

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008

FACE SHEET

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

X 2008

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 2007 TO: June 2008
Month Year Month Year

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Stacy Rudin 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: RudinS@dhhm.state.md.us

**COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT
FY 2008 APPLICATION**

September 2007

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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 2008, 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 which services meet individual needs, with the goal of recovery. Prior year's fiscal challenges have been resolved, access to services maintained and a consumer and family driven mental health system preserved. 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.

A detailed discussion of Maryland's significant highlights, new developments and progress are included in Section I. 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. Over the first half of calendar year 2007 the Mental Health Transformation Office (MHTO) successfully transitioned to new leadership, following the election of a new Governor. Moving forward in FY 2007 the MHTO plans to focus on key ongoing strategies that can be effectively implemented, in collaboration with MHA, other state agencies, and the mental health community, to support ongoing transformation in Maryland.

In Section II the service system's strengths, needs, and priorities for both adults and 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 2008 priorities include:

- continuation of MHA's successful approach to the implementation of evidence-based practices and efforts to monitor fidelity;
- expansion of hospital diversion projects in response to ongoing pressure for admission of uninsured individuals to state hospitals from emergency departments;
- 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 *Child and Adolescent Mental Health Institute* ;
- further development of an Outcomes Measurement System, focusing on analysis of data and development of reporting structures;

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- implementation of web-based pharmacy data information sharing among mental health providers and with somatic care providers;
- statewide development of the Youth MOVE (Youth Motivating Others through Voices of Experience) program;
- further implementation of activities to reduce reliance on psychiatric residential treatment by supporting development of community-based, in-home wraparound services for children and their families; and
- continuing collaboration with the Maryland State Department of Education (MSDE) in furthering the early childhood mental health initiative.

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 (NFR) Report. Finally national and State goals, targets, and action plans are presented.

In the FY 2008 State Mental Health Plan, MHA continues to organize state strategies around the six goals from The President's 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 2008 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 and 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.

In an introduction to the FY 2008 State Mental Health Plan, 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. The Plan includes numerous strategies to further strengthen consumer leadership and promote consumer and family- driven mental health care, recovery, and resilience. The Plan also addresses our increasing efforts to actively involve consumers and families in quality improvement and evaluation activities.

MISSION

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

The Vision

There will be a comprehensive accessible array of public and private services. These services will help individuals empower themselves to achieve the highest level of participation in community life while striving to achieve his or her full 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*

Mental health care 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 system must be linked to allow for continuity of care. The hospital is one part of the community-based mental health system. The mental health system must collaborate with other public and private human health 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 operation of the mental health system. An array of services and programs must be available to allow for consumer choice in obtaining and using necessary services. Programs and services relevant to and recognizing varying cultural, ethnic, and racial needs are imperative.

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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. A goal of our system is to support care in the community and to encourage communities to manage the care of their residents.

(5) ***LEAST RESTRICTIVE SETTING***

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

(6) ***WORKING COLLABORATIVELY***

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

(7) ***EFFECTIVE MANAGEMENT AND ACCOUNTABILITY***

We seek a well-managed mental health system, which provides services economically. Accountability is essential to consistently provide an acceptable level of mental health services. Essential management functions include monitoring and self-evaluation, rapidly responding to identified weaknesses in the system, adapting to changing needs, and improving technology. We must put the highest priority on measuring consumer satisfaction with the services they receive. Outcome measures will be a key component for evaluating program effectiveness.

(8) ***LOCAL GOVERNANCE***

Local management of resources, resulting from the implementation of Core Service Agencies, will improve continuity of care, provide needed services in a timelier manner, improve the congruence of services and resources 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.

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FY 2008 SYSTEM GOALS

These MHA goals, objectives, and strategies reflect much of what occurred through the community's involvement and discussions surrounding implementation of the transformation grant. Through the federal Mental Health Transformation State Incentive grant (MHT-SIG), existing interagency collaborations and public and private partnerships will be solidified while new ones will be formed to further build the infrastructure to coordinate care and improve service systems. Mental Health Transformation efforts and activities will be infused throughout the MHA State Mental Health Plan for children, youth, and adults.

- GOAL I: Americans 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**

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**ATTACHMENT C
ASSURANCES 2ND PAGE**

MR. McCann 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 22, 2007 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, 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 Plan Review 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 to the Joint Council mailing list of over 200 different members, stakeholders, interested parties, Core Service Agencies, and local mental health advisory committee chairmen. Throughout the year, the 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 X

Federal FY

State Expenditures for Mental Health Services

Calculated FY 1994
\$19,733,921

Actual FY 2006
\$137,321,500

Estimate/Actual FY 2007
\$146,913,516

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 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 medication.
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 2005	Actual FY 2006	Actual/Estimate FY 2007
\$308,366,690	\$321,954,238	\$ 334,279,329

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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 advise the Mental Hygiene Administration on the provision of services to citizens with mental illness and to “be a strong advocate of a comprehensive, broad-based approach to the social, economic, and medical problems of mental hygiene.” 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. The Joint Council meets monthly. 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 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. Standing committees of the Council include the Local Mental Health Advisory Committee (LMHAC), the Interagency Forensic Services Committee (IFSC), and the Planning Committee. The LMHAC Committee of the Council promotes and facilitates linkages with Core Service Agency (CSA) boards and local mental health advisory committees as they monitor and evaluate publicly funded mental health services for their local jurisdictions. The IFSC monitors and evaluates 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. The Planning Committee assists in the development and review of the State Mental Health Plan and CMHS Block Grant application materials. During the year, additional ongoing standing committees developed the Annual Report of the Joint Council, promoted membership, and followed legislative issues. Also, ad hoc committees are convened throughout the year to address specific issues. These committees provide opportunities to create focused flexible workgroups.

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, 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

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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."
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

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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.

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

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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 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.

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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,
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.

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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.

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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.

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.

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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.

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

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008

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

The Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council, referred to as the Joint Council, is composed of consumers, family members of persons with psychiatric disorders, mental health professionals, representatives of various State agencies, and other interested citizens and is an important source of advice and advocacy in Maryland. Many of the state agencies that MHA collaborates with on a regular basis, for a broad array of issues and services, are represented on the Council as well. The Joint Council meets monthly with the Mental Hygiene Administration (MHA) Director and key agency staff and takes full advantage of the distinctive level of access and participation it continues to have in both the planning and operation of the public mental health system. Joint Council members serve on various work groups, including representation on MHA's Administrative Service Organization (ASO) Quality Council and on its consumer subcommittee. Representatives from the Joint Council have been selected to serve on the Transformation Working Group (TWG). The executive directors of leading mental health advocacy, consumer and family organizations serve on the Joint Council and on the TWG as well. This overlap, along with the MHA director and other involved MHA staff, maximizes flow of information between the TWG and the Joint Council. In FY 2007, the Joint Council interacted with and participated in the Maryland Mental Health Transformation Grant endeavors in a variety of ways. In addition to the overlapping memberships of several members in both the TWG and the Joint Council, staff from the Mental Health Transformation Office regularly attends the monthly meetings of the Joint Council and participates in Council discussions. The Joint Council receives periodic reports from either the staff representative, the Director of the Mental Health Transformation Office or other overlapping members, on activities taking place under the grant and is able to provide input into planned and current activities in this way. The Joint Council has also designated representatives from the Joint Council to participate in the various workgroups and forums sponsored by the Mental Health Transformation Office to increase community participation and to help establish priorities for the project. The Mental Health Transformation Office is physically co-located with MHA headquarters, allowing for easy integration of activities and staff.

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 for the Joint Council's testimony at these hearings on behalf of the funding needs of the PMHS.

During 2007, 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. The focus this year has been on initiatives which emphasize services and systems change which promote consumer recovery and resilience.

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Presentations included: mental health needs and services for older adults, Maryland's Consumer Quality Team initiative, forensic services, dual diagnosis issues, children's mental health and juvenile services, housing initiatives, as well as updates on MHA facilities, the Governor's Office for Children, and the activities of MAPS-MD, the administrative services organization of MHA., Information from these presentations assist the Joint Council in better understanding the PMHS and its programs as it advocates at the national, State, and local levels.

Joint Council members, either as Council representatives or in their organizational capacities, also serve on numerous task forces, including those on consumer self-directed care, consumer quality teams, implementation of evidence-based practices, coordination of care, Interagency Task Force on Homelessness, and the Children's Blueprint for Mental Health Committee. The Council also supported a second On Our Own of Maryland's (a statewide network of consumer advocacy organizations) application to the federal Substance Abuse and Mental Health Services Administration, Center for Mental Health Services for its Statewide Consumer Network project. In addition to increasing opportunities to recruit more consumers to the Council, the grant helped to fund a third Statewide Leadership Summit on Mental Health Transformation in November of 2006. This summit, hosted by On Our Own of Maryland and the Bazelon Center for Mental Health Law, was designed to engage primary stakeholders in exploring key public policy issues and Maryland's new federal State Incentive Grant on Mental Health Systems Transformation.

The Joint Council remains actively involved in the development of the State Mental Health Plan and Block Grant Application. In an introduction to the FY 2008 State Mental Health Plan, 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. The Plan includes numerous strategies to further strengthen consumer leadership and promote consumer and family- driven mental health care, recovery, and resilience. Another strength is the successful approach to the implementation of evidence-based practices. Collaborating with the University of Maryland, demonstration projects in supported employment, assertive community treatment, and family psychoeducation have helped us identify both supports for and barriers to implementation. We were able to then strengthen the supports, resolve the barriers, and develop policy and financing for statewide implementation of these practices. Our work in supported employment, including outstanding integration between MHA and DORS, has been recognized by national leaders in implementation of evidence-based practices as exceptional.

