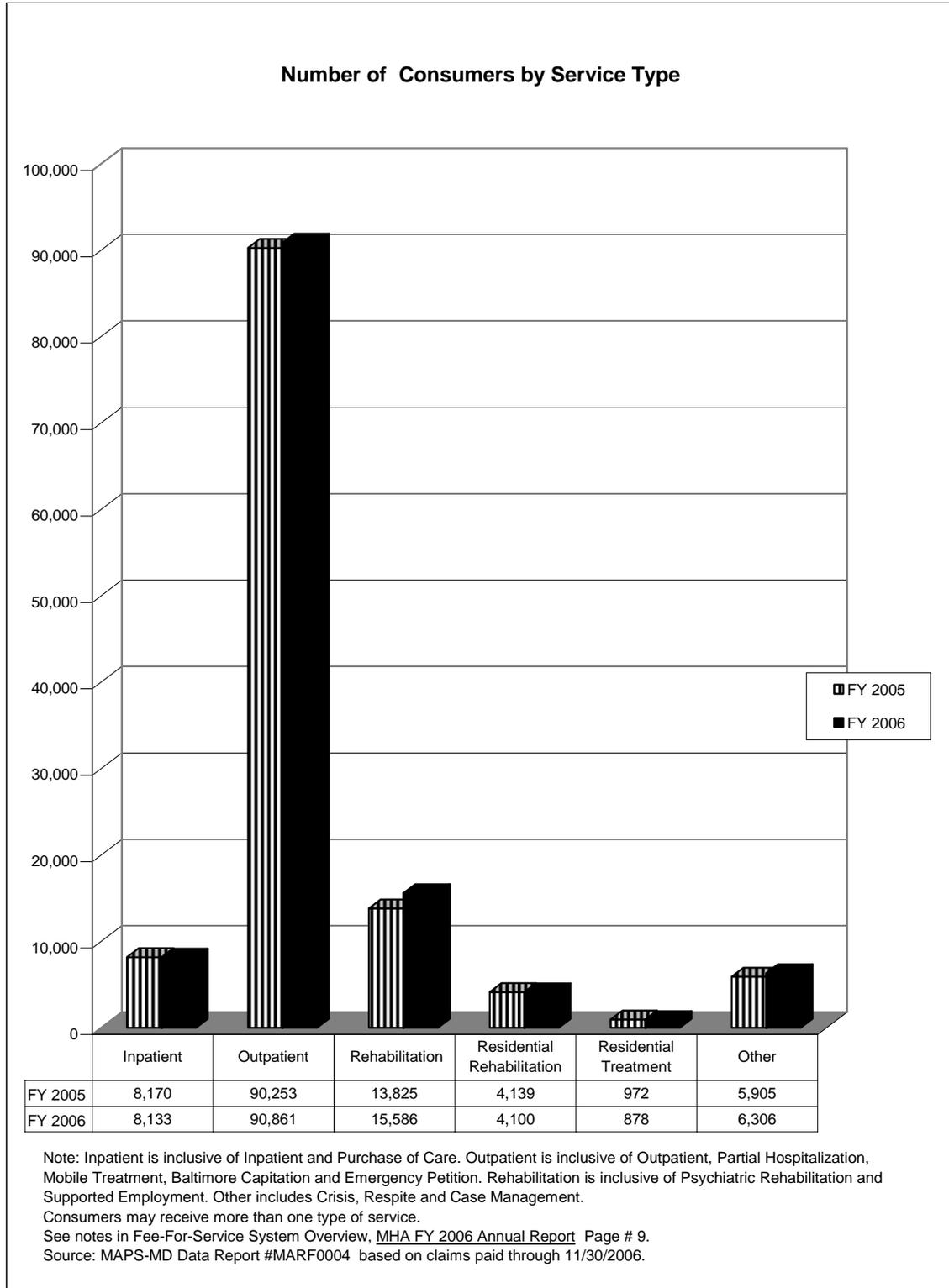
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A significant number of individuals in the PMHS have co-occurring disorders of mental illness and substance abuse – more than 11,000 adults in both FY 2005 and 2006.



Service Utilization

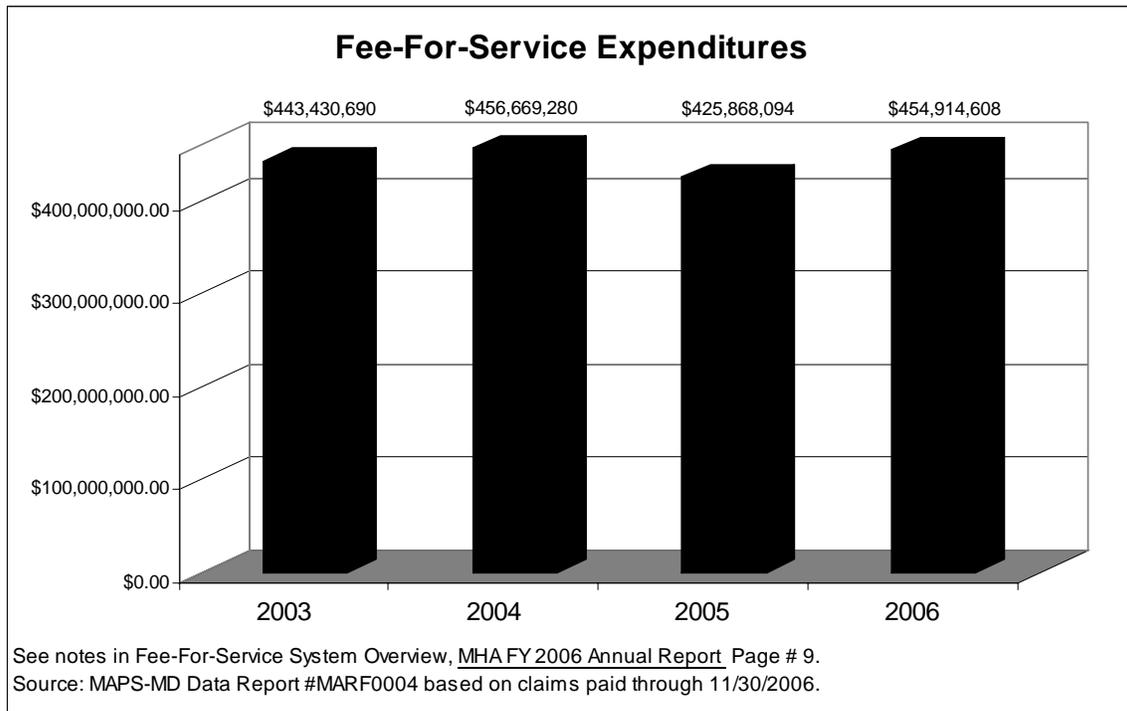
The following chart provides data on the numbers served within each service type for the fiscal years 2005 and 2006.



