

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2010

FACE SHEET

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

X 2010

STATE NAME: Maryland

DUNS#: 135218621

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Health and Mental Hygiene

ORGANIZATIONAL UNIT: Mental Hygiene Administration

STREET ADDRESS: Spring Grove Hospital Center 55 Wade Avenue – Dix Building

CITY: Catonsville STATE: MD ZIP: 21228

TELEPHONE: 410-402-8473 FAX: 410-402-8309

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: John M. Colmers TITLE: Secretary

AGENCY: Department of Health and Mental Hygiene

ORGANIZATIONAL UNIT: Office of the Secretary

CITY: Baltimore STATE: MD ZIP: 21201

TELEPHONE: 410-767-6505 FAX: 410-767-6489

III. STATE FISCAL YEAR

FROM: July 2009 TO: June 2010
Month Year Month Year

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Cynthia Petion TITLE: Director, Office of Planning, Evaluation and Training

AGENCY: Department of Health and Mental Hygiene

ORGANIZATIONAL UNIT: Mental Hygiene Administration

STREET ADDRESS: Spring Grove Hospital Center 55 Wade Avenue – Dix Building

CITY: Catonsville STATE: MD ZIP: 21228

TELEPHONE: 410-402-8473 FAX: 410-402-8309 EMAIL: CPetion@dhhm.state.md.us

**COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT
FY 2010 APPLICATION**

September 2009

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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 American 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.

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EXECUTIVE SUMMARY

During FY 2009, and moving into FY 2010, the Mental Hygiene Administration (MHA), the division of the State of Maryland Department of Health and Mental Hygiene (DHMH) that is responsible for overseeing the delivery of public mental health services in the state, was actively involved in numerous activities to refine, enhance, and improve management of the public mental health system (PMHS). MHA places a priority on the development of a system in which services meet individual needs across the lifespan coordinated efforts that support recovery and resiliency. Although faced with fiscal challenges, access to services is maintained and a consumer and family driven mental health system preserved and strengthened. Maryland operates the majority of its PMHS under a Medicaid 1115 Waiver. Specialty mental health care is carved out from physical care and is administered by MHA. The system is managed in collaboration with Core Service Agencies (CSAs), entities at the local level who, in collaboration with MHA, develop and manage a coordinated network of Maryland public mental health services.

An administrative services organization (ASO) assists MHA and the CSAs in the management of the system. The goal of the PMHS is to provide the benefits of the coordination of managed care, while preserving access to a comprehensive array of services, flexibility, and consumer choice. Last year, in responses to changes in Medicaid rehabilitation policies, PMHS case management services were reorganized under a system of contracts through the CSAs. This year MHA plans to transition back to fee for service billing for intensive case management under Medicaid policies.

A significant MHA management activity in FY 2009 was preparation of the RFP for rebidding of the ASO management contract, which resulted in the award of the ASO contract to a new vendor. In July preparations began with our current contractor to transfer operations for the PMHS. On September 1, 2009 MHA will transition to the new ASO, ValueOptions, Inc.

A detailed discussion of Maryland's significant highlights, new developments, and progress are included in Section I. Maryland's mental health system has seen many challenges as well as achievements over the past years. The current economic crisis occurring across the nation has had a significant impact on the State of Maryland. Declining revenue and increasing demands for services challenge the state budget and the PMHS. In FY 2008 and 2009, Maryland's Governor directed state Cabinet Secretaries to reduce state spending as an initial step in closing the deficit that the state faces. In FY 2010, the state is faced with a projected budget shortfall of more than \$700 million. Within MHA, strategic decisions will be reached to take its share of the budget reduction. Community-based services will be further challenged to meet the needs in the community and reduce hospital utilization. MHA, in collaboration with CSAs, will continue work to strengthen and support community-based services including diversion initiatives.

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Maryland's Public Mental Health System's strengths were recognized with the selection of Maryland as one of the original seven states to receive a Mental Health Transformation State Incentive Grant of \$13.5 million over five years from SAMHSA. MHA has a solid record of innovation and flexibility in developing, implementing, and sustaining a PMHS that is a model for transformation. Moving forward in FY 2010 the Mental Health Transformation Office (MHTO) plans to continue focus on key ongoing strategies that are being effectively implemented in collaboration with MHA, other state agencies, and the mental health community, to support ongoing transformation in Maryland. In FY 2010, the fifth and final year of the MHT-SIG, many of these Transformation projects include exploring and implementing sustainability. The State of Maryland continues to refine strategies to achieve organizational cultural change that will transform the delivery of mental health services and fully support recovery and resilience for consumers.

In Section II the service system's strengths, needs, and priorities for adults, children and adolescents are identified and analyzed. Review of this section provided both MHA staff and Joint Council members with the opportunity to engage in rich discussions about the strengths and weaknesses of the service system and to identify and reflect upon unmet service needs and gaps within the current system. This yielded further input into identification of state priorities and strategies included in the current State Mental Health Plan. MHA's FY 2010 priorities include:

- Provision of consistent and seamless access to services and supports for both PMHS consumers and providers during transition to the new administrative services organization (ASO) beginning September 1, 2009;
- Continuation of MHA's successful approach to the implementation of evidence-based practices and efforts to monitor fidelity;
- Continuation of statewide implementation of Wellness and Recovery Action Plan (WRAP) training to increase wellness and recovery orientation and utilize best practices within the consumer movement;
- Continuation of hospital diversion projects in response to ongoing pressure for admission of uninsured individuals to state hospitals from emergency departments;
- Increased PMHS emphasis on implementation of new strategies to improve coordination of care between somatic and behavioral health providers and to research best practices to address the reduction of negative side effects of medication and prevention of obesity and morbidity for children in the child welfare system.
- Continued implementation, in collaboration with the University of Maryland, the Johns Hopkins University, and the Maryland Coalition of Families for Children's Mental Health, of the *Maryland Child and Adolescent Mental Health Institute*;
- Continued utilization of Web-based pharmacy data information sharing among mental health providers and with somatic care providers;
- Continued development of the Youth MOVE (Youth Motivating Others through Voices of Experience) program;
- Further implementation of the Medicaid PRTF waiver activities to reduce reliance on psychiatric residential treatment by supporting development of community-based, in-home, wraparound services for children and their families; and
- Further development of an Outcomes Measurement System, focusing on analysis of PMHS data on outpatient registration and mandatory evaluation process; using interactive

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Website with aggregate information on consumers at the time their most recent measurement available for public, provider, and government stakeholders and measures change over time.

Section III presents the five (5) Statutory Criteria. Separate adult and child and adolescent plans are presented. However, there is significant overlap between the two plans, as the overall system structure and many approaches to the service delivery are identical for both age groups. In Criterion five (5) – Management Systems, the discussion applies to both adult and child. Under each Criterion, mental health transformation efforts and activities in Maryland are described and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Report. Finally, national and state goals, targets, and action plans are presented.

In the FY 2010 State Mental Health Plan, MHA continues to organize state strategies around the six goals from the New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. During the process of updating and drafting the goals, objectives, and strategies for the FY 2010 State Mental Health Plan, MHA staff, advocates, and all involved parties reviewed the goals and recommendations. Many of the key goals in the final report are fundamental concepts in the Mission, Vision, and Values of Maryland's PMHS. All are covered in some aspect of the State Plan, in our continuing efforts to promote recovery and resilience, implement evidence-based services, and cultivate a consumer and family driven system in which one's ethnic and cultural background is respected. Maryland takes pride in developing and delivering state-of-the art mental health services and will continue to do so while remaining fiscally and clinically responsible.

MISSION

The mission of the Mental Hygiene Administration is to promote recovery, resiliency, and health for individuals who have emotional or psychiatric disorders, through publicly-funded services and supports.

THE VISION

There will be a comprehensive and accessible array of coordinated age-appropriate, culturally sensitive public and private services that focus on treatment, behavioral health, support, recovery, and resilience. These services will be developed in collaboration with stakeholders to help empower individuals with mental illnesses to attain the highest level of participation in community life, while striving to achieve their fullest potential.

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

The Public Mental Health System must be responsive to the people it serves, coherently organized, and accessible to those individuals 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 Public Mental Health System must be linked to other systems as needed to allow for continuity of care. The hospital is one part of the community-based mental health system. The Public Mental Health System must collaborate with other public and private human health service 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 operational aspects 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. Relevant programs and services that recognize varying cultural, ethnic, and racial needs are imperative.

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(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.

(5) *LEAST RESTRICTIVE SETTING*

An array of services will be available throughout the state to meet a variety of consumer needs. These services should be provided in the least restrictive, most normative, and most appropriate setting.

(6) *WORKING COLLABORATIVELY*

Collaborations with other agencies at the state and local level will be fostered so support to consumers is inclusive of all activities of life. This will promote a consistently acceptable level of mental health services.

(7) *EFFECTIVE MANAGEMENT AND ACCOUNTABILITY*

Accountability is essential to consistently provide an acceptable level of mental health services. Essential management functions include monitoring and self-evaluation, responding rapidly 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 with needs, and increase economic efficiency due to the closer proximity of the service 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 comes from increased awareness and understanding of psychiatric disorders and treatment options.

FY 2010 SYSTEM GOALS

These MHA goals, objectives, and strategies are a result of the collaborative efforts related to the implementation of the federal Mental Health Transformation State Incentive Grant (MHT-SIG), existing interagency cooperation, and public and private partnerships. These alliances have been strengthened, and new partnerships formed to further build upon the infrastructure, to coordinate care and improve service systems. Mental health transformation efforts and activities have fostered the implementation of increased opportunities for public education; awareness; training of consumer, families, and mental health professionals; support of employment; self-directed care; and affordable housing options. Advancement will be effectively amplified through the support of Web-based technology that increases awareness and linkages to services; promotes wellness, prevention, and diversion activities; and enhances efforts in cultural competency, evidence-based and promising practices. These advancements are infused throughout the MHA State Mental Health Plan for children, adolescents, and adults. Recognizing the current fiscal environment, MHA strategies involve effective and efficient collaborations to identify and support sustainability of transformation gains that promote recovery, resiliency, and health-care reform.

GOAL I: Marylanders Understand that Mental Health Is Essential to Overall Health

GOAL II: Mental Health Care Is Consumer and Family Driven

GOAL III: Disparities in Mental Health Services Are Eliminated

GOAL IV: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice

GOAL V: Excellent Mental Health Care Is Delivered and Research Is Accelerated While Maintaining Efficient Services and System Accountability

GOAL VI: Technology Is Used to Access Mental Health Care and Information

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PART B

**ADMINISTRATIVE REQUIREMENTS,
FISCAL PLANNING ASSUMPTIONS,
AND SPECIAL GUIDANCE**

DESIGNEE LETTER

FUNDING AGREEMENT – 1st PAGE

FUNDING AGREEMENT 2ND PAGE

FUNDING AGREEMENT 3RD PAGE

**FUNDING AGREEMENT – 4TH PAGE
SIGNATURE**

ATTACHMENT B
CERTIFICATIONS 1ST PAGE

ATTACHMENT B – 2ND PAGE

ATTACHMENT B
CERTIFICATION – 3RD PAGE
SIGNATURE

ATTACHMENT B

DISCLOSURE – 1st PAGE

ATTACHMENT B

DISCLOSURE – 2nd PAGE

**ATTACHMENT C
ASSURANCES 1st PAGE**

**ATTACHMENT C
ASSURANCES 2ND PAGE**

MR. Colmers SIGNS

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I (4) PUBLIC COMMENT ON THE STATE PLAN

Each year, official public notice of the State Mental Health Plan, Block Grant application, and Implementation Report is published in the Maryland Register for citizen review. The Register is published two times per month and provides information on state government activities. The notice in the Register provides information regarding the availability of the documents. Due dates for the application and the implementation report are noted. Comments are requested in writing. Any received prior to finalization of documents are considered and incorporated, as appropriate. Comments are also accepted after submission of documents to the federal government. The notice provides the name of a Mental Hygiene Administration contact person and phone number. The notice was published this year in the June 4, 2009 edition.

The opportunity to comment on the plan is provided at different stages in the state planning process. The most critical stages of this planning process involve the work of the Joint Council discussed in Part B, Section IV state Mental Health Planning Council. The development of the goals, objectives, and strategies for the annual state plan involves a series of meetings with active participation from key PMHS stakeholders including representatives of consumer and family advocacy organizations, mental health advocacy groups, advisory council for special populations, such as the deaf and hard of hearing, traumatic brain injury, provider organizations, Core Service Agencies, and a wide range of groups, agencies, and individuals serving on the Joint Council. The annual Joint Council Review and Recommendation is summarized in the CMHS Block Grant review letter that is included as a part of this application.

During this public process, draft copies of the State Plan and key sections of the Block Grant application are distributed, through the Joint Council mailing and e-mail lists, for review and comment. The Planning Committee reviews the final draft of the State Plan and key Block Grant documents in two separate meetings with MHA staff.

Each year, following the adoption of the State Plan, the document is distributed through the Joint Council mailing list consisting of over 200 different members, stakeholders, interested parties, Core Service Agencies, and local mental health advisory committee chairmen. Throughout the year, the MHA Division of Planning provides copies of the State Mental Health Plan to interested parties upon request. The review and comment on the annual Block Grant Implementation Report follows a somewhat similar process prior to the December submission deadline.

MHA's Division of Planning, in collaboration with the Division of Health Management Information Systems, place the approved State Plan on the Department of Health and Mental Hygiene-Mental Hygiene Administration Web site as a vehicle for notification of the availability and/or for wider distribution of the document. We expect this process to engender questions during the year, which will assist with the development of the Plan for the following year.

