

**SECTION III**

**PERFORMANCE GOALS AND ACTION PLAN**

**TO IMPROVE THE SERVICE SYSTEM**

**Adult Mental Health Plan**

## **MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

### **ADULT PLAN**

#### **CRITERION #1: Comprehensive Community – Based Mental Health Service System**

**Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.**

#### **AVAILABLE SYSTEMS OF TREATMENT, REHABILITATION, AND SUPPORT SERVICES**

##### **Services Available**

At this time, community-based services in the fee-for-service benefits package include:

- Psychiatric hospitals
- Psychiatric units of acute care general hospitals
- Residential treatment centers (RTCs) (children and adolescents only)
- Psychiatric day treatment (also called partial hospitalization)
- Outpatient mental health clinics, many of which provide school-based and after-school treatment programs
- Psychiatric rehabilitation programs (PRPs)
- Residential rehabilitation programs (RRPs)
- Mobile treatment services
- Supported living programs
- Supported employment and vocational services
- Respite care
- Residential crisis services
- Therapeutic behavioral aides
- Mental health related laboratory services

Finally, MHA also provides funds through contracts to programs that provide specialized services (e.g., mobile crisis) that do not fit the fee-for-service model. These programs are eligible to apply for funds, as are consumer support programs such as peer support programs, family support groups, consumer-run businesses, and protection and advocacy services (at least two of which are peer run). **[NFC 2]**

Any provider who meets appropriate licensing, certification, accreditation, or other applicable standards is eligible to become a provider in the fee-for-service system. Eligible providers include facilities, programs, and individual practitioners. Individual practitioners include physicians, psychologists, nurse psychotherapists, clinical social workers, occupational therapists, and certified professional counselors who are allowed to practice independently under their Practice Acts. This increase in the provider community offers consumers an expanded choice of providers.

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In addition, services are available for specific populations. Examples include:

**Services for Individuals in the Criminal Justice System.** In 1995, the U.S. Department of Housing and Urban Development (HUD) awarded MHA a five-year, \$5.5 million Shelter Plus Care grant to provide housing for individuals who are homeless with serious mental illnesses (with or without accompanying substance abuse) and their dependents, who are being released from the detention center or are in the community on the intensive caseloads of parole and probation. Last year, the FY 2007 Shelter Plus Care Housing grant was renewed for \$2,580,217 due to increases in the Fair Market Rental Values determined by HUD. Additionally in 2007, MHA received \$759,236 through eleven small grants targeted to specific jurisdictions. The jurisdictions awarded the five-year grants were Allegany, Anne Arundel, Baltimore, Cecil, Frederick, Harford, and Prince George's Counties. Effective July 1, 2007 (FY 2008), MHA was awarded funding in the total amount \$3,186,648 for 14 of the Shelter Plus Care renewal grants. Currently, MHA is serving a total 642 persons, 149 single individuals with mental illnesses and 157 families with 268 children and 68 other family members through all of the Shelter Plus Care programs.

The Maryland Community Criminal Justice Treatment Program (MCCJTP), with total State funds of \$1.9 million, supports specific programs targeted at individuals with mental illnesses in detention centers. Mental health services are provided in conjunction with substance abuse services. In FY 2006 the MCCJTP operated in 23 Maryland counties and served approximately 5,591 individuals with approximately 5,565 units of service provided. MHA continued to partner with Baltimore City to provide post-booking aftercare planning through the Forensic Aftercare Services Team (FAST). Additionally, in FY 2006, MHA convened a workgroup in response to House Bill (HB) 990/Senate Bill (SB) 960. The workgroup worked with corrections, mental health, substance abuse, consumer and advocacy groups, and other key stakeholders to develop a survey to gather data on the number of individuals with mental illness incarcerated, services currently available for individuals involved in the criminal justice system, services needed, cost of the services needed, and recommendations to improve access, quality and the scope of services. The survey was distributed to State and the local correctional facilities in Maryland. MHA collaborated with the Maryland Correctional Administrators' Association (MCAA) who coordinated the gathering of the data and completion of the survey. In FY 2007, MHA continued to convene the workgroup and submitted a final report of the findings from the survey. Also in FY 2007, MHA continued to co-chair the MCAA's mental health and substance abuse subcommittee and served as an active member of MCAA's Executive Committee to provide assistance coordinating services, addressing systems related issues pertaining to services and resolving mental health crises as they arose in the local detention centers. [NFC 2]

Beginning with a SAMHSA grant, MHA developed one of nine national jail diversion sites. The Phoenix Project provided an array of pre and post booking alternatives to incarceration for women with co-occurring disorders. This demonstration project enhanced existing services by addressing gender-specific needs of women and children. Ongoing research on the Phoenix Project demonstrated that the majority of women served maintained their freedom from incarceration during the first three years of the project. As federal grant funding expired, State general funds were provided, through the Wicomico County Core Service Agency, to continue these services.

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MHA also provides State general funds for a program to provide treatment for incarcerated men and women who have histories of trauma and also have mental illnesses. The inmates may also have a co-occurring substance abuse disorder. The TAMAR (Trauma, Addictions, Mental health, And Recovery) Program which is projected to serve approximately 372 individuals in FY 2007 is located in nine county detention centers and one State psychiatric hospital. Participating sites are: Anne Arundel, Baltimore, Caroline, Dorchester, Frederick, Garrett, Howard, Prince George's and Washington Counties, and Springfield Hospital Center. In the past the AIDS Administration provided funding for four of the sites. TAMAR has incorporated HIV/AIDS prevention strategies in many sites. Currently, MHA provides state funding for all ten sites. [NFC 5]

The majority of the women with co-occurring disorders in the justice system have children and a smaller population is pregnant while incarcerated. MHA was instrumental in developing and implementing the TAMAR's Children Program. In FY 2006, MHA continued to partner with federal, State, local, and private agencies to coordinate mental health services and housing for the TAMAR's Children Program. This program was for pregnant women who were incarcerated or at risk of incarceration in local detention centers and the Maryland Correctional Institute for Women (MCIW). The TAMAR's Children Program was initially funded through a SAMHSA Targeted Capacity Expansion grant program known as Building Healthy Communities, the Department of Housing and Urban Development (HUD) program (additional Shelter Plus Care), a Department of Justice Residential Substance Abuse Treatment grant, local and State in-kind service commitments, and private foundation funding. The aim of this holistic program was to provide appropriate treatment to women with mental health, substance abuse, and trauma related disorders as well as mother/child intervention to enhance capacity for secure attachments. The program provided services during the period of incarceration, in a community rehabilitation setting, and re-entry to community with housing and case management services. The program as originally constructed ceased operation near the close of FY 2006. Involved agencies remained committed to serving this population. In 2007, MHA collaboratively worked with the Department of Public Safety and Correctional Services, the Administrative Office of the Courts, the Alcohol and Drug Abuse Administration, the Family Health Administration, Baltimore Mental Health Systems, Inc. and the Archdiocese of Baltimore to create a new statewide diagnostic and transitional program for pregnant women who are at least 18 years of age who might otherwise be incarcerated. As a result of this collaborative partnership, a new program named, the Chrysalis House Healthy Start Program was created. This program, funded through state general funds will consist of a 16-bed diagnostic and transitional facility (in the former location of the Tamar's Children Program) for pregnant and post partum women and their babies. Pregnant women may be referred by the Court, the state, Defense Attorney, or DHMH. A comprehensive assessment will be conducted by a licensed clinician and an individualized treatment plan will be developed between each woman and treatment team. After the newborn's birth, the mother and baby will remain in the residential facility and receive a comprehensive array of services.

Services will include medical care through contract with a health care organization, mental health treatment which includes trauma and attachment-based treatment interventions, substance abuse treatment and co-occurring treatment services, legal services, parenting and childcare services which includes involvement from the Healthy Start and Family Tree

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Programs, housing, after hours residential support, health education, and other support services. This program has started accepting referrals and is expected to open August 2007.

Also in FY 2007, MHA continued to offer and/or provide consultation to state and local agencies serving pregnant and post-partum women and their children on mental health and trauma. MHA continued to fund outreach, case management, and housing assistance to graduates of the Tamar's Children Program through funding provided to Prisoner's Aid Association.

MHA also provided training on trauma during fiscal year 2007. MHA sponsored a small training on Trauma and Resilience on June 8, 2007 for disaster behavioral health staff and trauma specialists. Additionally, MHA, with the Baltimore City Criminal Justice Coordinating Council, Baltimore Mental Health Systems, and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, co-sponsored a conference on trauma titled "Addressing Trauma in the lives of Consumers in the Criminal Justice System" .

**Services for the Deaf and Hard of Hearing.** The Director of the Office of Special Needs Populations, in collaboration with CSAs, works with community-based programs, the State hospital and the Office of the Deaf & Hard of Hearing (ODHH) Advisory Council to coordinate community and inpatient services for persons who have a serious mental illness and are deaf and hard of hearing. MHA currently operates a separate unit at a State hospital for deaf consumers in need of hospitalization. The unit provides full accommodations for deaf consumers and employs a full complement of deaf mental health professionals who are fluent in American Sign Language. MHA also provides client support funds and \$791,482 in contract funding to CSAs to provide assistance in order for 161 deaf consumers to access outpatient treatment, psychiatric rehabilitation services, case management, and residential rehabilitation services which have interpreters and/or staff fluent in American Sign Language. Additionally, limited outpatient clinic and residential rehabilitation services are available to individuals who have a serious mental illness who are deaf and hard of hearing through the fee-for-service system.

Also in FY 2007, MHA, the Office of Mental Health Transformation and several CSAs participated on the mental health subcommittee of the ODHH Advisory Council. MHA will continue to work with the ODHH Council to explore alternative technological approaches, i.e. remote video interpreting, telepsychiatry, and improve access to outpatient treatment and housing for individuals who have a serious mental illness who are deaf and hard of hearing.

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**Services for Individuals with Mental Illness and Substance Abuse.** Under the HealthChoice program, managed care organizations (MCOs) provide enrollees with somatic care and, when needed, substance abuse treatment.

In the past, Maryland has emphasized cross-training of staff and coordination of services as a means of providing access to services by individuals needing both mental health and substance abuse services. A number of existing mental health treatment and rehabilitation programs, as well as programs established through the DHMH Alcohol and Drug Abuse Administration (ADAA), have developed dual diagnosis capability and are able to offer substance abuse treatment services to individuals with mental illnesses. MHA, in collaboration with ADAA, sponsors a program for the treatment of co-occurring disorders. The program is operated by a private provider, Second Genesis, in a 16-bed unit on the grounds of the former Crownsville Hospital Center. Specialized hospital programs have been developed at Upper Shore Community Mental Health Center, Walter P. Carter Center, and Springfield Hospital Center. Mental health and substance abuse services for individuals with co-occurring disorders are well coordinated in the previously mentioned TAMAR Project.

MHA continues to address the challenge of how to implement evidence-based practices to improve services for individuals with the co-occurring disorders of mental illness and substance abuse. In FY 2008 MHA will continue multiple collaborations with DHMH to promote integrated treatment for consumers with co-occurring disorders at the local level. Currently representatives from MHA and DHMH regularly meet with county leaders to provide assistance and support for regional initiatives. This includes initiatives at the county level to implement the Comprehensive, Continuous, Integrated Systems of Care (CCISC) for Consumers with Co-occurring Mental Health and Substance Use Disorders model. Worcester County, Montgomery County, Anne Arundel County, Baltimore County, Prince George's County, and St. Mary's County are currently involved in strategic planning processes. In FY 2008 MHA will assist up to eight jurisdictions to initiate or complete consensus documents, local action plans and train local staff in implementing CCISC. In addition, MHA is chairing a work group that is developing a pilot project in implementation of an evidence-based practice for treatment of individuals with co-occurring disorders. Issues addressed in the pilot will prepare the state for statewide implementation in the future. [NFC 5]

An important development in the provision of co-occurring services to individuals with mental illness and substance disorders was the Substance Abuse and Mental Health Services Administration (SAMHSA) grant awarded to provide substance abuse and mental health services for homeless people. The grant will enable communities to expand and strengthen their treatment services for homeless individuals with substance abuse disorders, mental illness, or co-occurring substance abuse disorders and mental illness. In Maryland, People Encouraging People, long a leader in mental health services and outreach to the homeless in Baltimore City, was awarded \$400,000 per year for five years to create a comprehensive dual diagnosis treatment program for persons who are homeless and have substance abuse and mental health problems.

The Secretary of the Department of Health and Mental Hygiene has also demonstrated commitment to co-occurring disorders by appointing an administrative officer from his office to work with MHA and ADAA. As a result of coordination through this

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newly formed position, a State-level leadership team has been convened to provide leadership toward enhanced service coordination across systems. There is now a State Charter, reflecting the State's ongoing development toward service integration across the systems. Maryland was selected by SAMHSA to attend the National Policy Academy on Co-Occurring Disorders in 2005. This policy academy was attended by the Director of MHA, Director of ADAA, the Medical Director of ADAA, the DHMH Program Administrator for Co-Occurring Disorders, a state delegate from the Maryland House of Representatives, the Health Officer from Worcester County, along with representatives from the Department of Public Safety and Correctional Services, Department of Juvenile Services, Maryland Medicaid, and the Maryland Mental Health Association. A state action plan has been created as a result. MHA's FY 2008 State Mental Health Plan includes a strategy to work on items within that action plan (including data collection, workforce development, screening and assessment) to support county initiatives and assure that policy and regulatory changes be reflected in state and local level plans.

### **Housing for Adults with Psychiatric Disabilities**

Housing that is affordable, accessible, and integrated in the community is a major factor in enhancing the well being and stability of persons with serious mental illnesses residing in the community. Toward this end, MHA actively collaborates with the Maryland Department of Housing and Community Development (DHCD), the federal Housing and Urban Development (HUD) as well as non-profit developers and mental health providers. These partnerships promote access to housing development that is affordable with specialized government-supported housing opportunities. DHCD is represented on the Joint Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council.