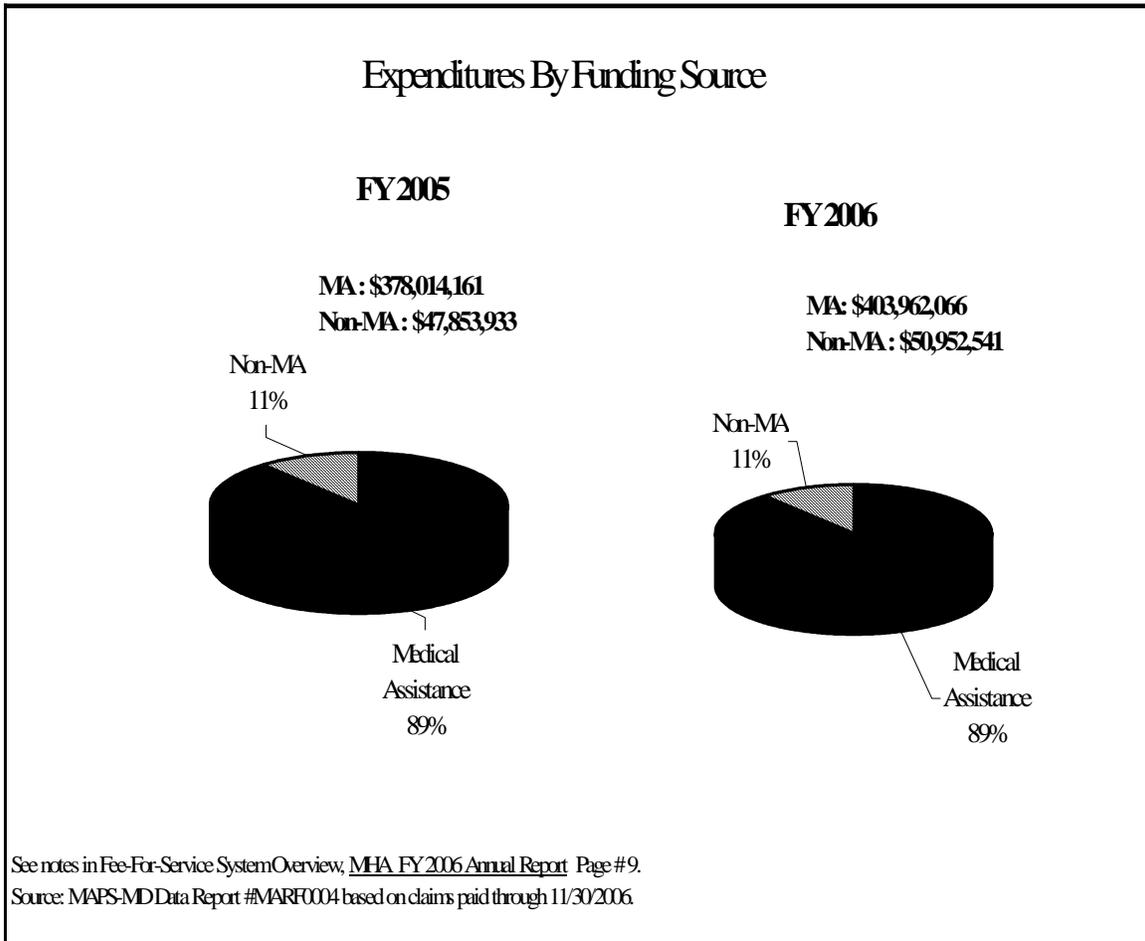
There have been increases in the number of individuals using rehabilitation services (12.7%) and crisis, respite and case management (6.7%). The number of youth served in residential treatment centers (RTCs) has decreased nearly 10% between the two years.

Service Expenditures

Increasing access to mental health services has been a hallmark of the redesigned PMHS under the MA 1115 Waiver. Fueled by the growth in MA eligible individuals, increasing numbers have received services with associated increases in expenditures. There was a 3% increase in overall spending (MA and state general funds) from FY 2003 to FY 2004. The 6.9% decrease in FY 2005 represented MHA’s success in bringing its expenditures in line with its appropriation.