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II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY

Federal FY

State Expenditures for Mental Health Services		
Calculated FY 1994	Actual FY 2008	Estimate/Actual FY 2009
\$19,733,921	\$149,856,815	\$ 143,211,666

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

1. The portion of the FY 2008 appropriation attributable to psychiatric medication is an estimate based on prior years' experience. The Medical Assistance appropriation (which includes funds for psychiatric medication) does not break down to the specific level of psychiatric medications. 2. The calculated FY 1994 rate reflects correction of clerical error in previous years applications. Compliance with the set-aside requirement has been continuously achieved.

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III. MAINTENANCE OF EFFORT REPORT (MOE)

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY	Federal FY	State Expenditures for Mental Health Services	
Actual FY 2007	Actual FY 2008	Actual/Estimate FY 2009	
\$341,478,336	\$346,971,399	\$337,685,155	

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

The portion of the FY 2007 appropriation attributable to psychiatric medication is an estimate based on prior years' experience. The Medical Assistance appropriation (which includes funds for psychiatric medication) does not break down to the specific level of psychiatric medications.

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IV. MARYLAND ADVISORY COUNCIL ON MENTAL HYGIENE/ PL 102-321 PLANNING COUNCIL REQUIREMENTS

The Maryland Advisory Council on Mental Hygiene was created in 1976 to serve in an advisory and advocacy capacity in addressing mental health issues in Maryland. The Council was expanded in 1989 to comply with the composition requirements of Public Law (PL) 99-660 and subsequently PL 102-321. The Council is now designated as the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council and is often referred to as the Joint Council. Its membership is composed of consumers, family members of persons with psychiatric disorders, mental health professionals, representatives from various agencies that serve individuals with psychiatric disorders, and other citizens interested in the state's mental health delivery system. The Joint Council continues to participate in the planning and operation of the Public Mental Health System (PMHS), meeting monthly with the Mental Hygiene Administration (MHA) Executive Director and key agency staff.

The Joint Council operates under by-laws that set forth a committee structure to enhance its ability to monitor progress towards goals included in the Mental Hygiene Administration's (MHA) State Mental Health Plan and the federal Block Grant application. Committees of the Council include: the Interagency Forensic Services Committee (IFSC), the Planning Committee, the Legislative Committee, and the Membership Committee. These ongoing committees, among many other activities, develop the federal mental health block grant application, promote membership, follow legislative issues, and examine issues applicable to persons with serious mental illness incarcerated or at risk of incarceration in jails and detention centers.

During the past year, the Council has, through its desire to increase its involvement in the monitoring and decision-making processes of the Mental Hygiene Administration, changed its planning responsibilities to a yearlong timeline. A Planning Committee consisting of Council representation of consumers, officers, agency members, rights advocacy organizations and members who represent interests across the lifespan, have been meeting monthly, not only to fulfill established duties of reviewing planning and implementation documents but also, to research and discuss ways to further impact MHA's future budget planning through focus on key mental health issues. At present, the Committee is exploring issues such as housing and employment, as well as the use of available data presentations in these areas.

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Additionally, the Council promotes and facilitates linkages with Core Service Agency boards and local mental health advisory committees as they monitor and evaluate publicly-funded mental health services for their local jurisdictions.

The by-laws of the Joint Council are on the following pages.

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**MARYLAND ADVISORY COUNCIL ON MENTAL HYGIENE/
PL 102-321 PLANNING COUNCIL BY-LAWS**

PURPOSE:

Pursuant to the Annotated Code of Maryland, Health General, Title 10, Mental Hygiene Law, Subtitle 3, and Public Law 102-321, the State of Maryland has established the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council for the purpose of advising the Governor and other State and federal officials on the needs of citizens with mental illnesses and the ways in which the State can meet those needs. The Maryland Advisory Council on Mental Hygiene is mandated by State law to “be a strong advocate of a comprehensive, broad-based approach to the social, economic, and medical problems of mental hygiene.” Under federal law, the State Mental Health Planning Council is required “to advise, review, monitor and evaluate all aspects of the development and implementation of the State plan.” For purposes of implementing and coordinating the duties of the federal and State Councils, a Joint Council has been established and is herein referred to as “the Council.”

Article I: Duties

The Council shall:

1. Advocate for a comprehensive, broad-based approach to meet the social, economic, and medical needs of people with mental illnesses, as mandated by Health General 10-305.
2. Review plans provided to the Council by the Mental Hygiene Administration and submit to the State any recommendations of the Council for modifications to the plans, as mandated by PL 102-321.
3. Monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services, as mandated by PL 102-321.
4. Serve as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems, as mandated by PL 102-321.
5. Submit an annual report of its activities to the Governor and, subject to Section 2-1312 of the State Government Article, to the General Assembly.
6. Submit reports to the federal government, as mandated by PL 102-321.

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7. Receive and review annual reports submitted by County Advisory Committees, as mandated by Health General 10-312, and,
8. Serve as a forum for the dissemination and sharing of information concerning the public mental health system between MHA staff, mental health advocates, Joint Council Members, including consumers, and providers of mental health services in Maryland, and other interested persons.
9. Serve as a linkage with other State agencies seeking collaboration for improved mental health services.

Article II: Membership

A. Composition:

1. The Maryland Advisory Council on Mental Hygiene consists of 18 members appointed by the Governor. Representatives include people from a broad range of agencies and groups that are concerned directly or indirectly with mental hygiene, e.g., courts, police, probation offices, clergy, labor, management, legal profession, medical profession, mental health associations, State and local government, private employee groups, local citizens groups, and major socio-economic and ethnic groups.
2. The PL 102-321 Planning Council consists of residents of Maryland, including representatives of (a) the principal State agencies (mental health, education, vocational rehabilitation, criminal justice, housing and social services); (b) public and private entities concerned with the need, planning, operation, funding and use of mental health services and related support services; (c) adults with serious mental illness who are receiving (or who have received) mental health services; (d) family members of adults who are receiving (or who have received) mental health services; and (e) family members of children with serious emotional disturbances, who are receiving (or who have received) mental health services. Members also shall include representatives from local Mental Health Advisory Committees.
3. A minimum of 50 percent of the total membership of the Council will be individuals who are not State employees or providers of mental health services. The Council shall strive to assure the majority of members represent present and former recipients of mental health services and their families, and,

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further, that the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council. The membership of the Council shall be in compliance with PL 102-321, all subsequent amendments, and applicable State laws.

B. Term of Membership:

1. Members of the Maryland Advisory Council on Mental Hygiene are appointed by the Governor to serve three-year terms. A member may be appointed to serve a shorter term when serving the remaining term of a seat vacant due to a resignation. A member who is appointed after a term has begun serves only for the rest of the term and until a successor is appointed and qualifies. At the end of a term, the member continues to serve until a successor is appointed and qualifies.
2. Members of the PL 102-321 Planning Council are appointed by the Director of the Mental Hygiene Administration for three-year terms. Agency/organization representatives of PL 102-321 are chosen by their respective agencies. The selected representatives remain as members of the Council until such time that they leave the agency and/or position or the agency itself selects a replacement for them.
3. Terms of all Council members are staggered so that one third of members' terms end each year.

C. Removal:

1. Members of the Maryland Advisory Council on Mental Hygiene are subject to Article 41, Section 1-203 of the Annotated Code of Maryland that states: "Any member of any State Board or Commission appointed by the Governor who shall fail to attend 50 percent of the meetings of the Board or Commission of which he is a member during any period of twelve consecutive months shall be considered to have resigned and the Chairman of said Board or Commission shall forward or cause to be forwarded to the Governor, not later than January 15 of the year following such nonattendance with the statement of such nonattendance, and the Governor shall thereupon appoint his successor for the remainder of the term. If the member has been unable to attend meetings as required by this section for reasons satisfactory to the Governor, the Governor may waive such resignation if such reasons are made public."

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2. Non agency/organization representatives of the PL 102-321 Planning Council who fail to attend 50 percent of meetings during any period of 12 consecutive months shall be considered to have resigned. The Chairperson shall forward or cause to be forwarded to the Director of the Mental Hygiene Administration a statement of nonattendance and a request for removal. If the member has been unable to attend meetings as required for reasons satisfactory to the Director, the Director may waive such resignation if such reasons are made public.

3. In the event an agency/organization representative on the PL 102-321 Planning Council fails to attend 50 percent of the meetings during any period of 12 consecutive months, the Chairperson shall recommend to the head of the agency/organization that the member be replaced. If the agency member has been unable to attend meetings as required for reasons satisfactory to the Director, the Director may waive such resignation if such reasons are made public.

D. Travel Allowance:

Council members whose transportation costs are not reimbursed by an agency, group or organization, and who need financial assistance in order to attend a Council meeting and/or when officially representing the Council at other meetings, are eligible for reimbursement by the Mental Hygiene Administration. Travel expenses shall be consistent with the Standard State Travel Regulations and are dependent upon resource availability. Council members are responsible for completing all expense reporting forms in a timely manner, and submitting appropriate accompanying documentation as required.

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Article III: Meetings, Agenda, Voting, Official Records

A. Meetings

The Council shall meet at the times and places that it determines. There shall be at least six meetings per year. Special meetings of the Council shall be authorized by the Executive Committee, at the request of two-thirds of the total Councils' voting members. Ad hoc and standing subcommittee meetings may be convened whenever necessary. If necessary, the Executive Committee or any other committee can meet and converse by telephone when it is not feasible to convene and an immediate decision is required. Decisions reached by telephone shall be recorded as meeting minutes for that date and considered official meeting minutes.

B. Agenda

Any member of the Council may submit to the Chairperson an item for the agenda. Whenever possible, this shall occur at least two weeks before the scheduled date of the meeting. The agenda for regular meetings of the Council shall be distributed to members during the week prior to the scheduled meetings. At the beginning of each meeting of the Council, the Chairperson shall entertain motions for additions or changes in the agenda.

Voting

A quorum for any meeting of the Council shall consist of a simple majority of its members present at that meeting. Robert's Rules of Order govern the voting procedures. Only members of the Council are eligible to vote. Members with any conflicts of interest are expected to make a declaratory statement on same and refrain from voting on the issue(s). No member of the Council may cast a vote on any matter that would provide direct financial benefit to that member or otherwise give the appearance of a conflict of interest.

C. Official Record

The minutes of the Council meeting shall be the official record of the Council. The minutes shall be distributed to all members of the Council and to the Director of the Mental Hygiene Administration within a three-week period following a meeting. After final adoption, minutes will be mailed to all local Mental Health Advisory Committees. All minutes, recommendations, and other materials will

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2010

be kept on file by the Mental Hygiene Administration. Minutes may be distributed to interested members of the public, providing any and all confidential information has been excised.

Article IV: Support Services

The Mental Hygiene Administration shall provide secretarial, consultant, and other staff services needed by the Council within resource availability. The support staff shall be responsible for obtaining meeting facilities, recording of minutes, disseminating meeting notices, agenda, minutes, reports, etc.

Article V: Officers

A. Chairperson

The Chairperson shall be elected from among the appointed membership of the Maryland Advisory Council on Mental Hygiene. The Chairperson shall serve for two years and may be reelected for no more than two consecutive terms. Elections shall be held annually in June and the term shall begin on July 1 through June 30.

The Chairperson shall be responsible for:

1. Calling and presiding over all joint meetings of the Council;
2. Coordinating the activities of the Council, including preparation of the required State and federal reports;
3. Preparing the agenda for the meeting of the Council;
4. Appointing the Chairpersons and members of the Nominating Committee and the Chairpersons of ad hoc subcommittees;
5. Serving as ex-officio on standing and ad hoc committees, except for the Nominating Committee; and,

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2010

6. Representing the opinion of the Council to the public.

B. Vice Chairperson

The Vice Chairperson shall be elected from among the appointed membership of the Maryland Advisory Council. The Vice Chairperson shall be responsible for the Chairperson's duties in the absence of the Chairperson. The Vice Chairperson shall be elected in June and the term shall begin on July 1 through June 30. The Vice Chairperson shall serve for two years and may be reelected for no more than two consecutive terms.

C. PL 102-321 Coordinators

Two persons shall be elected from the PL 102-321 membership as PL 102-321 Coordinators. The Coordinators shall serve for two years and may be reelected for no more than two consecutive terms. The Coordinators shall be responsible for assuring tasks and issues related to the Council's role and implementation of the State plan are completed. One Coordinator should be a recipient or former recipient of mental health services or a relative of such an individual.

Article VI: Committees

A. Nominating Committee

The Nominating Committee Chairperson and four other members shall be appointed by the Chairperson. Members shall be selected equally from both Councils. The Nominating Chairperson is responsible for convening the Nominating Committee, soliciting nominations and submitting the Committee's report to the Council in May for elections to be held in June.

B. Executive Committee

The Executive Committee shall be composed of the Chairperson, Vice Chairperson, the PL 102-321 Coordinators and Committee and Ad Hoc Committee Chairpersons. The Executive Committee shall meet on an ad hoc basis. Minutes shall be recorded for all Executive Committee meetings. The Executive Committee responsibilities include, but are not limited to, preparing, reviewing or approving testimony or other public presentations/documents/reports submitted on behalf of the Council when sufficient time does not permit review and approval of the entire Council and timing is of critical importance, etc.

C. Interagency Forensic Services Committee

This Committee shall advise, review, monitor and evaluate the development and implementation of the State plan applicable to persons with serious mental illness incarcerated or at risk of incarceration in jails and detention centers. This Committee may invite others outside of appointed Council members to consult and participate in the activities of this Committee. The Chairperson of this Committee shall be elected by the members of the Committee, with the approval of the Council Chairperson, for a two year renewable term.