Over the past several years the Plan Review Committee has encouraged staff to the increase inclusion of quantifiable measures to help readers of the plan to better evaluate accomplishments and increased emphasis on consumer-focused issues, such as peer counseling and self-directed care. Maryland's FY 2007 Block Grant application was approved by the federal peer review panel, with no corrective actions required.

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The Council also reviewed key sections of the FY 2008 Block Grant application, including the adult and child service systems' strengths, needs, and priorities; Goals, Targets, Action Plans, and the Block Grant Spending Plan. Those involved concurred that the Block Grant supports many community-based efforts and interagency initiatives and was often a source of funds that helped support an array of school-based services and services for transition age youth, homeless individuals, those with co-occurring disorders, crisis response systems working with local law enforcement, and implementation of evidence-based practices. 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, titled "The Future of the Public Mental Health System: Transformation Challenges and Opportunities. In 2007, the Council was represented by one of our two Planning Council Coordinators, an adult consumer representative, who participated in the full day Leadership Training for Mental Health Planning Councils by the National Association of Mental Health Planning and Advisory Councils (NAMHPAC).

This year the Joint Council leadership participated in the Maryland Mental Health Block Grant Site Visit from July 10-12. Joint Council members and representatives of local advocacy organizations met with the peer review team on July 11, 2007 to inform them of Council activities and perspectives on the mental health system and on transformation in Maryland.



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 8, 2007

Ms. Lou Ellen M. Rice
Grants Management Officer,
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 2008 Mental Health Block Grant Application

Dear Ms. Rice:

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 2008 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 2008 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 the original seven (7) states to receive a Mental Health Transformation State Incentive Grant of \$13.5 million over five years from SAMHSA. This award confirms our belief that transformation in Maryland has already been underway and this award will now allow us to broaden the scope of our activities. 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.

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

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Our Joint Council meets monthly with the Mental Hygiene Administration (MHA) Director and key agency staff. During FY 2007, the Joint Council closely followed 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, housing, implementation of evidence-based practices, mental health and the criminal justice system and mental health outreach programs to returning veterans.

Joint Council members, either as Council representatives or in their organizational capacities, also serve on numerous task forces and workgroups. In FY 2007, this included participation of several consumer and family leadership representatives on the Transformation Working Group (TWG). We look forward to the ongoing participation of these Council members as transformation activities unfold. Additionally, the Joint Council provided testimony on MHA's budget at hearings before key Committees of the State Legislature.

The Joint Council is actively involved in the development of the State Mental Health Plan and Block Grant Application. Three important meetings were held to develop and review these documents:

- On April 27, 2007 the Joint Council leadership participated in a planning meeting with representatives of mental health advocacy organizations, core service agencies (CSAs) and members of the MHA Management Committee to discuss concepts for the FY 2008 State Mental Health Plan.
- Once these concepts were translated into specific strategies, the Plan Review Committee of the Joint Council met on June 29th to review a draft of the Goals, Objectives, and Strategies for the FY 2008 Plan and modified, expanded, and strengthened the strategies as appropriate. The Joint Council approved the State Plan on July 17th.
- On July 17th the Plan Review Committee held an additional meeting to review key sections of the FY 2008 Block Grant Application. Our review included: 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 several State selected performance indicators and the FY 2008 Block Grant Spending Plan.
- Additionally, on July 11th a representative group of Joint Council officers had the opportunity to participate in the Federal Mental Health Block monitoring visit and met with the monitoring visit review team. This visit offered another chance for us to demonstrate and share Maryland's deep strength as a consumer and family focused system.

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On July 17, 2007 the full Maryland Advisory Council on Mental Hygiene/ PL 102/321 Planning Council met and received the recommendations of the Plan Review Committee. Following discussion, the Joint Council recommended the adoption of the Plan along with the following comments:

- We commend MHA's continued commitment to increase the availability of consumer and family-operated support services. 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.
- We are especially proud of MHA's collaborative work with the Division of Rehabilitation Services (DORS) to increase employment opportunities through evidence-based practices in supported employment. We also applaud the implementation of the Maryland's Medicaid Buy-In program, Employed Individuals with Disabilities Program (EIDP), through collaborative efforts with Medical Assistance. The collaboration between MHA and DORS is a model for the nation. The Council supports these efforts to encourage employment as a component of a recovery based system.
- 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.
- Efforts to involve consumers in quality improvement and self-directed care are noteworthy. MHA, the Mental Health Transformation Office, the Mental Health Association of Maryland, and Maryland Department of Disabilities (MDOD) worked collaboratively to implement Consumer Quality Teams (CQT) in three counties and a pilot project on consumer self-directed care in one county. The Joint Council will continue to monitor the progress of these activities.
- We are pleased that Maryland, with strong leadership from the Secretary of the Department of Health and Mental Hygiene, is planning new strategies to implement the Mental Health First Aid program for community prevention and intervention. This program, modeled from Australia and Scotland, provides a public health approach and responds to the needs identified through the recent national tragedy at Virginia Tech.
- We look forward to monitoring the recent implementation of the web-based pharmacy data information sharing that will promote system improvement and coordination of somatic and mental health care.

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- In reviewing the needs of transition age youth (TAY), we identified unmet needs and system issues that go beyond the single issue of service capacity. The Joint Council will work to promote identification of best practices in the delivery of services for transition age youth;
- We are proud that Maryland will be the first to initiate statewide development of the Youth MOVE (Youth Motivating Others through Voices of Experience) program;
- We are excited by the 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 *Child and Adolescent Mental Health Institute*;
- The Joint Council continues to advocate for the psychiatric and somatic needs of older adults. Addressing the needs of older adults will require continuous planning at the federal, state and local levels to increase access to a range of outpatient and supportive mental health services.
- 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.

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 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

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PART C. STATE PLAN

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008

**SECTION I.
DESCRIPTION OF STATE SERVICE SYSTEM**

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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 is approximately 1.06% annually. In 2006, Maryland's population was estimated at 5,661,634 compared to 5,602,250 in 2005, according to projections from 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 ranked 4th among the States with per capita income in 2005 growing to \$41,760. 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 \$56,662 and Somerset County with the lowest per capita income of \$21,741. In 2004, average household median income for the State was \$57,424. Maryland's workforce is 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)

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.

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 27.9% African Americans, as opposed to the United States' 12.3%. There is a larger Asian population (4.0%) and more individuals of Hispanic or Latino origin (4.3%), compared respectively to the United States' figures of 3.6% and 2.5%. American Indian or Alaska Native persons make up only .3% of Maryland's population, while they make up .9% of the United States' population.

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In June 2007 a total of 671,575 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. Of this, approximately 59% were age 18 and below; 41% were 19 and above. In June 2007, 92,949 children up to age 19 were enrolled in the Maryland Child Health Program (MCHP).

- **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.

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, in FY 1998, MHA began to administer all State and federal, including Medicaid, funds related to mental health services.

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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. MHA contracts with MAPS-MD of APS Healthcare to provide various administrative services. The major responsibilities of MAPS-MD 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 operates seven inpatient psychiatric facilities and three residential treatment centers for adolescents. 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 designated liaisons with those agencies, as well as many others. Through Maryland's Mental Health Transformation Systems Improvement Grant these interagency collaborations and partnerships will be solidified while new ones will be formed to further build the infrastructure to coordinate care and improve service systems.

- **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.**

After successfully reining in spiraling expenditures and with a balanced budget, MHA was able this year to turn its attention more fully to policy, program, and quality improvement. Several initiatives, which have been in the planning stages for the past few years came into fruition. 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

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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. An enhanced rate for provision of these evidence-based models was instituted in FY 2007. The availability of this financing and the incentives to provide the service created by it will further stimulate the adoption of these models by additional providers.

MHA was able this year to further support consumer-operated services through increased funding and through working with OOOMD to plan a three year phase-in of restructuring their programming to a wellness and recovery orientation. With the Mental Health Transformation Office and MHA's Office of Consumer Affairs support, On Our Own of Maryland (OOOMD) will begin to offer training in the Wellness Recovery Action Plan, in all of its consumer centers across the state. A consumer self-directed care pilot project has been initiated and will be studied for future statewide implementation. A Consumer Quality Team, through the Mental Health Association of Maryland, has begun operating in three counties and is providing valuable feedback to providers and making suggestions for quality improvement based on the consumers' interviews. Through the Mental Health Transformation Grant, Maryland will also launch 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. Support of the MHT-SIG will also enhance implementation of a web-based technology around the state so that consumers, family, and youth can more quickly identify resources they need and consolidate their personal health information in one place.

This year brought full-scale implementation of an Outcomes Measurement System (OMS). MHA instituted the OMS for individuals ages six to sixty-five 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. In conjunction with this, MHA revised authorization processes for these programs in its ongoing efforts to move towards the next generation of managed care. MHA is now focusing on utilization management at the program level, rather than at the individual consumer level. Initial information on the population utilizing these outpatient services is now available. MHA, with the ASO, the University of Maryland Systems Evaluation Center, and provider representatives, are beginning to process the data to develop a structure for outcomes reporting.