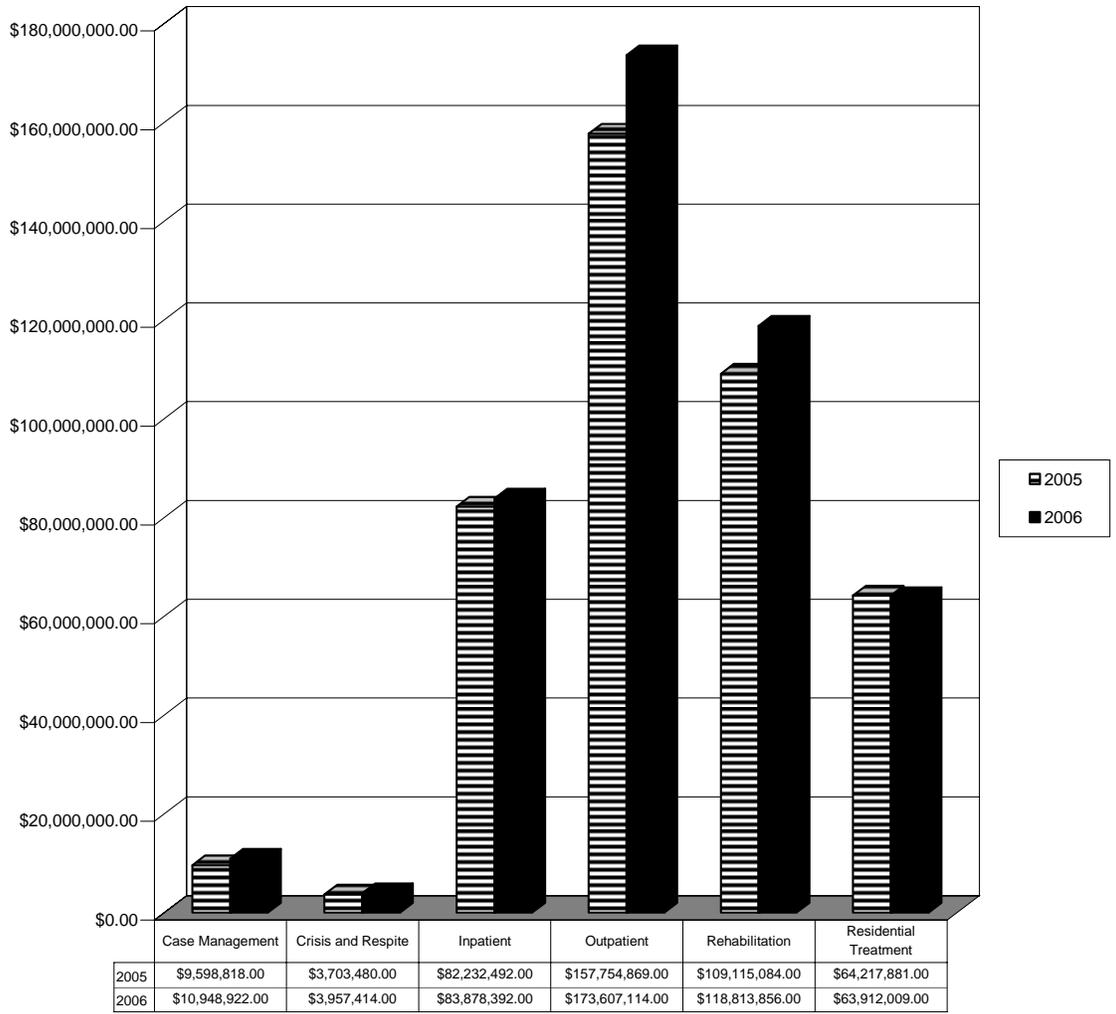


The majority of expenditures in the PMHS are for services reimbursed by MA. Federally matched MA expenditures represent 89% (see the chart below) of total expenditures. Non-MA expenditures include those for MA-ineligible recipients, non-MA reimbursable services provided to MA recipients, and for services for individuals within state-only MA eligibility categories. The overall growth in expenditures in FY 2006 is largely within outpatient and rehabilitation services.



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Fee-For-Service System Expenditures By Service Type

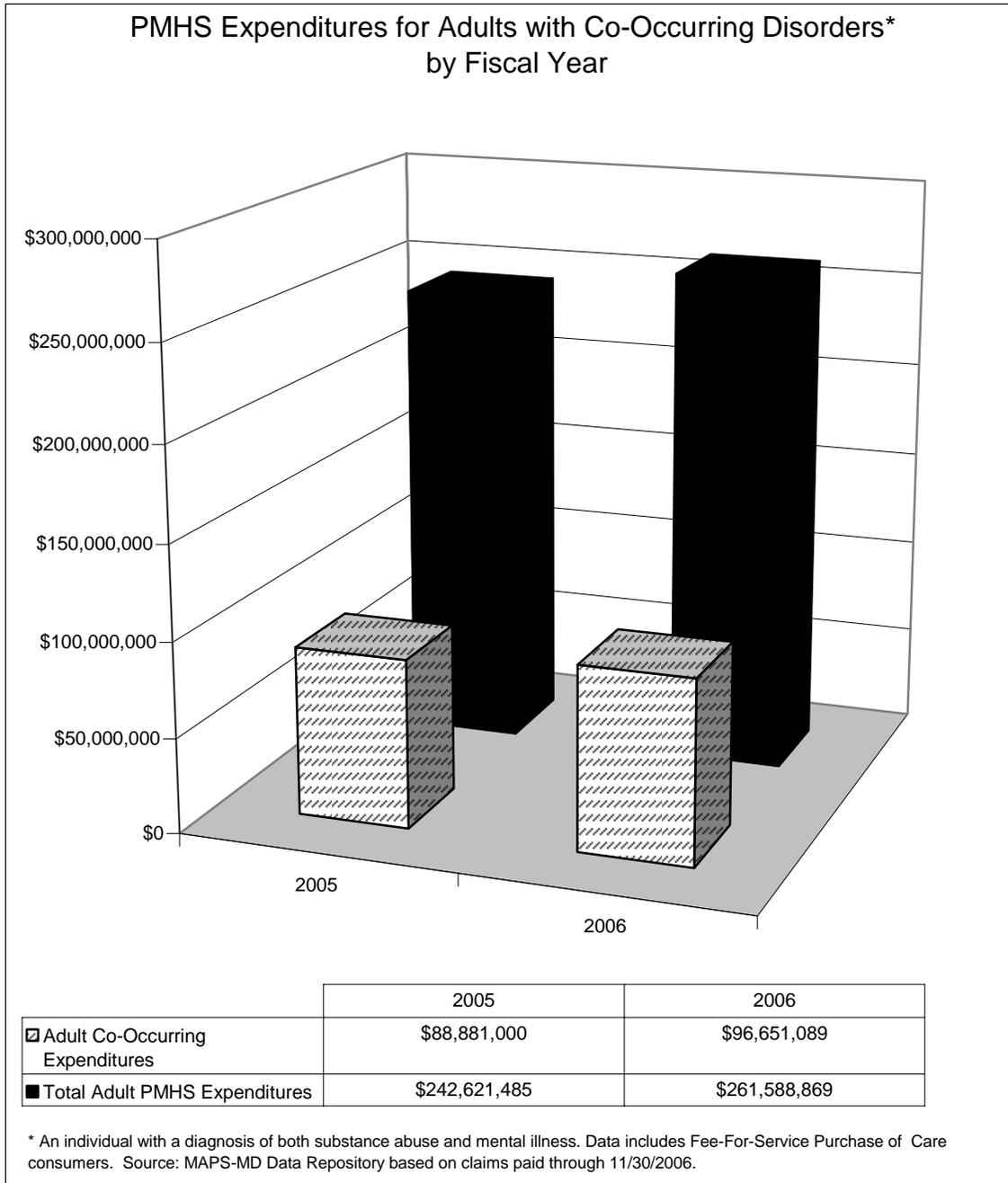


Outpatient is inclusive of Outpatient, Partial Hospitalization, Mobile Treatment, Emergency Petition and Baltimore Capitation. Rehabilitation is inclusive of Psychiatric Rehabilitation, Residential Rehabilitation and Supported Employment. Inpatient is inclusive of Inpatient and Purchase of Care.