To assure that consumers of mental health services have a continuum of housing and other residential options, MHA encourages the CSAs to work with local housing authorities and housing developers to develop affordable and safe housing in their regions. This has resulted in extensive partnerships to provide consumers with affordable housing with accompanying support services as requested and needed by the consumer. Several CSAs have supported local housing authorities in applications for HUD 811 and designated funding which utilizes Flexible Housing Choice Vouchers. However, due to changes in the Federal budget priorities and the increase in the cost of all housing, access to new housing vouchers for individuals with disabilities is limited. Despite this, MHA will continue to work with CSAs to expand mainstream rental opportunities that enhance affordable housing options for individuals with serious mental illnesses. At the provider level, many mental health providers have also helped consumers successfully pursue HUD Housing Choice programs including the Housing Choice Vouchers and other rental assistance services. Additionally, MHA has encouraged and provided some financial incentives to establish non-profit housing development entities. Many of these entities, as well as mental health provider organizations, have developed affordable housing through community bond grants through Maryland's DHMH's Administration-Sponsored Capital Program. MHA has identified housing as its priority for receipt of these bond monies. Several of this year's Capital Program awards addressed this priority. [NFC 2]

MHA continues to fund Main Street Housing, Inc., a consumer-operated project, whose mission is to enable consumers with limited income to live in the least restrictive setting. Main Street Housing, a subsidiary non-profit corporation of On Our Own of

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Maryland, is dedicated to providing decent, safe, and affordable housing to persons with psychiatric disabilities. Main Street Housing is now designated as a Community Housing Development Organization (CHDO). Main Street Housing currently operates four rental housing units in Washington County serving eight persons. Main Street Housing has purchased and renovated two townhouses in Howard County to serve six persons. In Harford County, Main Street Housing has purchased two homes to serve six persons in the community. In Frederick County, Main Street has purchased two homes that support the housing needs for six persons. Currently, Main Street is looking at properties in Washington County to serve an additional three persons. [NFC 2]

Other partnerships with mainstream housing developers, Community Housing Development Organizations (CHDOs), and other non-profit housing agencies have also produced a steady growth in affordable housing. Examples include:

Baltimore City: Community Housing Associates, Inc. (CHA), a private, non-profit housing development agency, provides low-cost housing for individuals with psychiatric disabilities through an innovative combination of grants, loans, and tax incentive programs. CHA now owns a total of 87 units that provide housing for 250 individuals and, in some cases, family members. In addition, CHA administers 161 Shelter Plus Care certificates. CHA works with the CSA to provide case management and other supports to help consumers remain in their own homes.

Anne Arundel County: Supported Housing Developers, Inc. (SHD), a non-profit agency, operates 35 units/residences providing housing to 68 individuals. SHD maintains a landlord – tenant relationship and encourages occupants to exercise choice about participation in mental health programs. PRPs in the county provide, to the extent needed, support services to the consumers. SHD is currently looking to develop affordable housing for mixed income individuals, including individuals with disabilities.

Montgomery County: Housing Unlimited, Inc. (HUI), a CHDO formed by the Montgomery County chapter of the Alliance on Mental Illness, maintains a landlord-tenant relationship with each resident, who may elect to receive mental health services from a local provider of his or her choice. Currently, 27 residences house 90 tenants. In FY 2008, HUI is continuing its efforts to purchase four scattered-site townhouses to provide housing for seven six to ten nine individuals.

Baltimore County: MOSAIC, Inc. and its housing subsidiary, ReChodo, Inc., provided housing for 78 individuals in 19 residences in suburban Baltimore County.

Mid-Shore Counties: Shore Alliance for Independent Living, Inc. (SAIL), incorporated in 1999, is a private not-for-profit 501 (c) (3) charitable corporation whose mission is to provide affordable rental housing to consumers with very low incomes. SAIL has purchased and rehabilitated two homes in Dorchester County for eight tenants and one house in Queen Anne's County for four residents. One home was purchased in 2003 in Caroline County for four residents. SAIL currently serves 20 individuals in the Mid-Shore area. In 2007 SAIL, in collaboration with the Mid-Shore CSA, successfully moved property management responsibilities from Crossroads, Inc. to Main Street Housing, Inc. Main Street, Inc. supports the SAIL program with a full time property manager who is located on the shore and available to tenants, the CSA and other community resources.

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Through reallocated funds from the closure of Crownsville Hospital at the end of FY 2004, the Mental Health Agency of Anne Arundel County Core Service Agency has developed a Housing First model, utilizing an assertive community treatment (ACT) team to provide treatment and supports. This initiative provides MHA funded housing subsidies for approximately 30 individuals from Prince George's and Anne Arundel Counties. These subsidies have enabled programs to provide permanent housing for persons who were once homeless or unable to access housing through traditional means due to lack of a stable income, bad credit or criminal background.

Historically, MHA has promoted, through its State housing plan, and its work with the Governor's Committee on Community Access and other statewide initiatives, the separation of housing from treatment/ supports. This resulted in DHMH contracting with the Technical Assistance Collaborative, Inc., a Boston consulting agency, which produced a report titled "Assessment of Housing Opportunities for People with Severe Disabilities in Maryland". This report included specific recommendations to implement a housing strategy to expand decent, safe, affordable, accessible, and integrated housing consistent with the principles of the Americans with Disabilities Act. One of the recommendations in this report resulted in the establishment of the cross disability Olmstead – Maryland Affordable Housing Resources Association Housing Taskforce. In the fall of 2005, this Taskforce became the Special Needs Subcommittee, a part of the Maryland Association of Housing and Redevelopment Agencies (MAHRA) which has been active in the area of facilitating partnerships between local housing authorities and human service systems.

Based upon another recommendation of the Technical Assistance Collaborative, Inc., a statewide resource directory was completed. The update of this directory will be completed in FY 2008. The directory has been a useful tool for the local housing authorities to assure that individuals with disabilities have access to information on services and supports needed to maintain housing of choice. It will be distributed to public housing authorities and will be available on the DHMH, MDOD, and DHCD websites.

In December 2004 the final report from the Governor's Commission on Housing Policy published its recommendations. Representatives from MHA and other disability and housing stakeholders are currently implementing one of the recommendations. This recommendation creates a bridge subsidy to provide rental assistance to 100 individuals with disabilities for three years. The Bridge Subsidy Pilot Program began in January, 2006 in several counties around the state including the Eastern Shore counties and Carroll, Harford, Howard, St. Mary's, and Frederick counties. Currently the Bridge Subsidy program is providing rental assistance to 22 consumers with mental illness in over ten counties and across disabilities. [NFC 2]

Persons with serious mental illnesses also access housing through licensed assisted living providers located throughout the State. MHA has long funded residential rehabilitation programs (RRPs), which are programs that offer residential services to persons with serious mental illnesses in need of intensive services and supports to eventually integrate into the community. Expansion of RRP beds in the last several years has been targeted to specific initiatives. MHA continues to encourage the expansion of the supported living model through which individuals with psychiatric disabilities may access an array of flexible service delivery programs, including PRPs, case management and other supports to

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enable them to live in housing of their choice. In this model, consumer housing is not dependent on the receipt of services.

### **Vocational and Educational Opportunities**

MHA has prioritized increasing employment opportunities for individuals with psychiatric disabilities as an important role of the PMHS. MHA and the Division of Rehabilitation Services (DORS) have a Memorandum of Understanding between the State agencies to promote employment for individuals with mental illnesses through training and increased collaboration. MHA staff meets regularly with DORS staff to promote collaborative relationships at both the system level and the individual level toward the evolution of a more cohesive, integrated, and seamless system of services for individuals with serious mental illnesses who desire successful employment experiences.

MHA, in collaboration with the DORS, launched its Evidence-Based Practice (EBP) in Supported Employment Initiative in 2002. Throughout the Initiative, Maryland has consistently ranked first or second, among states participating in the National EBP Project, in the rate of competitive employment achieved across existing EBP sites. In FY 2004, MHA and DORS received the Crystal Award from the Johnson & Johnson Foundation for the production and filming of an employer-focused job development video in Maryland, sponsored and underwritten by the New Hampshire-Dartmouth Psychiatric Research Center and the Johnson & Johnson Foundation. In 2007, MHA was selected as finalist for the Science to Service Implementation Award for dissemination and implementation of Evidence-Based Practice in Supported Employment in Maryland. [NFC 5]

MHA has worked with the EBPC and other national researchers on dissemination materials and implementation protocols for EBP in SE. The evidence-based approach to supported employment was initially implemented and monitored at six pilot sites. By the end of FY 2007, 30 of the existing 44 supported employment programs will have been trained or be in the process of receiving training, comprising 68% of approved programs, representing 65% of all local jurisdictions. The CSAs and providers currently involved in this initiative are: Anne Arundel CSA – Arundel Lodge, Omni House, PDG Rehabilitation; Baltimore County CSA – Alliance, Mosaic Community Services, and Progressive Walk of Maryland; Baltimore City CSA. – Chesapeake Connections, Creative Alternatives, Johns Hopkins-Bayview; Harbor City Unlimited, Mosaic Community Services, North Baltimore Center, STEP; Calvert County –Southern Maryland Community Network; Carroll County CSA – Granite House and STEP; Cecil County CSA – Upper Bay Counseling & Support Services and Support Services; Charles County CSA – Pathways, Inc.; Frederick County CSA – Way Station; Harford County CSA – Alliance and Community Behavioral Services; Howard County CSA – Humanim; Montgomery County Mental Health CSA – Family Services Agency, Jobs Unlimited, St. Luke’s House, and Rock Creek Foundation; Prince George’s County – Village Family Network; St. Mary’s County CSA- Pathways, Inc.; and Washington County CSA. – Turning Point of Washington County; the Mental Health Center of Western Maryland. The EBP Initiative is also developing supported employment outcome measures and data collection methods for implementation across all sites.

This year, MHA has used three distinct training modalities: one with the existing Consultant and Trainer at the University of Maryland Evidence-Based Practice Center (EBPC), one through identified Training Resource Programs (TRPs); and one through a

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Collaborative Learning Implementation Process (CLIP) approach. TRPs are established supported employment programs which have already been effectively trained in the EBP service approach and which have consistently met all of the requirements to be a model supported employment program (SEP). In the second approach, the TRPs have provided a mechanism for the ongoing training and technical assistance in the EBP in Supported Employment (SE) service approach to newly selected SEPs. Access to model TRPs provide collegial support, resource and information sharing, job shadowing, and expert consultation from experienced staff who have been involved in all phases and at all levels of EBP in Supported Employment implementation. The third approach is condensed three month learning collaborative that incorporates effective features of the two earlier training modalities and is designed to build a community of practice. It is MHA's expectation that this latter training approach will impact greater numbers of programs and their staff.

Throughout FY 2006 MHA staff continued to provide technical assistance to SEPs Statewide. In FY 2006, 1,581 adults received supported employment services within 44 MHA-approved SEPs, which are widely distributed across all regions of the State.

Under the PMHS, SEPs are reimbursed for providing authorized services during each phase of the individual's course in the program. MHA reimburses for: 1) pre-placement services, including vocational assessment, referral to DORS, service planning, education regarding entitlements and work incentives, and job placement; 2) intensive job coaching, if not otherwise reimbursed; and 3) extended support, at a monthly rate. In FY 2004, MHA combined rates and simplified the rate structure for SEP services. In addition, MHA initiated a new service and rate for Psychiatric Rehabilitation Program (PRP) services delivered to individuals receiving SEP services, increasing the overall reimbursement level for supported employment services. In FY 2007, MHA has developed incentives within its rate structure to promote the use of the evidence-based practice (EBP) model of supported employment (SE). Programs currently implementing the practice, which have been trained through one of the various training options and which have achieved adherence to the practice, as evidenced by meeting or exceeding certain MHA defined criteria on a SE fidelity assessment, are paid a higher rate for these enhanced services than those programs who have not met such criteria. This includes reimbursement for clinical coordination to integrate supported employment efforts with mental health treatment. **[NFC 5]**

A new unified supported employment referral, application, authorization, and eligibility determination protocol has been implemented to create a more seamless transition to DORS services upon entry to supported employment within the PMHS. With this new protocol, individuals who are eligible for PMHS services, and meet eligibility criteria for supported employment, will be automatically presumed eligible for DORS services and prioritized for DORS funding. Vocational rehabilitation plan development, job development and placement follow immediately, thereby expediting supported employment service provision across the two systems, streamlining and eliminating duplicative administrative processes, and reducing the paperwork burden for DORS counselors and providers.

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In FY 2007, MHA continues the involvement of the Advocacy Training Project of On Our Own of Maryland in meetings with EBP – Supported Employment Initiative participants. Through collaborative efforts, they have designed and implemented workshops on the Employed Individuals with Disabilities (EID) program, the state’s Medicaid Buy-In. This program is offered to all supported employment sites in Maryland as well as On Our Own affiliates. This is part of a statewide plan to inform individuals with disabilities about the Medicaid Buy-in, an opportunity for Marylanders with disabilities to work and access important health benefits. [NFC 2]

The federal Ticket to Work and Self-Sufficiency Program was authorized by the 1999 Ticket to Work and Work Incentives Improvement Act. The program has been phased in across the states and the program is now fully available in Maryland. Under the auspices of this Act, Social Security beneficiaries are eligible to receive a ticket to purchase vocational services from an identified Employment Network (EN). For several years, SSA has been actively working with stakeholders to redesign the Ticket Program to address inherent program design flaws which have resulted in limited participation nationwide. The proposed regulations seek to address these flaws in several ways: first, by providing significantly more up-front funding for ENs to assist beneficiaries in reaching their competitive employment goals; second, by promoting collaboration between the state Vocational Rehabilitation authority and ENs; and finally, by encouraging the provision of long-term employment supports. MHA plans to implement a demonstration project, under the auspices of the new Ticket regulations which connects selected Core Service Agencies (CSA) - Harford County CSA, Anne Arundel County CSA, and Baltimore City CSA- and the respective supported employment programs within those jurisdictions, into a single EN consortium. The Ticket program complements the focus on integrated, competitive employment and encourages long-term career development by requiring that supported employment programs assist individuals to achieve significant levels of earnings. The ticket is an opportunity to reward supported employment programs for the successful outcomes that they are already achieving and to create incentives to strengthen their ability to support more individuals in competitive employment and at higher levels of wages and hours worked.

