



VISION AND RESULTS

The Annual Report
of the

MENTAL HYGIENE ADMINISTRATION

FISCAL YEAR 2007

***WORKING TOGETHER TO PROMOTE
RECOVERY***

Martin O'Malley, Governor

Anthony G. Brown, Lieutenant Governor

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

Arlene Stephenson, Acting 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 2007

**BRIAN HEPBURN, M.D.
EXECUTIVE DIRECTOR**

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 2007 Annual Report, which highlights MHA's programmatic and fiscal accomplishments for the year. Working with stakeholders, we have had many achievements during the year. We have seen success in furthering evidence-based practices in the areas of supported employment, assertive community treatment, and family psycho-education. Additionally, evidence-based practices (EBP) in child and adolescent services and in services for individuals with co-occurring disorders continued to be a focus and we anticipate new successes in these areas of EBP implementation.

Now three years into the federal Mental Health Transformation-State Incentive Grant implementation, advancements in interagency collaborations, and public and private partnerships have continued to build upon the infrastructure for an improved continuum of care. The promotion of family and youth participation and leadership in program and policy development demonstrated ongoing efforts in furthering recovery and resilience. Maryland will be the first statewide chapter of a national youth-driven organization dedicated to creating change in the lives of youth involved in mental health and other youth-serving systems. Building the infrastructure to support an improved continuum of care for individuals across the life span continued to be the emphasis within transformation to enhance the Public Mental Health System. The Mental Health Transformation Office (MHTO) continues to collaborate with the Maryland Health Care Commission to develop a plan to guide the future development of the mental health service continuum for Maryland.

Maryland has adopted the Australian program, Mental Health First Aid (MHFA), as an educational effort to assist the general public in recognizing individuals with mental health problems and facilitating mental health assistance when needed. The program is similar to medical first-aid that is provided to individuals in crisis. The program will provide the general public with the knowledge and resources to support individuals in mental health distress. The program will be presented throughout Maryland, including schools and universities, as a public health initiative in building healthier communities.

State funding was provided through the Governor's Office for Children (GOC) to fund high-fidelity wrap-around pilot programs to enhance community-based services for children and youth at risk of out-of-home placement. Efforts by Maryland's Mental Health Workforce Steering Committee have led to the development of basic core competencies and curriculum modules to support training of providers of mental health services for children and adolescents.

In response to a growing number of returning veterans, Department of Health and Mental Hygiene/MHA and the Maryland National Guard and Defense Force have implemented a new national model to provide assistance to veterans and families. An initiative to provide coordination of behavioral health services for returning veterans of the Iraq and Afghanistan conflicts was a collaborative effort at the state and local level to help bridge the gap in services for veterans until service benefits from the Veterans Administration can be obtained.

MENTAL HYGIENE ADMINISTRATION

We are working to further develop parameters for telepsychiatry to improve access to mental health services, especially for individuals living in rural and medically underserved areas. Telepsychiatry is being utilized in several detention centers and in selected state facilities to enhance long distance training and referral processes. Additionally, we are implementing the web-based Networks of Care around the state to enable consumers, families, and youth to more quickly identify resources they need and consolidate client information in one central place.

New leadership, through the inauguration of Governor Martin O'Malley, and the appointment of Department of Health and Mental Hygiene Secretary, John M. Colmers, brings ongoing commitment to mental health. With their support and leadership, Maryland has and will continue to cultivate a system of care which emphasizes resiliency and recovery; strengthens partnerships with consumers and families; integrates cultural competence throughout its services and programs; and furthers existing collaborations within and across systems to promote and enhance excellent mental health care.

Brian Hepburn, M.D., Executive Director

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Mission

The mission of the Mental Hygiene Administration is to create and manage a coordinated, comprehensive, accessible, culturally competent, 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.

Maryland's Mental Health Transformation

The accomplishments and initiatives in this report are emphasized within the broader context of Maryland's transformation efforts. The federal Mental Health Transformation State Incentive grant (MHT-SIG) continues to build public and private partnerships and interagency collaborations that enhance the continuum of care. These alliances further the infrastructure that enables Maryland's Public Mental Health System to improve services and remain successful in enhancing evidence-based practices toward building a culturally competent, recovery-oriented, and resiliency-based care system.

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 2007

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). MHA continued to facilitate access to medically necessary services and supports. The report also highlights enhanced delivery of supports and services, effective collaborations and partnerships, and the progress of several initiatives and pilot projects implemented in FY 2007 and over the past two years. These major innovations, which play an essential role in supporting recovery and resiliency of children and adults, include:

- More than 94,000 individuals have accessed the Public Mental Health System in FY 2007. Approximately 52,503 adults and 42,160 children received services through the fee-for-service Public Mental Health System (PMHS).
- We have advanced efforts to implement statewide evidence-based practices (EBPs). Within the programs of supported employment (SE), assertive community treatment (ACT), and family psycho-education (FPE) that achieved fidelity to the national model, more than 1,800 people were served. Maryland was recently recognized for its work in evidence-based practice in SE with Substance Abuse and Mental Health Services Administration's (SAMHSA) Science-to-Service Award. Additionally, a new training model, utilizing trained high fidelity evidence-based SE programs to train other providers in the model was implemented. Thirteen supported employment programs, three FPE providers, and five mobile treatment teams providing ACT services have achieved fidelity as of FY 2007.
- The Outcomes Measurement System (OMS), fully implemented statewide in FY 2007, collects outcomes information on consumers ages 6-64 who are receiving treatment in specified outpatient settings. As of July 2007, more than 43,000 individuals have completed at least one questionnaire. In the coming year we will focus on analysis of data and development of reporting structures.
- Partnerships have been implemented to enhance early childhood mental health and other activities through the newly developed Child and Adolescent Mental Health Institute. A train-the-trainer program has been developed to assist clinicians and other providers to gain expertise in working with young children. This year, 35 master level clinicians received specialized training through the Early Childhood Mental Health Certificate Program the University of Maryland Department of Child and Adolescent Psychiatry.
- During FY 2007, 396 children and families received community-based, in-home wrap-around services. The development and implementation of these services has served to reduce reliance on psychiatric residential treatment.
- Hospital diversion services have been implemented in two jurisdictions through pilot programs in response to ongoing pressure for admission of uninsured individuals to state hospitals from emergency departments. Early data suggests successful diversion of individuals to community alternative placements in FY

2007. These programs will continue and expand to other jurisdictions.
- We have supported efforts to involve consumers in monitoring services through the pilot Consumer Quality Team. In 2007 twenty-two (22) site visits were made to community programs in three jurisdictions, which provided valuable feedback to providers, the CSAs, and the state. Also, Maryland begun a Self-Directed Care Pilot project, in which adult consumers will be assisted in the development of their individualized plans that will become the basis for moving towards their self-defined recovery.
 - This year pharmacy data information-sharing was made available for mental health providers on MAPS-MD's web site. Also, Networks of Care is creating a web-based system that enables consumers, family, and youth to more quickly identify resources they need and consolidate their personal health information in one place. Efforts to expand telemental health to improve access to mental health services across Maryland are underway.
 - Additional accomplishments can be found on pages 23-27.

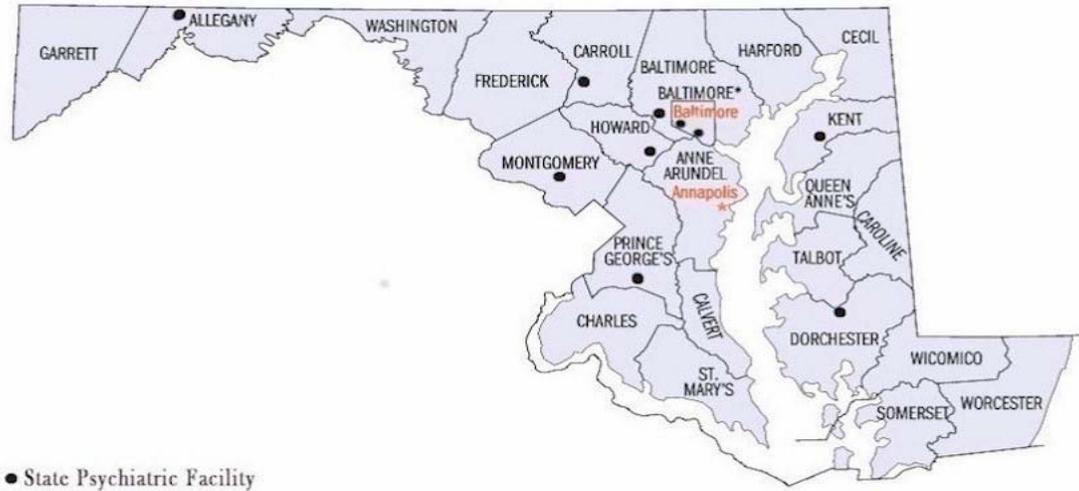
DESCRIPTION OF THE SYSTEM

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. 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 both 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 is located 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.