In response to ongoing pressure for admission in hospital emergency rooms, MHA began hospital diversion projects in Maryland's most populous counties. Projects are underway in Montgomery and Anne Arundel Counties and in Baltimore City. Early data suggests that they are being successful in diverting persons presenting in emergency departments from admission and providing alternative services. Projects are planned for Prince George's and Baltimore counties as well.

Maryland's community forensics and community criminal justice initiatives have flourished this year as well. Restructuring of a program for pregnant women with histories of substance use, mental illness, and trauma, who would otherwise be

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incarcerated has resulted in improved working relationships among a variety of State agencies and the Baltimore City judiciary. A long standing program with the local detention center continues with the MHA Director of the Office of Special Needs Populations receiving the Maryland Correctional Administrators – Presidents Award. This award was given to show appreciation for the partnership in co-chairing a committee to address the needs of individuals with mental illnesses and co-occurring disorders who are incarcerated, as well as for the work of HB 281 which will involve developing uniform screening and assessment tools to be used in every local detention centers (jails).

Maryland applied for and, in December 2007, was awarded one of the 10 Psychiatric Residential Treatment Facility (PRTF) Demonstration Projects from Center for Medicare and Medicaid Services (CMS). This allows 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). These 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 by year 05. The two pilot sites, Baltimore City and Montgomery County, will continue as initial waiver sites with the addition of St. Mary's counties. Additional jurisdictions will be phased in as they develop the capacity to meet MD-Wrap service criteria. Based on feedback from CMS, Maryland withdrew its 1115 application.

The ongoing collaboration with the Maryland State Department of Education (MSDE) and the Mental Health Workforce Development Steering Committee led to the development of baseline mental health core competencies to support the training of providers of mental health services for children and youth and their families. This effort represents one approach to addressing the area of workforce development.

Efforts to address the mental health needs of youth in the juvenile justice system was another area needing particular attention. Collaborations with the Department of Juvenile Services (DJS) resulted in an extensive plan for integrating behavioral health into the juvenile justice system. Implementation elements of the plan have increased the availability of mental health clinical care in juvenile detention centers statewide and also for children and adolescents receiving informal supervision within the community from DJS.

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. This year's FY 2008 State Mental Health Plan includes the six goals of the New Freedom Commission on Mental Health. In reviewing the FY 2008 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.

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

A recent development to further enhance coordination of care and access to medication information among PMHS providers, managed care organizations (MCOs), and CSAs is the availability of pharmacy data through the ASO's web-based registration and authorization system, known as CareConnection®. A rolling 12 month history of filled prescriptions will be accessible to authorized professionals thereby allowing mental health and health providers to better integrate mental health and total wellness plans. The data on a consumer will be available only to those providers with existing open authorizations to treat that consumer. CSAs will only be able to view data for consumers in their jurisdictions. Medications indicated for the treatment of HIV infection or AIDS are not included in the pharmacy data provided. In the fall, primary care physicians, who sign a user agreement and agree to confidentiality procedures, will also have access to this information.

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 will 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.

Maryland's Governor directed state Cabinet Secretaries to reduce state spending by \$200 million, as an initial step in closing the deficit that the state faces in the upcoming years. Within MHA, a strategic decision was reached to take its share of the budget reduction (\$13 million) 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.

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

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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. 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.

- **Legislative initiatives and changes**

The 2007 legislative session included the passage of several mental health related bills and legislative actions:

- House Bill 524 – Workgroup on Cultural Competency and Workforce Development for Mental Health Professionals – This initiative will involve collaborations with Maryland’s Mental Health Transformation Office, MHA’s Cultural Competency Advisory Group (CCAG), DHMH’s Office of Minority Health and Health Disparities, and advocacy groups to look a mechanisms for addressing cultural competency and workforce shortage issues in the mental health arena.
- House Bill 281 – Mental Health – Incarcerated Individuals with Mental Illness – Implements several recommendations of the HB990/SB960 workgroup and its two year effort to identify ways to end the cycle of re-arrest and re-incarceration of persons with mental illness. Among other revisions, the bill will provide funds for new benefit coordinators in prisons and in DHR to ensure more rapid access to Medicaid upon release.
- Senate Bill 646/House Bill 640 – Mental Hygiene Facilities – Patient Rights – This bill alters the requirement that individuals in mental health facilities be free from restraints and seclusions.
- Senate Bill 472 – Mental Hygiene Law – Petition for Emergency Evaluation-Confidentiality – Prevents contents of emergency petitions from being divulged except special circumstances.
- Senate Bill 579/House Bill 1226 – Children with Disabilities – Voluntary Placement Agreements – Improves the voluntary placement agreement process that is supposed to be used, per 2003 legislation, as an alternative to parents having to give up custody to obtain appropriate treatment for their children.
- House Bill 1046 – Public Health – Self Mutilation – Awareness, Training and Distribution of Materials – Requires MSDE and DHMH to provide awareness and training to educators, parents, and students on self-mutilation.
- House Bill 390/Sentale Bill 83 – Sexual Offenders – Evaluation Before Sentencing – Requires a mental health assessment of certain categories of sex offenders.

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MHA is further required to submit a variety of reports to the Joint Chairmen, including: 1) a report on the specific eligibility criteria for services delivered in the fee-for-service system to the Medicaid-ineligible and barriers to enrolling this population in the PAC program; 2) a report on the development of a plan, in conjunction with the Maryland Health Care Commission (MHCC), to include a statewide mental health needs assessment of the demand for inpatient hospital services and community-based services and programs needed to prevent or divert patients from requiring inpatient mental health services, including services provided in hospital emergency rooms; 3) develop, with DHMH, MDOD, and DHCD, a strategic plan to maximize the utilization of existing resources available to develop affordable independent housing for persons with developmental disabilities and mental illnesses, as well as to identify how to overcome previously identified barriers to the development of this housing; and 4) a report with DHMH, the Legislature, and the Judiciary, which assesses current resources, state facility infrastructure needs, facility-based care and community-based treatment capacity and identifies the demand and treatment service options for: 1) forensic patients in all health programs within DHMH, including patients with serious criminal charges; and 2) individuals currently in the criminal justice system as they re-enter into community settings.

- **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 department, quasi-government body, 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.

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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. The CSA planning role is critical to confirm that services are congruent with the preferences of consumers, reflect consumers' ethnic and cultural background and are "user friendly". Through empowerment of consumers and families in the planning, decision making, and evaluation processes, the local mental health system can be more responsive to the people it serves. Additionally, CSA representatives participate on 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 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. Additionally, the CSAs collaborate with other State and local agencies in identifying systems' barriers.

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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	Patti McQuade 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 Belair 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	Arleen Rogan 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-Quasi-Governmental	Tina St. Clair Leonardtown MD
Somerset County	Somerset County Core Service Agency	Part of County Health Department	Lisa Hartman 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	Robin Travers Snow Hill MD

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- **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. MHA has forged strong relationships with agencies responsible for housing and vocational opportunities in order to create greater access to their programs. MHA has taken the lead in reaching out to the Alcohol and Drug Abuse Administration and to public safety and corrections 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 Executive Director of MHA has been appointed to the Board of Directors of the National Association of State Mental Health Program Directors as the North-Eastern Regional Representative. Also MHA's strong involvement in development of the application for the Mental Health Transformation grant and its provision of consultation, technical assistance and support to the Transformation leader, Project Director, and the Transformation Working Group will remain essential as Maryland leadership and constituencies move forward towards achieving the goals of the New Freedom Commission on Mental Health.

SECTION II

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

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Adult

STRENGTHS AND WEAKNESSES

Maryland's public mental health system's strengths were recognized with the selection of Maryland as one of the seven original states to receive a Mental Health Transformation State Incentive Grant of \$13.5 million over five years from SAMHSA. Transformation in Maryland has been underway for several years and this award allows us to enrich and broaden the scope of our activities. MHA has a solid record of innovation and flexibility in developing, implementing, and sustaining a PMHS that is a model for transformation. Many collaborative working relationships and services projects have been developed among Department of Health and Mental Hygiene administrations and with other State departments. Cross agency efforts and public-private partnerships are common in Maryland and such efforts will be enhanced and embedded with the Mental Health Transformation-State Incentive Grant (MHT-SIG). Over the first half of calendar year 2007 the Mental Health Transformation Office (MHTO) successfully transitioned to new leadership, following the election of a new Governor. Moving forward in FY 2007 the Mental Health Transformation Office (MHTO) plans to focus on key ongoing strategies that can be effectively implemented to support the ongoing transformation in Maryland.

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 inception, and, in fact, fostered their development. They are included in every level of MHA planning, policy development and decision-making and are active in Maryland's systems transformation efforts. In November 2006 On Our Own of Maryland, Inc. and the Bazelon Center for Mental Health Law held the third annual Statewide Leadership Summit to engage stakeholders in exploring key public policy issues. The extensive and broadly based participation by consumers, advocates, providers, and State representatives in this Center for Mental Health Services (CMHS) funded forum is an indicator of all mental health stakeholders' recognition of the central role of consumers in the planning and evaluation of the mental health system. The forum provided Maryland a statewide opportunity to report on the first year's activities under the transformation grant and to engage consumers and other stakeholders in exploration of key public policy issues affecting systems transformation towards consumer and family driven care and the goals of recovery and resiliency.