A committee formed by DHMH, in collaboration with the Coalition for Work Incentives Improvement and other stakeholders, has continued implementation of a Medicaid Infrastructure Grant. The goal of the grant is to develop the needed infrastructure and operational capacity to permit employed individuals with disabilities to attain and preserve access to Medical Assistance upon employment. The committee continues to meet monthly with Medical Assistance Office of Planning and Finance to coordinate activities to expand and promote a Medicaid Buy-in option for other Medicaid beneficiaries who choose to return to gainful employment. The FY 2006 State Budget included an appropriation of \$4 million to implement the Medicaid Buy-In program for individuals with Social Security Disability Insurance (SSDI). The FY 2007 budget contained funds to fully implement an invigorated Medicaid Buy-In program. This program, the Employed Individuals with Disabilities (EID) Program began in FY 2007. As noted above, MHA is collaborating with On Our Own of Maryland to provide training to PMHS stakeholders on accessing EID Program. In FY 2007, a total of 754 consumers received training on the EID. [NFC 2]

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In follow-up to the work of the Committee and the implementation of the Medicaid Buy-In program, MHA contracted with consultants to examine the current reimbursement system and administrative procedures for supported employment. The consultants conducted focus groups with providers and consumers and met with other stakeholders before developing recommendations. MHA will continue to work with the consultants and the committee to monitor the implementation and outcomes of Medicaid Buy-In.

Access and linkage to educational services are primarily managed through PRPs. The rehabilitation assessment includes review of the individual's strengths, skills, and needs for education and vocational training. Based upon the assessment, the individual rehabilitation plan includes a description of needed and desired program services and interventions and, when appropriate, identification of, recommendations for, and collaboration with other services to support the individual's rehabilitation. Some PRPs offer GED programs within their own service continuum, while those who do not have developed the necessary linkages to refer consumers to classes offered elsewhere. Community colleges and local universities in many counties are sites for higher education and a spectrum of low cost/subsidized programs (both federal and state subsidies) are available to individuals with disabilities. Many PRPs utilize a "supported education" model, supporting the consumer in his/her choice and pursuit of education in the community at large. [NFC 2]

### **Consumer and Family Involvement**

Maryland has a rich tradition of and an ongoing commitment to consumer and family involvement in planning, policy and program development and evaluation. The MHA has encouraged the input of advocates on all levels. As discussed in Section II previously Maryland is proud of its commitment to system transformation focused on consumer and family involvement to assure that services are continuously examined and redesigned to best support recovery and resiliency.

The MHA Office of Consumer Affairs participates in systems level activities at all pertinent MHA meetings. The Consumer Affairs Liaison within the Office is involved in coordinating and implementing the Leadership Empowerment Advocacy Project (LEAP). This ongoing project has been funded by the MHA since 1990. The goals of LEAP include expanding the number of consumers playing a prominent role within State and local policy-making bodies. Through participation in LEAP, consumers acquire the necessary skills to become leaders and advocates within the PMHS. LEAP also teaches skills that enhance the participants' ability to direct peer support groups and other consumer-related positions within the state. In FY 2008, the Office of Consumer Affairs will be offering paid internships to LEAP graduates allowing them to receive hands on experience with the MHA, the public mental health system and the legislative advocacy as a continuation of their training. The LEAP graduates involvement in leadership and advisory roles in the PMHS will also continue in this fiscal year. Outcomes based on the LEAP participants stated goals will be assessed and the information gathered will be used to plan for future LEAP workshops. [NFC 2]

MHA and its local CSAs have been instrumental in encouraging the development of local advocacy organizations throughout Maryland. There are currently 22 wellness and recovery centers (formerly known as drop-in centers) in Maryland. Twenty of those centers are affiliates of OOOMD. Many of these centers address co-occurring disorders in mental

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illness and substance abuse within their programming. Many other consumer-run support groups are held in the centers on a regular basis. There will be an increased focus on the recovery and wellness centers involvement in surrounding community organizations and activities to allow for the centers and their members to become active members of the greater community. This year MHA will collaborate and support OOOMD's initiative to transform its consumer network toward a wellness and recovery oriented system, including enhanced peer support activities and the use of best practices within the community. The Wellness Recovery Action Plan (WRAP) will be introduced into all centers as a model for peer support.

Additionally, the wellness and recovery centers will provide training to consumers in development of advanced directives and will promote the use of electronic personal health records when available. Consumers will be encouraged to use the new web based technology that is being implemented in CSAs around the state.

OOOMD, in collaboration with MHA, continues to conduct workshops and trainings through their Recovery Training Project (formerly Advocacy Training Project). They will continue to conduct workshops on the Employed Individuals with Disabilities (EID) program that assists consumers to reach their goals of working while continuing their medical assistance benefits. The training "Encouraging Consumer Empowerment through Employment" will focus on employment for consumers. They will also provide training entitled "What Next: Moving Forward in Recovery" to consumers that will concentrate on the vision of recovery. [NFC 2]

OOOMD and MHA continue to collaborate to fight stigma within the mental health system through the Anti-Stigma Project (ASP). The ASP uses workshops to help participants identify stigmatizing behaviors and attitudes as well as possible solutions, communication techniques, and actions as vehicles for change. Workshops may be designed and tailored to address specific populations and situations such as issues related to cultural competency, housing, co-occurring disorders, and the reduction/ elimination of seclusion and restraint. Workshops were presented in many educational settings, as well as several local, state and national conferences. One of the goals this year was to continue to branch out into different venues, and bring the issue of stigma to light on topics that are intertwined with it, such as stigma as a barrier to housing, the relationship between stigma and eliminating the use of seclusion and restraint, and reducing environmental stigma. Presentations were made to very diverse audiences, from housing authority personnel from the mid-Atlantic region at the Maryland Association of Housing and Redevelopment Agencies annual conference, to members of the national taskforce charged with eliminating the use of seclusion and restraint in psychiatric hospitals. OOOMD continues to receive requests for the teaching videotape, "Stigma...In Our Work, In Our Lives", which has gained national and international attention and is now being used in more than 39 states and four other countries. Additionally there are several requests for "Stigma: Language Matters" posters. In FY 2007, the Anti-Stigma Project presented 50 workshops throughout the State with over 3,000 people reached. [NFC 1]

MHA, in partnership with OOOMD, developed a project under the federal Olmstead Planning Grant titled the Olmstead Peer Support Program. Two Peer Support Specialists (PSS) worked part-time with patients in two State facilities: Springfield Hospital Center, and Upper Shore Hospital Center. A consumer was interviewed and hired to work in Finan

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Center beginning in August 2007. In FY 2007 a total of 74 consumers in state hospitals were seen by the PSS staff. The PSS staff facilitates consumers' discharges and provides on going support during the consumers transition into the community. PSS staff provide help and referrals to recovery and wellness centers, CSAs and other organizations that work to enhance recovery. MHA and OOOMD are working with state hospitals to continue and expand peer support specialist positions. They continue to develop procedures to ensure the continued success of the program.

MHA and the Mental Health Transformation Office implemented a consumer self-directed care pilot program in Washington County which is slated for future statewide implementation. A committee on Consumer-Self-Direction, co-chaired by leadership of OOOMD is addressing issues surrounding how to advance public mental health in Maryland towards a system that supports recovery through its financing, regulations, and policy. After the project is implemented, MHA will explore the use of Medicaid reimbursement for systemic long-term financing. Future activities will include training providers in Maryland on the need for consistency in working with consumers toward recovery.

In collaboration with the MHA, Maryland Department of Disabilities (MDOD), Mental Health Association of Maryland (MHAM), and the Consumer Quality Team (CQT) Committee, the three-county pilot CQT project for select community programs in Anne Arundel and Howard counties and Baltimore City was implemented. The overall response to the CQT team has been very positive and comments from the consumers have been mostly positive. A website has been nearly completed as well as brochures for distribution. [NFC 2]

Finally, Maryland provides support to both the Statewide National Alliance on Mental Illness of Maryland (NAMI MD) organization and its local affiliates. MHA worked successfully with NAMI MD in promoting the NAMIWALKS, a successful kick-off event for promoting *MAY MENTAL HEALTH MONTH*. NAMI MD has developed a strong Family to Family Education presence in the State. The "In Our Own Voice" program is an informational outreach program on recovery. Peer-to-Peer is a unique, experiential learning program for people with any serious mental illness who are interested in establishing and maintaining their wellness and recovery. In FY 2008 MHA will continue to support NAMI MD's public education and training efforts. Maryland's strong, well-developed network of consumer, family, advocacy, and provider participation continues to play an essential role in the ongoing success of the public mental health system. [NFC 2]

### **Case Management**

Over the past several years, the MHA has increased both the availability and comprehensiveness of case management services and has created a variety of mechanisms for funding case management activities. MHA has emphasized implementing the strengths model of case management, which recognizes the individual's assets and promotes access to services that optimize the individual's quality of life. Providers have indicated that they utilize various formats in delivering case management. For autonomous case management programs, the broker model, case management services which coordinate and link consumers to community resources, is prescribed by MHA policy.

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Under the PMHS, the ASO collects and reports on data regarding utilization and costs of mental health services. CSAs can review this information and determine whether those individuals with high volume and costly service utilization are receiving appropriate services or whether another strategy, including use of case management, will be helpful in bringing about utilization of the most effective constellation of services.

### **Case Management Delivery**

MHA policy has mandated that individuals with SMI and SED in MHA's priority populations be targeted for publicly funded case management. Maryland has funded case management activities in four ways. First, psychiatric rehabilitation programs are expected to provide case management activities as an integral part of the care they provide. The rate paid to providers under the PMHS is intended to support this level of activity. Many individuals with serious mental illnesses receive case management services in this way.

Second, mobile treatment programs are conceptually defined as combined clinical and case management treatment programs for a specific subset of the MHA priority population, i.e., those individuals who have not engaged in traditional treatment and rehabilitation activities. As of July 1, 2007, nineteen mobile treatment programs were operating throughout the State, with five now meeting fidelity to the evidence-based practice model of assertive community treatment.

Mobile treatment is Maryland's model which approximates assertive community treatment (ACT). MHA participated with Baltimore Mental Health Systems, Inc. and the Veteran's Administration in their federally and privately funded project on implementation of the evidence-based practice of ACT in four existing mobile treatment programs (two in the public sector, two in the VA system). Through this experience, MHA was able to gain further understanding of barriers and opportunities for implementation of the practice in accordance with the nationally developed fidelity measures. In FY 2004, MHA was awarded a SAMSHA/Center for Mental Health Services (CMHS) grant for State Training and Evaluation of Evidence-Based Practices. Maryland's application focused on ACT. MHA contracted with the University of Maryland Evidence-Based Practice Center and Systems Evaluation Center to carry out activities under this grant, effective April 2004. This grant, which is ending its final year, trained four existing mobile treatment programs and two new ACT teams in the practice. The closure of Crownsville Hospital and reallocation of funds for community-based services afforded the State the opportunity to establish these two new ACT teams. These teams adhere to the evidence-based practice model and are evaluated according to the Dartmouth Assertive Community Treatment Scale (DACTS) fidelity scales. A wireless system allows for real-time communication and data entry for staff, increasing efficiency and accountability. This project also includes rural areas and an adaptation of the ACT model has been implemented in those areas for both adults and children and adolescents. The adapted in-home intervention teams have a greater rehabilitation focus (rather than clinical treatment) and include implementation of the Illness Management and Recovery evidence-based practice. A modified DACTS fidelity scale measures adherence to the adapted model. This year, a forensic assertive community treatment team, which meets fidelity criteria, was established in Baltimore City. This team will serve up to 80 forensic clients. Individuals with a legal status of Not Criminally Responsible who have lengths of stay of six months or more in state psychiatric facilities are included in the population served

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by the team. The provider has also obtained private foundation funding to assist with housing. [NFC 5]

The third way in which case management has been funded is through Medical Assistance intensive mental health case management. Services were authorized and paid through the fee-for system managed by the ASO. Persons of all ages who met certain diagnostic and functional criteria were eligible for these services. Case management programs operated in 24 jurisdictions throughout the State.

Additionally, eight jurisdictions have had general case management services available to provide services to adults who did not meet the criteria for inclusion under the MA case management option but whose service needs are complex enough to warrant case management. Several counties have also provided case management through the PATH program, Shelter Plus Care community outreach programs, or special jail-based programs. Additional case management services are provided in some counties through this federal block grant. These case management services are all funded outside the fee-for-service system.

Through recent communications with the Center for Medicaid and Medicare Services (CMS) regarding Maryland's option for mental health case management within the state's MA Plan, several changes necessary for the state to continue Medicaid reimbursement for this service were identified. These changes included a new rate setting methodology and more stringent instructions, which would have resulted in significant reductions in current rates. After considerable analysis, a decision was reached to withdraw Maryland's Medicaid state plan option for mental health case management. Utilizing the historical State match funds, MHA will contract with the CSAs, who in turn, will contract with case management providers for the service. Funds for general case management, as described above, will be incorporated into the contracts. While overall there will be a decrease in funding available, this strategy allows the service to be preserved. Some administrative burden will be reduced, creating greater flexibility in the provision of the service. Priority populations for the service will remain the same. At a later date, Maryland plans to reevaluate case management services, and if feasible, reapply to CMS for a state plan amendment for mental health case management.

During FY 2007, the Community Support Leadership Network (CSLN), which is composed of directors and case managers of case management units, continued to meet quarterly to discuss issues related to policy and program development. In addition, the CSLN assisted in planning the annual State-approved case management training, which is required by the State regulations governing intensive case management.