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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:



Over the years, Maryland has configured its state hospital system so that it now maintains only one hospital unit for adolescents at Spring Grove Hospital Center 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 for those meeting medical necessity.

MHA continues to operate a centralized admission referral center (CARC) to assist emergency rooms (ERs) in locating and accessing state hospital beds. This center receives referrals of uninsured individuals for state hospital beds, 24 hours per day, 7 days per week. However, in FY 2007, in efforts to address the continued demand for state inpatient beds, the admission and referral process has been revamped to include greater reliance on using local systems of care. Eastern Shore Hospital Center (ESHC) manages the requests for admission from Eastern Shore emergency rooms to ESHC and Upper Shore Community Mental Health Center. Finan Center in Western Maryland now directly manages the referral and state hospital admissions for individuals presenting in ERs in Frederick, Washington, Garrett, and Allegany counties. As a result, there have been improvements in the coordination of care among the community mental health system, Core Service Agencies, local hospitals and the state hospitals. The collaboration will better promote use of alternative services to hospital levels of care and facilitate the discharge of long – stay state hospital patients.

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 within local jurisdictions. 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), MAPS-MD. 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 2007, 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 on Mental Illness of Maryland, the Mental Health Association of Maryland, the Maryland Coalition of Families for Children's Mental Health, the Community Behavioral Health Association of Maryland, and the Maryland Association of Resources for Families and Youth, 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 created 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, are composed of consumers, family members, mental health professionals, representatives of various state agencies, and other interested persons who 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 formulate MHA's annual planning efforts. Additionally, 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 includes:

- Psychiatric hospitals
- Psychiatric units of acute care general hospitals
- Residential treatment centers (RTCs) (children and adolescents only)
- Psychiatric day treatment (also called partial hospitalization)
- Outpatient mental health clinics (OMHCs) (including some school-based and after-school treatment programs)
- Individual practitioner services
- Psychiatric rehabilitation programs (PRPs)
- Residential rehabilitation programs (RRPs)
- Mobile treatment services (MTS)
- Supported living programs
- Supported employment (SE) 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 FY 2007, a decision was made to change the financing for mental health case management due to new requirements from the Centers for Medicare and Medicaid Services (CMS) on rate setting methodology. Rather than use Maryland's Medicaid state

plan option and protocol for case management, MHA will contract with the CSAs, who in turn, will contract with case management providers for the service.

In addition, MHA continues to contract with the 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 \$35.5 million in state general funds and \$16.4 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 State Incentive Grant, and the Evidence-Based Practice Training and Evaluation grant.

SYSTEMS PERFORMANCE OVERVIEW

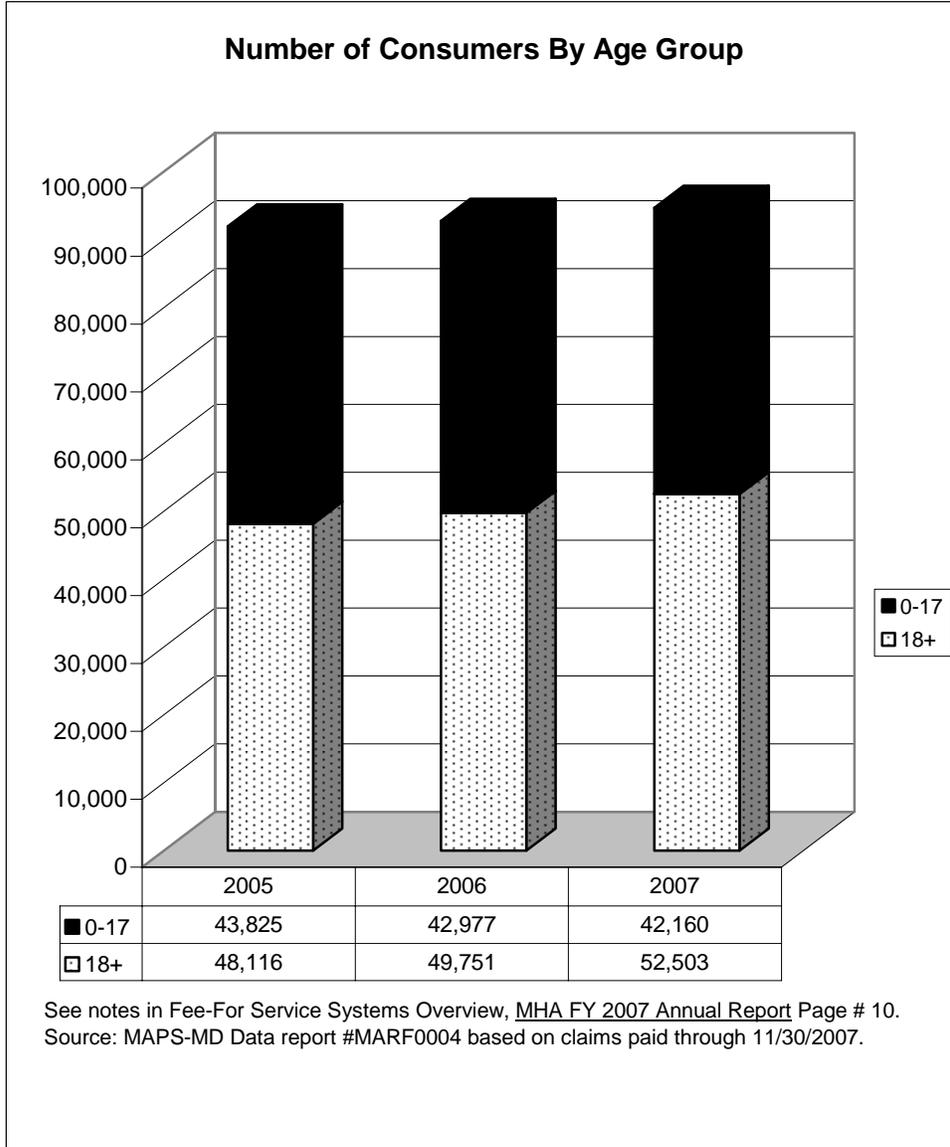
THE FEE-FOR-SERVICE SYSTEM

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, 2007. Since claims may be submitted up to nine months from the date of service, data for FY 2007 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:

- In FY 2004, funding for psychiatric rehabilitation services for Medical Assistance (MA) ineligible individuals returned to the fee-for-service system. Payment of Medicare crossover claims moved to Maryland Management Information System (Medical Assistance) and is no longer reflected in PMHS activity.
- 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.
- In FY 2007, through the Primary Adult Care Program, individuals with income and assets above existing MA limits, but below other thresholds, became eligible for outpatient somatic and mental health services paid for by Medicaid. Many individuals previously served as uninsured became MA eligible.
- This data set does not include information on services funded through contracts.