See notes in Fee-For-Service System Overview, [MHA FY 2006 Annual Report](#), Page # 9.

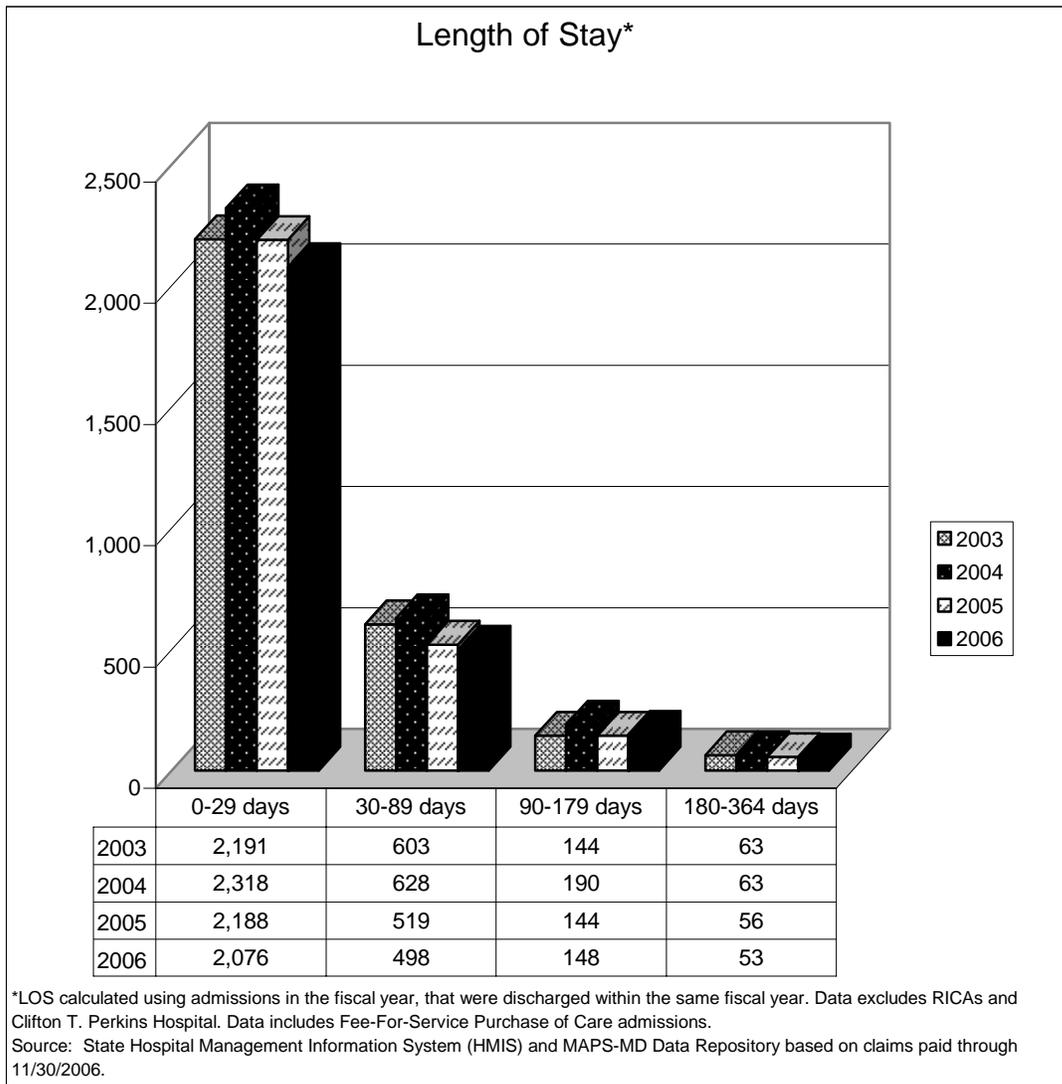
Source: MAPS-MD Data Report #MARF0004 based on claims paid through 11/30/2006.

As noted earlier in the chart on page 12, adult individuals who have co-occurring mental illness and substance abuse disorders, represent 23% of the adults served in the PMHS. Expenditures for these individuals represent 37% of the total adult service expenditures for PMHS, as shown in the following chart.