In an introduction to the FY 2008 State Mental Health Plan, 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 children, youth, and adults. The Plan includes numerous strategies to further strengthen consumer leadership and promote consumer and family - driven mental health care, recovery, and resilience. The Plan also addresses our increasing efforts to actively involve consumers and families in quality improvement and evaluation activities. A Consumer Quality Team, through the Mental Health Association of Maryland, has begun

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operating in three counties and is providing valuable feedback to providers. The teams, staffed solely by consumers and family members, make unannounced site visits to mental health programs in Maryland. During their visit, consumers volunteer for confidential interviews and share their satisfaction with the program, specific needs, and overall quality of life.

Maryland's public mental health system places a priority on the development of a system in which services meet individual needs, with the goal of recovery. A strong system of local core service agencies (CSAs) assists the MHA in this task through planning, management, and coordination of local mental health systems. Active community and interagency linkages help CSAs create coordinated, comprehensive systems of care in their communities. There is a wide array of services available, from acute care to rehabilitation to consumer self-support. In FY 2006, nearly 50,000 adults received services through an extensive provider system. Maryland continues to provide access to services for the target service population of adults with serious mental illnesses (SMI).

MHA has developed over the past several years, a successful approach to the implementation of evidence-based practices. Collaborating with the University of Maryland, demonstration projects in supported employment, assertive community treatment, and family psychoeducation have helped us identify both supports for and barriers to implementation, and to then strengthen the supports, resolve the barriers and develop policy and financing for statewide implementation of these practices. Our 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 by national leaders in implementation of evidence-based practices as exceptional. Implementation of an integrated systems model for co-occurring mental health and substance use disorders is being promoted by the State and is gaining ground through local initiatives. Development of a pilot project in an evidence-based model for co-occurring treatment is underway.

The 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 housing programs. 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. This year, MHA participated in the interagency effort to implement the Bridge Subsidy Pilot Program, Which provides three year rental subsidies to persons with disabilities, including consumers with mental illness, through participating housing authorities in Maryland. The success of this pilot has allowed for expansion in the upcoming year.

Projects for Assistance in Transition from Homelessness (PATH) funds, Shelter Plus Care funds, and State general funds are creatively leveraged and packaged to

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provide services to homeless individuals and persons with mental illnesses in local jails. The Maryland Community Criminal Justice Treatment Program (MCCJTP), nationally recognized through the GAINS Center for People with Co-Occurring Disorders in the Justice System, provides treatment and/or case management services in all local detention centers. Maryland has recognized the role of trauma in the lives of many persons with mental illnesses. Specialized trauma programs, as well as adjunctive trauma treatment within several MCCJTP programs, have been established.

Crisis mental health response systems, often working with local police, have been developed in several of the large jurisdictions and a few smaller counties. Community leaders praise their efforts to divert admissions from hospitals and jails and assist in community incidents. New hospital diversion projects developed in three jurisdictions this year are already showing reductions in admissions of uninsured individuals to State hospitals and creative, successful use of community-based alternatives.

Maryland's strong public-academic partnerships allow executive staff at MHA and university leaders to collaborate regularly on system and program development. In 2002, this partnership was expanded to assist MHA in its efforts to infuse evidence-based practices into everyday practice and to evaluate the quality, effectiveness, and outcomes of services. Commitment to consumer recovery, use of evidence-based practices, and an outcomes driven system continues to move Maryland's PMHS forward. Public-academic- and private sector collaboration is an emerging strength as the MHA, universities, the ASO, and provider organizations have worked together in the operational development and implementation of an outcomes measurement system. This collaboration will move forward in the next year to begin the analyses of data and will broaden to include consumer and family collaboration.

In tandem with the successful consumer, family, provider, advocacy, and academic partnerships, Maryland's success is also due to a strong, established leadership and workforce within MHA and its partners. Many of MHA's leadership team has 20-30 years experience in the public sector. This consistency of leadership in the state has also allowed for effective, ongoing relationships with our federal partners. Executive and legislative support has been gained over the years through development of relationships and consistent messages back and forth. Ties to academia and the private sector have enabled the public system to maintain access to the knowledge and expertise of former public sector employees. Consumer, family, and advocacy and provider organization leadership has been consistent and has worked with MHA for many years. It is through these long-term relationships that the state is able to effectively and efficiently air differences, reach consensus and act.

Expanding access to services has been one of the greatest strengths of the PMHS. Maryland has a long-standing, strong public-private sector provider partnership. There are virtually no State-operated community services. Providers of these services range from individual practitioners to diversified, multi-million dollar mental health/health care corporations. Large university-based services providers have demonstrated commitment

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to the needs of public sector consumers and have developed a range of inpatient and community services.

However, access to services for the uninsured remains a major issue for the state. Approximately 13.5% of Maryland's population is uninsured. Last year's General Assembly began to address the issue and we expect that this year this critical issue will remain in the forefront. The mental health community is united in its message that in any plans to address the uninsured that mental health needs must also be considered.

Recruitment and retention of qualified mental health professionals, direct care workers, and administrators within MHA and the many programs of the PMHS remains 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 than in many other occupations makes competing for employees challenging. The training needs of the direct care workers are not systematically addressed and there is a wide range of capacity within the private sector to adequately train its staff. Likewise, mental health professionals do not always receive training in evidence-based and effective practices. Training and implementation of evidence-based practices (EBPs) is resource intensive. Workplace cultures and system financing do not always support change and movement towards "state-of-the-art" practice. Workforce issues – compensation, recruitment, retention, and training - are priorities agenda for the major PMHS private provider organizations in Maryland's transformation.

Despite excellent collaboration with the DHCD and HUD, access to affordable housing within regions of the State remains a critical shortage for persons with mental illness and movement to increasing independence can be restricted. In Maryland, work continues on initiatives developed in response to recommendations of the Governor's Commission on Housing Policy. Specific and measurable actions to increase and preserve quality, affordable housing for working families, and individuals with disabilities, the homeless, and the elderly were identified.

Access to specialty mental health services and adaptation of models of care developed for urban settings can be a challenge in rural communities. CSAs in non-urban and rural counties help the PMHS maintain its focus on issues at play in these counties and to develop solutions. Use of technology e.g. telemedicine, to address some of these needs can be more fully explored and implemented.

Finally, data sharing across agencies remains a challenge with differing data systems and capacities. Momentum is building, however, to address this at various levels within the agencies and within state government overall.

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UNMET NEEDS/CRITICAL GAPS/SOURCE OF DATA

There are several sources of data which the MHA uses to identify unmet service needs and gaps. The management information system of the administrative service organization (ASO) is a comprehensive data source. The ASO data systems can 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. In FY 2008, information from the Medicaid Management Information System (MMIS) on prescriptions filled by consumers in the PMHS will be incorporated into the ASO database. A second data source is the State Hospital Management Information System (HMIS) which provides data on all admissions and discharges from State-operated facilities. A new management information system for State facilities is being procured this year. Finally, MHA, through Medical Assistance and the MMIS can access somatic care information on PMHS consumers.

In addition to these databases, MHA obtains information through its network of CSAs, consumer, family, provider, and advocacy partners. MHA's inclusive style of management brings these stakeholders to the table in policy, planning, program development, quality assurance, and evaluation. Regular meetings are held between MHA and each constituency group. These bodies regularly provide their input about the shortfalls of the PMHS and work with MHA to find solutions. They advocate for needed resources and services with other governmental bodies, legislators, and the Governor. These stakeholders are also represented members of the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council. The Joint Council further includes representatives of other State agencies, the Protection and Advocacy agency, and interested citizens. Monthly meetings include a report from the Director of MHA and/or his deputies and members utilize this time to obtain information and inform him of their views. Finally, a major source of information about unmet service needs and gaps are the annual/biannual plans of the CSAs. CSAs are required by law to develop plans for their local jurisdictions. MHA guidelines for CSA plans require that CSAs perform needs assessments and identify gaps and needs. CSAs employ various methods to obtain information. These local needs assessments assist State policymakers to identify significant areas of need across the State and to develop strategies to address them.

There is general consensus that the benefit package in the adult service system is comprehensive and compares favorably with the limited mental health services provided under many private health insurance plans. The issues that are 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.

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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 group needs assessments and local housing waiting lists support this need. Additionally, consumers speaking at forums, focus groups, and conferences identify the desire and need to work as a critical issue on the path to recovery. Development of employment opportunities and support in finding and keeping jobs is the most noted need. Transformation of some traditional mental health programming into more recovery-oriented programming is a goal for mental health consumers. Consumers' desire to direct their own care and to have the system structured to promote recovery and hope has emerged as a driving theme.

Specialty trained mental health professionals and specialty programs are also identified as needs. 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. Financing the outreach component, so often necessary to engage homeless individuals in treatment and support systems, remains difficult. Programs geared to meet the needs of transition-age youth remain at capacity. Outreach and treatment services specifically focused on the needs of the elderly are identified by CSAs and advocates for the elderly as a gap in the continuum of services. 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., treatment for sexual offenders), and lack of crisis response capacity as significant gaps.

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PRIORITIES AND PLANS TO ADDRESS UNMET NEEDS

Both Maryland's newly elected Governor and State Legislature have identified finding approaches to access to health care for the uninsured as an important issue requiring attention in the coming years. MHA and the mental health stakeholder community will continue to voice the need for attention to mental health care in these deliberations. Equal vigilance will be necessary as the state prepares to address its long-term structural deficit and as scenarios for managing this are proposed, debated, and enacted.