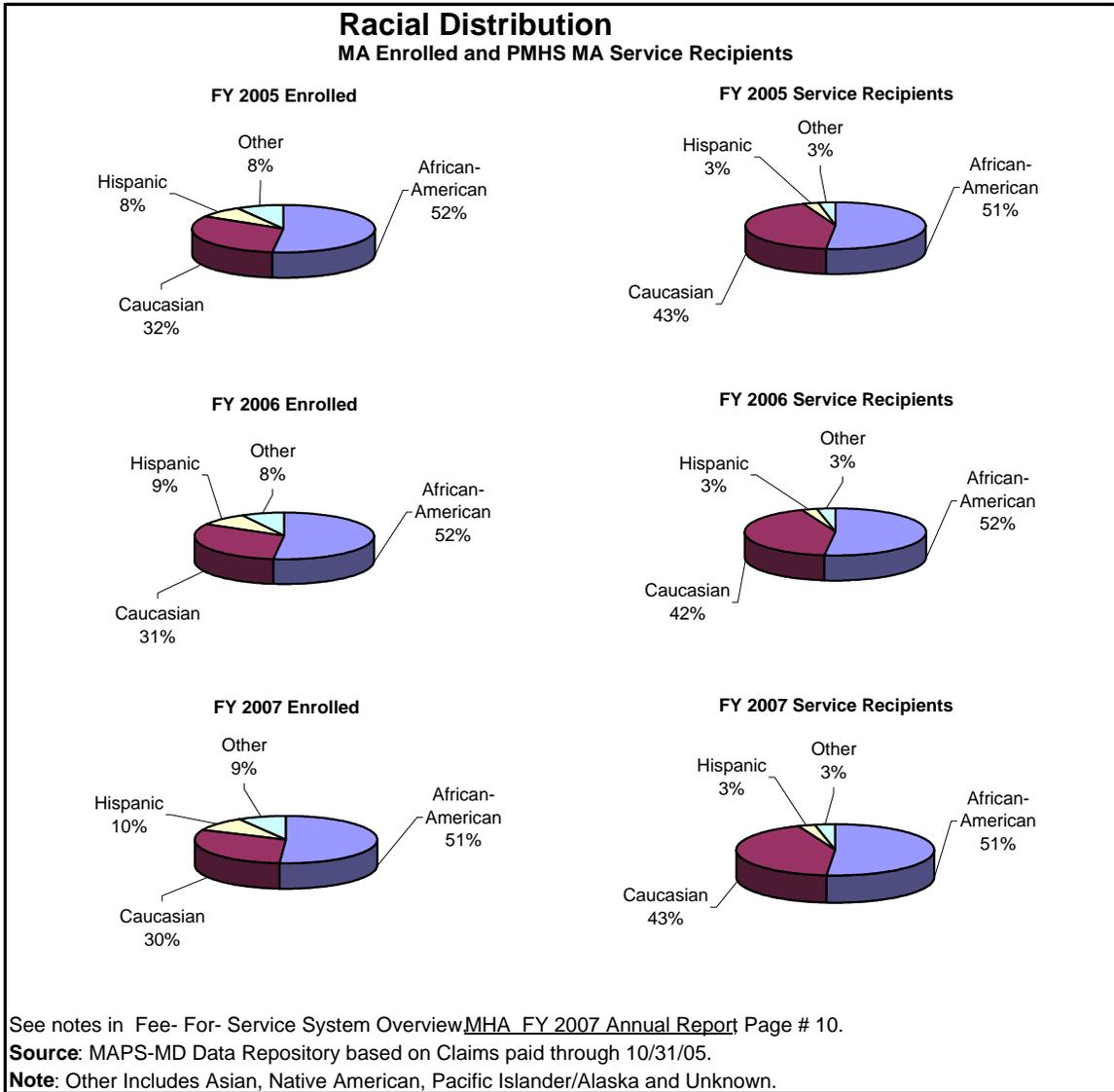
Population Served

The number of individuals served in the fee-for-service PMHS has increased from 91,941 in FY 2005 to 94,663 in FY 2007. An almost equal number of males and females received services in the PMHS. In FY 2007, 55% of the people served were adults, 45% were children.



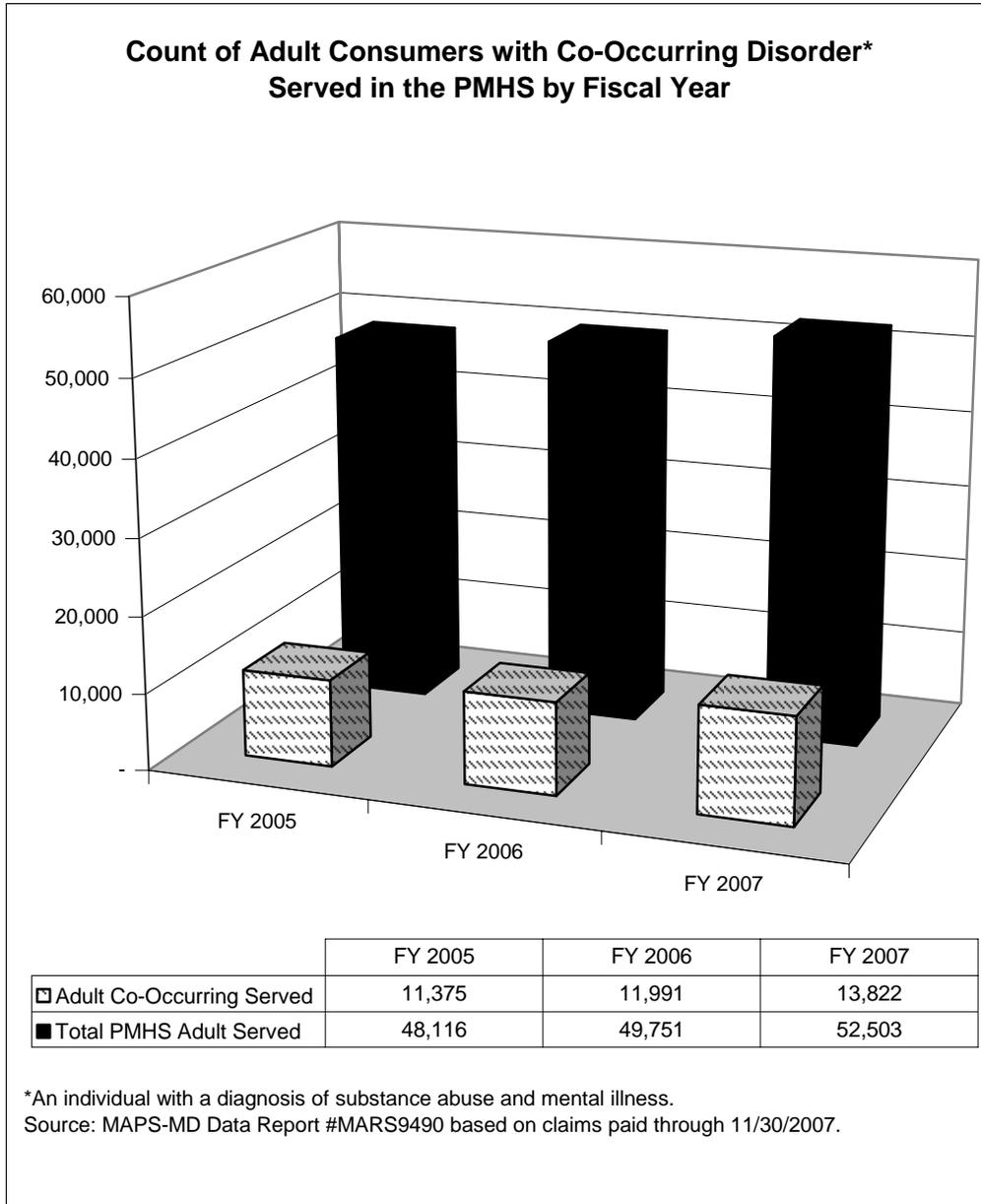
MENTAL HYGIENE ADMINISTRATION

The racial distribution of the MA enrolled population has remained relatively constant since FY 2005, with the African-American population between 51% and 52% and Caucasians at 30%-32%. The Hispanic population has risen from 8% in FY 2005 to 10% of the MA enrolled population in FY 2007. Of the MA population served in the PMHS fee-for-service system in FY 2007, African Americans represent approximately 51%, Caucasians 43%, and Hispanic individuals approximately 3%.



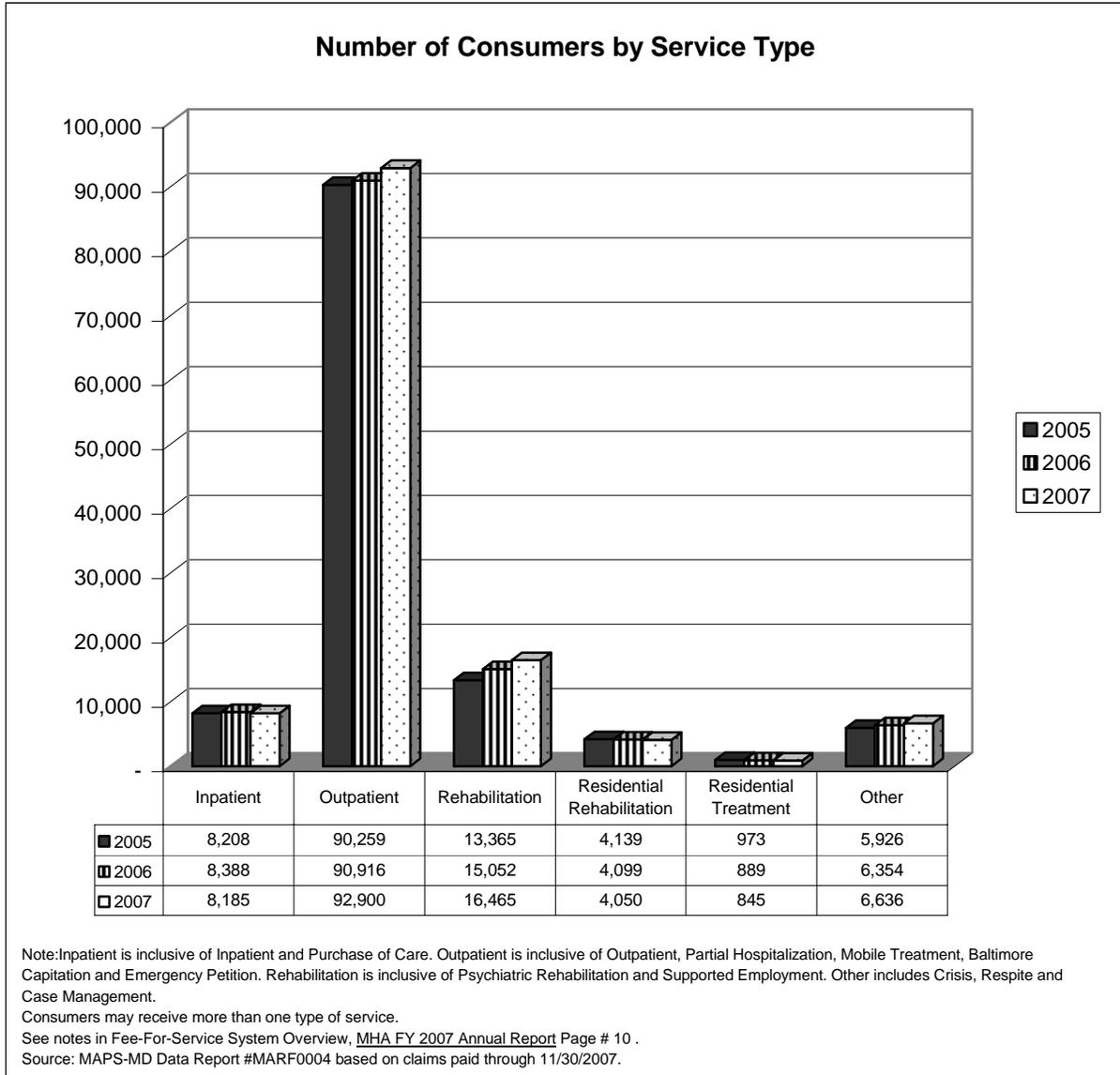
The PMHS serves individuals with a range of psychiatric diagnoses. The three most common diagnostic groupings for children and adolescents are attention deficit disorders, adjustment disorders, and major depression. The most common for adults are major depression, bipolar disorders, followed by other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