D. Local Mental Health Advisory Committee

The duties of this committee include promoting and facilitating linkages with local mental health advisory committees. The Committee may assist in developing specific training programs pertaining to mental health issues and the roles of the committees in local mental health systems. This Committee may invite others outside of appointed Council members to consult and participate in the activities of this Committee. The Chairperson of this Committee shall be elected by the members of the Committee, with the approval of the Council Chairperson, for a two year renewable term.

E. Legislative Committee

The duties of this committee include review and promotion of legislation that impacts on the purpose and responsibilities of the Council.

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F. Planning Committee

The duties of this committee include assisting in the plan development, review and final recommendation of the State Mental Health and Federal Mental Health Block Grant Plans.

G. Annual Report Committee

The duties of this committee include collection of relevant material to document the activities of the Council, summarizing activities and listing goals for the next year in accordance with the Council's priorities, and recommendations to the Governor and MHA. The draft of the report shall be completed in November, submitted to the Council in December for approval, and submitted to the Governor by January 31. The Council Chairperson shall appoint members to this committee no later than September.

H. Ad Hoc Committees and Special Studies/Workgroups

The Chairperson may appoint temporary committees or Council representatives for a specified purpose and time. Upon completion of the task, the committee shall be dissolved. Examples of ad hoc committees are as follows:

1. Ad Hoc Committees

The duties of these committees are to address a specific mental health priority area identified by the Joint Council for review, presentation, and possible advocacy recommendation.

2. Special Studies/Workgroups

The duties of this committee may include an individual(s) representing the Council on various Mental Hygiene Administration or other agency or organization sponsored task forces, workgroups, etc.

Article VII: Amendments

The By-laws may be amended by recommendations of the Executive Committee and two-thirds of the voting members of the Council who are present, provided that copies of the proposed amendments and notice for consideration have been mailed to every member at least two weeks before the date of the meetings, during which adoption of the amendment(s) would be considered.

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2010

THE MARYLAND ADVISORY COUNCIL ON MENTAL HYGIENE/102-321 PLANNING COUNCIL MEMBERSHIP LIST

TABLE 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Adams, Dorinda A.	State Employees	Social Services	311 W. Saratoga Street Room 259 Baltimore,MD 21201 PH:410-767-7323 FAX:410-333-0256	
Albizo, Lynn H.	Others(not state employees or providers)	National Alliance for Mental Illness - Maryland	804 Landmark Drive Suite 122 Glen Burnie,MD 21061 PH:410-863-0470 FAX:410-863-0474	
Allenza, Carol	Family Members of Children with SED	Maryland Coalition of Families for Children's Mental Health	10632 Little Patuxent Pkwy Suite 119 Columbia,MD 21044 PH:410-730-8267 FAX:	
Bhagat, Kay	Others(not state employees or providers)	Maryland Disability Law Center	1800 North Charles Street #400 Baltimore,MD 21201 PH:410-727-6352 FAX:	
Blair, Richard W.	State Employees	Criminal Justice	6515 Coffman Farms Road Keedysville,MD 21756 PH:240-313-2122 FAX:	
Bohrer, Terezie	Others(not state employees or providers)	Mental Health Association, Inc.	16304 Bawtry Court Bowie,MD 20715 PH:301-262-2772 FAX:301-262-3797	

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2010

THE MARYLAND ADVISORY COUNCIL ON MENTAL HYGIENE/102-321 PLANNING COUNCIL MEMBERSHIP LIST

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Bryant, Tracee E.	Others(not state employees or providers)	Black Mental Health Alliance, Inc.	733 West 40th Street Suite 10 Baltimore,MD 21215 PH:410-338-2642 FAX:410-338-1771	
Burns, Sarah	Consumers/Survivors/Ex-patients(C/S/X)		1631 Ingleside Avenue Apt #26 Baltimore,MD 21207 PH:443-200-5701 FAX:	
Cohen, Peter R.	State Employees	Other	Alcohol and Drug Abuse Administration 55 Wade Avenue Catonsville,MD 21228 PH:410-402-8677 FAX:410-402-8601	
Cromwell, Herb	Providers	Community Behavioral Health Association of Maryland	18 Egges Lane Catonsville,MD 21228 PH:410-788-1865 FAX:410-788-1768	
Cuozzo, Lisa	Others(not state employees or providers)	Mental Health Association of Maryland, Inc.	711 W. 40th Street Suite 460 Baltimore,MD 21211 PH:410-235-1178 X208 FAX:410-235-1180	
Diehl, M. Sue	Others(not state employees or providers)		6005 Lake Manor Drive Baltimore,MD 21210 PH:410-377-4446 FAX:	

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2010

**THE MARYLAND ADVISORY COUNCIL ON MENTAL
HYGIENE/102-321 PLANNING COUNCIL MEMBERSHIP LIST**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Drake, Catherine	State Employees	Vocational Rehabilitation	2301 Argonne Drive Suite A304 Baltimore,MD 21218 PH:410-554-9440 FAX:410-554-9412	
Finkle, Michael S.	Consumers/Survivors/Ex-patients(C/S/X)	On Our Own of Maryland, Inc.	On Our Own of Maryland 1521 S. Edgewood Street, Suite C Baltimore,MD 21227 PH:410-646-0262 X13 FAX:410-646-0264	
Froehlinger, Vira	State Employees	Education	200 W. Baltimore Street Baltimore,MD 21201 PH:410-767-0171 FAX:	
Gibson, A. Scott	Consumers/Survivors/Ex-patients(C/S/X)		104 Walnut Street Apartment #1 Frostburg,MD 21532 PH:301-697-8560 FAX:	
Gray, Geraldine	Family Members of adults with SMI		1 Hamill Road #D Baltimore,MD 21210 PH:410-433-9263 FAX:	
Jerscheid, Julia	Consumers/Survivors/Ex-patients(C/S/X)		201 Federal Street #33 Easton,MD 21601 PH:410-822-4917 FAX:	

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2010

**THE MARYLAND ADVISORY COUNCIL ON MENTAL
HYGIENE/102-321 PLANNING COUNCIL MEMBERSHIP LIST**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Johnson, Heather R.	Consumers/Survivors/Ex-patients(C/S/X)		P.O. Box 22 Worton,MD 21678 PH:410-778-4908 FAX:	
Lang, Michael	Consumers/Survivors/Ex-patients(C/S/X)		10720 Georgia Avenue Apt. #104 Wheaton,MD 20902 PH:301-942-8285 FAX:	
Lipford, Sharon	Providers	Maryland Association of Core Service Agencies	Harford County Core Service Agency 29 West Courtland Street Bel Air,MD 21014 PH:410-803-8726 FAX:410-803-8732	
Lipman, George M.	Others(not state employees or providers)		Hargrove District Court 700 E. Patapsco Avenue Baltimore,MD 21225 PH:410-878-8316 FAX:	
Liss, Phoenix	State Employees	Other	Maryland Department of Aging 301 W. Preston Street Rm. 1007 Baltimore,MD 21201 PH:410-767-4665 FAX:	
McQuade, Patti	State Employees	Medicaid	201 W. Preston Street Room 200 Baltimore,MD 21201 PH:410-767-6505 FAX:	

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2010

**THE MARYLAND ADVISORY COUNCIL ON MENTAL
HYGIENE/102-321 PLANNING COUNCIL MEMBERSHIP LIST**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Oliver, Edwin C.	Providers		C/o Baltimore Lab 2220 St. Paul Street Baltimore,MD 21218 PH:410-261-5500 FAX:	
Pazourek, Livia	Family Members of adults with SMI		578 Belmawr Place Millersville,MD 21108 PH:410-768-6777 X234 FAX:410-760-6811	
Pender, Robert	Others(not state employees or providers)		Box 294 Terry Drive Port Tobacco,MD 20677 PH:301-934-3145 FAX:	
Petion, Cynthia	State Employees	Mental Health	Spring Grove Hospital Center 55 Wade Avenue-Dix Bldg Cationsville,MD 21228 PH:410-402-8473 FAX:410-402-8309	
RachBeisel, Jill	Others(not state employees or providers)	University of Maryland, Dept. of Psychiatry	701 West Pratt Street Room 354 Baltimore,MD 21201 PH:410-328-5161 FAX:410-328-3311	
Rafferty, Cindy	State Employees	Housing	100 Community Place Crownsville,MD 21032 PH:410-514-7537 FAX:410-987-3721	

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2010

**THE MARYLAND ADVISORY COUNCIL ON MENTAL
HYGIENE/102-321 PLANNING COUNCIL MEMBERSHIP LIST**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Raines, Linda J.	Others(not state employees or providers)	Mental Health Association of Maryland, Inc.	711 West 40th Street Suite 460 Baltimore,MD 21211 PH:410-235-1178 X204 FAX:410-235-1180	
Reifsnider, Charles	Consumers/Survivors/Ex-patients(C/S/X)		10134-B Liberty Road Frederick,MD 21701 PH:301-898-3044 FAX:	
Reinsel, James	State Employees	Other	217 E. Redwood Street Suite 1300 Baltimore,MD 21202 PH:410-767-3635 FAX:	
Rigsby, Michelle	Family Members of Children with SED		1542 Forest Park Avenue Baltimore,MD 21207 PH:410-788-9470 FAX:	
Solomon, Anita	Providers		7517 Holiday Terrace Bethesda,MD 20817 PH:301-340-0999 FAX:301-229-0833	
Sparer, Sheryl	Consumers/Survivors/Ex-patients(C/S/X)		1612 Hilltop Road Edgewater,MD 21037 PH:410-956-8695 FAX:	

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2010

**THE MARYLAND ADVISORY COUNCIL ON MENTAL
HYGIENE/102-321 PLANNING COUNCIL MEMBERSHIP LIST**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Thompson, Garth	Others(not state employees or providers)		213 Ridgemeade Road Baltimore,MD 21210 PH:410-467-0365 FAX:410-467-0365	
Vaeth, Susan	Others(not state employees or providers)	Howard County Office on Aging	6751 Columbia Gateway Drive Columbia,MD 21046 PH:410-313-6535 FAX:	
Walker, Jane	Family Members of adults with SMI	Maryland Coalition of Families for Children's Mental Health	10632 Little Patuxent Pkwy. Suite 119 Columbia,MD 21044 PH:410-730-8267 FAX:	
Williams, Della	State Employees	Social Services	311 W. Saratoga Street Room 503 Baltimore,MD 21201-3521 PH:410-767-7630 FAX:	
Zahm, Carol	State Employees	Criminal Justice	120 West Fayette Street Baltimore,MD 21201 PH:410-230-3122 FAX:	

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2010

Council Composition by Type of Member

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	41	
Consumers/Survivors/Ex-patients(C/S/X)	8	
Family Members of Children with SED	2	
Family Members of adults with SMI	3	
Vacancies(C/S/X and Family Members)	0	
Others(not state employees or providers)	12	
TOTAL C/S/X, Family Members and Others	25	60.98%
State Employees	12	
Providers	4	
Vacancies	0	
TOTAL State Employees and Providers	16	39.02%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

G. ROLE OF THE MARYLAND ADVISORY COUNCIL ON MENTAL HYGIENE/PL 102-321 PLANNING COUNCIL IN IMPROVING THE PUBLIC MENTAL HEALTH SYSTEM

Joint Council members, either as Council representatives or in their organizational capacities, serve on various workgroups and task forces and participate in plan/policy development meetings as requested. During 2008-9, some of these workgroups impacted areas of: consumer recovery and leadership, consumer quality teams, implementation of evidence-based practices, coordination of care and systems of care for youth, Network of Care, Wellness Recovery Action Plan (WRAP), peer-operated Recovery and Wellness Centers, suicide prevention, and Children's Mental Health. Also, representatives of the Council attended meetings of the Mental Health & Criminal Justice Partnership (formerly called the House Bill 281 Workgroup) which examined mental health issues for individuals in Maryland's correctional system.

The Joint Council closely follows the developments of Maryland's federal Mental Health Transformation State Incentive Grant. Over the past year, Maryland's Mental Health Transformation Office has continued to undertake a number of innovative projects to transform the mental health system and build upon both transformational efforts that pre-date Maryland's grant award and strategies that began during the first three years of the Grant (MHT-SIG). Emphasis has been placed on ensuring statewide impact and sustaining MHT-SIG efforts. Representatives from the Joint Council serve on the Transformation Working Group (TWG) and its various sub-committees, which were formed to oversee grant activities in the areas of Mental Health First Aid, Network of Care, cultural competence of the mental health workforce, the Wellness and Recovery Action Plan (WRAP) training, and the development of projects to strengthen service infrastructure to support older adults.

During FY 2009, the Joint Council followed closely the progression of events within the PMHS through reports from the Executive Director of MHA and through various presentations throughout the year. Presentations included: a meeting with the new DHMH Deputy Secretary of Behavioral Health and Disabilities, highlights of the priorities of the Core Service Agencies, WRAP, the Outcomes Measurement System and Network of Care, Maryland's Commitment to Veterans, an update on child and adolescent services issues, and an update on activities of the Mental Health Transformation Office. Information from these presentations assists the Joint Council in understanding the PMHS and its programs, which aids in its advocacy work at the national, state, and local levels.

Additionally, the Joint Council's Legislative Committee, active during the Maryland legislative session and when needed, kept the Council members informed of legislation regarding mental health issues. During MHA's budget hearings before the State Senate and the State House of Delegates, the Legislative Committee and the Executive Committee, consisting of Council officers, provided input to representatives of the Joint Council who gave testimony at these hearings on behalf of the funding needs of the PMHS.

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2010

The Joint Council remains actively involved in the development of the State Mental Health Plan and Block Grant Application. In the introduction to the most recent State Mental Health Plans, it is noted that MHA goals, objectives, and strategies reflect much of what occurred through the community's involvement and discussions surrounding the transformation. Mental health transformation efforts and activities are infused throughout the MHA State Mental Health Plan for adults, youth, and children.