In response to ongoing pressure for admission of uninsured individuals to state hospitals from emergency departments in general hospitals, MHA will further expand its hospital diversion project into a minimum of two additional populous counties, for a total of five jurisdictions. The success of these projects in diverting admissions and use of alternative community-based services will be tracked. Diversion project providers will be responsible for assessing individuals in emergency departments and developing alternative to hospitalization plans, whenever feasible. Diversion projects in Prince George's and Baltimore counties will join those initiated in FY 2007 in Montgomery, Anne Arundel, and Baltimore City CSAs. These projects will further assist in the demand for beds as MHA manages proposed reductions in the state hospital budget and anticipated bed reconfiguration.

This year several state strategies address improved coordination of care in the PMHS. MHA will continue to strengthen the ongoing collaborative work among the administrative services organization (ASO) and managed care organizations (MCOs). A significant new development is the availability of information on MA-reimbursed medications filled by individuals in the PMHS. Through the ASO's web-based registration and authorization system, known as CareConnection®, a rolling 12 month history of filled prescriptions will be accessible to authorized professionals thereby allowing mental health and health providers to better integrate mental health and total wellness plans. Additionally, MHA will 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 illness.

Housing for programs to address poverty are significant state priorities. MHA will continue to promote supported housing in its policies and capital financing resources as local public housing authorities gain greater knowledge of services available in their local mental health systems. As noted previously, the Bridge Subsidy Pilot Program will increase the number of individuals with mental illness who obtain affordable and safe housing through the Bridge Subsidy Pilot Program. The FY 2007 Joint Chairmen's Report requires DHMH, DOD, and DHCD to develop a strategic plan to maximize the utilization of existing resources available to develop affordable independent housing for persons with developmental disabilities and mental illness, as well as to identify how to overcome the barriers to the development of this housing.

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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, public safety, and corrections 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. The FY 2007 Joint Chairmen's Report requires DHMH, the Legislature, and the Judiciary to identify the demand and treatment service options currently available and those needed for: 1) forensic patients in all health programs within DHMH, including patients with serious criminal charges; and 2) individuals currently in the criminal justice system as they re-enter into community settings. MHA will continue to collaborate 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 could be transitioned to more appropriate care settings. A Traumatic Brain Injury Waiver provides for placements for a total of 30 individuals. MHA has received a five year renewal Medicaid waiver.

MHA has a number of strategies in FY 2008 related to implementation of evidence-based practices. Monitoring fidelity to models now in statewide implementation will be ongoing; growth in available evidence-based practice providers/programs is anticipated with consequent growth in the numbers of individuals receiving these services. Work on developing integrated care for co-occurring disorders through a State action plan and through local initiatives will continue. 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. This year MHA will work with stakeholders to initiate a pilot project through which an evidence-based model for co-occurring treatment is implemented at select provider sites and followed to identify and resolve issues for future statewide implementation.

During the upcoming year, MHA will continue to utilize existing data sources and create opportunities for integration of additional data into its planning, management, and evaluation activities. The additional power of the pharmacy data, the new and enhanced state hospital management information system, and the Outcomes Measurement System will provide additional information on service utilization, consumer characteristics, and consumer outcomes. Continued participation in the federally sponsored Other State Agency (OSA) study will promote further integration with other state partners in obtaining data about mental health consumer characteristics and expenditures. All of these data sources, when fully synthesized over the next several years, will allow for even greater capacity to utilize the rich data inherent in all of these systems.

This year's plan also includes efforts to address concerns regarding access to specialty care, access to care in underserved/rural areas, and access to care by specific populations through exploration of technology. Development of guidelines and exploration of potential financing for use of telemedicine within the PMHS for direct services, consultation, and education is planned.

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MHA will also continue to orient its activities towards consumer recovery. MHA will collaborate and support On Our Own Of Maryland, Inc.'s (OOOMD) initiative to transform its existing network of consumer drop-in centers and consumer-operated services towards a wellness and recovery orientation, including enhanced peer support activities and use of best practices within the consumer movement. MHA will continue to support the Consumer Quality Team initiative, a consumer/family led site visitation program and the self-directed care pilot project. The Olmstead Planning Grant for peer counselors in State hospitals will continue, enabling consumers to work with other consumers as they move from hospitals to the community.

Along with all of the above-mentioned initiatives, MHA will actively participate in activities through the Mental Health Transformation State Incentive Grant (MHT-SIG), which provides \$13.5 million dollars over five years to support the development of state infrastructure to move forward in meeting the goals outlined in the President's New Freedom Commission Report on Mental Health. MHA and the Mental Health Transformation Office will align their activities to produce substantive and lasting enhancements and improvements across systems which serve individuals with mental illnesses. Priorities of the Mental Health Transformation Office include system wide activities and specific projects for adults and children. Implementation of a web-based platform which provides information, resource directories, and on-line availability of a site for personal health record information and advance directives for consumers is planned through the CSAs. The Mental Health Transformation Office will engage with other stakeholders in addressing the cultural competence of the workforce and in addressing disparities. Increasing the system orientation to recovery is also a priority of the Mental Health Transformation Office. Working with MHA, and the provider, family, and consumer organizations, recovery orientation training for providers will be enhanced. Mental Health Transformation Office staff will participate in the ongoing projects in implementing WRAP in consumer-operated centers, consumer self-direction and the consumer quality team. The MHT-SIG evaluation process will also provide a vehicle for increasing consumer involvement in evaluation activities.

The Mental Health Transformation Office is launching a specific adult recovery project, working with consumers at various parts of the system to see what they feel they need to move to the next level of recovery, starting in three key areas: consumers in residential rehabilitation and supported employment, consumers who have been in state hospitals for over a year and consumers who are in the state hospital system because they have been found to be not criminally responsible. Individual meetings will be held with consumers and person - centered plans will be formulated to enable moving to the next level of recovery. From those individual interviews and discussions, lessons learned will be synthesized, the need for system changes will be identified and action plans to make the changes developed.

Finally, in response to the national tragedy at Virginia Tech and to carry out the first goal of the New Freedom Commission, the DHMH, with the Mental Health Transformation Office and MHA, has taken the lead to work with other states to implement Mental Health First Aid in America. This program started in Australia, and is

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used by Scotland and several other countries to ensure that schools, universities and the general public have the information needed to effectively address mental health concerns, similar to the way first aid courses work for physical health. To further address the nexus of mental health and overall health care in Maryland, the Mental Health Transformation Office will work with the Maryland Health Care Commission (MHCC) to conduct a study of who is served by the state mental health hospitals, hospital emergency rooms, inpatient psychiatric units and community alternatives. The MHCC is charged with convening a taskforce of interested parties to develop a plan for the continuum of mental health services. The plan shall include a statewide mental health needs assessment of the demand for inpatient hospital services and community-based services and programs needed to prevent or divert patients from requiring inpatient mental health services, including services provided in hospital emergency rooms.

RECENT SIGNIFICANT ACHIEVEMENTS

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.

Implementing enhanced rates to support and incentivize the implementation of evidence-based supported employment, assertive community treatment, and family psychoeducation and creating MHA staff positions to monitor fidelity annually was a most significant achievement this year. This is the culmination of years of preparatory work, which will serve as a model for implementation of other practices in the years to come. Our experience in implementation of adult practices will also be invaluable as we embark on dissemination and implementation of child and adolescent evidence-based practices.

The statewide implementation of the Outcomes Measurement System (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. Ongoing collaborative work is envisioned, as a conceptual framework for data analysis and development of reporting structures and design are tackled in the upcoming year.

Consumer-directed, recovery-oriented projects were at the forefront of MHA activity this year. MHA provided increased financial support to local consumer centers to support their efforts to restructure and re-orient their activities towards wellness and recovery. A plan to offer WRAP training at local centers has been developed through a train-the-trainer model, in collaboration with the Mental Health Transformation Office. A consumer self-directed care pilot is being implemented and will continue in the upcoming year. Finally, consumer and family involvement in quality improvement activities has been actualized through the implementation of the Consumer Quality Team. In its first months of operation the team has been credited by both consumers and community providers as helping to make significant improvements for consumers in the programs they attend.

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, with one program achieving a 31% diversion rate. Emergency departments and local communities have embraced these projects as means to provide services for individuals in their home communities.

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Maryland's Community Criminal Justice Treatment Program and the MHA Office of Forensics have provided exemplary programs and services for individuals with mental illness involved in the criminal justice system. Local detention centers have applauded the MCCJTP and recognized MHA for its leadership in this program. The Office of Forensics has worked diligently with interested stakeholders in development of a set of recommendations for incarcerated persons with mental illness, in response to legislation last year. The creative approach to use of Shelter Plus Care grants was recognized by the U.S. Department of Housing and Urban Development (HUD) which invited MHA's Director of Special Populations to serve as a panelist for the National SuperNOFA Broadcast on March 27, 2007. This broadcast discussed the process for applying for the \$1.25 billion in Homeless Continuum of Care funding available through HUD. The MHA Director of Special Populations discussed her experience administering HUD funded programs, i.e. Shelter Plus Care, as well as to discuss indicators/benchmarks for success; and provide advice on how to manage grants; tips on successfully acquiring grant funds; and partnerships developed with HUD and other organizations.

FUTURE VISION

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.

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The MHA envisions a future in which:

- individuals 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.