### **Other Supports**

Medicaid is the joint federal and state program that provides health and long term care coverage to low-income individuals. The main low-income populations covered under Medicaid include children and their parents, pregnant women, older adults, and individuals with disabilities. Medicaid also covers Medicare cost-sharing for certain low-income Medicare enrollees.

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Federal Medicaid requires coverage of the following services: inpatient and outpatient hospital, physician, nurse midwife and certified nurse practitioner, laboratory and x-ray, nursing home and home health care, rural health and federally qualified health centers, and early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21. EPSDT requires coverage of all medically necessary services, including dental services, for children under age 21. Maryland Medicaid also covers “optional” services, such as drugs, therapies, medical day care, and personal care. **[NFC 4]**

In Maryland, about 80% of Medicaid beneficiaries are in HealthChoice, Maryland Medicaid’s mandatory managed care program. Individuals choose a primary care provider (PCP) and enroll in one of seven HealthChoice managed care organizations (MCOs). MCOs provide almost all Medicaid benefits, except for certain “carved-out” services that are provided on a fee-for-service basis. Specialty mental health is a key carve-out service. MCOs also provide additional services. For example, Maryland Medicaid does not cover dental services for adults, but all seven MCOs have opted to offer a dental benefit to their adult enrollees. The State requires MCOs to cover dental services for children and pregnant women.

Certain individuals are not in an MCO and receive their services on a fee-for-service basis. These populations include individuals who are eligible for Medicare, age 65 or over, eligible for Medicaid under a “spend down” category, continuously enrolled over 30 days in a long term care facility, or qualify for and opt to be in the Rare and Expensive Case Management (REM) program.

DHMH promotes coordination of MCO and fee-for-service specialty mental health services. Enrollees can self-refer to the Specialty Mental Health System, and Medicaid regulations state that an MCO or an MCO primary care provider shall refer an enrollee to the Specialty Mental Health System when the MCO PCP cannot meet the enrollee’s needs. The regulations also state that an MCO shall cooperate with the Specialty Mental Health System in developing referral procedures and protocols.

Meetings among Medicaid and MHA staff, MCO medical directors, and MAPS-MD medical directors promote coordination. Special needs coordinators at the MCOs currently have access to identified care managers at the ASO, who are specifically commissioned to fulfill this coordinating function. In addition, information on pharmacy utilization is shared across systems. Medicaid receives real-time information on MCO and fee-for-service pharmacy claims in order to prevent drug contraindications at the point of sale. On a monthly basis, Medicaid sends reports to each MCO of their enrollees’ fee-for-service mental health drug use, so MCOs and PCPs have information on the mental health drugs their enrollees are taking. In a new initiative, MHA, MA, and the ASO have worked together to include pharmacy data within the ASO’s web-based authorization system. Beginning July 1, 2007, mental health providers will be able to access information on prescriptions filled by consumers for psychotropic drugs and medications paid for through the MCOs. A 12 month rolling history of filled prescriptions will be maintained. Plans include developing access to the information for primary care providers for the MCOs later this year. **[NFC 6]**

In 2006, DHMH implemented two new expansion programs for populations not eligible for Medicaid. The Employed Individuals with Disabilities (EID) program extends Medicaid benefits to working Marylanders with disabilities. All Medical Assistance services

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are covered. EID lets individuals return to work and qualify for Medicaid by paying a small premium. Individuals can make more money or have more resources in EID than in regular Medicaid.

The Primary Adult Care (PAC) program provides a limited benefit package of primary care, pharmacy, and outpatient mental health services to low-income adults who are not eligible for Medicaid or Medicare. Similar to HealthChoice, individuals in PAC select a PCP and enroll in one of three participating MCOs. Two MCOs have opted to offer a dental benefit as an added PAC service. Individuals in PAC receive their mental health services through the PMHS. Eligibility for PAC is the same as for the previous Maryland Pharmacy Assistance Program (MPAP). Any Maryland resident age 19 and over, who is not on Medicaid or Medicare, and whose income is no more than 116% of the Federal Poverty Level (FPL) and whose assets are no more than \$4,000 may be eligible. For couples/households of two, the income limit is 100% FPL with assets less than \$6,000.

All individuals previously enrolled in MPAP moved either to Medicare Part D to receive their pharmacy benefit if they were Medicare eligible, or to PAC if they were not Medicare eligible. MPAP was discontinued. The Maryland Pharmacy Discount Program which previously served Medicare recipients was also discontinued with the advent of Medicare Part D drug coverage.

In ongoing efforts to manage pharmacy costs, Medical Assistance (MA) developed a Preferred Drug List (PDL) to make better use of less expensive, but equally effective medications. Cooperating drug manufacturers have offered the State additional revenue in the form of supplemental rebates for purchasing some of the brand name drugs. Fifty-three classes of drugs currently fall under the preferred drug list. According to PDL regulations, for each therapeutic class where there are three or fewer drugs, the PDL may be limited to only one drug; for each therapeutic class in which there are four or more drugs, at least two drugs must be included on the PDL. Prescribing of non-preferred drugs requires a preauthorization. The PDL affects all fee-for-service recipients and those HealthChoice and Primary Adult Care (PAC) recipients who take certain mental health drugs. The PDL impacts nearly all MA fee-for-service prescribers, and since mental health drugs are “carved out” from the MCOs’ formularies, it affects MCO prescribers of mental health drugs. Atypical antipsychotics and antiretroviral agents have been excluded from the PDL and can be prescribed without preauthorization; however, atypical antipsychotics are limited to U.S. Food and Drug Administration (FDA) recommended quantities. Preauthorization phone numbers and fax are available for prescribers who prefer to use non-PDL drugs. Preauthorizations for non-preferred drugs are granted upon request and require no justification or criteria at this time. There is also a hotline for recipients to use if they feel they are having difficulty getting their medications. However, due to budget reductions, the atypical antipsychotic carve-out from the PDL is scheduled to end in January 2008.

The Maryland General Assembly established the Maryland Health Insurance Plan under the Health Insurance Safety Act of 2002. A Board of Directors governs the plan, which operates as an independent unit of Maryland Insurance Administration. Individuals who are not eligible for group health coverage, COBRA, government –sponsored health insurance programs and some other special categories, may be eligible. The MHIP includes in its benefits coverage for mental health services. MHIP also has a Prescription Drug program which provides coverage at different levels and includes a deductible. MHIP also operates

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another prescription assistance program, targeted toward Maryland seniors. The Senior Prescription Drug Assistance Program (SPDAP) provides a subsidy for Medicare beneficiaries who have incomes below 300% of poverty to pay for all or some of the co-insurance, monthly premiums and co-pays that are required under Medicare Part D. Enrollment in the program is subject to available funds, and MHIP is required to maintain a waiting list for those individuals who meet the eligibility requirements but are not able to enroll because of lack of funds. The FY 2007 budget contained \$14 million (general funds) for this program.

Some individuals who receive services through the PMHS are not Medicaid or waiver-eligible and not enrolled in MCOs, and some of these individuals do not have a regular PCP. CSAs have found innovative ways to promote somatic and dental care for uninsured adults in their jurisdictions, e.g., through pro bono initiatives, medical and dental school clinics or pharmaceutical companies. Additionally, CSAs have been provided with some funds to purchase needed medical/pharmacy/laboratory services for uninsured individuals who cannot afford their costs and for whom no other source of funds or access to the service/drugs are available. These funds are frequently used to prevent the need for more intensive levels of service or reduce the risk of hospitalization. Another resource is the Maryland Medbank Program, which assists low-income, uninsured persons in gaining access to free medicines available through pharmaceutical manufacturers' patient assistance programs. Individuals are referred by their physicians and must meet income and other eligibility criteria set by the supplying drug companies. Only brand name drugs are available and are subject to supply. [NFC 1]

### **Hospitalization under the Public Mental Health System**

**Hospital Utilization.** The MHA has promoted the development of community-based services and the concurrent reduction of State psychiatric hospital census for over 25 years. Community expansion initiatives, census reduction initiatives, capitation projects, and demonstration financing projects have been used to affect these reductions in census and increases in community-based services. Over the past twenty plus years, MHA has reduced the average daily population (ADP) of State-operated psychiatric hospitals from over 2,500 to 1,154 in FY 2007. The ADP this year for the adolescent units at two hospitals was 25. MHA has not operated beds for children under age 12 since FY 1994. Beds are purchased from the private sector, when necessary. Residential rehabilitation program beds (RRP) which are generally utilized when long stay individuals are discharged from the hospital have only been increased through special initiatives since FY 2002. With the closure of Crownsville Hospital Center at the end of FY 2004, one million dollars in reallocated savings was made available for community placements. Another four million dollars was reallocated to the five counties most affected by the closure. These counties have developed a variety of services, focusing on diversion from and alternatives to State hospitalization. Assertive community treatment teams, in-home intervention programs for adults and children and adolescents, and services in the jails are examples of the types of services developed.

High occupancy rates, pressure for admissions, and long waits in emergency departments have characterized the total inpatient psychiatric care system, not only the State hospital system. Admissions to State psychiatric hospitals have decreased from FY 2005, with concurrent increased utilization of beds in the private sector for uninsured individuals, purchased through MHA state general fund dollars. While available data is still incomplete,

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it appears that admissions overall, in both state facilities and through purchase of care, are somewhat lower. The implementation of the hospital diversion projects (described below) and their success may be contributing to this; further analysis is underway. Fifty percent of the State's beds are occupied by forensic patients. Although MHA continues to work with the judicial system to secure timely dispositions for these individuals, lengths of stay for this group are longer than for non-forensic populations. Twenty-seven percent (27%) of forensic admissions are discharged within 30 days. Sixty-three percent (63%) of non-forensic patients are discharged within 30 days of admission. Acute admissions with MA and private insurance are directed to the private or general hospital sectors. State hospital beds currently are used for uninsured individuals (when no general hospital psychiatric bed is available-Maryland's all payor system covers costs of uncompensated care for general hospitals), court-ordered individuals, individuals who have exhausted their private insurance or have already stayed 30 days in the private/general bed and continue to require hospital level care, and for those who require a longer stay in hospital level care. There continues to be long waits in emergency departments for beds, whether in private, general hospital psychiatric units, or State hospitals. Emergency department visits in general are increasing and while the percentage of visits for mental health reasons remains at its historical level of 4.3%, the overall increase in visits creates a greater number of people seeking mental health dispositions. Over the last five years, there has been a 2% decrease in acute general hospital psychiatric beds. During the same time period, there has been an 8% increase in acute general beds. If the psychiatric beds had kept pace with the acute general beds, there would be 70 additional psychiatric beds, which could greatly relieve the waiting time in emergency rooms and provide resources for admission. The Maryland Health Care Commission (MHCC), in collaboration with the Mental Health Transformation Office, will 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. [NFC 2]

As noted previously, the state is projecting a structural deficit, with expenditures projected to outpace revenues by FY 2009. In response, there are initial budget reductions to occur in FY 2008 to begin to address the problem. MHA's budget was reduced by \$13 million, which will be taken from the facilities. Two major facilities, Springfield and Spring Grove, will each take one unit off line. Community-based services will be called upon to further meet needs. Initiatives to reduce emergency department pressure (designed prior to the announcement of the budget reduction) will further assist with the decrease in available beds and are described below. One of the two adolescent units, which operated under capacity, will be converted to an adult unit. Each of the three Regional Institutes for Children and Adolescents (RICAs) will be reduced by eight beds. It is anticipated that excess capacity in the private RTC sector, the 1915(B) waiver, and the dollars for wraparound in the state budget will be sufficient to absorb the need. Currently it is projected that these changes in hospital configuration will be in place by January 2008.

MHA has altered the previous centralized admission and referral process for emergency departments (ED) to use in locating and accessing State hospital beds. The process now relies heavily on using local systems of care. This change began with the

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Eastern Shore Hospital managing the requests for admission from eastern shore EDs to Eastern Shore and Upper Shore State hospitals. Finan Center in Western Maryland now directly manages the referral and state hospital admissions for individuals presenting in EDs in Frederick, Washington, Garrett and Allegany counties. Through changing the locus of the admission system to the state hospitals to the region where the service is located, better coordination of care has developed between the community mental health system, core service agencies, local hospitals and the state hospitals. The collaboration will better promote use of alternative services to hospital levels of care and facilitate the discharge of long stay state hospital patients.

MHA also implemented hospital diversion projects with local core service agencies in jurisdictions with the greatest use of state hospitals and purchase of private inpatient psychiatric care. In August 2007, MHA, with Montgomery County CSA, implemented a hospital diversion project for individuals who are uninsured in Montgomery County EDs who were requesting admission to the state hospital. Since MHA had been purchasing care in private psychiatric hospitals for Montgomery County residents due to lack of state hospital beds, MHA agreed to reprogram these funds to provide a comprehensive system designed at diverting inpatient admissions. The Montgomery County Department of Health and Human Services (MCDHHS) crisis system developed evaluation and triage teams that evaluate individuals in the ED who are uninsured and for whom hospitalization is being requested. In addition to the on site evaluation teams, MCDHHS developed and enhanced an array of community services to provide urgent care and treatment for those individuals who do not need inpatient psychiatric care. This includes residential crisis services, residential addictions services, and outpatient mental health and addictions treatment. To date this project has diverted 31% of individuals seen by the MCDHHS diversion team. In addition the project is reviewing all requests for state hospital admission. If the project determines an individual needs state hospital care, the project approves the admission. With this new project, Montgomery County residents (non-forensic) are hospitalized at the Finan Center, when state hospitalization is required., better utilizing the capacity of Finan and to manage the unit reduction at Springfield. [NFC 4]

Starting in April 2007, the Anne Arundel Mental Health Authority (AAMHA) began its hospital diversion project. It is expanding upon its current crisis response system to include on site evaluation and triage for Anne Arundel residents who are uninsured in Anne Arundel emergency departments. This project is evaluating, diverting, and referring and accessing care through the mental health and addictions system. AAMHA has worked with the local health department to access addictions treatment through a co-occurring initiative aimed at improving access for both systems of care. While this program has only been operational for two months, it has diverted 44% of individuals in EDs. This project is also reviewing and coordinating admissions to the state hospitals with Springfield Hospital Center.