A significant number of individuals in the fee-for-service PMHS have co-occurring disorders of mental illness and substance abuse – and has increased from more than 11,000 adults in FY 2005 and 2006 to more than 13,000 in FY 2007. The percentage of adults served in the PMHS with co-occurring disorders increased by 2%.



Service Utilization

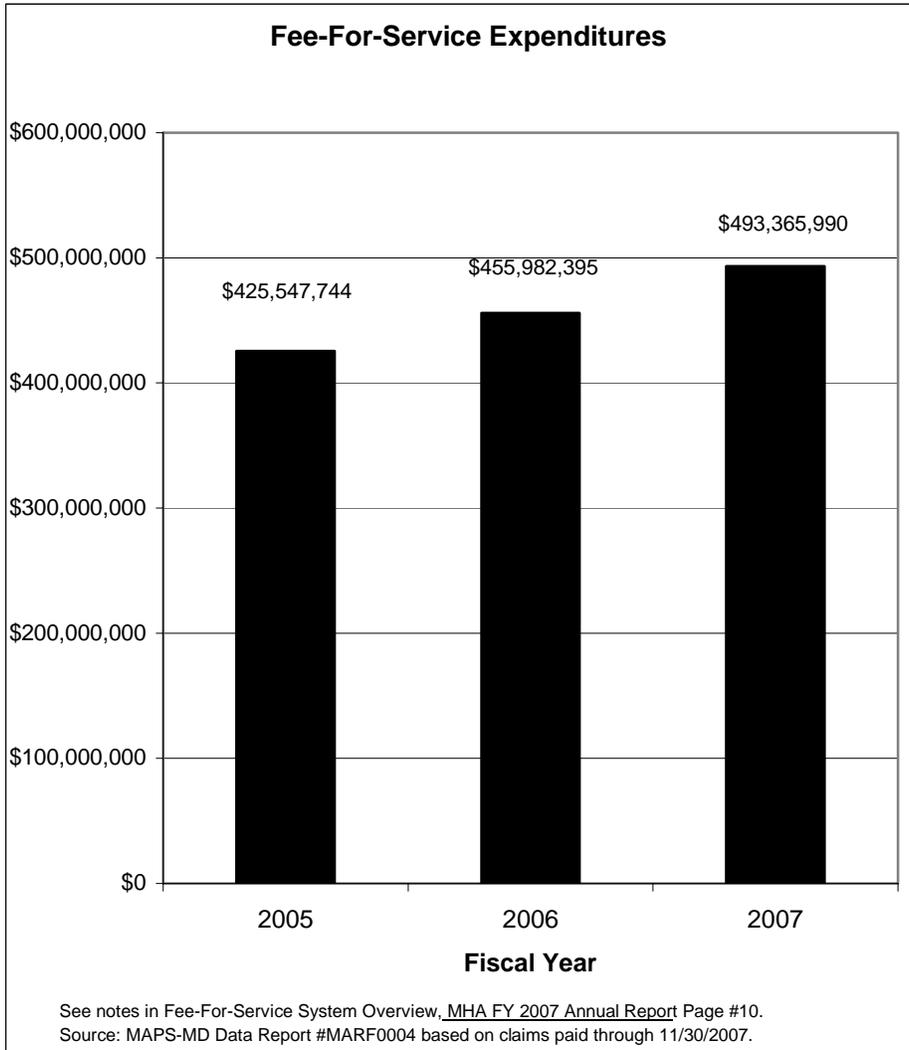
The following chart provides data on the numbers served within each service type for the fiscal years 2005-2007.



Between FY 2005 and FY 2007 there have been increases in the number of individuals using community services, such as rehabilitation services and crisis, respite and case management (other), while the numbers served through outpatient and inpatient services remained relatively stable. The number of youth served in residential treatment centers (RTCs) has decreased nearly 13% between FY 2005 and FY 2007. Rehabilitation Services includes supported employment, all programs statewide, which has seen a 25% growth in numbers served between 2006 and 2007.

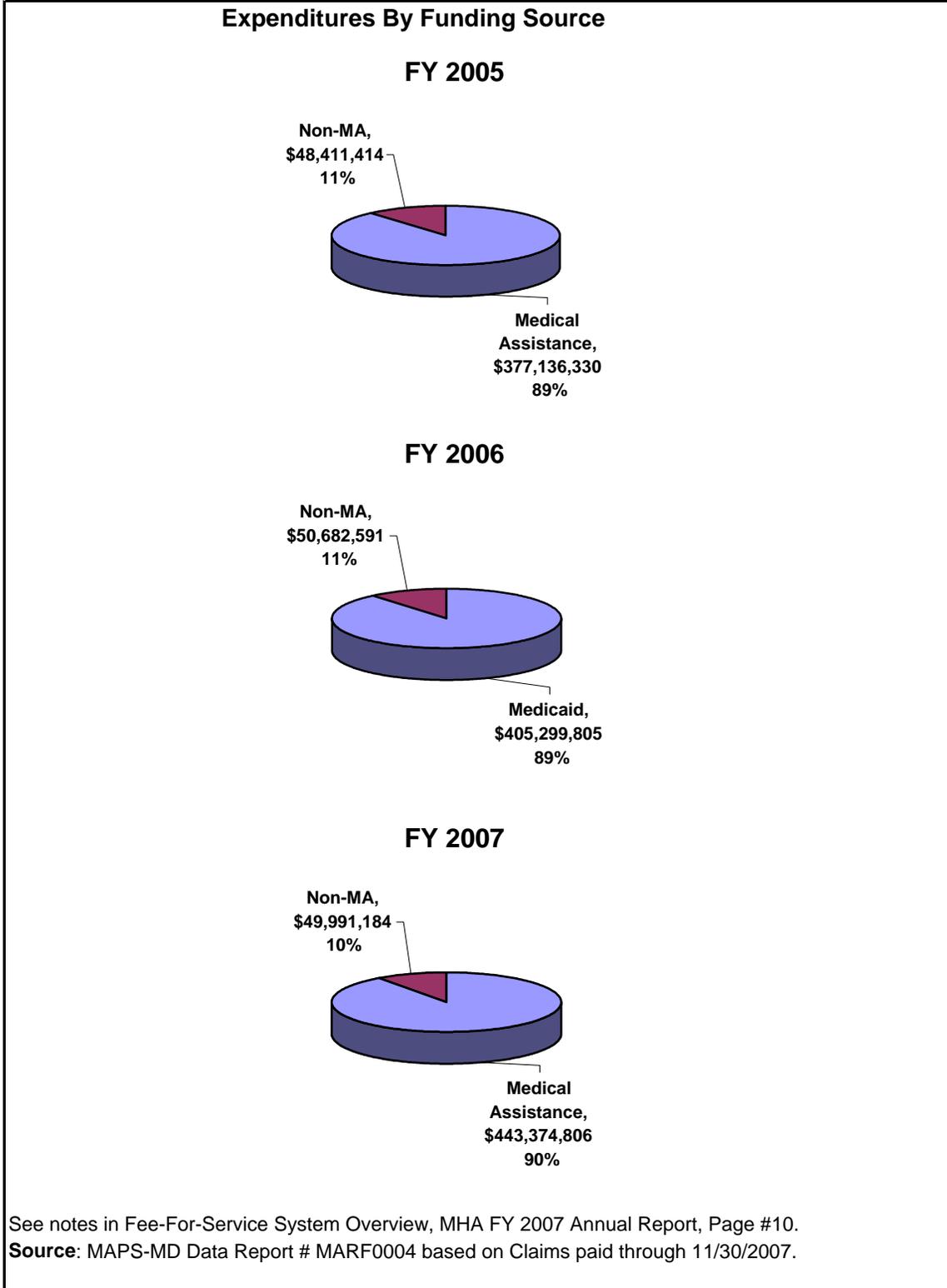
Service Expenditures

Increasing access to mental health services has been a hallmark of the redesigned fee-for-service PMHS under the MA 1115 Waiver. Fueled by the growth in MA eligible individuals, increasing numbers have received services with associated increases in expenditures.