Committee members positively noted several items including:

- MHA's collaboration with the Mental Health Transformation Office (MHTO) and advocacy to provide Wellness and Recovery Action Plan (WRAP) training in consumer-operated programs
- Establishment of the Maryland Child and Adolescent Mental Health Institute to further develop and disseminate evidence-based practices (EBPs) for children and adolescents.
- MHA's continued commitment to increase the availability of consumer and family-operated support services, as well as youth leadership initiatives.

At the start of FY 2009, the Planning Committee met again to review and make recommendations for key sections of Maryland's FY 2009 Community Mental Health Services Block Grant (MHBG) Application, which incorporates strategies from the FY 2009 State Mental Health Plan.

Additionally, each year the Joint Council is represented at the Joint National Conference on Mental Health Block Grant and National Conference on Mental Health Statistics. In 2009, a Council member, representing child and family advocacy, attended the three-day conference which included a Training Day for Planning Council Representatives conducted by the National Association of Mental Health Planning Advisory Councils (NAMHPAC).



State of Maryland
Advisory Council on Mental Hygiene/Planning Council

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary, DHMH

August 4, 2009

Barbara Orlando
Grants Management Specialist,
Division of Grants Management, OPS, SAMHSA
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville MD 20857 (for First Class Mail) 20850 (Overnight Express)

RE: FY 2010 Mental Health Block Grant Application

Dear Ms. Orlando:

As a mandate of Public Law 102-321, the Maryland Advisory Council on Mental Hygiene/Planning Council submits this report of our review of the FY 2010 State Mental Health Plan and Mental Health Block Grant application. This council, referred to as the Joint Council, is composed of consumers, family members of persons with psychiatric disabilities, mental health professionals, representatives of other State agencies, and other interested citizens and is an important source of advice and advocacy in Maryland. The Joint Council also is in compliance with Maryland's law requiring a mental health advisory council. In accordance with Section 1915(a) of the Public Health Service Act, this letter includes public comments on the Maryland planning process, forms of advocacy employed by the mental health planning council, and recommendations on the FY 2010 State Mental Health Plan and Mental Health Block Grant Application.

Maryland is proud of its strong and well-developed system of consumer, family, advocacy, and provider participation in our Public Mental Health System (PMHS), Maryland's public mental health system's strengths were recognized with selection of Maryland as one of seven states to receive a Mental Health Transformation State Incentive Grant of \$13.5 million over five years from SAMHSA. The Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council values the unique level of access and participation in both the planning and operation of the PMHS and its presence on the Transformation Working Group.

The Joint Council is pleased to report that despite the challenges of the state and national economic crisis, which has dramatically reduced State tax revenue, State leadership has maintained access to services in the Public Mental Health System. The number of consumers who received services has actually increased approximately 8% in the past year. In recent years access to care for the uninsured has been a focus of the Joint Council's advocacy efforts. This February we testified at both MHA budget hearings that: "cuts to community services would drive up utilization of higher cost

c/o Mental Hygiene Administration

Spring Grove Hospital Center – 55 Wade Avenue – Dix Building – Catonsville MD 21228 – (410) 402-8473
TDD for Disabled – Maryland Relay Service (800) 735-2258

Healthy People in Healthy Communities

emergency room and inpatient services”. This fiscal year, although faced with State budget cuts, the Joint Council will continue to emphasize the “importance of maintaining the safety net focused on more efficient community services”.

Our Joint Council meets monthly with the Mental Hygiene Administration (MHA) Director and key agency staff. During FY 2009, the Joint Council followed closely the progression of events within the PMHS through reports from the Executive Director of MHA and through various presentations of activities surrounding family and children’s initiatives including: Children and Adolescent Mental Health Institute, System of Change, and Suicide Prevent grants, and, Consumer Quality Teams, Wellness Recovery Action Plans (WRAP, housing, implementation of evidence-based practices, mental health and the criminal justice system initiatives, and mental health outreach programs to returning soldiers.

Joint Council members, either as Council representatives or in their organizational capacities, also serve on numerous task forces and workgroups. In FY 2009, this included participation of several consumer and family leadership representatives on the Transformation Working Group (TWG). Additionally, the Joint Council provided testimony on MHA’s budget at hearings before key Committees of the State Legislature. (Please refer to Section G – ROLE OF THE MARYLAND ADVISORY COUNCIL.)

The Joint Council is actively involved in the development of the State Mental Health Plan and the federal Mental Health Block Grant Application. Previously the Council conducted a one day retreat facilitated by a team from the National Association of Mental Health Planning and Advisory Councils (NAMHPAC), to brainstorm on ways to enhance the plan review process and the role of the Council the Planning Committee. As a result of that process, the Planning Committee is now monitoring public mental health system data and more effectively participating in the planning process year round. In 2009, a series of Planning Committee meetings were held to develop and review these key documents:

- The Planning Committee, which meets monthly after the full Council meeting, discussed priorities and prepared for the MHA public meeting April 29, 2009 to develop the State Mental Health Plan. This year this meeting included broader participation of stakeholders with approximately 75 representatives of mental health advocacy organizations, core service agencies (CSAs), local mental health advisory committees, and members of the MHA Management Committee. The meeting was reformatted to include break out groups based on the New Freedom Commission Goals and develop strategy concepts for the 2010 Plan.
- The Planning Committee of the Joint Council met again on June 16th to review a draft of the Goals, Objectives, and Strategies for the FY 2010 Plan and modified, expanded, and strengthened the strategies as appropriate.

- On July 17th the Planning Committee held an additional meeting to review key sections of the FY 2010 federal Block Grant Application, including Section I- which highlights Maryland's service system, progress and new developments, Section II-identification and analysis of service system's strengths and needs, Section III – presentation of targets and action plans for the required National Outcome Measures (NOMS), as well as State selected performance indicators and the FY 2010 Block Grant Spending Plan. Planning Committee Members observed reader friendly improvements in key narrative sections of this year's MHBG application.
- At the July 21st Joint Council meeting, members approved the FY 2010 State Plan and received the report of the Planning Committee from on the FY 2010 Mental Health Block Grant. The Joint Council, based on the Planning Committee's report, approved both the State and Federal Block Grant plans. The Executive Committee was charged with completion of the final letter of review to be included in the federal Mental Health Block Grant for submission to CMHS.

The full Maryland Advisory Council on Mental Hygiene/ PL 102/321 Planning Council recommends the adoption of the Plan along with the following comments which were developed following the review of the Block Grant on July 17 and 21, 2009.

- We are especially proud of MHA's collaborative work with the Division of Rehabilitation Services (DORS) to increase the number of consumers, including transition aged youth, to be employed through multiple strategies including evidence-based practices in supported employment. Several innovative strategies in the State Plan support this State priority.
- The Joint Council continues to advocate for the psychiatric and somatic needs of older adults. This year, in response to our advocacy, MHA through the Mental Health Transformation Office (MHTO) added staff resources to undertake several strategies to enhance the coordination of care between somatic and behavioral health care providers. We support MHA's focus on smoking cessation as a key response to disparities in mortality rates for people with mental illness.
- The work of the Children's Cabinet continues to be a great strength for our State, especially this year with the implementation of MD CARES, a system of care grant based in Baltimore City with a focus on the special needs of children and youth in foster care; and implementation of the CMS funded RTC Medicaid waiver allowing youth to be served in intensive individualized plans of care as alternatives to institutionalization.

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2010

- The Joint Council commends MHA's collaboration with the Mental Health Transformation Office and On Our Own of Maryland, to provide for Wellness and Recovery Action Plan (WRAP) training in consumer-operated programs, as part of ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, and utilize best practices within the consumer movement; also noteworthy are other MHTO supported consumer initiatives including Consumer Quality Teams, Youth MOVE, and adult and family member leadership institutes.
- We commend MHA's continued commitment to increase the availability of consumer and family-operated support services, as well as youth leadership initiatives. This year's State Plan, Block Grant Application, and Comprehensive Mental Health Plan under the Mental Health Transformation grant include significant strategies that will enhance these services and will promote the goals of recovery and resiliency.
- The availability of affordable housing remains a particularly critical need for consumer independence and recovery. The Council continues to encourage and support interagency efforts to promote a range of housing and residential options in Maryland.
- Through our Interagency Forensic Services Committee (IFSC), we will continue to monitor activities regarding the delivery of mental health services to individuals who are incarcerated or at risk of incarceration in jails and detentions centers, including diversion from the criminal justice system, and their reintegration into the community following incarceration.
- The implementation of new technology such as the Tele-Psychiatry Network Program, the rural tele-mental health equipment grant and the Network of Care are valuable strategies efficiently delivery of mental health services and consumer information in these challenging economic times.
- The need for expansion of crisis intervention services into all regions of the state was identified as an efficient hospital diversion activity that could assist the PMHS in the reduction of more costly, higher intensity services.

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2010

In summary, the Joint Council commends the work of the MHA staff in collaborating with key stakeholders in planning and implementing systems' change. We are pleased with the emphasis on consumer participation and direction throughout the PMHS. We continue to advocate strongly for maintaining access to service, especially for uninsured consumers. We are proud of our involvement in the ongoing development of the PMHS and the opportunities identified through this year's State Mental Health Plan to continue to improve the system, including ways to increase our role as a proactive force in the planning and priority setting processes. The Joint Council fully supports the current Mental Health Block Grant Application.

Sincerely,

Robert Pender
Chairperson

cc: The Honorable Martin O'Malley, Governor
John M. Colmers, Secretary, DHMH
Brian Hepburn, M.D., Executive Director, MHA

PART C. STATE PLAN

SECTION I. DESCRIPTION OF STATE SERVICE SYSTEM

In this section, States are requested to identify any issues or initiatives within the State that are important in understanding the State plan in the context of the broader system.

Maryland ranks 42nd among the States in size with 9,844 square land miles and total area (including inland water and the Chesapeake Bay) of 12,193 square miles. Maryland ranks 19th in population among the States and ranks 6th in population density with 541.9 persons per square land mile. Maryland's population increase was approximately .9% annually according to Maryland Department of Planning, however in recent years Maryland's population estimates are slowing. In 2007 Maryland's population estimate was 5,618,344, a slight increase of only 0.047% from the 2006 of 5,615,727 according to projections from Maryland Vital Statistics Annual Report 2007 based upon the ten years U.S. Census. Maryland's population is projected to grow to 5,904,425 by 2010 and to 6,337,075 by 2020. (Maryland Manual, Maryland Vital Statistics).

Maryland ranked 5th among the States with per capita income in 2008 growing to \$48,091. This average fails to capture the great economic diversity and the disparity that exists between the counties such as Montgomery County with the highest per capita income of \$67,525 and Somerset County with the lowest per capita income of \$24,053. In 2007, average household median income for the State was \$68,080 the second highest in the nation Maryland's workforce is one of the best educated, across the states, with over one third of its population 25 years or older having at least a college degree. Maryland ranks second among the states with 13.7 % of the population aged 25 or older having a graduate or professional degree. (Source – Maryland Department of Business and Economic Development www.choosemaryland.org/factsandfigures/demographics) In recent years Maryland's funding under this Community Mental Health Block grant has been reduced due to formula shifts like the State's high economic standing.

Local government exists in Maryland's 23 counties, Baltimore City, and 154 municipal corporations (including Baltimore City). The Constitution of Maryland requires that the State budget be balanced; total estimated revenues must equal or exceed total appropriations; Governor presents budget, and legislature can only approve or reduce.

About 90% of the population lives in the densely populated corridor between Baltimore City and Washington, D.C. (Maryland Department of Business and Economic Development, 2004). 2000 Census Data shows Maryland's population based on age and sex closely mirrors the United States population. However, Maryland consists of 30.0% African Americans, as opposed to the United States' 12.3%. There is a larger Asian population (5.3%) and more individuals of Hispanic or Latino origin (6.3%), compared respectively to the United States' figures of 3.6% and 2.5%. American Indian or Alaska Native persons make up less than 1.0% of Maryland's population, while they make up .9% of the United States' population. (US Census for national 2000 and Maryland Vital Statistics Annual Report 2007)

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In March 2009 a total of 759,472 individuals were enrolled in Medical Assistance or one of the coverage groups included in the Maryland Department of Health and Mental Hygiene's HealthChoice Information System. This is an increase of 10.4% over the previous March, 2008 enrollment of 687,698. In March 2008, 106,454 children up to age 19 were enrolled in the Maryland Child Health Program (MCHP). In March 2009, MCHP enrollment decrease 2,288 from the previous year to 104,166.

Overview of the State's Mental Health System

- **An overview of the State's mental health system: a brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.**

The Mental Hygiene Administration (MHA) is the agency within the Department of Health and Mental Hygiene responsible for the oversight of public mental health services in Maryland. Maryland operates the majority of its public mental health system under a Medicaid 1115 waiver. The waiver permits the Secretary of DHMH to require that all Medical Assistance (MA) recipients, except certain exempted populations, be enrolled in and receive their somatic care through managed care organizations (MCOs). Waiver-eligible Medical Assistance recipients are enrolled in MCOs under Maryland's HealthChoice program. Under the terms of the waiver, MCOs receive a capitated rate for providing somatic care, substance abuse treatment, and primary mental health care to enrollees. Primary mental health services, as defined by the enabling legislation, means the clinical evaluation and assessment of mental health services needed by an individual and the provision of services or referrals for mental health services as deemed medically appropriate by a primary care provider. Both the MCOs and MHA are required to assure that somatic care and substance abuse treatments are coordinated with mental health care.