In February 2007, Baltimore Mental Health Systems, Inc. (BMHS) received funding from MHA to expand the hours and availability of its mobile crisis teams in order to cover the local EDs in Baltimore City. In addition to the expansion of the mobile crisis teams, BMHS, through Baltimore Crisis Response System, Inc (BCRI) has expanded the number of residential crisis beds from 12 to 21. These residential crisis services are now located in space at the Walter P. Carter Center. BCRI will be managing the Baltimore City admissions for the Walter P. Carter beginning August 2007. Since BCRI operates substance abuse

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detoxification beds funded through the Baltimore City Substance Abuse Services, Inc, individuals will have access to services designed as alternatives to hospital level of care.

In FY 08, MHA plans to implement two additional hospital diversion projects in Prince George's and Baltimore counties. In order to better coordinate the efforts of the hospital diversion projects and create learning communities among the projects, MHA convenes a monthly meeting of representatives from the CSAs, state hospitals, and hospital diversion projects. Both projects have successfully reduced the amount of time individuals are waiting for evaluation and treatment in EDs. This is resulting in more comprehensive systems of care and better clinical outcomes for these individuals.

**Olmstead Related Activities.** The Maryland Department of Disabilities develops a cross-disability plan that addresses housing, employment, transportation and consumer rights. The 2006 Plan continues to provide direction for Olmstead – related activities for the State and calls upon units of State government to cooperatively engage in a variety of activities to promote consumer self-direction and consumer-centered services. It is anticipated that the Maryland Department of Disabilities will become increasingly involved in the housing issues for persons of all disabilities, in order to streamline cross-disability efforts and maximize State and federal resources.

To facilitate the discharge of long-stay State hospital residents, in FY 07 MHA, with the University Of Maryland EBPC, focused on the development of Assertive Community Treatment (ACT) teams and special residential projects. Forty - four individuals have been discharged from State hospitals through the support of ACT teams in Prince George's and Anne Arundel Counties. MHA evaluated these teams and determined that the ACT teams demonstrate high fidelity to ACT model. As a result, the agency was eligible for MHA's EBP rates and the project moved from a contract into the fee for service system. MHA continues to use the reallocated dollars from the closure of Crownsville Hospital Center for the housing subsidies that support individuals living in the community. A Housing First model is utilized, with the ACT teams providing the necessary supports in the homes. In Baltimore City, two ACT teams discharged 48 patients from state hospitals, including 41 individuals with forensic involvement. MHA provided reprogrammed resources to the Baltimore City CSA to implement this team in FY 07. A private foundation funded housing subsidies, which are critical to the success of the forensic ACT team. These two teams have met MHA's fidelity requirements and now are receiving the EBP ACT rate. MHA's reprogrammed funds will be used to continue the housing subsidies started by the private foundation. [NFC 5]

In addition, MHA is expanding residential services in Washington County to serve individuals currently hospitalized in the Finan Center. MHA continues to work with Frederick County to monitor the program assisting transition age youth with mental illness and developmental disabilities, who are aging out of residential treatment centers, in State hospitals, or returning from out-of-state placements. This project is being implemented in partnership with the Developmental Disabilities Administration. MHA continues to fund and partner with Montgomery County CSA regarding an independent living project using 10 Moderately Priced Dwelling Units (MDPU) for 10 individuals from state hospitals. Finally, MHA will continue utilizing the federal Olmstead planning grant to contract with On Our Own of Maryland for peer support counselors in State hospitals who work with consumers,

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supporting their transition to the community. Currently peer support counselors are in Springfield Hospital Center and Upper Shore Hospital.

MHA, which is the lead agency for Traumatic Brain Injury (TBI) in Maryland, is responsible for guiding the States' plans and initiatives for this population. MHA's current TBI initiatives include a Home and Community-Based Waiver for individuals with TBI, which was initially approved by the Centers for Medicare and Medicaid Services in FY 2003 and then renewed for an additional five years in 2006. The waiver supports up to thirty individuals each year in specialized brain injury community placements. [NFC 2]

Additionally, through a federal TBI grant from the Health Resources and Services Administration, Maternal and Child Health Bureau, resource coordination programs have been developed in Frederick, Washington, Howard, Baltimore and Montgomery Counties to link individuals with TBI with the community services and supports that they need. In addition to assisting individuals with TBI to access community resources, the project provides education and consultation to local mental health providers and other human service agencies on recognizing the signs of TBI, and strategies for affectively serving and supporting those individuals in the least restrictive setting.

MHA also provides staff support to Maryland's TBI Advisory Board, which is legislatively mandated to report annually to the Governor and the General Assembly on the needs of individuals with TBI, including identified gaps in services and recommendations for needed services and for use of state and federal funds. The Advisory board first annual report was completed in November 2006.

Since FY 1994, the Baltimore City CSA, Baltimore Mental Health Systems, Inc. (BMHS), has operated a pilot partial capitation project. Fifty percent (50%) of individuals served through this project are individuals who had hospitalized for longer than six months (often for much longer) and who had not been discharged to the community because their treatment needs, for both somatic and mental health care, were complex. The other 50% are individuals in the community who have frequently been admitted to psychiatric hospitals or have frequently been seen in hospital emergency rooms. Annual evaluations of the project have consistently demonstrated its success in placing and maintaining people in community life. In FY 2003, approximately 310 people were served. In FY 2004, the MHA expanded the project to serve another 41 individuals discharged from State psychiatric facilities. No further expansion has occurred. The program is nearing capacity. [NFC 1]

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### **SFY 2008 OBJECTIVES FOR CRITERION 1:**

#### **SERVICES FOR ADULTS**

- In collaboration with the Department of Health and Mental Hygiene (DHMH) and the Mental Health Transformation Office (MHTO), adapt from Australia and Scotland and begin to implement the Mental Health First Aid program which provides training in basic understanding and appropriate responses to mental health disorders, with special focus on training individuals in education settings. **[NFC 1]**  
MHA Monitor: Brian Hepburn, MHA Office of the Executive Director
- Continue, in collaboration with the University of Maryland, CSAs and key stakeholders, statewide implementation of evidence-based practice (EBP) models in supported employment, assertive community treatment, and family psycho-education. **[NFC 5]**  
MHA Monitor: Lissa Abrams, Office of Adult Services
- In collaboration with the administrative services organization (ASO) and managed care organizations (MCOs) improve utilization of existing systems of care delivery across agencies and organizations to improve coordination of care between somatic and mental health care. **[NFC 1]**  
MHA Monitor: Gayle Jordan-Randolph, Office of the Clinical Director
- Continue to implement the Self Directed Care project in Washington County and develop an evaluation protocol for the project. **[NFC 2]**  
MHA Monitor: Lissa Abrams, Office of Adult Services
- MHA, in collaboration with the Mental Health Transformation Office and On Our Own of Maryland, will 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. **[NFC 2]**  
MHA Monitor: Clarissa Netter, Office of Consumer Affairs
- Collaborate with On Our Own of Maryland, Inc. (OOOMD) to continue the implementation of the statewide anti-stigma campaign through the Anti-Stigma Project. **[NFC 1]**  
MHA Monitor: Cynthia Petion, Office of Planning, Evaluation, and Training
- Collaborate with the Mental Health Transformation Office (MHTO) in the creation of a Recovery Project targeted to: (1) consumers in supported employment and residential rehabilitation to help them move to their defined next level of recovery, and (2) long term State hospital consumers. **[NFC 2]**  
MHA Monitor: Daryl Plevy, Mental Health Transformation Office

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- Enhance crisis response systems and support the development and use of alternative services in Montgomery, Anne Arundel, and Prince Georges Counties, and Baltimore City CSAs, to reduce the need for inpatient treatment and divert adults, children and adolescents from Emergency Departments and inpatient psychiatric services. **[NFC 5]**  
MHA Monitor: Lissa Abrams, MHA Office of Adult Services
- Increase the number of individuals with mental illness who obtain affordable and safe housing through the Bridge Subsidy Pilot Program, and provide outreach and training for providers, CSAs and new tenants in order for individuals to maintain housing. **[NFC 2]**  
MHA Monitor: Penny Scrivens, Office of Adult Services
- Provide information and technical assistance for MHA facility staff, CSAs, and community providers regarding the discharge and community reintegration of individuals who are court-ordered, committed as incompetent to Stand Trial, Not Criminally Responsible, or otherwise under limitations of rights required by law. **[NFC 2]**  
MHA Monitor: Larry Fitch, MHA Office of Forensic Services
- Monitor community placements, other services, and plans of care for consumers with traumatic brain injury (TBI) through the TBI waiver. **[NFC 3]**  
MHA Monitor: Stefani O’Dea, Office of Adult Services
- Within existing state and local jail diversion programs, secure private, local, state, and federal funding to provide increased services for both women and men with co-occurring disorders and histories of trauma, including training providers to identify trauma and understand best practices for treatment of trauma. **[NFC 3]**  
MHA Monitor: Marian Bland, MHA Office of Special Needs Populations
- Collaborate with the DPSCS, ADAA, Family Health Administration, the Judiciary, and the Archdiocese of Baltimore to implement the new women’s transitional program (Chrysalis House Health Start Program) which is targeted to serve pregnant and post-partum women and their babies. **[NFC 3]**  
MHA Monitors: Marian Bland, MHA Office of Special Needs Populations
- MHA, in collaboration with Maryland Department of Health and Mental Hygiene (DHMH) and CSAs, will continue to support initiatives at the county level to implement integrated systems of care for consumers with co-occurring mental health and substance use disorders. **[NFC 5]**  
MHA Monitor: Tom Godwin, MHA Office of the Clinical Director and Pat Miedusiewski, DHMH

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- MHA, in collaboration with CSAs and stakeholders, will develop a plan to implement a nationally recognized evidence-based practice for individuals with co-occurring disorders. [NFC 5]  
MHA Monitors: Lissa Abrams, MHA Office of Adult Services
- In collaboration with the Maryland Health Care Commission (MHCC), promote efforts to delineate the roles of general hospital adult inpatient psychiatric units and state hospitals in the provision of acute and long term care. [NFC 2]  
MHA Monitor: Brian Hepburn, Office of the Executive Director
- Revise the Leadership Empowerment and Advocacy Project (LEAP) which prepares consumers to take on leadership and advocacy roles in the PMHS. [NFC 2]  
MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs
- Continue to interface with other agencies and administrations to support a comprehensive system of mental health, somatic health, and other services and supports. The following is a listing of the agencies with which a liaison is maintained and the responsible MHA monitor. [NFC 1]

Maryland State Government

MHA Monitor

Maryland Department of Disabilities (MDOD)

Brian Hepburn  
MHA Office of the Executive Director

Governor's Office for Children (GOC)

Al Zachik and Marcia Andersen  
MHA Office of Child and Adolescent Services

Maryland State Department of Education (MSDE)

Al Zachik, Cyntrice Bellamy, and Joyce Pollard  
MHA Office of Child and Adolescent Services

Division of Rehabilitation Services (DORS)

Lissa Abrams and Steve Reeder  
MHA Office of Adult Services

Department of Human Resources (DHR)

Lissa Abrams  
MHA Office of Adult Services  
Al Zachik  
MHA Office of Child and Adolescent Services  
Marian Bland  
MHA Office of Special Needs

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	Populations
Department of Housing and Community Development (DHCD)	Penny Scrivens MHA Office of Adult Services Marian Bland MHA Office of Special Needs Populations
Maryland Department on Aging (MDoA)	Lissa Abrams and Marge Mulcare MHA Office of Adult Services
Department of Public Safety and Correctional Services (DPSCS)	Larry Fitch MHA Office of Forensic Services Marian Bland MHA Office of Special Needs Populations
Department of Juvenile Services (DJS)	Al Zachik and Cyntrice Bellamy MHA Office of Child and Adolescent Services Larry Fitch MHA Office of Forensic Services
Judiciary of Maryland	Larry Fitch MHA Office of Forensic Services
Alcohol and Drug Abuse Administration (ADAA)	Tom Godwin MHA Office of the Clinical Director
Family Health Administration (FHA)	Al Zachik and Joyce Pollard MHA Office of Child and Adolescent Services
Developmental Disabilities Administration (DDA)	Stefani O’Dea MHA Office of Adult Services Lisa Hovermale MHA Office of the Executive Director
Maryland Health Care Commission (MHCC)	Brian Hepburn MHA Office of the Executive Director
Health Services Cost	Randolph Price

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Review Commission (HSCRC)	MHA Office of Administration and Finance
Children's Cabinet Results Team	Al Zachik MHA Office of Child and Adolescent Services
Office of Health Services (Medical Assistance)	Brian Hepburn MHA Office of the Executive Director Susan Steinberg MHA Office of the Deputy Director for Community Programs and Managed Care Gayle Jordan-Randolph MHA Office of the Clinical Director
Office of Operations and Eligibility (Medical Assistance)	Brian Hepburn MHA Office of the Executive Director Susan Steinberg MHA Office of the Deputy Director for Community Programs and Managed Care
Office of Health Care Quality (OHCQ)	Sharon Ohlhaber MHA Office of Planning, Evaluation, and Training
Office of Planning and Capital Financing	Cynthia Petion MHA Office of Planning Evaluation, and Training
AIDS Administration	Marian Bland MHA Office of Special Needs Populations
Maryland Emergency Management Administration	Laura Copland MHA Office of Special Needs Populations

## MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008

### ADULT PLAN

#### CRITERION #2: Adult Mental Health System Data Epidemiology

**Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.**

#### PMHS DATA SYSTEM

The primary PMHS data system is currently managed by an administrative services organization, MAPS-MD (*APS Healthcare*). Historical data from the previous vendor have been transferred to MAPS-MD. Historical data have also been placed at the University of Maryland Systems Evaluation Center (SEC). The SEC provides enhanced capacity for analysis of the data, particularly in relation to evaluation and outcome efforts.