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Child and Adolescent

STRENGTHS AND WEAKNESSES

Maryland's public mental health system's strengths were recognized with the selection of Maryland as one of the seven original states to receive a Mental Health Transformation State Incentive Grant (MHT-SIG) of \$13.5 million over five years from SAMHSA. Transformation in Maryland has been underway for several years and this award allows us to enrich and broaden the scope of our activities. MHA has a solid record of innovation and flexibility in developing, implementing, and sustaining a PMHS that is a model for transformation. Many collaborative working relationships and service projects have been developed among Department of Health and Mental Hygiene administrations and with other State departments. Cross agency efforts and public-private partnerships are common in Maryland and such efforts will be enhanced and embedded with the Mental Health Transformation State Incentive Grant. Following the election of a new Governor who took office in January 2007, the Mental Health Transformation Office (MHTO) successfully transitioned to new leadership. Moving forward in FY 2007, the MHTO plans to focus on key ongoing strategies that can be effectively implemented to support ongoing transformation in Maryland's mental health system.

The FY 2008 State Mental Health Plan's introduction notes that the MHA goals, objectives, and strategies reflect much of what has 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 children, youth, and adults. The plan includes numerous strategies to strengthen family and youth leadership and promote youth and family-driven mental health care, recovery, and resilience. The plan also addresses our increasing efforts to actively involve youth and families in quality improvement and evaluation activities.

Maryland's public mental health system (PMHS) places a priority on the development of a child- and family-oriented system in which services meet individual needs and emphasize resiliency. A strong system of local core service agencies (CSAs) assists the MHA in this task through planning, management, and coordination of local mental health systems. Active community and interagency linkages help CSAs create coordinated, comprehensive systems of care in their communities. There is a wide array of services available to meet the varying needs of children and adolescents, including those with serious emotional disturbances. Nearly 43,000 children and adolescents received services in FY 2006. Maryland continues to provide access to services for the target population of children with serious mental emotional disturbances (SED), as well as prevention and early intervention services.

A strong and well developed system of consumer, family, advocacy, and provider organizations provide input into state and local planning, policy, and decision making. The value of family member and youth participation and involvement continues to be actualized through MHA's involvement and funding of the Maryland Coalition of Families for Children's Mental Health. The Coalition maintains a network of Statewide

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Family to Family support groups to improve outcomes for children, youth, and their families. The Coalition also provides leadership training for families and youth involved in the mental health system. Coalition members regularly participate in MHA policy planning efforts as well as Maryland's systems transformation efforts. In June 2007 Maryland initiated its Youth MOVE (Youth Motivating Others through Voices of Experience) program, based on the national model (<http://www.tapartnership.org/youth/YouthMOVE.asp>). We will become the first state to take the initiative statewide during FY2008 with leadership from Marlene Matarese at the University of Maryland, Baltimore previously the national director of Youth MOVE.

The PMHS offers an array of children's services ranging from prevention/ early intervention services in day care and schools through community-based services for children and adolescents in need of intensive care either to keep them at home or help them transition back from institutional settings all the way to the most intensive institutional-based services. At each level MHA emphasizes finding the best fit for the child and family with the least restrictive environment and appropriate level of intervention with the goal of keeping children with their families in the community.

Maryland was one of only five states to implement a CMS Community-Based Treatment Alternatives for Children (C-TAC) grant. This grant focused on activities to reduce reliance on psychiatric residential treatment by supporting development of community-based, in-home wraparound services for children and their families. Two high-fidelity wraparound (MD-Wrap) pilot programs began January 2006 and have served 350 children and families as of June 30, 2007. State funding was awarded through the Governor's Office for Children to expand the program to more jurisdictions in FY 2007. This resulted in the two additional jurisdictions providing MD-Wrap to 45 children for a total of 396 children served in FY 2007.

This work provides the basis for Maryland's participation in the Psychiatric Residential Treatment Facility (PRTF) Demonstration Project awarded in December 2006 by the Centers for Medicare and Medicaid Services (CMS). Maryland is one of 10 states who are participating in this demonstration of the use of a 1915(c) waiver as a mechanism to serve children who meet criteria for PRTF care in their community using the Maryland Wraparound Process (MD-Wrap) – high fidelity wraparound services provided through a Care Management Entity. Maryland submitted the 1915(c) waiver on June 30, 2007 and plans to begin services upon approval of the waiver and writing and dissemination of the regulations in four communities, – Baltimore City), Montgomery County, St. Mary's County, and Wicomico County with other jurisdictions to be phased in over the five years of the demonstration project, as they are ready. The PRTF Demonstration Project will phase in participants and will serve up to 150 children by year 05 of the project. The target population for the project are children who are not eligible for Home and Community-Based Medicaid services (uninsured and with private insurance up to 300% of poverty) who either are in a PRTF or are in eminent risk for placement in a PRTF.

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Maryland continues to provide respite services to children and adolescents using state-only dollars. Respite has consistently been identified by parents as a priority need and MHA has responded to that by grants, through some CSAs, to expand the availability of respite across the state. In 2003, MHA was awarded a CMS Real Choice Grant to do a feasibility study and develop a model that would hopefully result in respite becoming a Medicaid service. Traditionally, respite has been considered support to the caregiver, rather than treatment for the child and it has never been approved as a stand alone Medicaid reimbursable service. Due to the documented importance of respite in reducing caregiver burden, it has been included in the benefit package under some waivers. The feasibility study has been under the auspices of the Maryland Caregivers Support Council, which was created in 2001 by the Maryland General Assembly to look at the support needs of Caregivers. Under the leadership of the MHA, members of the Maryland Caregivers Support Coordinating Council (MCSCC) and staff from the Center for Health Program Development and Management at the University of Maryland, Baltimore County (UMBC) analyzed regulations, conducted surveys, and developed a demonstration model for respite in Maryland. The final report was promulgated in August 2006. The PRTF waiver application includes respite as a covered service for all participants.

Maryland also has a SAMHSA grant to reduce the use of seclusion and restraint in the child and adolescent inpatient and residential treatment settings by bringing the training modules developed by the National Association of State Mental Health Program Directors (NASMHPD) and the Maryland Youth Practice Improvement Committee (MYPIC) to these facilities. During FY 2007 the project director, a doctorally prepared mental health nurse, worked with leadership teams from the five participating facilities (two state hospital in-patient units and three state residential treatment centers) focusing on culture shift, infusing trauma-informed care concepts, and implementing the manual. Year 03 of the activities will focus on adapting the START manual for seclusion and restraint prevention for use in adult facilities and disseminating the training and consultation to these facilities in addition to continuing support for staff in the youth facilities.

Interagency collaborations are a strength of the Maryland public mental health system. Collaboration with the Department of Juvenile Services (DJS) resulted in an extensive plan for integrating behavioral health into the juvenile justice system. Implementation of elements of the plan has increased the availability of mental health clinical care in juvenile detention centers statewide and also for children and adolescents receiving informal supervision within the community from DJS. Ongoing collaborations among MHA, the Maryland State Department of Education (MSDE), the Governor's Office for Children, the Maryland Coalition of Families for Children's Mental Health, advocates, and providers continue to advance the growth of school-based mental health services, including coordination with services to children served under the auspices of the Individuals with Disabilities in Education Act (IDEA). These stakeholders also work together to monitor the utilization and efficacy of the services. MHA Office of Child and Adolescent Services participated in the submission of a grant to the federal Department

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of Education to integrate mental health into schools in a rural jurisdiction. Grant award announcements are anticipated in mid-August 2007.

An additional strength of Maryland's PMHS is that PATH funds, Shelter Plus Care funds, and state general funds are creatively leveraged and packaged to provide services to homeless individuals, including parents with young children. Maryland has also recognized the role of trauma in the lives of many persons with mental illness. In May 2007, the MHA Office of Child and Adolescent Services submitted a grant to SAMHSA, in conjunction with the University of Maryland, Baltimore School of Medicine, Department of Child Psychiatry, to develop the *Center for the Study and Facilitation of Effective Treatment for Traumatized Youth – Child Welfare (SAFETTY-CW)*. The Center will work to improve the inclusion of empirically-based practices (EBPs) across the child welfare and public mental health systems by increasing access for youth placed in out-of-home care and their caregivers/families to valid, contextually appropriate, empirically-supported, trauma-informed practices. This will occur through managing a variety of interconnected activities in collaboration with National Child Traumatic Stress Network (NCTSN) partners to improve the importation of empirically-based practices (EBPs) across the child welfare and public mental health systems including: 1) development of an infrastructure for engaging stakeholders around the need for attending to trauma and its impact and the role of trauma-informed EBPs in addressing this need; 2) workforce development designed to increase the knowledge base of child welfare and mental health professionals regarding trauma's impact on child well-being and best practice service delivery approaches; 3) implementation of standardized, integrated screening/triage and assessment/referral protocols, Trauma-Focused - Cognitive Behavioral Therapy, Abuse-Focused - Cognitive Behavioral Therapy, Parent Child Interaction Therapy, and medication guidelines in three jurisdictions initially; and, 4) after exploration of multiple dimensions related to the adoption of EBPs in critical real world environments of child welfare recipients, move toward statewide implementation. Grant award announcements have not yet been made.

Crisis mental health response systems have been developed in several of the large jurisdictions and a few smaller counties. Many of these programs report high use of their services by families, particularly those with adolescent children. Community leaders praise their efforts to divert admissions from hospitals and juvenile facilities and their assistance in community incidents. These systems are routinely called upon to assist local school systems in managing crisis situations.

Maryland's strong public-academic partnerships have allowed executive staff at MHA and leaders from the University of Maryland and the Johns Hopkins University to collaborate regularly on system and program development for children and youth. In spring 2007, the MHA funded the *Maryland Child and Adolescent Mental Health Institute* with the purpose of furthering the collaborations between MHA, the two major universities and the Maryland Coalition of Families for Children's Mental Health around research, development and implementation of child and adolescent focused evidence-based practices in mental health.