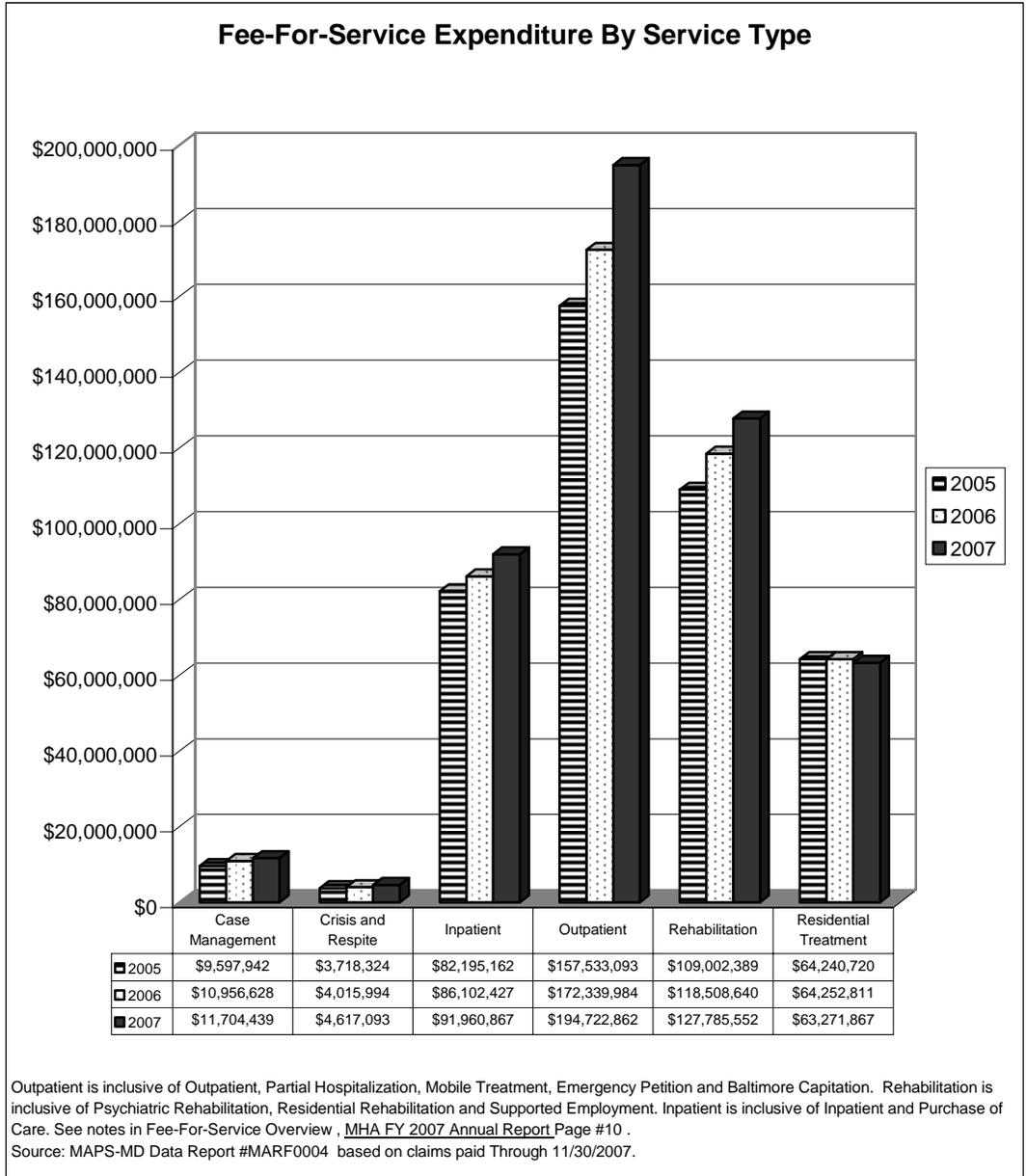
MENTAL HYGIENE ADMINISTRATION

The majority of expenditures in the fee-for-service PMHS are for services reimbursed by MA. Federally matched MA expenditures represent 89-90% (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.



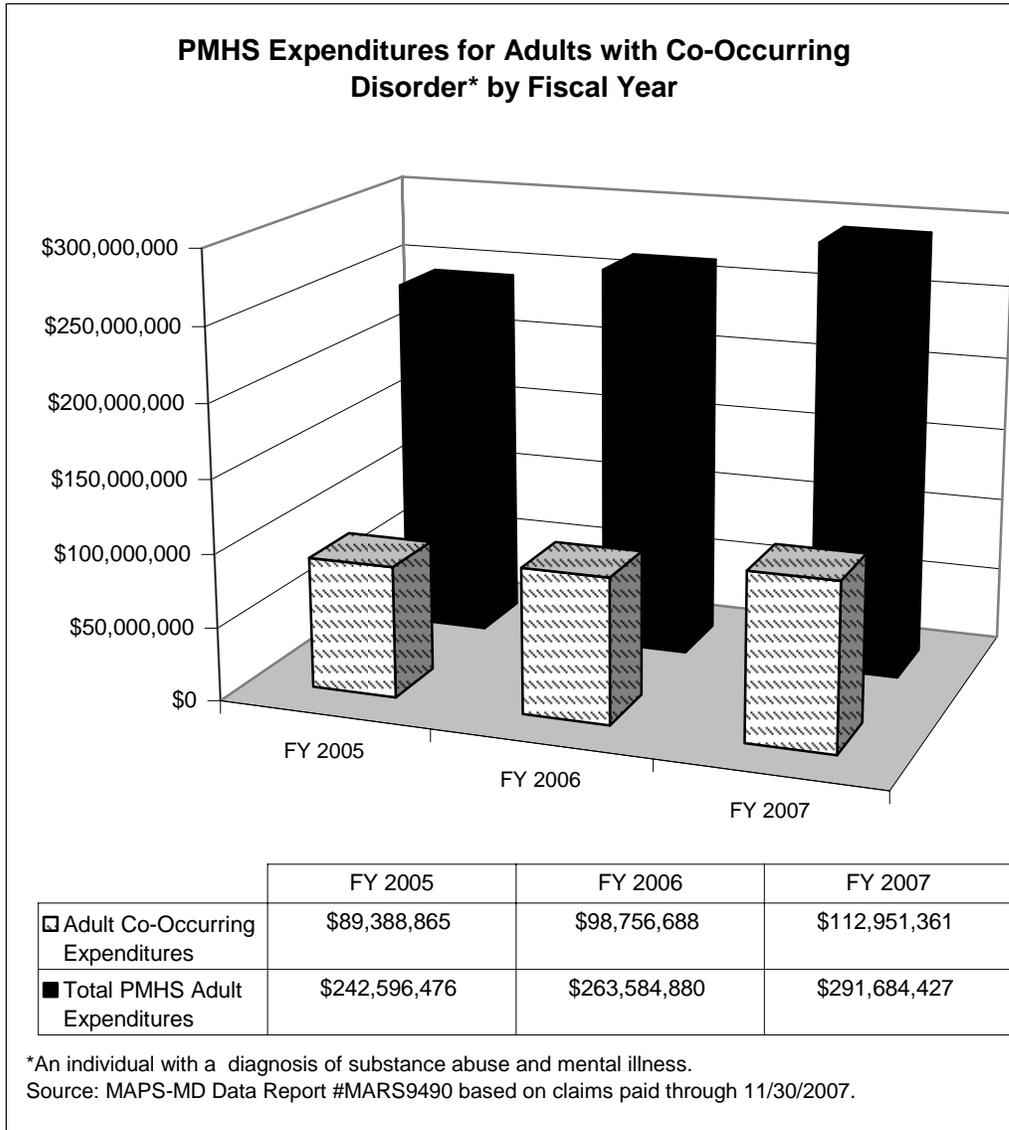
MENTAL HYGIENE ADMINISTRATION

The following chart provides data on expenditures within each service type for the fiscal years 2005-2007.