Under Maryland's 1115 Medicaid waiver, a redesigned public mental health system (PMHS) was conceptualized. Specialty mental health services - those mental health services that are beyond primary mental health services - are delivered through a "carve-out" arrangement that manages public mental health funds under a single payor system. The system serves Medicaid recipients and a subset of uninsured individuals who meet medical necessity criteria and financial and/or other specific criteria. The cost of mental health services is subsidized, in whole or in part with State general funds. Medically necessary mental health services are delivered to eligible individuals of all ages through the PMHS.

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Prior to the waiver, MHA administered all State funds allocated to it by the legislature for mental health services as well as some federal grant funds, but only a portion of the State and federal Medicaid dollars, specifically money that paid for services under the Medicaid clinic, rehabilitation and targeted case management options. Through implementation of the public mental health system, July 1997, MHA began to administer all State and federal, including Medicaid, funds related to mental health services.

The PMHS is managed in collaboration with the Core Service Agencies (CSAs) and the Administrative Services Organization (ASO). The CSAs are entities at the local level that have the authority and responsibility, in collaboration with MHA, to develop and manage a coordinated network of Maryland's public mental health services in a defined service area. Effective, September 1, 2009, MHA will begin a five year contract with Value Options, Inc., the new ASO, for Maryland's PMHS. The major responsibilities of Value Options include: access to services, utilization management, data collection and management information services, claims processing and payment, evaluation services and stakeholder feedback. The goal of the system is to provide the benefits of the coordination of managed care, while preserving access to a comprehensive array of services, flexibility, and choice.

MHA currently operates seven inpatient psychiatric facilities that provide acute, intermediate and long-term care for adults. Springfield Hospital Center offers inpatient care for individuals who are deaf or hard of hearing. In addition, MHA operates one psychiatric forensic facility and two residential treatment facilities for youth known as Regional Institutes for Children and Adolescents (RICAs). However, effective October 1, 2009, Walter P. Carter Center (WPCC) will close. In April, one third of its admissions were diverted to Spring Grove Hospital Center. In June, half were diverted to Springfield Hospital Center. From the time of admission, facilities work collaboratively with CSAs, community providers, consumers, and families toward patient discharge. The focus is on returning the individual to the lowest level of care necessary to meet the individual's medical needs. The State psychiatric hospitals are participants, along with the acute general hospitals and the private psychiatric hospitals, in the provision of psychiatric inpatient care in Maryland. The Mental Hygiene Administration, in collaboration with the various stakeholders, continue to have dialogue on developing and implementing a continuum of inpatient psychiatric care across the private and State sectors and defining the roles of each sector in the provision of acute and long-term care for individuals with Medical Assistance and those who are uninsured.

MHA recognizes that individuals with serious mental illnesses (SMI) and serious emotional disturbances (SED) often require services that are provided by other State departments and administrations, such as the State Department of Education, the Division of Rehabilitation Services, the State Department on Aging, the Governor's Office for Children, the State Department of Human Resources, the State Department of Juvenile Services, the State Department of Housing and Community Development, and other administrations within the Department of Health and Mental Hygiene. To ensure adequate access to those services, MHA maintains interagency agreements, and

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designated liaisons with those agencies, as well as many others. Through Maryland's Mental Health Transformation State Incentive Grant, a Children's Mental Health Initiative grant (Systems of Care grant), and a Community Alternatives to Psychiatric Residential Treatment Facilities Medicaid demonstration waiver, these interagency collaborations and partnerships continue to be solidified while new ones will be formed to further build the infrastructure to coordinate care and improve service systems.

- **A brief description of regional/sub-State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.**

Core Service Agencies (CSAs) are the entities at the local level that have the authority and responsibility to develop and manage a coordinated network of Maryland's public mental health services in a defined service area. There are twenty (20) CSAs covering all 24 jurisdictions. CSAs are agents of county or city government and 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 authority which 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.

MHA and CSAs share responsibilities in the PMHS. Together, they are responsible for determining the criteria for utilization management, establishing performance standards, and evaluating appropriateness and effectiveness of service. Additionally, CSAs are important points of contact for both consumers and providers in the PMHS. They are responsible for processing complaints, grievances, and appeals, as well as for monitoring the contract with the ASO and reporting findings to MHA.

The Maryland Association of Core Service Agencies, (MACSA) Inc., was established to promote and support the effectiveness of each CSA in Maryland to plan, monitor and manage its local, publicly-funded mental health service system. Each fiscal year MHA requires that CSAs develop and report on their progress in identifying and meeting local needs and State priorities. Additionally, CSA representatives participate on the Maryland Advisory Council on Mental Hygiene/Planning Council and various MHA committees such as the Finance Committee and the Clinical Committee which promote direct involvement with PMHS issues. Also, the CSAs work closely with the MHA Management Information System (MIS) staff to generate and disseminate data that is useful to the CSAs as they support initiatives and services that are the most beneficial for the public they serve.

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CORE SERVICE AGENCIES IN MARYLAND

JURISDICTION	TITLE OF CSA	ORGANIZATIONAL LOCUS	DIRECTOR LOCATION
Allegany County	Allegany County Mental Health Systems	Part of County Health Department	Lesa Diehl Cumberland MD
Anne Arundel County	Anne Arundel Co. Mental Health Agency, Inc.	Private - Non-Profit	Frank Sullivan Annapolis MD
Baltimore City	Baltimore Mental Health Systems, Inc.	Private- Non-Profit	Jane Plapinger Director Baltimore MD
Baltimore County	Baltimore Co. Dept of Health, Bureau of Mental Health	Part of County Health Department	Robert Blankfeld Towson MD
Calvert County	Calvert County Health Department Core Service Agency	Part of County Health Department	Douglas Weems Prince Frederick MD
Carroll County	Carroll County Core Service Agency	Part of County Health Department	Sarah Connelly Westminster MD
Cecil County	Cecil County Mental Health Department Core Service Agency	Part of County Health Department	Doug Sommers Elkton MD
Charles County	Charles County Human Services Partnership	Part of County Government	Mike Luginbill LaPlata MD
Frederick County	Mental Health Management Agency of Frederick County, Inc.	Private - Non Profit	Robert Pitcher Frederick MD
Garrett County	Mountain Top Mental Health Associates, Inc.	Part of County Health Department	Fred Polce Oakland MD
Harford County	Core Service Agency of Harford County	Private - Non-Profit	Sharon Lipford Bel Air MD

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CORE SERVICE AGENCIES IN MARYLAND - CONTINUED

JURISDICTION	TITLE OF CSA	ORGANIZATIONAL LOCUS	DIRECTOR LOCATION
Howard County	Howard Co. Mental Health Authority	Quasi-Governmental	Donna Wells Columbia MD
Mid-Shore: Kent, Caroline, Queen Anne's, Talbot, Dorchester Counties	Mid-Shore Mental Health Systems, Inc.	Private - Non-Profit	Joseph Newell Easton MD
Montgomery County	Montgomery County, Department of Health and Human Services, Mental Health Core Service Agency	Part of County Government	Raymond Crowel Rockville MD
Prince George's County	Prince George's Co. Dept. of Family Services, Mental Health Authority Division	Part of County Department of Family Services	L. Christina Waddler Hyattsville MD
St. Mary's County	Mental Health Authority of St. Mary's Co., Inc.	Part of County Health Department	Bennett Connelly Leonardtown MD
Somerset County	Somerset County Core Service Agency	Part of County Health Department	Lisa Renegar Westover MD
Washington County	Washington County Mental Health Authority, Inc.	Private - Non-Profit	Rick Rock Hagerstown MD
Wicomico County	Wicomico County Core Service Agency	Part of County Health Department	Cicely McElwain Salisbury MD
Worcester County	Worcester County Core Service Agency	Part of County Health Department	Jennifer LaMade Snow Hill MD

Role of the State Mental Health Agency

- **A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.**

MHA recognizes the importance of promoting mental health within the broader system. MHA staff have active liaisons with other State agencies, participate in other agency workgroups, and advocate for the availability of services offered in the broader system to persons with psychiatric disabilities. In FY 2008, the Maryland General Assembly created the Behavioral Health and Disabilities position, a new part of the DHMH organizational structure that now includes four deputy secretariats. In September 2009, Renata Henry was appointed Deputy Secretary for Behavioral Health and Disabilities. This position oversees the department's Mental Hygiene, Alcohol and Drug Abuse (ADAA) and Developmental Disabilities (DDA) administrations, as well as the Office of Forensic Services. Uniting the three administrations will help strengthen collaborative planning and coordination of care for Marylanders with co-occurring disorders and forensic issues. One initiative toward this effort is the development and implementation of regional forums on "Building the Behavioral Health Partnership". This is an effort designed to bring together stakeholders on how to better integrate care for co-occurring populations they serve. Additionally, in June 2009, under the leadership of the Deputy Secretary, Maryland was one of six states selected to participate in the national policy summit on the elimination of disparities in mental health care. MHA executive director, Brian Hepburn, M.D. and members of the Maryland delegation discussed an ongoing state initiative to link mental health, substance abuse and developmental disability data, with an end result focused on a better understanding of co-occurring behavioral health and disability issues.

MHA continues to forge strong relationships with agencies responsible for housing and employment opportunities in order to create greater access to their programs. MHA has taken the lead in reaching out to the Department of Public Safety and Correctional Services to initiate, sustain, and identify potential collaborations. MHA's work with Medical Assistance, which is the major financier of the mental health system, helps that organization remain attuned to mental health needs. MHA works with other leaders from community provider associations to address workforce issues through revisions to the PMHS rate structure and collaborates with professional associations and state regulators to maintain the quality of the workforce. The Leadership of MHA meets monthly with the Maryland Advisory Council on Mental Hygiene/ PL 102-321 Planning Council to share information, communicate concerning current developments and participate in planning, monitoring and evaluations for the PMHS. (Please refer to Section G. Role of the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council.)

The state of Maryland continues to refine strategies to achieve organizational culture change that will transform the delivery of mental health services and fully support recovery and resilience for consumers.

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- **Legislative initiatives and changes**

The 2009 legislative session included the passage of several mental health related bills and legislative actions:

- House Bill 415/Senate Bill 874 – Mental Hygiene Administration – Rights of Individuals with Mental Health Disorders in Facilities – this bill further clarifies the rights of individuals in psychiatric facilities including the right to an advocate of their choice, the right to receive treatment in accordance with their mental health advance directives and the right to be free from prone restraint.
- House Bill 411/Senate Bill 492 – Community Mental Health Services Programs – Financial Statements and Salary Information – this bill requires all licensed community mental health services programs to submit annual financial statements and salary information to the Mental Hygiene Administration (MHA) in accordance with the Department of Health and Mental Hygiene’s (DHMH) regulations; and authorizing the MHA to impose a penalty on a community mental health services program for failing to comply.
- House Bill 412/Senate Bill 493 – Mental Health Programs and Facilities – Reports of Death-this bill defines the term “program or facility” so as to restrict the application of specified reporting requirements regarding the death of an individual with mental illness to specified mental health programs and facilities; specifies that specified programs or facilities are required to submit only one report of death; requires the administrative head of specified non-residential psychiatric rehabilitation programs to make a report of death to the Director of the MHA by a specified time.
- House Bill 957/Senate Bill 796 – Office of the Treasurer – Community Services Trust Fund –Workgroup - this bill requires the Secretary of Health and Mental Hygiene, in collaboration with the Office of the Treasurer, to convene a workgroup to evaluate and make recommendations regarding the Community Services Trust Fund; requiring the DHMH to report the findings and recommendations of the workgroup to the Governor and the General Assembly on or before December 1, 2009.
- House Bill 1099 – Mental Health – Local Correctional Facilities – Incarcerated Individuals with Mental Illness – requires the managing official of a local correctional facility to provide an inmate who has been incarcerated in a local correctional facility for a least 60 days and who has been diagnosed with a mental illness with access to a 30-day supply of medication for the mental illness on the release of the inmate under specified circumstances; providing that part of the supply of medication may be provided by prescription under specified circumstances.

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MHA is further required to submit a variety of reports to the Joint Chairmen, including: 1) a report on proposed changes at Walter P. Carter Center and report on any additional revenue generated from the movement of the University of Maryland outpatient mental health center (OMHC) and the program of ACT from Carter Center shall be used to expand community mental health services; 2) MHA is required to update the 2007 staffing study to reflect the effect of cost containment measures of State-run psychiatric facilities; 3) MHA shall submit a report detailing State-run psychiatric facility admission protocols from local correctional facilities versus other patients, the total cost of somatic care to forensic patients, and a jurisdictional breakdown per patient (forensic vs. non-forensic) somatic care costs that exceed \$25,000 during the commitment of a patient.

Other New Developments and Issues

- **A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.**

Maryland's mental health system has seen many challenges as well as achievements over the past years. The current economic crisis occurring across the nation has had a significant impact on the State of Maryland. Declining revenues and increasing demands for services challenge the state budget and the PMHS. In FY 2008 and 2009 Maryland's Governor directed state Cabinet Secretaries to reduce state spending as an initial step in closing the deficit that the state faces in the upcoming years. In FY 2010, the state has dealt with a budget shortfall of over \$700 million and addition of rounds of budget cuts. Within MHA, a strategic decision was reached to take its share of the budget reduction from the state hospital budgets, leaving lower intensity services which reach many more individuals intact. Community-based services will be further challenged to meet the needs in the community and reduce hospital utilization. MHA, in collaboration with CSAs, will work to strengthen and support community-based services including diversion initiatives.