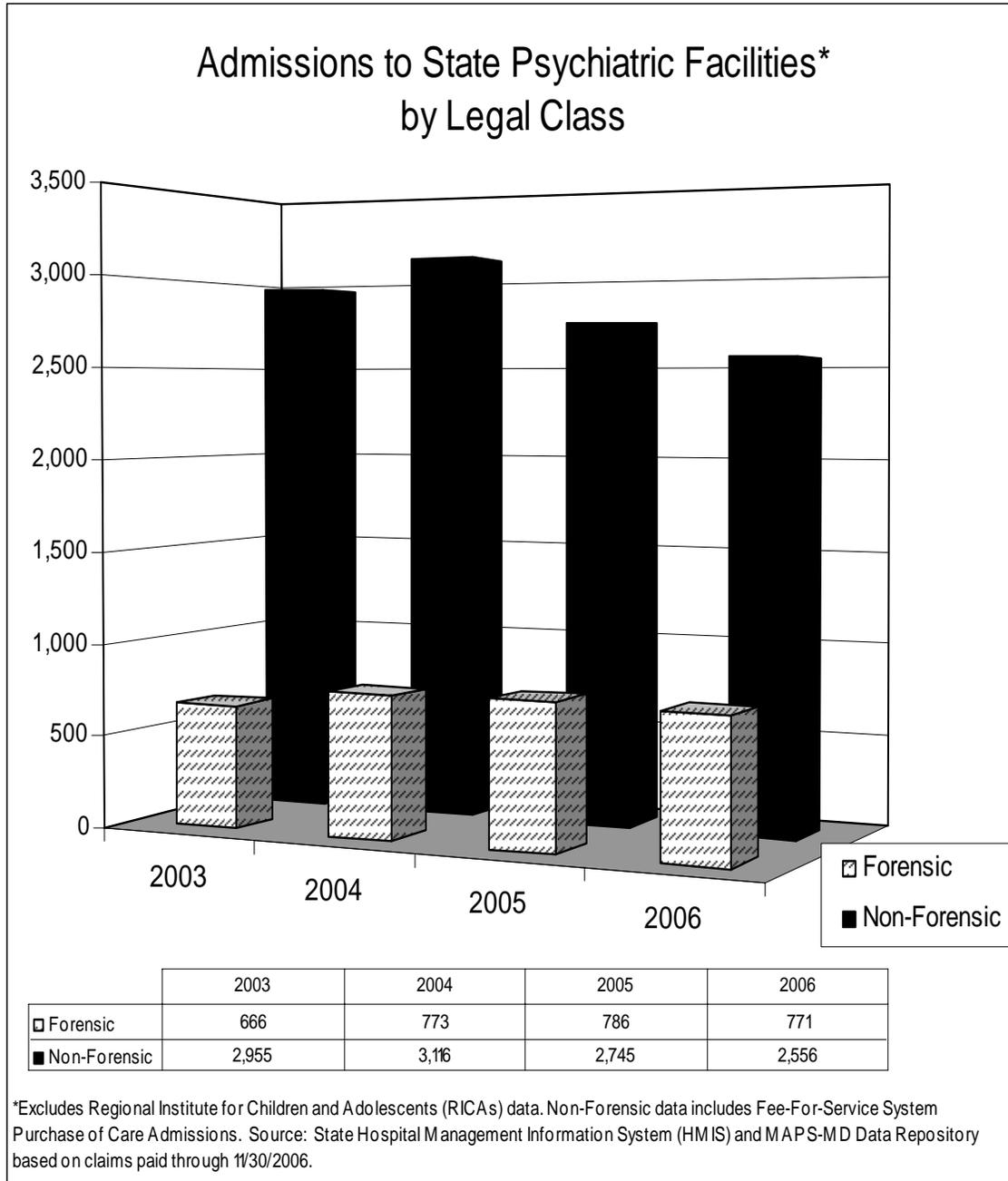
HOSPITALS AND STATE FACILITY SYSTEMS

MHA has oversight authority of ten state psychiatric facilities, including one forensic facility and three residential treatment centers (RTCs). In FY 2006, the average daily population of these facilities was 1,284. The state facilities operate at close to 100% of operating capacity at all times. MHA purchases inpatient care from private psychiatric hospitals and general hospital psychiatric units for uninsured individuals when beds in state facilities are not available. The average length of stay is usually seven days or less. The number of admissions through this purchase of care has increased steadily over the years. Purchase of care data is included in the next two charts.



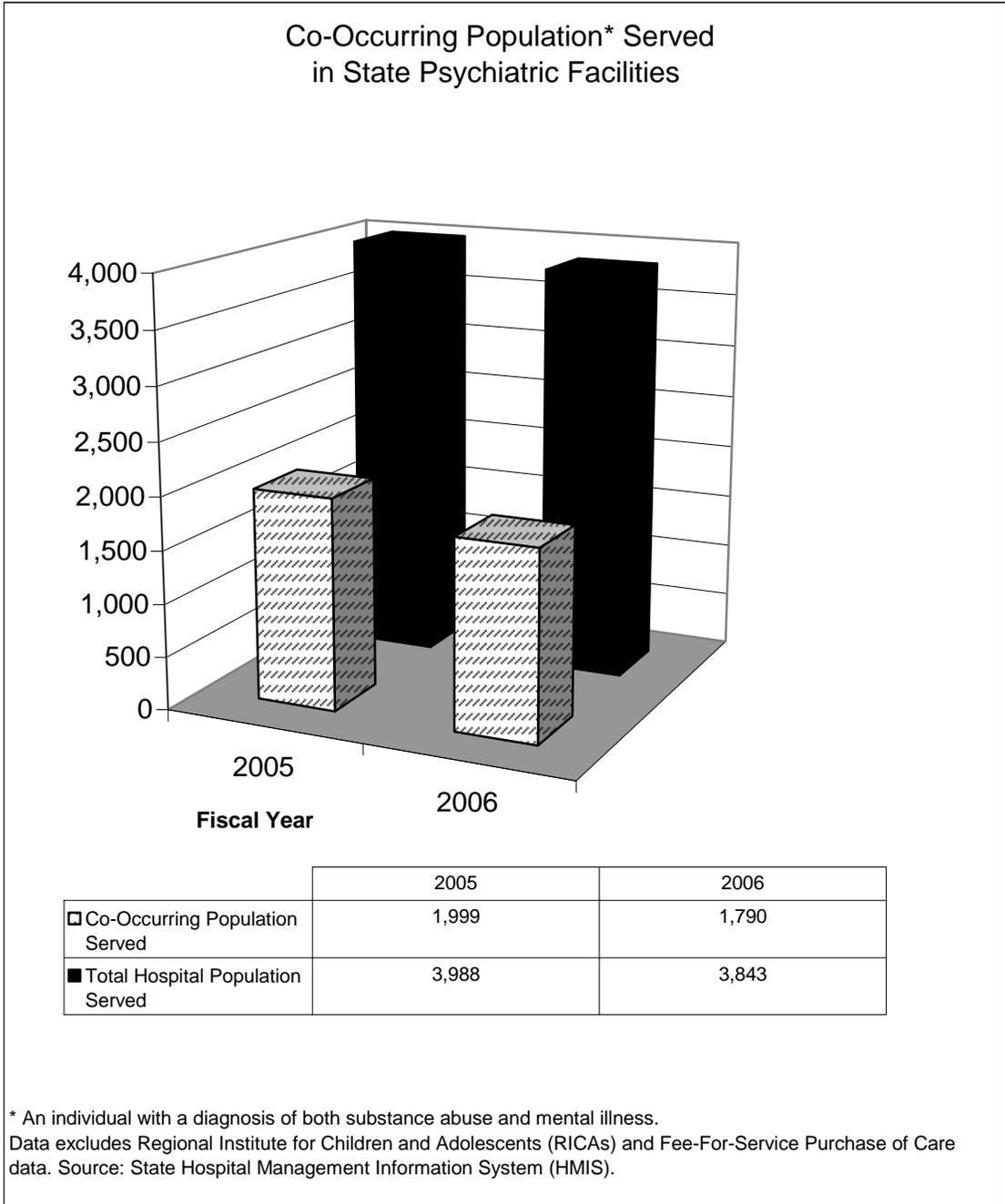
For those admissions that were discharged within the same fiscal year, between 72-75% of those discharges were within 30 days and between 92-93% were within 90 days of admission. Purchase of care admissions, 556 in FY 2003, 572 in FY 2004, 755 in FY 2005, and 706 in FY 2006, are included. All discharges were within 30 days.