The data system collects information on those who receive services in the fee-for-service system. The system is driven by a combination of authorizations and claims for mental health services. Inherent in the implementation of the PMHS is a series of extremely comprehensive data sets. Data sets on client's service authorization and events and the provider community are available. Client information is accumulated through either the Medical Assistance (MA) eligibility file or the subsidized client data forms. Unduplicated counts are calculated by using MA numbers, Social Security numbers and/or unique identifiers. Authorizations are made on-line and added to available data. Provider data come from provider enrollment files, which are used both for referral and for payment of claims. Finally, event and cost data are derived from claims files.

MAPS-MD's basic platform is CareConnection®, a proprietary system that currently meets a number of external mental health management standards, as well as internal standards required by internal operations and the State of Maryland (via extensive customization) of both care management and claims applications. MAPS-MD's CareConnection® system is supported by ACHIEVE, a claims processing and payment platform. This system allows MAPS-MD to be responsive to the MHA's evolving data analysis and program evaluation needs. [NFC 5]

CareConnection® is specifically designed to support mental health services access, utilization review, and care coordination tasks. CareConnection® collects and displays demographic, clinical service, provider and outcome information relative to an episode of care, and also links multiple consumer records into useful "episodes of care." Consisting of a series of interrelated databases and software routines, this system stores and can report over 200 elements for both inpatient and outpatient care. Also included among the numerous data fields, care management elements, and outcome indicators are:

- service authorizations and referrals
- services utilized by level of care and service
- treatment service lengths and number of units provided
- site visits, including record reviews and second opinion (peer) reviews of authorization

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All stored data can be retrieved and reported either in standard form, using an automated reporting system or by way of custom programming or ad hoc reports. The data may be formatted to produce monthly, quarterly or fiscal reports. Maryland operates on July-June fiscal year. Currently over 50 standard reports are generated to assist in general planning, policy, and decision making. The data may also be accessed to produce an unlimited range of reports via ad hoc requests.

In FY 2008, information on drug prescriptions filled by consumers in the PMHS will become available through CareConnections. This will be made accessible first to providers of mental health services. It will only be available to those providers with existing open authorizations to treat the consumer. The pharmacy data will be refreshed monthly and will include prescriptions filled during the 12 months prior to the refresh date. Later this year, information will be made available to MCOS, who can then communicate it to their primary care physicians. The availability of this new module will enhance service quality and will provide a rich resource to enhance data analysis efforts. [NFC 6]

An unanticipated problem resulting from PMHS implementation contributes to an undercount of persons with mental illness. The MAPS-MD Management Information System (MIS) does not capture data for individuals who receive no services reimbursed by MA and have Medicare as their only payer source. These Medicare reimbursed services cannot be subject to authorization and claims are not paid by MAPS-MD, the two mechanisms for capturing data. Additionally, beginning July 1, 2003, claims for individuals who are qualified for federally matched MA, and have Medicare, began to be processed by Medical Assistance and the data on their utilization of Medicare reimbursed services is no longer in the ASO data system. Therefore, the data on those served in the PMHS represents an undercount.

Tables on the following pages provide data on consumers served by age and number of consumers accessing care in FY 2006 since this is the last full fiscal year for which claims have been processed. However, FY 2007 data, based on claims paid through 5/31/07, shows that thus far, 87,048 individuals had claims submitted for mental health services through the fee-for-service system, with fifty-five percent (55%) being adults. Sixty-six percent (66%) of adults treated met the diagnostic categories selected for SMI.

The MAPS-MD MIS was utilized to produce most of the data included as performance indicators in this application. Data for FY 2005, 2006, and 2007 are based on claims paid through May 31, 2007. For FY 2005 and 2006, this produces reliable numbers. Since claims can be submitted up to nine months following the date of service, the data for FY 2007 is still incomplete. Full year projections were not made for FY 2007. Specific diagnoses were used to define SMI. An individual was categorized as SMI if, at any time during the fiscal year, a diagnosis in the specific categories was submitted on a claim.

The MHA submitted its application to SAMHSA/CMHS for a third round of Data Infrastructure Grant in June 2007. The required Basic and Developmental Tables were submitted in December 2006. All tables will be submitted this year, including developmental tables based on new consumer survey items. Data for these come from three sources. Community data are obtained from data that results from claims, authorizations, and

## **MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

Outcomes Measurement Systems (OMS) which are within the MAPS-MD system. Some data, such as employment status and residential status, along with detailed racial and ethnicity data, are not available from either standard claims or MA eligibility data sets. Efforts are made to obtain this information in the MAPS-MD system through requirements for registration and authorization by providers for services. The MAPS-MD information is supplemented by an annual Consumer Satisfaction Survey for many NOMs measures, though the newly implemented OMS may allow MHA to move to client level reporting for some of these measures. Data from State operated inpatient facilities are obtained from a Hospital Management Information System (HMIS). Currently, information is abstracted from the HMIS and integrated into data from the community system to complete all required URS and NOMs reporting. While this system does not use the same consumer identifiers at the ASO data system, there are elements common to both which MHA has used to establish a nearly unique identifier based on demographic variables. This identifier has been used to link data from the two systems. This system, which has been in place since 1986, is scheduled for replacement. Data for those tables reporting on individuals served and services provided are collected and reported at the person level. [NFC 5]

In addition to MAPS-MD, MHA contracts with the Systems Evaluation Center (SEC), a component of the Mental Health Services Improvement Collaborative of the University of Maryland School of Medicine, Department of Psychiatry, Division of Services Research to assist with evaluation and data infrastructure activities. As MHA's strategic partner, SEC maintains a copy of the community service's data repository which extends back to 1999. The University of Maryland SEC has accepted responsibility for the oversight of the effort to collect the data necessary to complete the Uniform Reporting System (URS) tables required to be included with Maryland's Mental Health Block Grant application. The SEC, MAPS-MD, and MHA are working jointly to develop an outcomes measurement system, described more fully in Criterion #5. In this coming year the SEC will continue to collaborate with MHA and key stakeholders to identify areas of interest related to the PMHS that could be analyzed using multiple databases. These databases include claims, authorization, the consumer satisfaction survey, the Outcomes Measurement System, the hospital management information system (HMIS), Medicaid, and other State databases, as available.

### **INCIDENCE AND PREVALENCE FOR ADULTS**

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For adults, the current estimate of population aged 18 and over for each county was multiplied by the rate cited in the federal definitions (5.4%)

Estimates of treated prevalence, however, were of necessity based upon a somewhat stricter definition of SMI. Specific Axis I and II diagnostic codes were selected to identify the SMI treated in the system. Very slight modifications were made within the diagnostic categories this year. All data have been updated to reflect these changes. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

## **MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities. Maryland's priority population remains as follows:

"Priority population" means those adults for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared priority for publicly-funded services.

Priority population includes:

- An adult, aged 18 to 64, with a serious and persistent mental disorder, which is a disorder that is:
  - Diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:
    - Schizophrenic disorder,
    - Major affective disorder,
    - Other psychotic disorder, or
    - Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; and
  - Characterized by impaired role functioning, on a continuing or intermittent basis, for at least 2 years, including at least three of the following:
    - Inability to maintain independent employment; social behavior that results in intervention by the mental health system,
    - Inability, due to cognitive disorganization, to procure financial assistance to support living in the community,
    - Severe inability to establish or maintain a personal social support system, or
    - Need for assistance with basic living skills.
- An elderly adult, aged 65 or over, who:
  - Is diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:
    - Schizophrenic disorder,
    - Major affective disorder,
    - Other psychotic disorder, or
    - Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; or
  - Experiences one of the following:
    - Early stages of serious mental illness, with symptoms that have been exacerbated by the onset of age-related changes,
    - Severe functional deficits due to cognitive disorders and/or acute episodes of mental illness, or
    - Psychiatric disability coupled with a secondary diagnosis, such as alcohol or drug abuse, developmental disability, physical disability, or serious medical problem.

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- An individual committed as not criminally responsible who is conditionally released from a Mental Hygiene Administration facility, according to the provisions of HealthGeneral Article, Title 12, Annotated Code of Maryland.

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**Mental Hygiene Administration  
Prevalence Estimates for Serious Mental Illness (SMI) by County  
Adult Population**

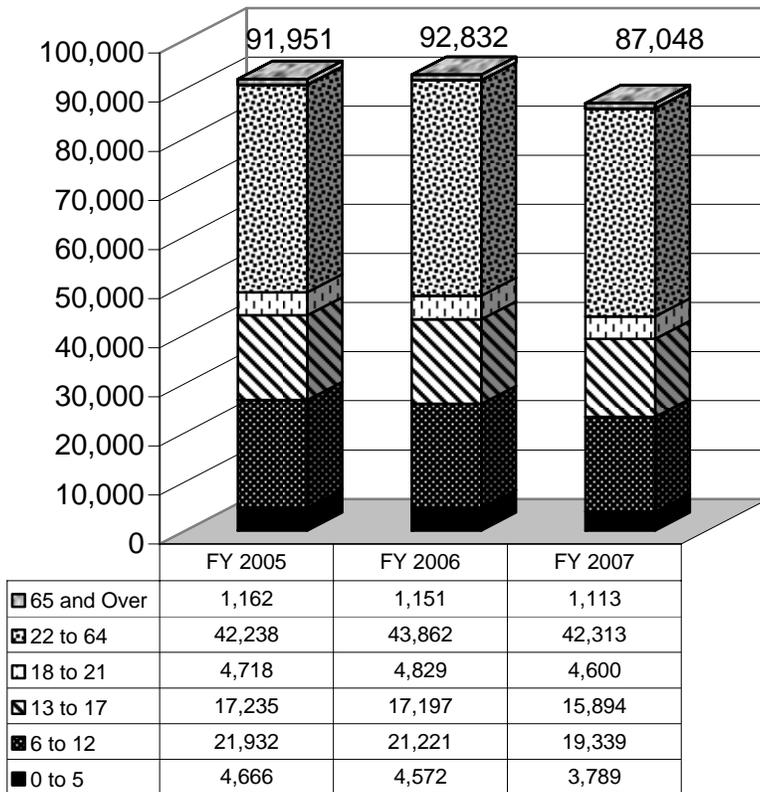
<b>County</b>	<b>Over 18 Population</b>	<b>Prevalence 5.4%</b>
Allegany	59,469	3,211
Anne Arundel	384,104	20,742
Baltimore County	604,624	32,650
Calvert	65,013	3,511
Caroline	23,860	1,288
Carroll	126,365	6,824
Cecil	72,982	3,941
Charles	101,071	5,458
Dorchester	24,442	1,320
Frederick	162,373	8,768
Garrett	22,974	1,241
Harford	176,971	9,556
Howard	197,291	10,654
Kent	16,213	876
Montgomery	692,274	37,383
Prince George's	619,195	33,437
Queen Anne's	34,720	1,875
St. Mary's	71,177	3,844
Somerset	21,129	1,141
Talbot	28,560	1,542
Washington	109,650	5,921
Wicomico	68,951	3,723
Worcester	39,352	2,125
Baltimore City	474,667	25,632
<b>Statewide Total</b>	<b>4,197,427</b>	<b>226,661</b>

Data Source:

July 1, 2005 Estimated Maryland Total Population by Age Group, Region and Political Subdivision

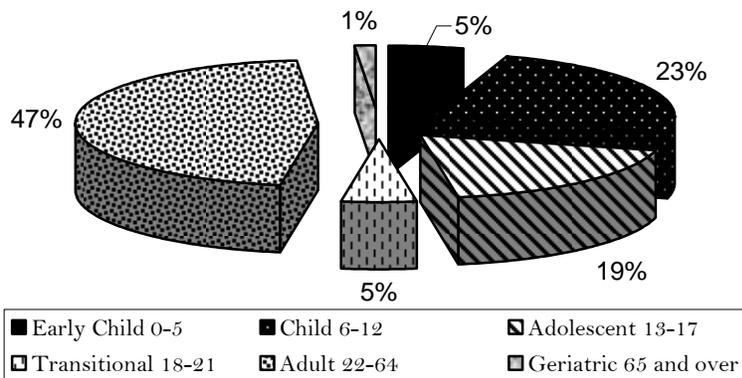
# MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008

Total PMHS Consumer Counts for FY 2005-2007 by Age Groups



Source: MAPS-MD Data report MARF0004. Based on Claims Paid through 05/31/2007. FY2007 data is incomplete as claims may be submitted up to nine months from date of service.

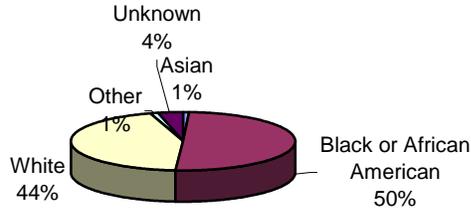
Percentage of PMHS Consumer Counts for FY 2006 by Age Groups



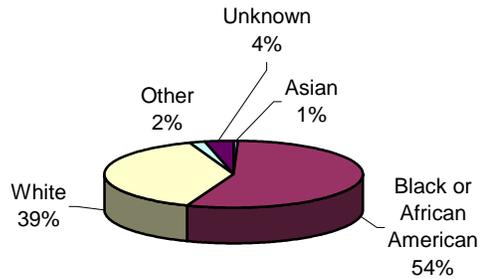
Source: MAPS-MD Data report MARF004. Based on Claims Paid through 05/31/2007. FY 2007 data is incomplete as claims may be submitted up to nine months from date of service.

**MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

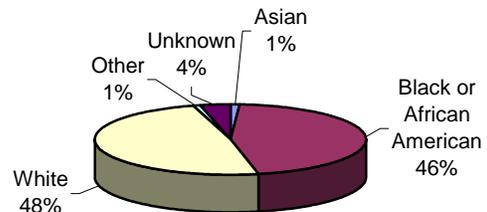
**Total Consumers Served  
in FY 2006 by Race and Age Group**



**Age 0-17**



**Age 18 and over**

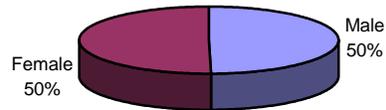


Source: FY 2006URS Table 2A

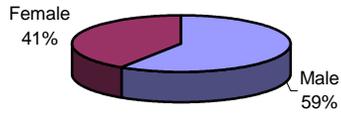
Note: Other includes: American Indian, Native Hawaiian, Pacific Islander and those consumers with more than one race.

**MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

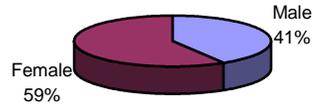
**Total Consumers Served  
in FY 2006  
by Gender and Age Group**



**Age 0-17**



**Age 18 and over**



Source: FY 2006 URS Table 2A

## **MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

### **SFY 2008 OBJECTIVES FOR CRITERION 2:**

#### **SERVICES FOR ADULTS**

- Continue to serve identified priority populations, maintaining an appropriate level of care for at least the same number of individuals in the populations who have historically utilized the PMHS. **[NFC 5]**  
MHA Monitor: Stacy Rudin, Office of Planning, Evaluation, and Training
- Continue activities to develop and/or refine management information systems, including the new State hospital information systems – Computerized Hospital Records Information Systems (CHRIS). **[NFC 6]**  
MHA Monitor: Robin Jacobs, MHA Office of Management Information Systems
- Collaborate with the Department of Human Resources (DHR), CSAs, ASO, and local homeless boards regarding the integration of local Homeless Management Information System data on the number of homeless individuals with mental illnesses who are served by Housing and Urban Development (HUD) funded programs into a State data base system. **[NFC 6]**  
MHA Monitor: Marian Bland and Jacqueline Powell, MHA Office of Special Needs Populations

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**ADULT PLAN**

**CRITERION #3: Not Applicable**

**ADULT PLAN**

**CRITERION #4: Targeted services to rural, homeless, and older adult populations**

**Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.**

**TARGETED SERVICES FOR RURAL POPULATIONS**

**Definition of Rural Areas**

Rural counties have historically been defined in Maryland as those with a population of 35,000 or less. Six counties continue to meet this criterion. Source: U.S. Census Bureau, Estimated Maryland Total Population by Political Subdivision, July 1, 2005 - Maryland Vital Statistics Annual Report 2005.

Maryland's definition was reviewed relative to the more complicated definitions of rural used by the U.S. Census Bureau. For Census 2000, the Census Bureau's classification of "rural" consists of all territory, population, and housing units located outside of urbanized areas (UAs) and urban clusters (UCs). The Census Bureau also looks at the population density with core census blocks of at least 1,000 people per square mile or surrounding census blocks with an overall density of at least 500 people per square mile. Many counties and metropolitan areas are split with UAs and UCs, often mixed with more rural areas. Based on population density alone, several other counties in Maryland, beyond the six, might be considered rural. However, other factors, including growth rate and proximity to major metropolitan areas (emerging bedroom communities), make these counties appear less rural. Based upon this, the six counties with populations under 35,000 will remain Maryland's defined rural areas for purposes of this application, while recognizing that pockets of "rural" areas exist in other counties.

**MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

Of the six Maryland counties that qualify under this definition, one rural county—Garrett—is the western-most jurisdiction in the state, and the other five—Caroline, Dorchester, Kent, Somerset, and Talbot Counties—are on the Eastern Shore. In recent years, several Eastern Shore counties have developed past the 35,000 threshold. Typically, as a rural county develops beyond the 35,000 threshold, it experiences growth in housing, commerce, and average household income that makes it more similar to the rest of the State.

<b>Rural County Population</b>
Caroline 31,822
Dorchester 31,401
Kent 19,899
Somerset 25,845
Talbot 35,683*
Garrett 29,909

Source: U.S. Census Bureau, Estimated Maryland Total Population by Political Subdivision, July 1, 2005  
Maryland Vital Statistics Annual Report 2005

Talbot County is an excellent example of a county that is in the process of transforming from a rural to non-rural area. On July 1, 2003 the population was 34,670. On July 1, 2005, the last year in which official age specific population was available, the number increased to 35,683, barely exceeding Maryland’s self defined “rural” threshold of 35,000. Projections indicate that the population of Talbot County continued to increase an estimated 36,062 in 2006. For purposes of this year’s block grant application we will continue to include Talbot County among the six rural counties. (Utilization data from all six counties are used in the block grant performance indicator.) Talbot County now has an average per capita personal income of \$50,872, up from \$46,144 in 2005.

The five Eastern Shore rural counties have personal per capita incomes ranging from a low of \$23,125 in Somerset County to the high of \$50,872 in Talbot County, compared to a statewide average per capita personal income of \$41,972. The demographics of Somerset County and most of the Shore counties also reflect issues affecting rural areas. For example, Somerset has experienced little growth in recent years. Somerset County’s 2004 household median income was one of the lowest in the State at \$34,000. Statewide household median income was 64,450. Over the past five years, the number of Medical Assistance Program enrollees has risen.

## **MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

Garrett County, in western Maryland, provides a useful example of how rural communities differ from jurisdictions in more rapidly developing areas of the State. Garrett County has one of the lowest per capita incomes (\$27,843) of the State's 24 subdivisions. In 2004, the median household income was \$37,050 (Maryland Department of Business and Economic Development). Unemployment rates in Garrett County are almost double that of the State of Maryland. Garrett County adults with less than a twelfth grade education comprise 20.7% of the population. Sixteen point six percent (16.6%) of the County residents, among the highest of Maryland jurisdictions, are enrolled in Medical Assistance. In its FY 2008-2009 Plan, Garrett County is described as an isolated, rural, mountainous county in the northwestern most corner of Maryland. Limitations, typical of rural areas exist in availability of transportation, access to healthcare and health information for a number of socioeconomic, geographic, educational, and cultural reasons. Low education levels create a barrier to seeking and understanding health information.

### **Available Services**

At present, the range of mental health and support services in rural counties is similar to those that are available in urban and suburban jurisdictions. Some services in contiguous counties are provided by programs that provide services at multiple sites throughout the area served. Mental health providers in rural areas have a history of cooperation and coordination as well as a history of sharing resources, with each other and with other service related agencies, to address the service needs of specific populations. Through this cooperation, providers have developed innovative services that are tailored to the unique needs of their areas. [NFC 3]

The maintenance of effective Core Service Agencies (CSAs) is a key statewide strategy to meet rural needs. The Mid-Shore Mental Health Systems, Inc. (MSMHS) is the CSA responsible for public mental health services in Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties, located on Maryland's Eastern Shore. MSMHS is currently the only regional CSA in Maryland.

In its two year Community Mental Health Plan, MSMHS discussed the rural nature of counties in the region. Population per square mile ranges from 55.4 persons per square mile in Dorchester County to 130.1 per square mile in Talbot County, with a regional average of 89.9. The Plan emphasizes that in "planning processes to improve the system of care to assure consumer focus and one (system) that is recovery oriented, it is apparent that the unique needs of the rural jurisdictions must be given a priority."

In its FY 2008 Plan Update - Community Mental Health Plan, the MSMHS reported the following special initiatives and collaborative efforts in FY 2007:

- MSMHS has taken the role of the lead agency for the HUD Continuum of Care (CoC), and was successful in the development of 35 Shelter Plus Care permanent housing units, 17 permanent supportive housing units, and a regional Homeless Management Information System. Affordable housing/ homeless shelters was one of three prioritized regional needs identified by stakeholders. The CoC has engaged three faith-based groups that have volunteered to operate shelters in the region. [NFC 3]

## **MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

- MSMHS and its providers promote a long-term recovery model for consumers with serious mental illness and have developed outcome measures for PMHS community – based services. In FY 2007, MSMHS collaborated with local providers to develop outcome measures for contractually funded services, as well as for select services within the fee-for-service system, including adult psychiatric rehabilitation programs, residential rehabilitation programs, and supported employment.
- Chesapeake Rural Network (the region’s peer support network) underwent leadership change and a complete restructuring, resulting in an improved operations plan that will benefit all consumers in the region.
- MSMHS collaborated with the Local Management Boards (LMBs) to develop local access plans. Through a negotiation process with the Governor’s Office for Children (GOC), the LMBs were awarded \$251,543 to implement a single point of access, through an Adult Review and Evaluation Services (ARES) accredited warm line and to hire three full-time family navigators for the region.
- MSMHS developed various components of crisis services and expanded Intensive Support Services, which are in-home intervention services available to families in the region. Approximately 354 children and their families were identified who required intensive services through the Intensive Support Services (ISS) initiative. [NFC 4]
- The eight counties that comprise the mid and lower Eastern Shore were awarded \$500,000 through negotiations with GOC to develop a group home on the lower shore. It is hoped that the group home will have the capability to provide diagnostic services, crisis respite as well as typical services of a therapeutic group home.

After several years of moderate expansion, Somerset County CSA (SCCSA) has worked to maintain the array and number of services available. As the second smallest county in the State, Somerset County has only seen a 5.6% growth in population in the past 10 years, with little of that growth in recent years, and has one of the lowest median income rates in the State. These factors make it important to avoid duplication of effort and to acknowledge the need for collaboration with both in-county and tri-county (Somerset, Worcester, and Wicomico) stakeholders on planning, service expansion, and coordination of activities and efforts. The Tri-County Provider Forum continues to meet to discuss issues regarding the PMHS and to increase provider knowledge.

In FY 2008-2009 Plan, the Somerset County Core Service Agency reported on the following accomplishments:

- Partnered with the Family Services Division of the Circuit Court to update and re-distribute the county resource guide;
- Continued to coordinate the Somerset County Adult Multi-disciplinary Team;
- Partnered with the local Department of Social Services to provide Applied Suicide Intervention Skills Training for 30 professional and paraprofessional staff providing services in the county;
- Continued working in partnership with the two other CSAs on the lower shore and received a HUD grant to provide 62 slots in the tri-county region to address permanent housing and case management needs;
- Provided leadership and management for the Salisbury Homeless Outreach Project that was funded by the City of Salisbury through Community Development Block Grant monies;

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- Worked collaboratively with staff from the Somerset County Adult Evaluation and Review Services, MHA, the Peyton Unit of McCready Memorial Hospital and the Alice B. Tawes Nursing Home to appropriately transition 11 patients from the special psycho-geriatric inpatient unit to nursing home level care; and
- Partnered with Seton Center, local affiliate of Catholic Charities to provide mental health educational information in the Spanish language. **[NFC 3]**

The Fiscal Year 2008 – 2009 Plan for the Garrett County Core Service Agency (GCCSA) included accomplishments for the prior years. Highlights included:

- GCCSA has allocated additional time for the Older Adults Transition Service (OATS) Social Worker to provide increased outreach, support and training for volunteers. This mental health professional links older adults to community services and provides consultation to nursing home staff, assisted living providers and adult medical day service providers on mental health issues. **[NFC 4]**
- GCSCA continued to support the Adventure Sports Institute (ASI) of Garrett College, which operates the Transition Age Youth (TAY) project. TAY graduates now act as mentors to incoming TAY participants. The ASI applied for a \$20,000 Consolidated Technical Assistance Grant from the Appalachian Rural Commission (ARC) to support year-round adventure sport therapeutic activities for high school students in the TAY programs. If the grant is received, the Garrett County Commissioners and Garrett College have agreed to provide the \$20,000 match.

The following table provides an overview of the six rural counties and the major programs available. Not included in the table is the broad array of individual providers in these rural communities.

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<b>CONTINUUM OF MENTAL HEALTH SERVICES</b>	<b>Mid-Shore Mental Health Systems</b>	<b>Somerset County CSA</b>	<b>Garrett County CSA</b>
Advocacy- Adult and Child	X	X	X
Community Support Funds(pharmacy, lab, transportation, other needs)	X	X	X
Detention Based Mental Health Services	X	X	X
Inpatient Services Adult Adolescents Child	X X X	X (youth and family services in Crisfield)	Emergency Room only
Intensive Outpatient Services	X		X
Intensive In-Home Services	X	X	X
Outpatient Mental Health Adult Child and Adolescent	X X	X X	X X
Peer Support Services	X	X	X
Psychiatric Rehabilitation Program Adult Child and Adolescent	X X	X X	X X
Respite Care Adult Child	X X	X X	X
Supported Employment Services	X	X	X
Transition Age Youth Programs	X	Go-Getters committed six residential slots	X
Targeted Case Management Adult Child and Adolescent	X X	X X	X

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### Service Needs

In order to best assess local service needs and implement services to meet those needs, MHA strongly supported the development of CSAs in rural counties. As noted previously, all rural counties in Maryland are served by CSAs. The rural CSAs are challenged to plan, both independently and collectively, for their residents' needs and the most efficacious use of resources. All CSAs are required to include a description of their needs assessment process and findings, including gaps in services, in their local mental health planning documents. The consistent and recurring service needs identified are: adequate number and mix of providers, need for specialty service providers, transportation, crisis treatment services, and efforts to address the needs of individuals with co-occurring disorders.

One of the major challenges for a rural area is the recruitment, retention, and ongoing training of mental health professionals. The number of qualified professionals in the Mid-Shore area has increased over time and this may be attributed to the growing nature of some of the Mid-Shore counties. Conversely, in its FY 2007 Plan Update, the Garrett County Core Service Agency reports that there is only 1.6 full-time equivalent of psychiatrist time available in the county. The need for psychiatric care for the child and adolescent population is acute. Garrett County and Kent County (as well as a number of very urban census tracts in Baltimore City with special needs related to the homeless population) are designated by the Federal Department of Health and Human Services, Bureau of Primary Health Care as mental health professional shortage areas (MHPSA). MHPSA designation may provide needed assistance in the recruitment of physicians.