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Faculty from both institutions is members of the Child and Adolescent Evidence-Based Practice Workgroup to assist in its efforts to infuse evidence-based and sound, clinically-based practices into everyday practices. These academic partners also assist MHA in efforts to evaluate the quality, effectiveness, and outcome of services provided through the PMHS. Commitment to consumer recovery and resilience, use of evidence-based practices, and an outcomes driven system will move Maryland's PMHS forward over the next years.

The PMHS recognizes the importance of building resilience and facilitating recovery for our children, adolescents and their families. Using the May 2006 Office of Child and Adolescent Services sponsored workshop on nurturing resiliency in youth as a jumping off point, MHA in conjunction with the University of Maryland, Baltimore sponsored a two-day workshop on evidence-based practices in child and adolescent mental health. This exciting event was targeted to CSA staff, community and hospital-based providers, teachers, parents, and interested others. There was a concurrent and interwoven track for youth to initiate Youth MOVE in Maryland. This forum was also used to formally introduce the *Maryland Child and Adolescent Mental Health Institute* to the community.

Over the years, Maryland has configured its State hospital system so that it only maintains a small safety net of two hospital units for adolescents, with an average daily population of 21. One of the units will be phased out during FY 2008. Hospital-level services for children under 12 are only available through the private sector, with the State purchasing care if needed.

Expanding access to services has been one of the greatest strengths of the PMHS. Maryland has a long-standing, strong public-private sector provider partnership. There are virtually no State-operated community services. Providers of these services range from individual practitioners to diversified, multi-million dollar mental health/health care corporations. Large university-based services providers have demonstrated commitment to the needs of public sector consumers and have developed a range of inpatient and community services. Over the last five years many new and existing providers have begun offering services to children and adolescents, widely expanding choices available.

However, access to services for the uninsured remains a major issue for the state. Approximately 13.5% of Maryland's population is uninsured. Last year's General Assembly began to address the issue and we expect that this year this critical issue will remain in the forefront. The mental health community is united in its message that in any plans to address the uninsured that mental health needs must also be considered.

Along with these strengths are other acknowledged weaknesses in the current system. Although the number of providers has burgeoned, recruitment and retention of qualified mental health professionals and direct care workers within the many programs of the PMHS 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

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many other occupations makes competing for employees challenging. The training needs of the direct care workers are not systematically addressed and there is a wide range of capacity within the private sector to adequately train its staff. Likewise, mental health professionals do not always receive training in evidence-based and effective practices. Training and implementation of EBPs is resource intensive.

Workplace cultures and system financing do not always support change and movement towards “state-of-the-art” practice. Workforce issues – compensation, recruitment, retention, and training - are priorities agenda for the major PMHS private provider organizations in Maryland’s transformation. The Maryland Mental Health Workforce Steering Committee, consisting of 38 interdisciplinary participants, is meeting monthly to address these issues. The Committee has developed a set of core competencies to be used as the baseline for training of all mental health professionals as they serve children and their families. A Workforce Action Plan has been drafted which includes data on recruitment and retention in addition to training strategies.

There is a geographic maldistribution of qualified providers, particularly those at higher educational levels with the more rural jurisdictions having fewer providers. The availability of qualified child psychiatrists, particularly in rural areas, is limited. Access to specialty mental health services and adaptation of models of care developed for urban settings can be a challenge in rural communities. Maryland’s system of CSAs helps the PMHS maintain a focus on services and needs in the rural and non-urban counties. Family members and advocates continue to identify the need for more school-based and after-school mental health services.

Finally, data sharing across agencies remains a challenge with differing data systems and capacities. Momentum is building, however, to address this at various levels within the agencies and within state government overall.

UNMET NEEDS AND CRITICAL GAPS WITH SOURCES OF SUPPORTING DATA

There are several sources of data which MHA uses to identify unmet service needs and gaps. The management information system of the administrative service organization (ASO) is a comprehensive data source. The ASO data systems can 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. In FY 2008, information from the Medicaid Management Information System (MMIS) on prescriptions filled by consumers in the PMHS will be incorporated into the ASO database. A second data source is the State Hospital Management Information System (HMIS) which provides data on all admissions and discharges from State-operated facilities. A new management information system for State facilities is being procured this year. Finally, MHA, through Medical Assistance, can access the Maryland Medicaid Information System (MMIS) which houses pharmacy and somatic care information. For children and adolescents there are developing opportunities to obtain selected data elements from other state agencies.

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In addition to these databases, MHA obtains information through its network of CSAs, consumer, family, provider, and advocacy partners. MHA's inclusive style of management brings these stakeholders to the table in policy, planning, and program development. Regular meetings are held between MHA and each constituency group. These bodies regularly provide their input about the shortfalls of the PMHS and work with MHA to find solutions. They advocate for needed resources and services with other governmental bodies, legislators, and the Governor.

These stakeholders are also represented as members of the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council. The Joint Council further includes representatives of other State agencies, the Protection and Advocacy agency, and interested citizens. Monthly meetings include a report from the Director of MHA and/or his deputies. Members utilize this time to obtain information and inform him of their views.

Finally, a major source of information about unmet service needs and gaps are the annual/ biannual plans of the twenty CSAs. CSAs are required by law to develop plans for their local jurisdictions. MHA guidelines for CSA plans require that CSAs conduct needs assessments and analyses and then identify gaps and needs. CSAs employ various methods to obtain information, frequently collaborating with the Local Management Boards and other local agencies. In aggregate, these local needs assessments assist State policymakers to identify significant areas of need across the State and to develop strategies to address them.

There are a number of needs/gaps that emerge from the data analysis.

- Financing prevention-focused child and adolescent mental health services such as early childhood mental health consultation and interventions, school-based mental health services and after school services is challenging since both federal and state sources of funds are limited.
- 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 be addressed for a small number of children through the PRTF Demonstration Project.
- 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.

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- 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.

PRIORITIES/PLANS TO ADDRESS UNMET NEEDS

Both Maryland's newly elected Governor and State Legislature have identified finding approaches to access to health care for the uninsured as an important issue requiring attention in the coming years. MHA and the mental health stakeholder community will continue to voice the need for attention to mental health care in these deliberations. Equal vigilance will be necessary as the state prepares to address its long-term structural deficit and as scenarios for managing this are proposed, debated, and enacted.

This year several state strategies address improved coordination of care in the PMHS. MHA will continue to strengthen the ongoing collaborative work among the administrative services organization (ASO) and managed care organizations (MCOs). A significant new development is the availability of information on MA-reimbursed medications filled by individuals in the PMHS. Through the ASO's web-based registration and authorization system, known as CareConnection®, a rolling 12 month history of filled prescriptions will be accessible to authorized professionals thereby allowing mental health and health providers to better integrate mental health and total wellness plans. Additionally, MHA will 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 for children and youth with mental illness.

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In FY 2008 MHA will implement the PRTF waiver by providing MD-Wrap for 50 children, youth and their families who are currently not eligible for community Medicaid. Additionally, the Governor's Office for Children is continuing the Systems of Care Initiative which provides seed funds to local jurisdictions to implement local access plans to assist children, youth and families to find services that they need and access them. Each jurisdiction will have a plan using the "single point of entry or no wrong door" philosophy tailored to the locale's needs and resources.

The Department of Juvenile Services received funding to improve mental health assessments for youth appearing in Juvenile Court, to prevent placement in more restrictive services in order to access evaluation and/or services. Additionally, MHA is working with DJS to provide consultation and training for staff in detention centers around mental health needs of adolescents.

MHA will continue collaboration with the Maryland State Department of Education (MSDE) in furthering early childhood mental health screening, prevention, and intervention services for preschool children at risk of developing emotional and mental health disorders. MSDE received \$2.5 million from the State for FY 2008 to support this initiative. Additionally, MHA is collaborating with MSDE on the USDE grant for School Mental Health Integration which will focus on a full continuum of mental health promotion, prevention, early intervention, treatment and crisis intervention in schools in a rural county on the Eastern Shore. It is designed to enhance the knowledge and skills related to making appropriate referrals, and will improve the links among school teams, families, youths, health care providers and the larger public mental health system.

Transition age youth will benefit from several employment-related initiatives within the State budget. These include job training for youth transitioning from school to employment, and efforts focused on supporting youth with learning disabilities who enroll in community colleges.

Funds for capacity development for residential placements will be targeted to those areas of the State which are under-resourced and whose children must move far from their families and home communities when residential care is appropriate and necessary. Additionally, the CSAs are working with their local providers to develop community-based services to keep children closer to home. MHA, in collaboration with Medical Assistance, DDA, and the ASO, will continue to promote utilization of In-home Therapeutic Behavioral Aides for children and adolescents. These services assist families/caregivers in supporting their children with intensive needs in their own homes.

MHA continues to co-chair the Maryland Mental Health Workforce Development Steering Committee with MSDE. This committee is developing strategies to increase the number and develop the competencies of the child and adolescent mental health workforce. Products developed in FY 2007 are: 1) core competencies for child and adolescent mental health professionals; 2) a plan for pre-service curricula based on competencies developed; and, 3) a draft white paper on the importance of child and adolescent mental health workforce development. The core competencies were used by

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the School of Social Work at the University of Maryland, Baltimore to develop curricula leading to a certificate as well as integrated into pre-professional education.