The number of forensic admissions, and their percentage of the total number of admissions, have risen by 15.7% over the four years. In FY 2003, 18% were forensic admissions. In FY 2006, 23% were individuals with forensic involvement. During FY 2006, individuals that have forensic or some type of court involvement utilized over 24% of state hospital beds. Consistently over the four years, 60%-67% of forensic admissions are discharged within the same fiscal year.



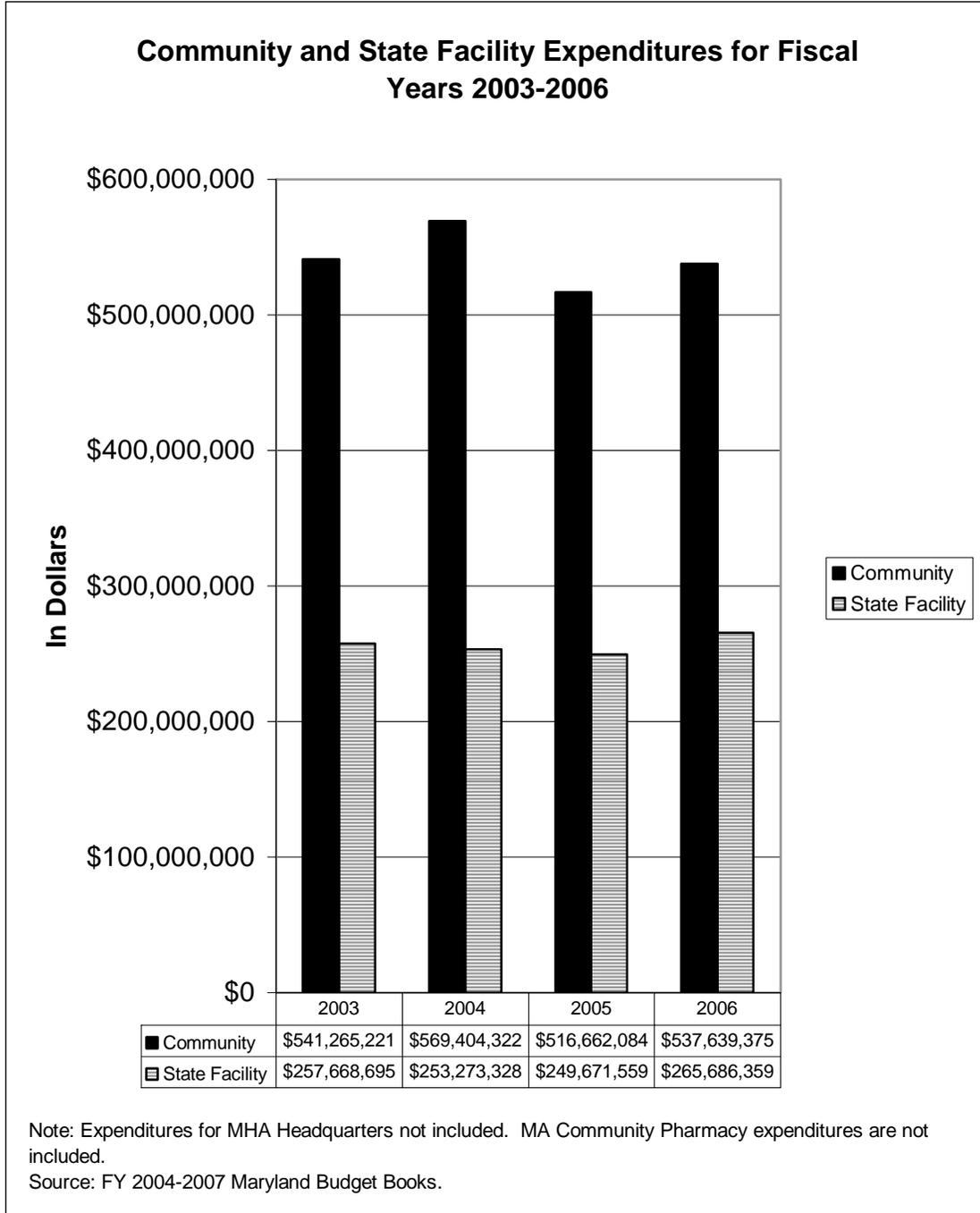
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Individuals with co-occurring disorders constituted 47% of those served in state facilities during FY 2005 and 50% in FY 2006.



COMMUNITY AND STATE FACILITIES EXPENDITURES COMPARED

In FY 2006, 67% of total expenditures were for community-based services (including those in the fee-for-service system and in grants and contracts). In FY 2007, a total of \$855.5 million has been appropriated for MHA – \$576.4 million (\$471.1 million from MA) for community services (67%), \$271.6 million for state-operated institutions, and \$7.5 million for program administration.