Maryland continues to refine strategies to achieve a collaborative process that will transform mental health service delivery and fully support recovery and resilience. With a continued focus on policy, program, and quality improvement, several initiatives have been implemented that build upon the success of evidence-based practices, promising practices, and programs directed toward a sustainable recovery for individuals. Maryland's efforts in implementation of evidence-based practices, starting with the earliest involvement in the National Evidence-Based Practice Project, came into full-scale with statewide implementation of evidence-based practice models of supported employment, assertive community treatment, and family psychoeducation. Maryland's evidence-based practice of supported employment is recognized for the best outcomes in the country. Additionally, work is underway to initiate a pilot project through which an evidence-based model for co-occurring treatment is implemented at selected sites. Under the leadership of the Department's Deputy Secretary of Behavioral Health and

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Disabilities, there is continued collaboration with the Mental Hygiene Administration, Developmental Disabilities Administration (DDA) and the Alcohol and Drug Abuse Administration (ADAA) to develop competencies and a curriculum, as well as a method for cross-training on co-occurring disorders across the three administrations.

To alleviate the increased pressure on the general hospital emergency departments and the PMHS, particularly state psychiatric beds, MHA increased collaboration with CSAs in select jurisdictions, to implement hospital diversion projects. These projects divert consumers who do not need state hospital care to community based programs. The PMHS also continued to see increases in the number of individuals with court-related charges or involvement in the criminal justice system. Collaborative efforts with the Judicial system were implemented to divert individuals from incarceration when appropriate, while maintaining compliance with court orders and judicial recommendations. Diversion efforts include crisis intervention teams (CITs), mobile crisis teams (MCTs) and assertive community treatment (ACT). CSAs have the discretion to choose which services to develop with support from MHA.

Maryland's community forensics and community criminal justice initiatives continue to flourish. Over 1,000 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. Restructuring of a program for pregnant women with histories of substance use, mental illness, and trauma, who would otherwise be incarcerated has resulted in improved working relationships among a variety of State agencies and the Baltimore City judiciary. The initiative, known as the Chrysalis House Healthy Start Program, consists of a 16-bed diagnostic and residential facility in Baltimore City for pregnant and post-partum women and their babies. Pregnant women are referred by the courts, the Office of the State's Attorney, the Office of the Public Defender, defense attorneys, and correction facilities or DHMH.

MHA continued efforts to promote consumer-driven care through increased funding and through working with On Our Own of Maryland (OOOMD) to implement restructuring of their programming to a wellness and recovery orientation. In the previous year, the Mental Health Transformation Office and MHA's Office of Consumer Affairs, with the support (OOOMD) began to offer training in the Wellness Recovery Action Plan, in all of its consumer 'wellness and recovery' centers across the state. To date it is estimated that at least 300 Marylander's including Wellness and Recovery Centers' staff and volunteers have participated in the introductory WRAP training and have completed personal Wellness and Recovery Action Plan. There are 51 trained WRAP facilitators and 18 more are scheduled to be trained in the future. Through the Mental Health Transformation Grant, Maryland has launched the first statewide Youth M.O.V.E. (Motivating Others through Voices of Experience) so that youth have a significant leadership role in the system. The Youth MOVE program is developing leadership skills among young people with mental illness. Half of the state is now covered by this

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program. Local organizations are being developed to support young participants in Youth MOVE.

The Outcomes Measurement System (OMS), implemented in FY 2007, was developed to collect information ranging from housing to school attendance to substance abuse on individuals, ages six to 64, who are receiving outpatient mental health services in Outpatient Mental Health Clinics (OMHCs), Federally Qualified Health Centers (FQHCs), and hospital-based outpatient mental health clinics statewide. By the end of FY 2008, more than 50,000 individuals had completed at least one OMS interview. Information is collected at the beginning of treatment and every six months thereafter while an individual is receiving treatment. This information makes it possible for MHA to conduct a change over time analysis which helps assess the benefits of treatment. The data mart, a user-friendly website launched in FY 2008, provide a summary information about the people who are receiving services, based on the answers to their most recent OMS questionnaire.

Maryland was awarded, one of the 10 Psychiatric Residential Treatment Facility (PRTF) Demonstration Projects from Center for Medicare and Medicaid Services (CMS). This allowed the state to apply for a 1915(c) waiver to provide community-based services to children who meet the medical necessity criteria for admission to a PRTF but who can be served in the community using high fidelity wraparound services (Maryland Wraparound). The recently approved 1915 (c) Waiver will cover care coordination and services would be paid for by Medicaid (50/50 state match). The target population for the PRTF waiver are children under 18 years of age with serious emotional disturbance who meet the Maryland PRTF level of care. Children do not have to be eligible for Medicaid or MCHP. The waiver will provide services for up to 150 children and youth and their families. The two pilot sites, Baltimore City and Montgomery County, will continue as initial waiver sites with the addition of St. Mary's and Wicomico counties. Additional jurisdictions will be phased in as they develop the capacity to meet MD-Wrap service criteria.

MHA accomplished many of its objectives in the past year. Many more achievements are noted in Sections II and III of this document and their descriptions will not be repeated here. Maryland's FY 2009 State Mental Health Plan includes the six goals of the New Freedom Commission on Mental Health. In reviewing the FY 2009 State Mental Health Plan and this Maryland Mental Health Block Grant Application, the Plan Review Committee of the Joint Council (see Part One, Section IV) noted that Maryland's objectives and strategies are congruent with the recommendations in the President's New Freedom Commission of Mental Health.

- **New developments and issues that may affect mental health services in Maryland**

In FY 2008, MHA implemented Maryland's Commitment to Veterans, which is a three-year collaborative partnership among the Department of Health and Mental Hygiene (DHMH), the U.S. Department of Veterans Affairs, the Maryland Department of Veterans Affairs, and the Maryland Defense Force. The project, funded by the State of

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Maryland, is designed to help combat veterans and their families obtain the behavioral health services they need upon the veteran's return from conflict. The primary objective is helping Veterans of the Iraq and Afghanistan conflicts link to eligible services within the U.S. Department of Veteran Affairs. Maryland was the first state in the country to add a comprehensive veterans' portal to the state's Network of Care site as an additional resource to obtaining access to services.

To further develop parameters for telemental health to improve access to mental health services, especially for individuals living in rural and medically underserved areas, Maryland was awarded, through the federal Health Resources and Services Administration, a three year grant to purchase telemental health equipment and support to further development of the system in rural areas. Telemental health is being utilized by Correctional Mental Health Services in detention centers in several jurisdictions and in selected state facilities to enhance long distance training and referral processes.

In collaboration with the Mental Health Transformation State Incentive Grant (MHT-SIG) from the Substance Abuse and Mental Health Services Administration (SAMHSA), consumer leadership efforts will be strengthened, Web-based resources will be implemented, and evidence-based and promising practices for children and adolescents will be promoted with particular focus on children in the child welfare system. MHA, DHMH and other state agencies continue to work together to address the mental health needs of individuals across the life span, in planning systems' reform to foster recovery and resiliency models across governmental agencies and the private sector.

Another important development to improve service delivery to children and adolescents is the implementation of the Child and Adolescent Mental Health Institute. MHA, in collaboration with the Maryland Coalition of Families for Children's Mental Health and the Divisions of Child Psychiatry at the University Of Maryland School of Medicine and the Johns Hopkins School of Medicine, will lead this initiative to research and develop child and adolescent evidence based practices in mental health as well as best practices and evaluation efforts.

The Children's Cabinet, the Advisory Council for Children, and the Governor's Office for Children – all formed in June 2005 by Executive Order – provide a coordinated, comprehensive, interagency approach to the development of a continuum of care that is family and child – oriented and emphasize prevention, early intervention, and community-based services for all children and families with special attention to at-risk populations. The Children's Cabinet Results Team (CCRT), the working group of the Children's Cabinet, has led the development of the three-year plan establishing goals and strategies for delivery of integrated services to children and families. The Governor's Office for Children promotes the well-being of children by collaborating with Local Management Boards, (agencies responsible for coordinating services provided to children, youth, and families in ways similar to the CSA function described under Section I, Regional/sub-State Programs), expanding SCYFIS (State Children, Youth and Families Information System) and developing and implementing Systems of Care Initiative.

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MHA's Child and Adolescent Services Director is an active member of the CCRT and MHA staff participate in several of the sub-committees of the Children's Cabinet.

SECTION II

**IDENTIFICATION AND ANALYSIS OF THE
SERVICE SYSTEM'S STRENGTHS, NEEDS, AND PRIORITIES**

Adult

IDENTIFICATION AND ANALYSIS OF SYSTEM STRENGTHS, NEEDS, AND PRIORITIES

Maryland's Mental Health Transformation

The state of Maryland continues to refine strategies to achieve organizational culture change that will transform the delivery of mental health services and fully support recovery and resilience for consumers. Over the past four years, Maryland's Mental Health Transformation Office has continued to undertake a number of innovative projects to transform the mental health system and build upon transformational efforts that pre-date Maryland's grant award as well as strategies that began during the first three years of the Mental Health Transformation State Incentive Grant (MHT-SIG). Maryland's transformation efforts are now being recognized nationwide. The state was one of only six to be awarded a grade of "B" – the highest rating given in the National Alliance on Mental Illness' (NAMI) *Grading the States 2009* report. In its report, NAMI recognizes Transformation as an innovative program. NAMI officials note that Maryland is a national leader in several areas, including support of consumer empowerment, collaboration with consumer and advocacy organizations, and in its wellness and recovery approach to mental health services. The Transformation Program has played a significant role in developing these efforts. In FY 2010, the final year of the transformation grant, our goal is to identify and achieve sustainability for innovative programs.

Partners in Recovery and Resilience

The strength of Maryland's PMHS lies in large part in its long-term, well-organized, and effective consumer, family, advocacy, and provider organizations. MHA has partnered with these organizations since their inceptions and, in fact, fostered their development. Additionally, MHA's partnerships include academic institutions; and federal, state, and local agencies. MHA in collaboration with local mental health authorities known as core service agencies (CSAs) manages the PMHS. Mental health transformation efforts and activities are infused throughout the MHA State Mental Health Plan for children, youth, and adults. The Plan includes numerous strategies to further strengthen consumer and family leadership and the promotion of a coordinated and efficient system that supports recovery and resilience across the life span.

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

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The Consumer Quality Team (CQT) a consumer and family member run program dedicated to improving quality oversight of the Public Mental Health System (PMHS), records and addresses individual consumers' satisfaction with the services received and makes site visits to psychiatric rehabilitation programs and inpatient mental health facilities serving adult consumers. Program administrators and MHA also received information about staff, programs, and activities that have been effective in helping consumers recover and change their lives. CQT began as a pilot program in three counties in 2006 and expanded in 2007. The CQT has increased the number of consumers interviewed from over 200 in FY 2007 to over 500 in FY 2009.

MHA has developed over the past several years, a successful approach to the implementation of evidence-based practices. Collaboration with the University of Maryland in supported employment, assertive community treatment, and family psychoeducation, has helped identify both supports for and barriers to implementation. This collaboration has also strengthened the supports, resolved the barriers and developed policy and financing for statewide implementation of these practices. The relationship with the state Division of Rehabilitation Services (DORS) and MHA is an example of Maryland's strengths. Maryland's work in supported employment, including outstanding integration between MHA and DORS at the state level and among CSAs, programs, and local DORS offices at the local levels, has been recognized as exceptional by national leaders in implementation of evidence-based practices.

MHA has long promoted the concept of supported housing and consumer choice in housing and has developed policies and programs that reflect this commitment. Rates in the fee-for-service system help to support individuals' abilities to live in their own homes. Priority for community bond (capital) financing is given to development of affordable housing projects. Excellent interagency collaboration with the Department of Housing and Community Development (DHCD) has resulted in increased housing options for consumers of mental health services. Active work with local public housing authorities helps secure access to and stability in housing for consumers.

The PMHS continues to improve access to services. Using technology to improve access to mental services, MHA launched a Web-based resource site, Network of Care (NOC) for Behavioral Health, which provides local, state, and national information to help consumers and families access services and manage their mental illness. Maryland was the first state to implement the NOC Website for veterans. This is a signature effort for the Lieutenant Governor and was highlighted in his Memorial Day communications throughout the state.

UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM; (including identification of data sources used to identify the needs and gaps)

There are several sources of data which the MHA uses to identify unmet service needs and gaps. The ASO data systems combine MA eligibility, service authorization, and claims payment data into a rich, multi-variable database. A multitude of reports including consumer characteristics, service utilization, and expenditures can be generated. Special state reports on individuals with co-occurring illness show that they consume a disproportionate share of PMHS resources. Providers and programs proficient in working with co-occurring mental illness and substance abuse, as well as mental illness and developmental disabilities, are limited and the need far exceeds availability.

There is general consensus that the benefit package in the PMHS is more comprehensive than the limited mental health services provided under many private health insurance plans; however, there are concerns among all stakeholders that maintaining access to services at this time of national and state economic crisis will be challenging. The issues raised are about the number or location of service programs, as well as the availability of highly specialized treatment services. Recent discussions have centered on continuous improvement in the quality of services; assuring that services are effective, recovery focused, and consumer driven; and that those most in need are able to receive the services. Coordination of care between somatic and psychiatric sectors remains critical, and has been made evermore pressing by the publication of new reports on the morbidity and mortality of individuals with serious mental illnesses (SMI).

Housing

There are several themes that emerge when analyzing all the information and data that are gathered. The need for more housing across the continuum of residential options for consumers has been identified in the state plan and in local CSA plans. Focus groups, needs assessments, and local housing waiting lists support this need. The 2007, Joint Chairmen's Report requested that the Departments of Health and Mental Hygiene (DHMH), Housing and Community Development (DHCD), and Disabilities (DOD) jointly develop a strategic plan for the Development of Affordable Independent Housing for Persons with Disabilities, specifically those with serious and persistent mental illness (SPMI) and those with a developmental disability. The Plan includes strategies to maximize the utilization of existing resources available to develop affording housing, as well as to identify how to overcome the barriers to development of housing. The Plan also includes strategies to: generate 1,800 rent subsidies during FY 2010 – 2014, continue to expand the production of affordable units and the use of existing affordable housing units; target rent subsidies to the highest priority target populations served by MHA and the Developmental Disabilities Administration (DDA); and strengthen planning and advocacy efforts at the local, state and federal levels and with the private sector to increase affordable housing opportunities. Additionally, in FY 2010 MHA will continue

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to increase the number of individuals with mental illnesses, who obtain affordable and safe housing through the Bridge Subsidy Pilot Program.