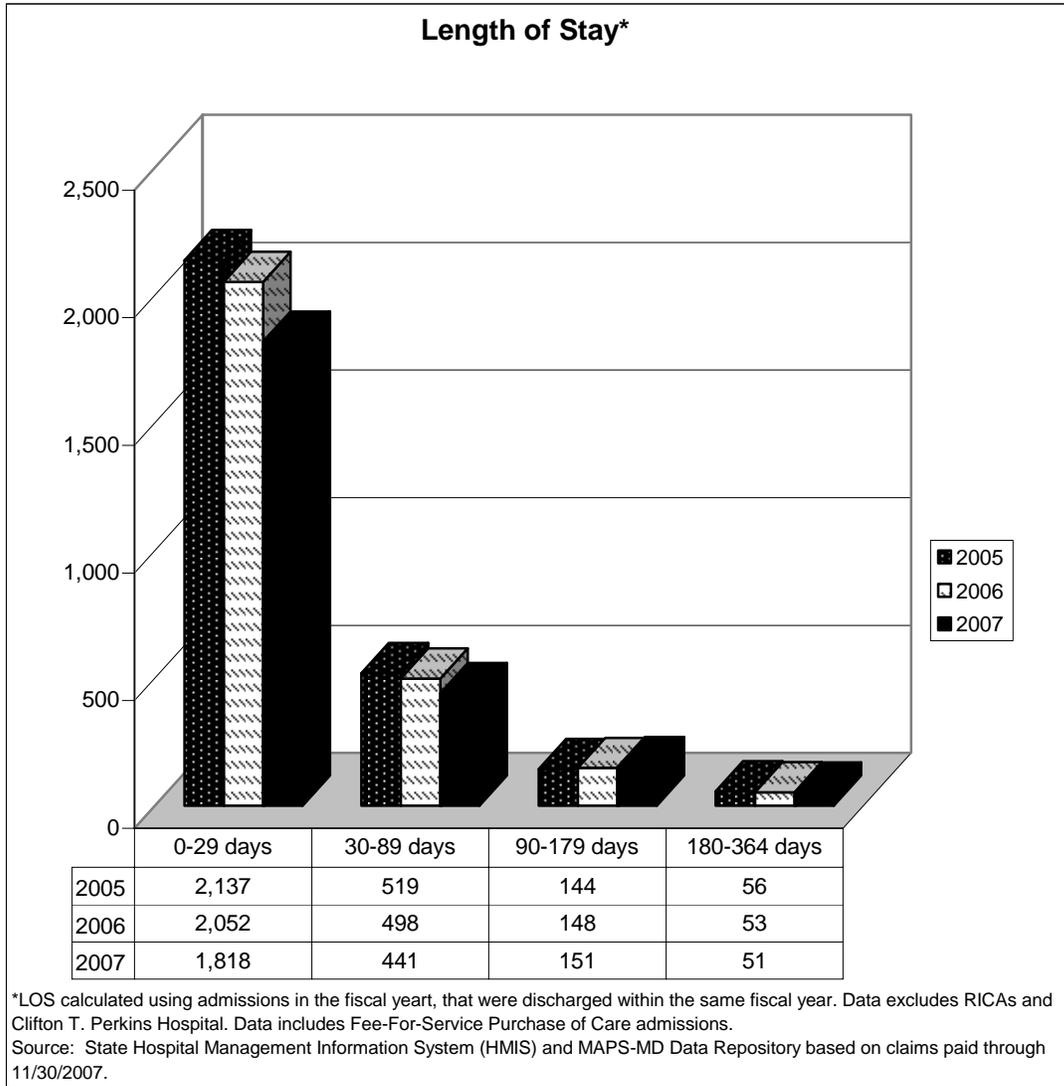
MENTAL HYGIENE ADMINISTRATION

As noted earlier in the chart on page 13, adults who have co-occurring mental illness and substance abuse disorders, represent 26% of the adults served in the fee-for-service PMHS in FY 2007. Expenditures for these individuals in the same fiscal year represent approximately 39% of the total adult service expenditures for PMHS, as shown in the following chart.



HOSPITALS AND STATE FACILITY SYSTEMS

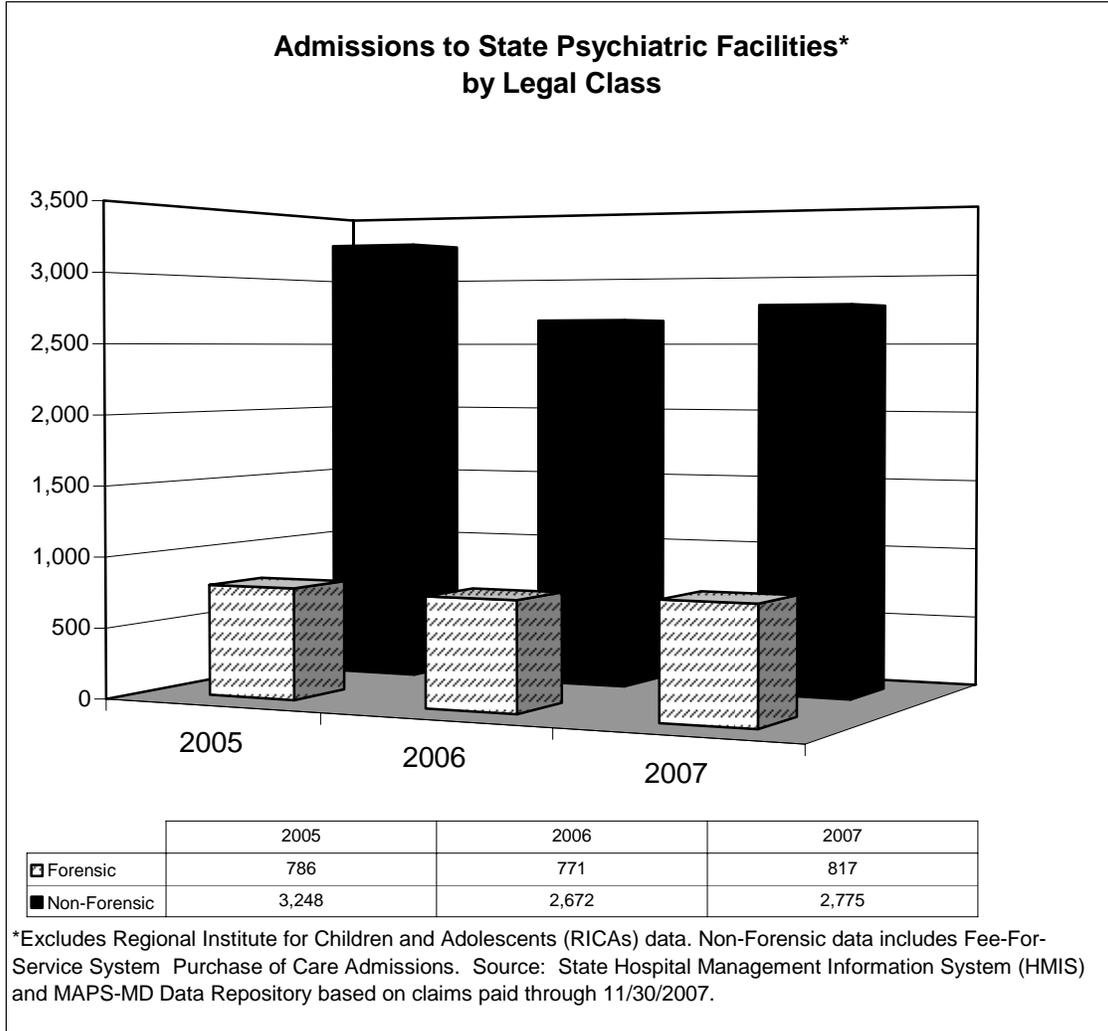
MHA has oversight authority of ten state psychiatric facilities, including one forensic facility and three residential treatment centers (RTCs). In FY 2007, the average daily population (ADP) of these facilities was 1,154. The state facilities operate close to 100% of operating capacity at all times. 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 for this purchase of care beds is usually nine 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.