This year's plan includes continuing efforts to address concerns regarding access to specialty care, access to care in underserved/rural areas, and access to care by specific populations through exploration of technology and application of telemedicine for use with these populations/areas.

MHA will continue its support of the Maryland Coalition of Families for Children's Mental Health. Maintaining and expanding its role in, and capacity for, involvement in planning, policy development, and evaluation of the system will remain a priority. Along with the activities of the Coalition in evaluating the system, MHA will continue to work with the University of Maryland Systems Evaluation Center in implementing the outcome management system for children and adolescents.

The Maryland Committee on Children's Mental Health (MCCMH), authors of Maryland's *Blueprint for Children's Mental Health* (2003) and currently an advisory committee to MHA, continues its work to implement the *Blueprint's* recommendations via several subcommittees. In January 2006 the MCCMH approved *Service Definitions for the Continuum of Care* for children and adolescents. This document provides a set of common definitions and parameters for services including target population(s), statute, funding method, staffing and credentials, psychiatric symptoms and risk criteria, service delivery location, and duration/ frequency/ intensity with the goal of creating a uniform understanding of these issues. The Expanded School Mental Health Workgroup (a MCCMH subcommittee) is collaborating with the Center for School Mental Health Analysis and Action at the University of Maryland to develop a web-based community of practice across the state.

The Evidence-Based Practice Workgroup of the MCCMH has worked diligently this year to systematically investigate and prioritize EBPs for MHA to address in the future. Members of this group include MHA, the University of Maryland Division of Mental Health Services Research, the Maryland Coalition of Families for Children's Mental Health, the Maryland Association of Resources for Families and Youth, NAMI-MD, CSAs, other advocates and providers. The first EPB to be addressed is Treatment Foster Care which was the subject of a 45+ person round table in June 2007. The participants are currently developing a white paper with recommendations to the EBP Workgroup. Several jurisdictions are implementing evidence-based practices (EBPs) including Multisystemic Therapy, Treatment Foster Care, and Functional Family Therapy. However, these efforts are limited to only a few programs/providers currently.

The MCCMH held a one-day strategic planning retreat in October 2006 resulting in a white paper published in February 2007. The degree of accomplishment of the three original strategies (mental health promotion; service delivery, support and treatment; and quality and system improvement) were assessed. Plans for continuing work in these areas and the development of additional foci were developed. Recommendations included:

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- Support for the System of Care (SOC) paradigm shift to a community-based, family-focused, youth-guided system across the state through the creation and articulation of a Master Plan for various mental health services and support that includes a results-based financial plan to fully fund the continuum of services;
- Prioritize the implementation of workforce development enhancements to include – pre-service, continuing education, monitoring, family engagement skills to develop a mental health trained and culturally reflective workforce to serve the individualized needs of children, youth, transitional-age youth and families;
- Prioritize the integration of EBP's, Practice-Based Evidence Approaches, and Promising Approaches to be integrated throughout Maryland in collaboration with the university systems through the implementation of research-based services; and,
- Prioritize public awareness and education campaigns to address the stigma associated with children's mental, emotional and behavioral disorders. Also promote strategies that focus on social and emotional competencies, including resiliency in youth.

The Early Childhood Mental Health Steering Committee chaired by MHA and MSDE continues to work on integrating mental health consultation into all early childhood settings including day care, Head Start and Early Head Start, Infants and Toddlers programs, and Family Support Centers. Maryland is also a site for the implementation of consistent training for early childhood workers to assist them in promoting the child's social and emotional development. The training helps children be better prepared to enter school ready to learn. The training funded by the Federal Child Care Bureau and Head Start Bureau has been developed by the Center for the Social and Emotional Foundations of Learning (CSEFEL). To assist in workforce development a certificate program will be initiated by the University of Maryland in September 2007 for masters trained and above mental health professionals on working with young children ages birth through 5 years.

MHA will also continue to orient its activities towards building resiliency and facilitating consumer recovery. MHA and the Maryland Department of Disabilities are jointly sponsoring Maryland's Consumer Quality Team initiative, a consumer/family led site visitation program, which has been implemented as a pilot project for select adult community programs in three counties. Expansion of this project for child and adolescent community programs and state-operated inpatient/RTCs will be explored in FY 2008.

MHA is promoting the integration of strength-based approaches into child and adolescent assessment, planning, service delivery, and evaluation to develop resiliency in children, youth and families receiving mental health services. Child and Adolescent Coordinators have disseminated information from May 2006 conference *Nurturing Resiliency in Youth* in their jurisdictions. Additionally, MHA is also incorporating the discussion of strength-based approaches and resiliency into monitoring site visits (treatment foster care) with positive feedback provided for its documentation. The implementation of MD-Wrap further promotes planning and implementing services from a strengths-based perspective.

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During the upcoming year, MHA will continue to utilize existing data sources and create opportunities for integration of additional data into its planning, management, and evaluation activities. The additional power of the pharmacy data, the new and enhanced state hospital management information system, and the Outcomes Measurement System will provide additional information on service utilization, consumer characteristics, and consumer outcomes. Continued participation in the federally sponsored Other State Agency (OSA) study will promote further integration with other state partners in obtaining data about mental health consumer characteristics and expenditures. All of these data sources, when fully synthesized over the next several years, will allow for even greater capacity to utilize the rich data inherent in all of these systems.

Along with all of the above-mentioned plans, MHA will actively participate in activities through the Mental Health Transformation State Incentive Grant (MHT-SIG), which provides \$13.5 million dollars over five years to support the development of state infrastructure to move forward in meeting the goals outlined in the President's New Freedom Commission Report on Mental Health. MHA and the Mental Health Transformation Office will align their activities to produce substantive and lasting enhancements and improvements across systems which serve individuals with mental illnesses. Priorities of the Mental Health Transformation Office include system wide activities and specific projects for adults and children. Implementation of a web-based platform which provides information, resource directories, and on-line availability of a site for personal health record information and advance directives for consumers is planned through the CSAs. The Mental Health Transformation Office will engage with other stakeholders in addressing the cultural competence of the workforce and in addressing disparities. Increasing the system orientation to recovery and resilience is also a priority of the Mental Health Transformation Office. Working with MHA, and the provider, family, and consumer organizations, recovery orientation training for providers will be enhanced.

RECENT SIGNIFICANT ACHIEVEMENTS

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 children, adolescents and their families. A few of the major achievements are highlighted here.

The statewide implementation of the Outcomes Measurement System (OMS) in the outpatient system represents a significant achievement. It was the culmination of several years of collaboration among many interested stakeholders and is a model of public-private-academic collaboration. Ongoing collaborative work is envisioned, as a conceptual framework for data analysis and development of reporting structures and design are tackled in the upcoming year.

The Maryland Coalition of Families for Children's Mental Health continues to strengthen its advocacy role in planning, policy, and decision-making. The Coalition held its fourth Leadership Academy this year and its third class of trained family advocates graduated. It also co-sponsored the 3rd Youth Leadership Weekend for 15 youth (ages 14 to 21 years) who have a mental health diagnosis and who have been involved with one or more state programs such as special education, juvenile services or foster care. The goal of the program is "...to empower youth by teaching them self-awareness and self-advocacy within their communities." The addition of the Youth MOVE initiative will further expand the number of youth who are empowered to speak about their care to State policy makers.

Statewide efforts, through the activities of the Maryland State Early Childhood Mental Health Steering Committee, resulted in the refinement of the State plan to integrate mental health services into existing early childhood programs in urban and rural communities. Based on the evaluation of the two (2) pilot projects in which mental health consultation was provided in child care programs completed in December 2005 and the success of the interventions in several jurisdictions in FY 2007, the program has been expanded to all Maryland jurisdictions for FY 2008. Results indicate that the mental health consultation supports the ability of children to remain in programs, not be expelled, and to continue their social and emotional growth. The Legislature increased funding for the initiative for this year.

MHA continued its support of the Mental Health Association of Maryland's public awareness campaign, "Caring for Every Child's Mental Health". Kids on the Block, a traveling puppet show, gave hundreds of performances in local schools. Over 40,000 pieces of children's literature describing the symptoms of mental illness and how to get treatment were produced and distributed. A media campaign was implemented and a website was maintained and regularly updated.

In FY 2005, MHA was funded by SAMHSA to reduce the use of seclusion and restraints in child and adolescent inpatient and residential treatment centers. This is being

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done using the training modules developed by the National Association of State Mental Health Program Directors (NASMHPD) and the Maryland Youth Practice Improvement Committee (MYPIC) with the intent of reducing and possibly eliminating the use of seclusion and restraint in these settings. During FY 2007 the project coordinator provided ongoing consultation and technical assistance on-site and data on the use of seclusion and restraints to the participating facilities. Teams at each of the institutions meet regularly to review their progress with onsite support provided by the project coordinator. Teleconferencing is used to review records at the RTCs and adolescent inpatient units. In FY 2008 the project will be expanded to adult facilities using training modules modified to address the needs of 18 to 64 year olds.

FUTURE VISION

MHA's plan for its comprehensive, community-based public mental health system is to create a transformed system of care that is focused on family and child resilience, which employs evidence-based and effective practices, and which is outcomes driven. A consumer-centered system that offers a range of effective treatment and family support services is envisioned. The need for relinquishment of custody will be eradicated 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 and 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:

- individuals get the care they need regardless of the setting in which they find themselves,
- care provided is appropriate and is child and family driven,
- evidence-based practices are implemented and the use and evaluation of promising practices are encouraged,
- the workforce is trained and data are 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.