FY 2006 ACCOMPLISHMENTS

Major initiatives and accomplishments for FY 2006 included the following:

- MHA continued to facilitate access to medically necessary services and supports. Over 49,772 adults and 42,943 children received community-based mental health services in FY 2006 (based on claims submitted through November 30, 2006). The FY 2007 community services (fee-for-service and grants and contracts) appropriation was increased by nearly \$36 million over the FY 2006 appropriation.
- MAPS-MD, in collaboration with MHA, CSAs, and providers, developed and implemented audit tools for psychiatric rehabilitation programs, outpatient mental health clinics, residential treatment centers (RTCs), individual and group practice providers, and acute inpatient facilities. The tools address quality of treatment planning, service provision, and documentation. MAPS-MD conducted regional trainings for providers on the audit process. The tools are available on the MAPS-MD website for providers to review. Ninety-six (96) audits were conducted this year.
- MHA and the Department of Health and Mental Hygiene (DHMH) collaborated with state partners and key stakeholders, including representatives of consumer groups, to develop regulations and operational protocols for the new Employed Individuals with Disabilities program (EID), which is the Maryland version of the Medicaid Buy-in program. The FY 2006 state budget included an appropriation of \$4 million to implement the program for Medicaid beneficiaries who choose to return to gainful employment while retaining medical coverage.
- Pilot Wraparound programs, which serve as alternatives to psychiatric residential treatment services, are located in Baltimore City and Montgomery County. Enrollment began in March 2006 with 44 children and families served.
- All three Regional Institutes for Children and Adolescents (RICAs) continued to serve youth involved with the juvenile justice system, increasing the numbers of youth served as a result of collaborative efforts between MHA and the Department of Juvenile Services (DJS). RICA-Southern Maryland developed a special short-term residential Extended Diagnosis and Initial Treatment program (EDIT) for youth with emotional disorders who are involved with DJS. The program's combination of milieu and family therapy has helped support these youths' ties to their families and return to their communities.
- In FY 2006, mental health professionals, known as Family Intervention Specialists (FIS), provided mental health services to over 543 youth being served by DJS intensive aftercare teams. The CSAs have been designated lead agencies at the local level, assuring coordination with other mental health services.

- MHA, the Maryland State Department of Education (MSDE), DJS, the Mental Health Association of Maryland (MHAM), the Maryland Coalition of Families for Children's Mental Health, the University of Maryland Department of Child Psychiatry, and other agencies applied for and received an 18-month Schools and Mental Health Integration Grant from the U.S. Department of Education. The grant's focus is on development of a full continuum of mental health promotion, prevention, early intervention, treatment, and crisis intervention in schools within four jurisdictions. Additionally, MHA developed a Crisis Resource Guide in connection with this grant, which provides a listing of crisis resources in the four jurisdictions.
- Twenty-one individuals have been enrolled, as of the end of FY 2006, in the Medicaid Home and Community-Based Waiver to assist individuals with traumatic brain injury (TBI) to transition to the community from state psychiatric facilities. MHA received a five-year renewal of this waiver in June 2006, which included expansion of the eligibility criteria and the addition of a new service to those already included under the waiver.
- One thousand, one hundred and twenty-two (1,122) individuals were served in the detention centers and 98 individuals were served in the community through the Trauma, Addictions, Mental Health, and Recovery (TAMAR) program, which provides treatment for incarcerated men and women with mental illnesses who have histories of trauma. The program is funded through a blend of MHA general funds, AIDS Administration prevention funds, and funds obtained by local jurisdictions through the Governor's Office of Crime Control and Prevention. Additionally, training on trauma-informed care was held for child and adolescent state facilities followed by a few teleconference presentations.
- MHA served 713 persons including 176 single individuals with mental illnesses and 177 consumers in families with 287 children and 73 other family members through Shelter Plus Care, a federally financed program that provides housing subsidies for homeless individuals and those coming from detention centers. In FY 2006, the state's grants were renewed for \$2,677,608 and MHA successfully processed 10 new and 14 renewal grants. Baltimore City, Howard County, and Montgomery County operate independent Shelter Plus Care programs in addition to MHA's statewide program.
- In January 2006, the Bridge Subsidy Pilot Program began operation. The program offers rental subsidies, for a maximum of three years, to individuals with disabilities. A total of 35 individuals, in 17 jurisdictions, were provided with subsidies. Sixteen (16) of these were individuals with mental illness whose incomes were at the SSI level. With the Bridge Subsidy, these individuals were able to move into independent housing. This program is a cooperative effort among MHA, the Department of Housing and Community Development (DHCD), DHMH, the Developmental Disabilities Administration (DDA), the Maryland Department of Aging (MDoA), the Maryland Department of Disabilities (MDOD) and the Centers for Independent Living.

- Four projects totaling \$1,577,000 were funded under the DHMH Community Bond program to build, renovate, or acquire affordable housing and other community-based facilities serving persons with mental illnesses.
- MHA, with its continued collaboration with the University of Maryland Mental Health Systems Improvement Collaborative, expanded the implementation of evidence-based practice models in supported employment, family psychoeducation, and assertive community treatment. Twenty (20) supported employment programs are in various stages of implementing the model. Seven have achieved fidelity to the evidence-based practice model, serving 43% of the total number of consumers who received supported employment services. During the first three quarters of FY 2006, Maryland consistently ranked first among participating states in the national Evidence-based Practice Project, in the percentage of individuals competitively employed. Programs implementing the evidence-based model of family psychoeducation have served a total of 23 consumers and 28 family members this year. Through a Substance Abuse and Mental Health Services Administration (SAMHSA) grant, training of three existing mobile treatment teams continued with the goal of moving their services into the evidence-based practice model of assertive community treatment (ACT). Two new ACT teams, created and funded, in part, through reallocated dollars from the closure of Crownsville Hospital Center, have also been involved in training with the University. Thirty individuals have been discharged from state hospitals through the support of these two new ACT teams.
- The evidence-based model of Comprehensive Continuous Integrated Systems of Care (CCISC), which is designed to improve treatment capacity for consumers with co-occurring disorders, across the mental health and addictions systems, has been implemented in three jurisdictions - Anne Arundel, Montgomery, and Worcester Counties. A fourth county, St. Mary's, has begun this process with an initial steering committee meeting held in June, 2006.
- The Eastern Shore Hospital Center Treatment Mall program, a recovery-based treatment environment that allows individuals to work on life goals that will move them toward the goal of returning to the community, received a Caliber Award from the Mid-Shore Mental Health Systems, the local CSA, for achieving excellence through the empowerment of consumers. Springfield Hospital Center has also implemented some of the elements of the treatment mall model in two buildings. Approximately 150 people are served annually through this program.
- In 2006, the RICA Association, a private non-profit 501© (3) organization affiliated with the John L. Gildner RICA, provided \$16,000 in scholarships to eligible graduating seniors and former students continuing their education beyond high school.