Project for Assistance in Transition from Homelessness (PATH) and Shelter Plus Care funds will be used to continue to meet the needs of homeless individuals and those coming from detention centers. This year, MHA will work with courts, detention centers, and public safety and correctional services to better address the mental health needs of individuals entering or exiting these systems, as well as the needs of individuals in MHA facilities who are court-involved and ready for discharge. Starting July 2009 MHA collaborated with the Developmental Disabilities Administration (DDA) to develop services for individuals with mental illness and developmental disabilities who are currently in state psychiatric hospitals and will be transitioned to more appropriate care settings.

Employment

The national economic crisis has raised unemployment rates for all people. Maryland consumers speaking at forums, focus groups, and conferences identify the desire and need to work as a critical issue on the path to recovery. Budgetary shortfalls had led to an extensive waiting period for DORS-funded vocational services and its temporary closure in FY 2008. However, efforts of mental health advocacy groups, the Maryland Advisory Council on Mental Hygiene/ Planning Council, and other stakeholders resulted in a legislative approval of an increase in DORS budget that led to a reopened and period reduction of the waiting list. Supplemental federal funding through the American Recovery and Reinvestment Act of 2009 has assisted DORS in avoiding the placement of eligible individuals with the most significant disabilities on the waiting list for services. The challenging fiscal climate continues to compromise the financial viability of certain supported employment (SE) programs and has led to delays in access for some consumers and reductions in availability of SE services in some jurisdictions. MHA and DORS Executive Director Leadership teams have met frequently over the course of the last year to explore interim and long-term strategies for reconciling the gap in vocational rehabilitation funding in an effort to preserve the viability of SE services within the PMHS and to sustain the gains in braiding funding and system integration across both systems. Development of employment opportunities and support in finding and keeping jobs is the most noted need. This priority is the focus of a revised objective in the state plan that declares: *“MHA will increase the number of consumers employed”* Efforts to provide training in the Employed Individuals with Disabilities Program (EIDP) and utilization of Ticket to Work are promoted. (Both Housing and Employment Services are discussed under New Freedom Commission (NFC) Goal II and in Section III - Criterion 1)

Transportation

MHA obtains information through its network of CSAs, consumer, family, provider, and advocacy partners in reports to the Maryland Advisory Council on Mental Hygiene and in annual MHA staff review of the CSAs annual local mental health plans.

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The issues of need for improved local transportation, particularly in rural, is identified as a consistent barrier to care and a priority local need. Maryland operates mobility transportation services in many jurisdictions. Local health departments offer transportation for Medicaid recipients and PMHS community providers provide van pool transportation for program participants. Maryland's Association of core service agencies and the local mental health advisory councils have developed statewide rankings of local CSA service needs and consumer priorities. Additionally, the Maryland Department of Disabilities increasingly assuming leadership for cross-agency efforts for adults and transition-age youth especially in the areas of transportation, employment, and housing.

Workforce

Rural areas commonly identify difficulty in recruiting and retaining mental health professionals, particularly those who treat special populations, and accessing to specialized services/programming (i.e., treatment for sexual offenders). Recruitment and retention of qualified mental health professionals, direct care workers, and administrators within MHA and the many programs of the PMHS remain challenging. Particularly challenging is the recruitment of persons of diverse ethnic and racial groups to treat the increasingly diverse needs of PMHS consumers. Recruitment of emerging leaders for the PMHS reflects the dearth of younger people nationwide selecting public service for employment opportunities. The historically lower wages for human service workers in comparison to many other occupations make competing for employees challenging. Plans regularly identify workforce issues – compensation, recruitment, retention, and training – in the priority of agenda issues for major PMHS private provider organizations in Maryland's transformation. (Maryland's training initiatives and EBP development are discussed under the combined single Criterion 5 covering both the Adult and Child Plan)

Services for Co-occurring Disorders

The need for improved coordination of services to improve access for consumers with co-occurring disorders is identified in the strategies in the State Plan and in local CSA plans. Work will continue with CSAs and the state ADAA on developing integrated care for co-occurring disorders through a state action plan and through local initiatives. Efforts at implementing the Continuous, Comprehensive, Integrated Systems of Care (CCISC) model for co-occurring mental health and substance abuse disorders is intensifying at the local level. MHA, in collaboration with University of Maryland will continue to implement training initiatives for outpatient mental health clinics to improve services for individuals with co-occurring disorders. (See Criterion 1- Co-occurring Services).

THE STATE'S PRIORITIES AND PLANS TO ADDRESS UNMET NEEDS AND CRITICAL GAPS

As discussed previously, the FY 2010 State Mental Health Plan contains numerous strategies to address the aforementioned service needs and gaps. Many of these strategies have been under development for several years and will continue to move

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forward even in the current budget crisis. In Section III of this application, we will discuss all of the mandated federal mental health block grant criteria in greater detail. At the end of each Criterion we will list the state strategies/ block grant objectives for the coming year. These objectives are repeated as the action steps in the performance indicators listed in the appendix to the application and on the WebBGAS Indicators.

One of Maryland's priorities for the PMHS is the need to maintain continuity of services during transition to a new Administrative Service Organization (ASO). In September 2009 MHA will formally transition to a new ASO as a result of the state competitive procurement processes. MHA is working collaboratively with the ASO, the mental health stakeholder community, and providers to ensure a seamless transition.

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 currently contracts with the core service agencies (CSAs), who in turn contract with the case management providers for the service. In FY 2010, MHA will work with Medicaid to amend the Medicaid State Plan and regulations for case management. Once CMS approval is received, MHA in collaboration with the CSAs and the ASO, will implement and monitor the transition from contracted case management services to the fee-for-service system (FFS) for Medicaid recipients and uninsured individuals.

The development of hospital diversion programs in three large jurisdictions to reduce the pressure for admission to state hospitals and to provide community-based alternatives to state hospitalization has already shown successes. Hospital diversion projects divert consumers who do not need state hospital care to community-based programs. In select jurisdictions, local CSAs working with the support of MHA, have implemented a continuum of community-based crisis and emergency services, including urgent care and outpatients clinics; mobile crisis teams; and respite options and crisis support services for children and adolescents. These hospital diversion projects have led to dramatic reductions in admissions of uninsured individuals to state hospitals (ranging from 59 to 80% for the three programs launched in FY 2007). In addition, in FY 2008, more than 1,100 individuals were seen by mobile crisis teams in local hospital emergency departments, of whom more than 44% were diverted to community-based programs.

This year several state strategies address efforts to improve coordination of care in the PMHS. MHA will continue to strengthen the ongoing collaborative work among the ASO and managed care organizations (MCOs), as well as collaborate with the University of Maryland, School of Medicine, Department of Psychiatry, to research best practices in psychiatry to better address: the interplay of physical and psychiatric care on the total health of the individual; negative side effects of medication; and reduction of morbidity and mortality for adults with mental illnesses. In discussing priorities for the FY 2010 State Plan, MHA leadership identified the importance of strategies providing for collaboration with consumers, providers, and other mental health stakeholders to promote and implement the smoking cessation initiatives at all levels in the PMHS.

RECENT SIGNIFICANT ACHIEVEMENTS

Recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care;

Throughout this document the reader will find achievements that reflect Maryland's progress towards the development of a comprehensive community-based mental health system for adults. This past year, Maryland's Mental Health Transformation Grant reached the fourth year in its development processes and advanced the implementation of infrastructure to support key state initiatives. MHA was able to achieve significant progress in the advancement of important aspects of Maryland's consumer driven systems.

Consumer-directed, recovery-oriented projects were the most significant achievements for the PMHS. Supported by an infusion of transformation grant infrastructure and funding, MHA advanced the following activities to promote "Consumer-Driven" Care:

- **Network of Care**—a statewide implementation of the web-based Network of Care for Behavioral Health, providing simple and fast access to information on local, state, and national behavioral health services. Also launched is the Network of Care for Veterans and Service Members to ensure that they are a part of a healthy community.
- **Wellness and Recovery Action Planning (WRAP)**—MHA, in collaboration with OOOMD, Inc., began training and incorporating WRAP into all Wellness and Recovery Centers (consumer-run centers). Increased financial support was provided to local consumer centers to support their efforts to restructure and re-orient their activities towards wellness and recovery.
- **Statewide Recovery Training**—In collaboration with OOOMD, MHA Transformation sponsored a series of six regional recovery training sessions across the state in early 2008. A total of 605 people attended these sessions, including consumers, CSA staff, and providers of mental health services. In FY 2009, a specialized training was developed and conducted for psychiatrists.
- **Workforce Development**—Maryland is now working to establish Centers of Excellence among leading providers. This project will provide state-of-the-art training and technical assistance, overseen by the Recovery Training Institute of our statewide consumer organization to ensure that recovery is optimally supported within these provider organizations.
- **Mental Health First Aid (MHFA)**—MHA, in collaboration with the Mental Health Association of Maryland, and OOOMD, has adopted the MHFA program to educate the general public to recognize signs of an emerging mental illness or a mental health crisis and to develop the capacity to respond to individuals experiencing psychiatric emergencies.
- **Cultural and Linguistic Competence Initiative**—MHA continues and expands the implementation of training and technical assistance to enhance the cultural competence of mental health professionals.

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- **Aging Project**–Through the use of the transformation grant, MHA has retained a consultant with special expertise in the area of mental health services for older adults and their families to develop strategic plans for this population. Working with a broad range of stakeholders and experts in the field of geriatric mental health, the consultant has mobilized resources to: collect data on the current mental health needs of older Marylanders using the state’s Medicaid database; survey residential service providers to determine the characteristics and service needs of older people with both physical health needs and psychiatric disorders; and to identify best practices for addressing their needs.
- **Youth Move and other supports for Consumer Groups**–In June 2007 Maryland initiated its Youth MOVE (Youth Motivating Others through Voices of Experience) program, based on the national model. We are working to take Youth MOVE statewide. Currently 13 of Maryland 24 counties are funded to develop local Youth MOVE advocates and chapters. A total of 65 youths from across the state are actively involved in this initiative. (<http://www.tapartnership.org/youth/YouthMOVE.asp>).

PMHS Monitoring and Evaluation

- **Consumer Quality Teams monitoring, evaluation, and feedback**--Finally, consumer and family involvement in quality improvement activities has been actualized through the implementation of the Consumer Quality Team (CQT) in Collaboration with the Mental Health Association of Maryland. The CQT conducted 151 site visits to Psychiatric Rehabilitation Programs (PRPs) and three inpatient facilities interviewing more than 625 consumers. Monthly feedback meetings are held with representatives from the appropriate local core service agencies, provider organizations, and MHA.
- **The statewide implementation of the Outcomes Measurement System (OMS)**--(OMS) in the outpatient system is a second significant achievement. This, too, represents the culmination of several years of collaboration among many interested stakeholders and is a model of public-private-academic collaboration. In 2008, MHA launched the initial phase of the OMS data mart, accessed through the ASO’s website. This initial phase of the OMS data mart provided statewide summary information about the individuals who are receiving services, based on the individual’s most recent OMS questionnaire. For FY 2009, OMS information on more than 33,700 adults and more than 27,400 children and adolescents was available. With the change in MHA’s ASO vendor, effective September 1, 2009, plans for re-configuring the OMS data mart will be developed.

FUTURE VISION

A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

MHA's plan for its comprehensive, community-based public mental health system is to create a transformed system of care providing excellent mental health services that are focused on consumer recovery, which employs evidence-based and effective practices, and is outcome driven. A consumer-centered system which offers a range of effective peer support services and promotes consumer-defined recovery and self-direction is envisioned. The system will offer choices and encourage movement towards independence, as identified by the consumer. In Maryland's future mental health system, use of evidence-based, state-of-the-art treatments will become the norm. The culture of the workplace will be transformed to accept and promote the most advanced treatments. Additionally, efforts to promote cultural competence and meet the needs of an increasingly diverse population are a critical component of the future vision. Continuing anti-stigma activities will create the environment where people are comfortable about obtaining mental health services and help treatment providers recognize their own behaviors which may contribute to the stigma of mental illness and impede the very recovery of the individuals they treat.

The MHA envisions a future in which:

- The PMHS has sufficient resources to provide access to all individuals with significant mental health needs regardless of Medicaid insurance and/or individuals who are uninsured,
- individuals take the lead identifying their individualized plan of care; and then get the care they need regardless of the setting in which they find themselves,
- care provided is appropriate and is consumer and family driven,
- evidence-based practices are implemented and the use and evaluation of promising practices are encouraged,
- the workforce is trained and data is used to improve services' process and outcomes,
- opportunities for the best use of funding, including innovative, flexible options are explored and made available,
- services are continuously examined and redesigned to best support recovery and resiliency.
- public mental health services are well linked and coordinated with both substance abuse and somatic health services
- mental health consumers reduce current high levels of morbidity and mortality to improved levels similar to their peers with similar socio-economic life situations
- individuals with mental illness are achieving their goals and dreams and maximize their human potential.

Child and Adolescent

Identification and Analysis of System Strengths, Needs, and Priorities.