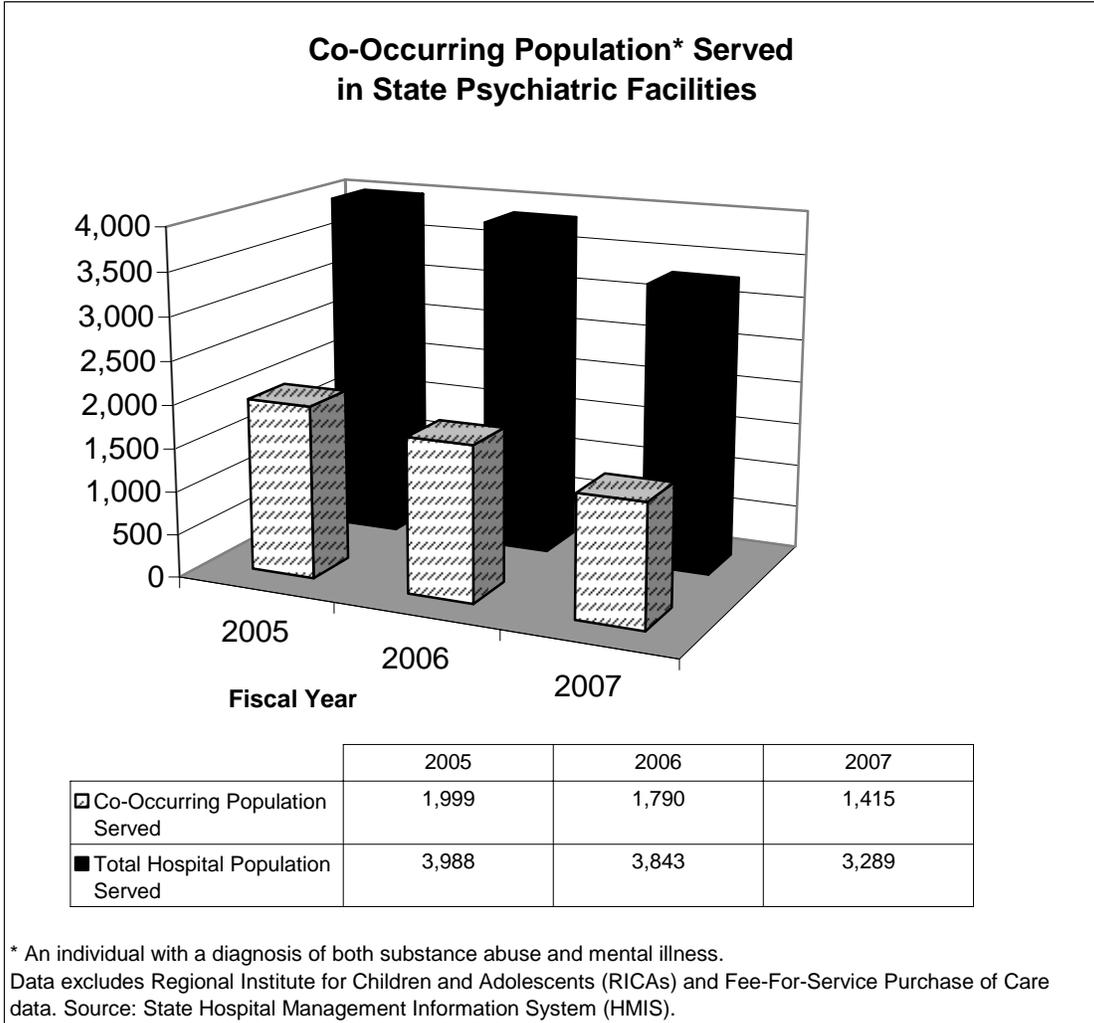
For those admissions that were discharged within the same fiscal year, between 72-75% of those discharges were within 30 days and between 92-93% were within 90 days of admission. Purchase of care (POC) admissions, 704 in FY 2005, 682 in FY 2006, and 925 in FY 2007, are included. All POC discharges were within 30 days.

MENTAL HYGIENE ADMINISTRATION

The number of forensic admissions has risen by 3.9% over the three years. In FY 2005, nearly 20% of the total state facility admissions were forensic admissions. In FY 2007, 23% were forensic admissions. In FY 2007, 62% of forensic admissions were discharged within the same fiscal year.

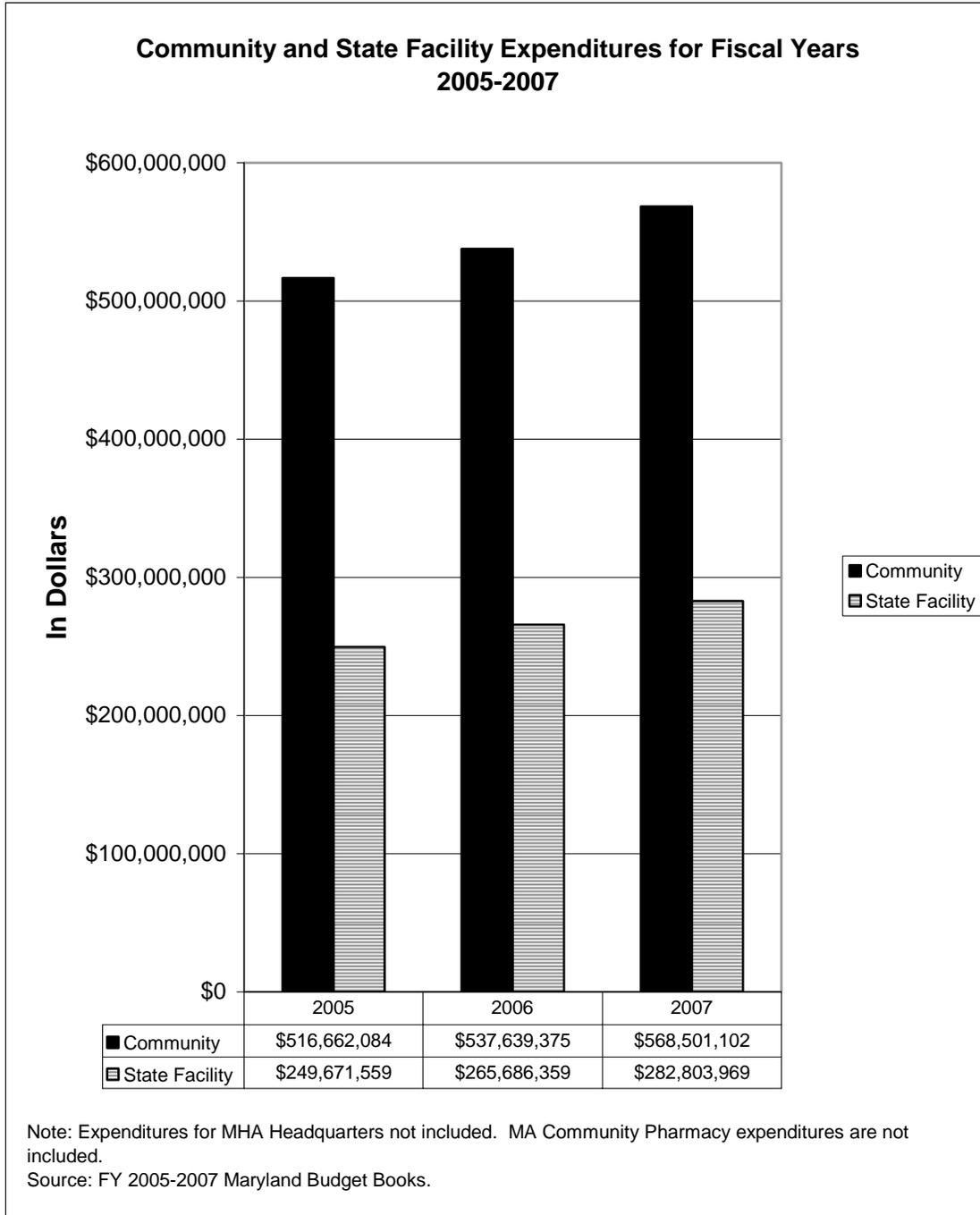


Individuals with co-occurring disorders constituted 50% of those served in state facilities during FY 2005 and 43% in FY 2007. The decrease may be attributed in part to the hospital diversion programs, which began during this year. These programs divert a high percentage of individuals with co-occurring or substance abuse disorders to community alternative placements.



COMMUNITY AND STATE FACILITIES EXPENDITURES COMPARED

In FY 2007, 66.9% of total expenditures were for community-based services (including those in the fee-for-service system and in grants and contracts). In FY 2008, a total of \$893.2 million has been appropriated for MHA – \$605.3 million (\$491.1 million from MA) for community services (68%), \$280.7 million for state-operated institutions, and \$7.2 million for program administration.