- MHA, in collaboration with the University of Maryland Systems Evaluation Center (SEC) and MAPS-MD, laid the foundation for statewide implementation of the Outcomes Measurement System (OMS), to begin in the fall of 2006 in outpatient mental health programs, federally qualified health centers, and hospital-based mental health clinics. A total of 18 agencies (with 32 programs) completed pilot testing of an adult version of the instrument for the OMS. MHA worked with the SEC to revise the adult questionnaire based on the experience of the pilot and to conduct an abbreviated child and adolescent pilot. MHA and MAPS-MD collaborated to adapt registration and authorization processes in Care Connections, MAPS-MD's web-based system, to include completion of the OMS tools. This included a shift in utilization management focus from the individual consumer level to program level utilization management.
- Maryland was one of seven states to receive a Mental Health Transformation – State Incentive Grant (MHT-SIG), a five-year, \$13.5 million dollar federal grant award. The MHT-SIG is a cooperative agreement grant which will foster further collaboration among state agencies and other stakeholders and will support an array of planning and infrastructure development activities to promote transformation in multiple systems involved with individuals with mental illness. A comprehensive resource inventory and needs assessment has been completed this year which will inform development of a comprehensive mental health plan.
- In collaboration with MHA, the University of Maryland Training Center sponsored and/or facilitated trainings for approximately 4,000 individuals in FY 2006. A variety of training modalities were utilized, including annual conferences, one to three day trainings/seminars, and interactive video conferences. MHA's annual conference, held in May 2006, focused on *Transforming Mental Health Care Together*.
- In FY 2006 over 4,856 consumers attended 19 drop-in centers located throughout Maryland. With the support of MHA, On Our Own of Maryland, Inc. (OOOMD) and the National Alliance for Mental Illness - Maryland (NAMI-MD) provided training and consultation on recovery, employment, and aging caregiver issues to over 1,200 consumers, family members, and providers. Also in FY 2006, in collaboration with OOOMD, MHA continued the fifth year of a six-year project under a federal Olmstead planning grant. Through the grant, peer support counselors in three state hospitals work with consumers, prior to discharge, to provide information on community resources and then make 30-day follow-up visits in the community. In FY 2006, a total of 64 consumers were contacted by the peer counselors to assist with their transition to the community.
- MHA, in collaboration with OOOMD, sponsored a two-day training for directors of consumer drop-in centers on June 19 & 20, 2006. Approximately 38 consumers, representing ten consumer drop-in centers, were in attendance. Training for the conference was provided by the Maryland Association of Nonprofit Organizations. Topics included legal issues, financial basics, strategic thinking, and nonprofit governance.

- In December 2006, the MHA Consumer Affairs Liaison collaborated with OOOMD, to train nine Leadership Empowerment and Advocacy Project (LEAP) participants in a three-day retreat setting. Training topics included communication and leadership as well as assertiveness and conflict resolution skills. Through LEAP, consumers are prepared to take on leadership and advocacy roles in the PMHS.
- All Hazards Behavioral Health Disaster plans have been developed for MHA and the Alcohol and Drug Abuse Administration (ADAA), which include the development of state and local infrastructure, communications systems, interagency coordination, and enhanced crisis response. A drill was held in April 2006 to test the effectiveness of the plans. Additionally, MHA's Behavioral Health Disaster Services staff has recruited over 1,400 licensed volunteers for the Maryland Behavioral Health Volunteer Corps, now under the auspices of DHMH. MHA provides clinical consultation and regular trainings to all branches of the Corps to ensure appropriate and quality care by behavioral health volunteers. During the Hurricane Katrina response, 15 members of the Behavioral Health Volunteer Corps were deployed to Jefferson Parish in New Orleans to assist the American Red Cross and were debriefed by MHA's Behavioral Health Disaster Services staff upon return.
- During academic year 2006, ten students were enrolled as scholars in the Maxie Collier Scholars program, a MHA-funded program in which minority undergraduate students are provided with scholarships and mentoring to encourage them to pursue graduate education towards a career in mental health. Other program elements include: career placement resources; general academic advisement; individualized graduate school preparation and support plan; and enrichment activities, i.e. mental health seminars, workshops, and conferences.
- On May 6, 2006, 24 participants graduated from the third Family Leadership Institute. This Institute, supported by MHA, is conducted by the Maryland Coalition of Families for Children's Mental Health. The sessions provided information, training, resources, and skills-building to families with children who have mental health needs; preparing them to become leaders in improving the system of care in Maryland. Additionally, in the spring of FY 2006, the Wicomico County CSA invited the Coalition to present a Leadership Institute to 15 families over two weekends.
- In FY 2006, approximately 1,800 people participated in the annual NAMI-MD Walk for the Mind of America. The 2.4-mile awareness walk, in which MHA participated and helped to promote, generated nearly \$124,000 in funds, which will be used to provide statewide NAMI-MD educational programs and support groups for consumers and their families, as well as for community members.

- In FY 2006 under the auspices of MHA and MHAM, the “Caring For Every Child’s Mental Health” campaign hosted mental health fairs, distributed over 40,000 pieces of literature to provide mental health education and awareness, and supported 296 performances of a traveling awareness-raising puppet show, Kids on the Block, for more than 12,000 people. The Campaign webpage, which was updated with new information on depression and schizophrenia in children, received over 26,000 page views. Additionally, the Campaign conducted a statewide promotion with transit and print advertising posted in Baltimore City and Baltimore, Anne Arundel, Prince George’s, Montgomery, Frederick, Howard Counties, midshore counties, and in Ocean City to alert riders/readers to the symptoms of mental illness in children and to encourage the use of the Maryland Youth Crisis Hotline as a resource.
- MHA and OOOMD continue to collaborate to fight stigma within the mental health system through the Anti-Stigma Project (ASP). In FY 2006, the ASP presented 50 workshops to more than 3,000 participants, addressing issues such as cultural competency, substance abuse, and juvenile justice. The teaching videotape, “Stigma...in Our Work, in Our Lives,” continues to gain national and international attention. Additionally the “Stigma: Language Matters” posters are being translated into Spanish in an effort to use a culturally diverse media to reach a wider audience.

We continue to support a system that offers choices and encourages movement towards recovery as defined by the individuals served. MHA’s goal is to create a transformed consumer and family driven system of care that focuses on consumer recovery and resiliency, uses evidence-based and effective practices, provides peer and family support services, and is outcomes driven. Collaboration and support from our sister agencies, providers, CSAs, advocacy groups and consumers and family members plays a significant and ongoing role in providing opportunities for recovery and resilience for the individuals within our system.