Strengths and Weaknesses of the Child and Adolescent Service System

Maryland's Child and Adolescent System continue to reflect a core set of key strengths that are solidly based in the values and guiding principles of the System of Care philosophy. These foundational strengths include:

- **The Children's Cabinet** – An active interagency policy, planning, and decision making body that oversees a large number of innovative interagency projects through implementation of the Maryland Interagency Strategic Plan.
- **Partnership with Maryland's Families and Youth** – A relationship that includes a deep commitment to fully enfranchising the statewide network for families, the Maryland Coalition of Families for Children's Mental Health, and the statewide network for youth – Maryland Youth MOVE – in all activities undertaken within the Children's Cabinet sphere and developments in the MHA – funded continuum of care.
- **Children's Mental Health Institute** – A project committed to improving quality of mental health care within MHA – funded service continuum through a MHA partnership among Maryland's youth and family organizations, the University of Maryland and Johns Hopkins University Schools of Medicine, focused on expanding and testing evidence based and promising mental health practices in the field.
- **Maryland Blueprint Committee** – An extensive advisory group with numerous working groups that is active in charting the course for efforts to improve services offered by MHA and assuring the integration of these efforts into the broader efforts of the Children's Cabinet. This planning and oversight process is based in a comprehensive vision of developmentally appropriate service improvement from pre-natal care and infancy through the end of the transition – age youth period at approximately 25 years of age. The Blue Print process includes special focus on outreach, human resource development, and quality improvement for cultural minorities and other specialized sub-populations across this critical part of the life span.
- **"Children's Mental Health Matters"** – A significant social marketing effort designed to improve public information, reduce the stigmatization of youth with mental health conditions, and garner public support for innovative system development through a major public awareness campaign. This effort may in some ways be our greatest strength because it goes beyond limited mandates for service improvement while addressing deeper contextual issues requisite for lasting system change and better results. The campaign features a media partnership with both FOX and ABC networks, and involves Maryland's First Lady, Katie O'Malley, as Honorary Chair and Debbie Phelps, mother of Michael Phelps, Maryland's celebrated Olympic swimmer, as media spokeswoman. A major media blitz occurred during Children's Mental Health Week, May 3-9, 2009, and will be continued in the upcoming year.

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These core areas of structural and relational strength and the various more detailed strategic activities planned in the upcoming year will be presented throughout this document. As such, they represent an outline for themes that will be repeated in several subsequent sections.

A few major projects for the upcoming year deserve to be highlighted in this section on strengths. Description of these projects will be expanded throughout the plan. As a result these descriptions serve only as previews introducing material that will follow with greater detail.

- Ongoing implementation of the CMS – funded Psychiatric Residential Treatment Facility (PRTF) Demonstration Project, a 1915(c) Medicaid waiver that will offer community – based services such as family-to-family peer support, youth-to-youth peer support, respite care, and other unique services in innovative ways under an approach to care management rooted in High Fidelity Wraparound philosophy.
- Implementation of a SAMHSA System of Care grant, Maryland CARES, with a special focus on children and youth in foster care in Baltimore City, that also relies on care management provided through High Fidelity Wraparound process.
- Issuance by the Children’s Cabinet of a major Request for Proposals to procure statewide care management systems through three regional Care Management Entities for a number of specially identified populations. These populations include youth enrolled in the PRTF 1915(c) waiver, and the Maryland Cares system of care grant projects noted above, as well as all youth in child welfare and juvenile justice funded group residential facilities. As a result, this anticipated service development will serve a major integrative function toward a System of Care if implemented as planned.
- Implementation of Maryland “Linkages to Life” statewide youth suicide prevention and early intervention plan with fiscal support from a SAMHSA statewide suicide prevention grant. This activity is undertaken in a broad new context of strong commitment by Maryland to addressing suicide prevention across the entire life span and in special risk groups such as veterans and college aged students. Thus we expect the strength of our youth suicide efforts will contribute greatly to an expanded focus on the need for suicide prevention for all age groups.

Identification of service needs and critical gaps

One of the greatest needs in the child and adolescent service sector is the lack of adequate mental health coverage for families served in the private insurance sector. This problem is extenuated by the fact that many of these families receive educational services under the provision of IDEA entitlement. The resulting disconnect often makes it difficult to develop the interagency system of care since free and appropriate education is considered a broad entitlement while publicly-funded health coverage is largely driven by financial eligibility. In addition, access to services for the uninsured remains a major issue for the state. This is a greater problem in the adult service sector than in the child and adolescent service system. The 1915(c) Medicaid waiver will begin to provide some small solutions to this problem as the waiver will provide an opportunity for some underinsured and uninsured families to receive Medicaid benefit services and specialized waiver services previously not available to them

Despite extensive child and adolescent human resource development initiatives described later in the plan, recruitment and retention of qualified mental health professionals and direct care workers within many programs of the child and adolescent system remains challenging. Particularly challenging is the recruitment of persons of diverse ethnic and racial groups to treat the increasingly diverse needs of PMHS consumers. The historically lower wages for human service workers compared with many other occupations makes competing for employees challenging. It should be noted that this problem is particularly acute in the non-professional work force where child care workers and other paraprofessionals are reimbursed at levels that are comparable to rates paid by fast food venues and other service jobs in the economy. Maryland has made strides in creating certification standards for residential child care workers and has established a pilot certificate program in partnership with a number of community colleges across the state to provide relevant training experiences and the possibility of a career ladder for these workers. Likewise, mental health professionals do not always receive training in evidence-based and effective practices. Training staff to deliver evidence-based practices (EBPs) is highly resource-intensive and current rate structures do not adequately support their implementation.

There is an uneven geographic distribution of qualified providers and provider types in the various jurisdictions of the state. For example, the availability of qualified child psychiatrists, particularly in rural areas, has been a long standing intractable problem. Overall access to specialty mental health services and tendency to adapt models of care developed specifically for urban settings can be a challenge in rural communities. Much of the system development activity in recent time in Maryland is based upon developing demonstration projects supported by grant funding. While this approach allows the state to focus on areas of greatest need and those service rich environments deemed ready to support a competitive demonstration, the approach contributes to widening disparities of service availability among the jurisdictions as a whole. This raises the problem of equity in service access. Maryland's system of CSAs helps the PMHS maintain a focus on services and needs in the rural and non-urban counties. Family

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members and advocates continue to identify the need for assuring a minimum core set of specialty services available in each jurisdiction, but this is a difficult problem to address in the context of resource reduction and financial challenge. A section on needs would not be complete without reference to the fiscal condition of the state. Interagency partners have sustained budget reductions in a number of areas, including a 3.5 Million dollar cut in the Governor's office for Children fund for Wraparound service delivery and a scaling back of the anticipated expansion of crisis services for foster children statewide described in last year's plan. As a result of these and other actions, our needs continue to expand through a process of attrition.

UNMET NEEDS AND CRITICAL GAPS WITH SOURCES OF SUPPORTING DATA

There are a number of needs/gaps that emerge from analysis of child and adolescent data sources:

- CSAs identified the statewide need for additional services to conduct Wraparound plans with children and adolescents. This need was identified locally as the General Assembly simultaneously reduced some funds in the Governor's Office for Children's budget in the past two years to conduct these kinds of services. The PRTF demonstration will offset some of these budget reductions. This need highlights one of the key gaps in Maryland's system.
- There is a need for alternative financing arrangements which would provide incentives for the development of home and community-based services instead of residential services. This gap will also be addressed for a small number of children through the PRTF Demonstration Project.
- Existing programs geared to meet the needs of transition-age youth remain at capacity and no expansion has been possible for the last few years. The need for services to support transition-age youth who are being discharged from residential treatment centers has been identified. Evidence-based practices for transition-age youth are limited but need to be explored and implemented as possible.
- Expansion of crisis response capability into jurisdictions statewide is consistently identified as an area of unmet need. Even though the Joint Council has advocated in this area and the crisis systems which exist are highly valued, replication of such systems, particularly for rural areas, is limited.
- Workforce development, particularly specialty trained mental health professionals and specialty programs, are also identified as needs. Of particular need in the child and adolescent system are treatment foster care parents and provider organizations which support them in delivering the service. Providers and programs proficient in working with co-occurring mental illness and substance abuse, as well as mental illness and developmental disabilities, are limited and the need far exceeds availability.
- Finally, rural areas commonly identify transportation, difficulty in recruiting mental health professionals, particularly those who treat special populations, access to specialized services/programming (i.e., child psychiatry, treatment for juvenile sexual offenders), and lack of crisis response capacity as significant gaps.

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PRIORITIES/PLANS TO ADDRESS UNMET NEEDS

MHA and the mental health stakeholder community will continue to voice the need for attention to mental health care in budget considerations. However, the projections for upcoming budget periods are not encouraging with regard to state revenues and the corresponding impact that they have on reduction of spending. Continued vigilance will be necessary as the state prepares to address its long-term structural deficit and as scenarios for managing this ongoing fiscal crisis are proposed, debated, and enacted. As a consequence, a number of priorities come to the fore:

- A major priority to address those needs connected to the broader financial needs of the State budget will be continuation of the Children's Mental Health Matters Campaign and activities designed to bolster public support for recognizing the importance of and the need to protect children's mental health programs.
- Additional priorities are found in the ongoing implementation of federally funded special projects such as the PRTF Demonstration Waiver, which will allow federal matching dollars for innovative services and care management functions and administrative costs that are currently funded only by the state. Similarly, implementation of SAMHSA funded demonstration projects such as the Maryland CARES System of Care grant and Linkages to Life Statewide Suicide Prevention grant are very important priorities. It is important to note the role that these federally funded programs play in offsetting the contraction of state revenues and its impact on staff morale through maintaining a sense of strength based growth and forward progress within the child and adolescent system.
- A significant priority is placed on the interagency development of Care Management Entities, which blend federal and state dollars across a variety of fund sources to achieve great efficiencies with our sister agencies in the context of this period of fiscal austerity. This development is subject to continued availability of funds needed to contract under the current open RFP.
- Quality of care issues remain a critical point of focus, with emphasis on improving the services that MHA delivers through its continuum. Even with increasingly scarce resources, these services will continue to be enhanced both by strengthening approaches through training of the work force, and by investigating and assuring that minimum standards of care are met within existing programs. The Child and Adolescent Division stands strongly with the rest of MHA in concerted priority efforts to root out fraud and abuse within a small fraction of the existing provider network in order to assure quality.

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RECENT SIGNIFICANT ACHIEVEMENTS

Our most significant achievements in the past year have been highlighted in the Strengths section above. These include Children's Mental Health Matters, the award of two major federal grants, innovative services planned under the PRTF waiver, the Children's Cabinet Interagency Strategic Plan, the Maryland Child and Adolescent Mental Health Institute and the Children's Cabinet release of an RFP for statewide implementation of Care Management Entities to be implemented next year.

MHA, in collaboration with the Maryland Child and Adolescent Mental Health Institute, MSDE, the Center for Maternal and Child Health, the Maryland Blueprint Committee, and other stakeholders, continue to build infrastructure and deliver training to improve quality of mental health screening assessment and intervention for young children. Activities include:

- The University of Maryland Early Childhood Certificate program offered to Bachelor's level participants. An additional 36 professionals will be trained.
- Continued implementation of project with the Center on the Social and Emotional Foundations for early Learning (CSEFEL).

MHA will work in conjunction with Department of Human Resources (DHR) and other stakeholders to improve screening, assessment, and service delivery for children and youth in foster care. Projects include:

- Efforts with Baltimore City to strengthen the mental health component of the local DSS child welfare health suite for all youth entering foster care in Baltimore City to assure combined health and mental health screening.
- Implementation of MD CARES – A comprehensive SAMHSA System of Care grant designed for foster care children in Baltimore City and explore replicability statewide.
- Continued provision of the Crisis Response and Stabilization Service Initiative in selected jurisdictions, supported by specialized training for police and emergency services workers, for children placed in foster care settings.

Through the support of the SAMHSA Statewide Youth Suicide Prevention and Early Intervention grant "Maryland's Linkages to Life", MHA will implement a diverse range of innovative statewide and local youth suicide prevention activities and training in evidence-based practices for suicide prevention /intervention such as:

- Development of local coalitions for implementation of prevention activities and training within local school systems
- Development of pilot projects for identified high risk rural counties and counties with large numbers of completed suicides.

FUTURE VISION

MHA's plan for its comprehensive, community-based public mental health system is to create a System of Care that is focused on family and child resilience, which employs evidence-based and effective practices, and which is outcomes driven. A family-driven, youth-guided system of care that offers a range of effective treatment and youth and family support services is envisioned. The need for relinquishment of custody will be fully eliminated and the financing of the system will encourage the use of family-centered, home and community-based wraparound services, rather than institutional and residential care.

In Maryland's future mental health system, use of evidence-based, state-of-the-art treatments will become the norm. Information about evidence-based, effective, and emerging best practices will be disseminated to a wide base of PMHS providers and to families. The culture of the work place will be transformed to accept and provide the most advanced treatments. Additionally, efforts to promote cultural competence and meet the needs of an increasingly diverse population are a critical component of the future vision. Continuing anti-stigma activities will create the environment where families, children, and adolescents are comfortable about obtaining mental health services. Families will consistently share in decision-making about treatment and family/provider partnerships will be encouraged.

The MHA envisions a future in which:

- The PMHS has sufficient resources to provide access to all children, youth and families with significant mental health needs regardless of Medicaid insurance and/or individuals who are uninsured,
- care provided is appropriate and is youth and family driven,
- evidence-based practices are implemented and the use and evaluation of promising practices are encouraged,
- the workforce is trained and data is used to improve services process and outcomes,
- opportunities for the best use of funding, including innovative, flexible options are explored and made available,
- services are continuously examined and redesigned to best support recovery and resiliency.
- Public Mental Health Services are well-linked and coordinated with both substance abuse and somatic health services.
- Promote health and wellness to reduce the risk of morbidity and mortality later in life.