FY 2007 ACCOMPLISHMENTS

Major initiatives and accomplishments for FY 2007 included the following:

- The FY 2008 community services (fee-for-service and grants and contracts) showed an increase of \$37 million over FY 2007. This increased appropriation included funds for a provider rate increase, utilization increase, and an increase in the number of people being served.
- MAPS-MD has incorporated information from the Medicaid Management Information System (MMIS) on prescriptions filled by consumers in the PMHS into APS CareConnections®, its web-based authorization system. Providers will be able to access medication information, allowing mental health and health providers to better integrate mental health and health care. A rolling 12 – month history of filled prescriptions will be accessible to PMHS providers, managed care organizations (MCOs), and CSAs. In FY 2008, primary care physicians, who sign a user agreement and agree to confidentiality procedures, will also have access to this information.
- MHA in collaboration with On Our Own of Maryland provided training in FY 2007 to approximately 816 consumers on the Employed Individuals with Disabilities program (EID), which is the Maryland version of the Medicaid Buy-in program. The FY 2007 Medicaid budget contained funds to fully implement a Medicaid Buy-In program for Medicaid beneficiaries who choose to return to gainful employment while retaining medical coverage.
- A curriculum on reducing seclusion and restraint in child and adolescent facilities has been developed and is being implemented. MHA continues implementation of a number of activities related to the SAMHSA Seclusion and Restraint Reduction/Elimination Grant in five state facilities. The SAMHSA Seclusion and Restraint Reduction/Elimination Grant Project Coordinator works closely with MHA facilities and with some of the therapeutic group homes around seclusion and restraint use.
- In FY 2007, 396 children and families were served through pilot wraparound programs, which serve as alternatives to psychiatric residential treatment services. These pilots, located in Baltimore City and Montgomery County are a result, in part, of Maryland being awarded one of 10 Center for Medicare/Medicaid Services demonstration projects for alternatives to psychiatric residential treatment facilities (PRTF) which allow the designated states to apply for a 1915(c) Medicaid Home and Community-Based Services waiver to serve children and youth at risk of out-of-home placement in the community.
- In FY 2007, mental health professionals, known as Family Intervention Specialists (FIS), provided mental health services to over 487 youth being served by the Department of Juvenile Services intensive aftercare teams. The CSAs have been

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designated lead agencies at the local level, assuring coordination with other mental health services.

- Statewide implementation follows successful programming and a rigorous evaluation conducted in two pilot projects in which mental health consultation was provided in child care programs. This initiative integrates mental health consultation into existing early childhood programs in urban and rural areas.
- The Medicaid Home and Community-Based Waiver for individuals with traumatic brain injury (TBI) has successfully served 30 individuals in FY 2007. This waiver program assists individuals with TBI to transition to the community from state psychiatric facilities, state-owned and operated nursing facilities, and chronic hospitals. 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 services already included under the waiver. A waiver registry list has been initiated and applications are mailed out to individuals on the registry as placements become available.
- 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 trauma-based 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 and funds obtained by local jurisdictions. Additionally, training on trauma-informed care was held for child and adolescent state facilities followed by a few teleconference presentations.
- MHA served 642 persons including 149 single individuals with mental illnesses and 157 consumers in families with 268 children and 68 other family members through Shelter Plus Care, a federally financed program that provides housing subsidies for homeless individuals and those discharged from detention centers.
- In January 2006, the Bridge Subsidy Pilot Program began operation, offering rental subsidies, for a maximum of three years, to individuals with disabilities. Currently the Bridge Subsidy program is serving 45 consumers with varying disabilities in fifteen counties. Thirty of those served were individuals with mental illness whose incomes were at the Supplemental Security Income level and were referred through residential programs and case management programs in the community. 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.
- Five projects totaling \$2,058,000 were funded under the DHMH Community Bond program to build, renovate, or acquire affordable housing and other facilities to augment the capacity to serve children and adults who have mental illnesses.

- 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, is at various stages of implementation in five jurisdictions - Anne Arundel, Montgomery, Worcester, St. Mary's and Baltimore Counties.
- Key project leaders of the federal Mental Health Transformation-State Incentive Grant (MHT-SIG), in its second year, have initiated numerous transformation projects in FY 2007 including: Networks of Care, Youth Motivating Others through Voices of Experience (Youth MOVE), child well-being, cultural competence, and Wellness Recovery Action Plans for consumers. Several other new projects are under development for FY 2008. The MHT-SIG is a cooperative agreement grant which fosters further collaboration among state agencies and other stakeholders and supports an array of planning and infrastructure development activities to promote transformation in multiple systems involved with individuals with mental illness.
- Maryland has participated with the National Association of State Mental Health Program Directors Research Institute and Center for Mental Health Services in a national study, *Multi-agency State Government Funding of Mental Health Services*, to examine the current and potential roles of other state agencies in providing public mental health services and essential supports to persons with mental illnesses. The study reaffirmed the importance of continued partnership and collaboration between MHA and other state agencies in delivering comprehensive treatment that is responsive and reflective of the overall needs of the individual across systems. The study also highlights the need to build data capacity to link expenditure and client data with common identifiers across systems. Maryland's participation in Phase I and Phase II of the project has helped to build relationships and opened the doors for future collaborations among other state agencies.
- In collaboration with MHA, the University of Maryland Training Center sponsored and/or facilitated trainings for approximately 3,000 individuals in FY 2007. A variety of training modalities were utilized, including conferences, trainings, and video conferences. MHA's annual conference, held in May 2007, focused on the *Behavioral Health Workforce*.
- More than 4,856 consumers attended 22 consumer Wellness and Recovery centers located throughout Maryland. With the support of MHA, On Our Own of Maryland, Inc. (OOOMD) provided training and consultation on recovery and employment issues to more than 1,200 consumers, family members, and providers. Also in FY 2007, in collaboration with OOOMD, MHA continued the sixth year of a peer support project under a federal Olmstead planning grant. Peer support counselors in three state hospitals worked with consumers, prior to discharge, to provide information on community resources and then made 30-day follow-up visits in the community. In FY 2007, a total of 74 consumers were contacted by the peer counselors to assist with their transition to the community.
- In collaboration with MHA's Office of Consumer Affairs and On Our Own of

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Maryland, training through the Leadership Empowerment and Advocacy Project (LEAP) was provided to 15 individuals. The training builds and enhances knowledge and skills for effective participation in state and local policymaking.

- 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. In FY 2007, MHA provided four trainings on stress management for disaster workers, and worked closely with Statewide Behavioral Health Volunteer Corps members on increasing enrollment, ongoing workshops and trainings, and activation protocols. Also, 60 of the volunteer corps members received specialized training designed by MHA and worked with Maryland National Guard Family Readiness Groups across the state to provide psychoeducational presentations, facilitate discussions, and provide support at National Guard-sponsored events, such as deployment send-off and welcome home.
- During academic year 2007, eight students were enrolled 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. 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. Since 1997, 31 students have successfully completed the program.
- The fourth Family Leadership Institute was held in FY 2007 with members of nine families graduating. This Institute, which trains family advocates and is 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, the Coalition co-sponsored the third Youth Leadership Weekend for 17 youth (ages 14 to 21 years) who have a mental health diagnosis and who have been involved with one or more state programs such as special education, juvenile services, or foster care. The goal of the program is to empower youth by teaching them self-awareness and self-advocacy within their communities. The addition of the Youth MOVE initiative in FY 2008 will further expand the number of youth who are empowered to speak about their care to state policy makers.
- In FY 2007, approximately 2,000 people participated in the annual NAMI MD Walk for the Mind of America. The 2.4-mile awareness walk, which MHA co-sponsored, was part of the state's Mental Health Month celebration and promoted awareness of mental health to further efforts to end the stigma surrounding mental illness. The event generated nearly \$165,000 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. Additionally, MHA continued to support NAMI MD's implementation of public education and training efforts such as Family to Family education, In Our Own Voice, the Peer to Peer Program, and an annual education conference.

- In FY 2007 under the auspices of MHA and the Mental Health Association of Maryland (MHAM), the “Caring For Every Child’s Mental Health” campaign hosted mental health fairs, distributed over 32,900 pieces of literature to provide mental health education and awareness, and supported 309 performances of a traveling awareness-raising puppet show, Kids on the Block, for more than 18,000 people. MHAM conducted a statewide media promotion to reach a minimum of 1.5 million individuals, giving warning signs of mental health problems in children and first steps to receiving treatment. The viewer ship count for the FY 2007 campaign was 1,182,682 households. During the fiscal year, the webpage received over 34,000 page views.
- MHA and On Our Own of Maryland, Inc. continued to collaborate to fight stigma within the mental health system through the Anti-Stigma Project (ASP). In FY 2007, the ASP has presented 50 workshops reaching more than 3,000 participants, addressing issues related to cultural competency, co-occurring disorders, housing, and internalized stigma. It has continued to offer services to various parts of the system – psychiatric rehabilitation programs, One Stop Centers, CSAs, state agencies, hospital facilities, human service programs at area universities, and consumer and family groups. The ASP has presented at various national and international conferences, including NASMHPD and the World Federation of Mental Health which was held in Hong Kong. The teaching videotape, “Stigma...in Our Work, in Our Lives,” continued to receive national and international attention.

Maryland’s Public Mental Health System places a priority on the development of a system in which services meet individual needs. MHA will continue to provide the benefits of the coordination of managed care, while preserving access to a comprehensive array of services, flexibility, person-centered planning, and consumer choice. We will continue to strengthen interagency collaborations and partnerships with consumers, families, and advocates; to enhance existing initiatives and create new opportunities for mental health care; to integrate cultural competence throughout our system; while building infrastructures that further the transformation of our mental health service delivery system toward one which is fully recovery and resiliency oriented.