CSAs, in both rural Western Maryland and rural Eastern Shore, have identified the need to travel to adjacent counties for some services as a significant rural issue. Transportation to and from services has been a barrier not only for appointments but for consumers attempting employment and increasing involvement in their local communities. Due to the lower population density and greater distances to all types of services, rural mental health programs have acquired and operate vehicles to link individuals to services, both through mobile services and by transporting consumers to needed services. Local health departments and Community Action Agencies also provide some publicly supported transportation in rural counties. Additionally, CSAs have some funding in their budgets for transportation services for eligible individuals. Stigma also plays a significant role as a barrier to accessing mental health services, particularly in rural settings. The CSAs on the Eastern Shore and Lower Shore Counties work collaboratively with stakeholders to address stigma through workshops and public awareness activities.

In the Fiscal Year 2008 Update of the Community Mental Health Plan, Mid-Shore Mental Health Systems, Inc. continues to focus on:

- Development of a system that is consumer driven and moves towards recovery [NFC 2]
- Defeating the stigma of mental illness; [NFC 1]
- Utilizing private/public partnerships to improve access;
- Maximizing existing resources by utilizing best practices with proven outcomes; and

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- Improving access to care in the rural region through the use of developing technology.

Additionally both the Board of Directors and the Regional Mental Health Advisory Committee has given a priority to improve:

- Interagency communication and collaboration that maximizes resources and eliminates duplication and unnecessary expenditures in order to develop a rural model of delivery that better serves the consumers in need;
- Collection and reporting of recovery-oriented outcomes measurement data

Mid-Shore Mental Health Systems, Inc., in collaboration with other community programs, recognizes the need for mental health services for Hispanic consumers that are uninsured. The Mid- Shore Council on Family Violence has two bi-lingual client advocates. For All Seasons, an outpatient mental health center, applied for a grant to obtain funding for a bilingual interpreter and MSMHS will provide the cost of the therapist, and limited psychiatrist time. [NFC 3]

In FY 2008-2009 Plan, the Somerset County Core Service Agency identified the following areas of need it will concentrate upon:

- Maintaining collaborative initiatives locally, regionally and statewide;
- Increasing awareness and public knowledge about mental illness and mental health resources;
- Developing strategies that address ending chronic homelessness in the mentally ill population;
- Addressing the need for integrated services for individuals with mental illness, substance abuse and developmental delays; and
- Developing and implementing outcomes management objectives for all contractual obligations.

The Garrett County Core Serve Agency (GCCSA) 2008-2009 Mental Health Plan focuses on solidifying and enhancing existing programs. Efforts will focus on:

- Coordination and collaboration with consumers, family members, providers and other county and state stakeholders to assure accessibility to quality mental health services;
- Strengthening the consumer run center and fostering a more cohesive consumer movement for quality based mental health services;
- Expansion of geriatric mental health services;
- Development of a continuum of community- based housing services for individuals who have severe mental illness;
- Continuation of suicide prevention activities;
- Ongoing development of services for the co-occurring population; and
- Identification of funds and programs which are targeted to increasing evidence based practices mental health services for children and adolescents and their families.

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### **Use of Technology**

There have been several preliminary efforts in telemedicine over the past few years. Since 2004, through a child and adolescent best practices project funded by MHA, in collaboration with the directors of the departments of child and adolescent psychiatry at the University of Maryland and the Johns Hopkins Hospital, seminars have been held once per month and are video conferenced to seven sites across the State. The goal is to provide state of the art information (best practices) to the child practitioners in Maryland on child psychiatry, psychopharmacology, and treatment. It is a live, interactive seminar that offers slide presentations, didactic material and interactive discussion. This project keeps State providers informed of the latest developments in their field without needing to travel many hours and at great expense. [NFC 3, 6]

In 2003, Sheppard Pratt Hospital Systems was awarded a grant from the U.S. Department of Agriculture (USDA) to install and furnish telemedicine equipment at several public and private mental health facilities in the State. Three units were set up in Worcester County in conjunction with the grant. Worcester County Health Department Core Services Agency, with funding from the Mental Hygiene Administration, contracted with Sheppard Pratt to provide telepsychiatry services to clients who were homeless, with mental illnesses and substance abuse problems. The Worcester County Core Services Agency has since expanded on these services by funding mental health treatment to children and adolescents. Additionally, a population of pregnant and post-partum women at the Center for Clean Start in Salisbury are served under the USDA grant. Sheppard Pratt was also awarded a grant in 2006 by the Health Resources Services Administration (HRSA) to purchase equipment, train providers and establish a telepsychiatry disaster network at several general hospitals and community mental health clinics in Maryland.

Sheppard Pratt has also completed a telepsychiatry inpatient attending physician demonstration project, one of the first in the country, with a general hospital on the Eastern Shore. The general hospital was in need of psychiatric coverage during a time of staff turnover, a common problem for rural general hospitals in Maryland as well as most other states. The hospital funded the professional fees portion of the pilot project as a demonstration of inpatient telepsychiatry utilization. Finally, a twice-monthly mental health grand rounds professional education program is provided via interactive videoconferencing to a number of hospitals and mental health clinics in Maryland.

Correctional Mental Health Services (CMHS) began utilizing telepsychiatry in 2004 at the St. Mary County Detention Center as part of a comprehensive program to provide mental health services to incarcerated individuals. CMHS currently provides telepsychiatry services at the St. Mary's, Charles and Wicomico County Detention Centers. CMHS provides both live and telepsychiatry services in all sites at which CMHS utilizes telepsychiatry.

MHA, in collaboration with CSAs, is now working to develop parameters for telemedicine, including its use to address access issues for remote locations, specialty services, and special needs groups. The Maryland Association of Core Service Agencies (MACSA) has applied for grants, (USDA and HRSA) to obtain funding for the purchase of equipment and has partnered in this grantsmanship effort with the Mental Hygiene

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Administration and the University of Maryland Department of Psychiatry. Unfortunately, funding has not been awarded to date. MHA is working with the former clinical director of Telebehavioral Services at Sheppard Pratt, who is now at the University of Maryland.  
[NFC 6]

### **TARGETED SERVICES TO THE HOMELESS**

The exact number of individuals who are homeless and who have a serious mental illness is unknown. The MHA has been participating in the efforts of the Maryland Department of Human Resources (DHR) and local communities to implement the Homeless Management Information System. All of the Maryland counties have established their systems. Most of the counties have trained shelters and providers on utilizing the Homeless Management Information System. Some counties are still trying to resolve issues regarding providers' resistance to using the Homeless Management Information System due to concerns about client confidentiality. Efforts are also underway develop a statewide data warehouse so that local homeless data may be accessed at the State level.

The DHR's Office of Transitional Services gathers information on those people who have stayed in emergency shelters, transitional housing programs, or who have been given a motel placement. Therefore, the estimate provided reflects only the number of homeless people who receive shelter as reported by local agencies on the Office of Transitional Services Homelessness Survey. The total number of people who were served by Maryland's homeless shelters in Fiscal Year 2006, the latest year for which data is available, was 37,432 person This is a 890 increase from the 34,654 people served in FY 2005. Preliminary data gathered through some of the local homeless management information systems indicates there has been an increase in the number of homeless persons served. Shelters also reported that on 34,191 occasions people were refused shelter or motel placements because of lack of space or lack of funds during FY 2006. The 4,326 decrease in turnaways may partly be due to several providers not collecting information regarding the numbers of persons turned away.

In regards to the unsheltered population, MHA estimates that there is at least another 25% (8,692) unsheltered. Based on the National Resource Center on Homelessness and Mental Illness, 20-25% of the homeless populations have a mental illness. Therefore it is estimated that there are 10,865 homeless persons who have a mental illness in Maryland.

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Projects for Assistance in Transition from Homelessness (PATH) is committed to creating a continuum of services for homeless individuals who have a serious mental illness or co-occurring substance use disorder in every jurisdiction in Maryland. The PATH program is not only concentrated in areas with the greatest number of homeless people, but incorporates the needs and challenges that individuals face in the rural jurisdictions. The PATH program will provide funding to all four geographic regions in Maryland. These regions are Central, Eastern, Southern and Western Maryland. Funding will be provided for PATH services in Baltimore City, Allegany, Baltimore, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Howard, Kent, Montgomery, Prince George's, Queen Anne's, Somerset, St. Mary's, Talbot, Washington, Wicomico, Worcester Counties, and Baltimore City. PATH funds are used for outreach, case management, supportive services in residential settings, screening and diagnostic services, supportive residential services, housing assistance, technical assistance in applying for housing, training, and referral to primary health, job training and educational services. [NFC 4]

The PATH program provided services in 22 of 23 counties and Baltimore City in FY 2007. In FY 2005, funding level was \$956,000. Local PATH supported agencies identified 2,932 homeless individuals with mental illnesses. Of these, 1,943 actually enrolled for PATH services. In FY 2006, the PATH funding level was increased to \$1,065,000. However due to federal cuts in the PATH Program, MHA received \$1,052,000 in PATH funding in FY 2007. The \$12,000 reduction in funding in FY 2007 did not affect direct services to PATH eligible consumers. The \$12,000 shortfall in FY 2007 was taken from Baltimore City's PATH award. These funds were used in previous years to provide statewide training and to provide scholarships for consumers and/or PATH providers to attend national, state, and local conferences to enhance skills. In FY 2008, PATH will be funding at \$1,053,000. PATH programs are projected estimated 2,237 individuals and families in FY 2008. In FY 2005, several counties received an increase in funding, including Baltimore, Harford, Frederick, and St. Mary's Counties and Baltimore City. Increases were awarded to counties which proposed to use PATH funding for activities consistent with Substance Abuse Mental Health Services Administration's (SAMHSA) Mental Health Transformations goals. Through the increased funding a consumer advocate was hired as a part of the Assertive Community Treatment Team in Harford County and Medbank Program was added to Frederick County's PATH Program, which assists consumers with obtaining free medications through the Patient Assistance Programs operated by pharmaceutical manufacturing companies. Additionally a PATH Outreach Worker/Case Manager was hired as a part of the TAMAR Community Project, a newly developed program funded by the AIDS Administration through a partnership with MHA. The TAMAR Community Project provides psychosocial support services to HIV positive, female prostitutes involved in the criminal justice system in Baltimore City. Also in Baltimore City, funding was awarded to partially fund a new SSI Project to Health Care for the Homeless (HCH) in Baltimore City. An SSI Outreach Specialist is housed at HCH to assist consumers with applying for SSI/SSDI presumptive eligibility. In St. Mary's County, the additional funding has contributed to the purchase of two dedicated two-hour blocks of telepsychiatry per week in a mental health clinic to serve homeless persons who have serious mental illnesses and who are transitioning out of the detention center. The following table presents a summary of the most current PATH program information:

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<b>SERVICE AREA OF PROJECT</b>	<b>ADMINISTRATIVE ENTITY</b>	<b>PATH SFY 2008 FUNDING</b>	<b>PROJ. # SERVD. SFY 2008</b>	<b>SERVICES PROVIDED UNDER PATH</b>
Allegany County	Allegany County Mental Health Systems	\$54,955	48	ALLEGANY COUNTY MENTAL HEALTH SYSTEMS - Community outreach, case management, staff training, housing assistance, supportive services, referrals to primary health services, job training, educational and relevant housing.
Baltimore City	BMHS Baltimore Mental Health Systems, Inc.	\$206,248	325	BALTIMORE MENTAL HEALTH SYSTEMS- Position funded in BMHS to provide technical assistance in locating and developing affordable housing, room and board training, registry of house resources.
				UNIVERSITY OF MARYLAND MEDICAL SYSTEMS- SSI outreach, linkage to services and housing, case management, liaison to homeless outreach teams, outreach assessment.
				HEALTH CARE FOR THE HOMELESS-Street outreach, SSI Presumptive Eligibility Project, mental health and addictions treatment, and case management.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2008 FUNDING	PROJ. # SERVD. SFY 2008	SERVICES PROVIDED UNDER PATH
				<p>PRISONER'S AID ASSOCIATION- Outreach, case management, linking women who have a history of mental illness and trauma to services and housing</p> <p>CHRYSALIS HOUSE HEALTHY START PROGRAM - 16 bed diagnostic and transitional facility for pregnant and post-partum women and their babies. The participants will be women who are incarcerated in local detention centers and have misdemeanor charges. Comprehensive assessment, outreach assessment, housing assistance, case management, access to appropriate treatment resources and services will be provided.</p> <p>STATEWIDE TRAINING</p>
Baltimore County	Dept. of Health Bureau of Mental Health CSA	\$96,200	120	PROLOGUE, INC. – Outreach, screening and diagnostic services, training, case management, housing coordination and matching, security deposits, one-time rentals (eviction prevention), support and supervision in residential settings, staff training.

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<b>SERVICE AREA OF PROJECT</b>	<b>ADMINISTRATIVE ENTITY</b>	<b>PATH SFY 2008 FUNDING</b>	<b>PROJ. # SERVD. SFY 2008</b>	<b>SERVICES PROVIDED UNDER PATH</b>
Calvert County	Calvert County CSA	\$30,380	50	CALVERT COUNTY MENTAL HEALTH CLINIC Outreach, screening, case management relevant housing services, referrals for primary health, community mental health services, substance abuse treatment, job training programs, educational services.
Carroll County	Carroll County CSA	\$37,000	50	KEYSTONE SERV.OF MD – Outreach, intensive case management, screening and diagnostic, assistance with linking to housing and services linking to training, support in residential settings.
Cecil County	Cecil Co CSA	\$5,000	4	CECIL COUNTY CORE SERVICE AGENCY -One - time only rental assistance, security deposits and training, contract with outreach and case management services.
Charles County	Charles County CSA	\$35,000	75	SOUTHERN MARYLAND DIVISION OF CATHOLIC COMMUNITY SERVICES – Outreach, referral to intensive case management, mental health, linkage to mental health services, screening and diagnostic treatment, assistance in planning for housing, technical assistance with housing, referrals to alcohol and drug treatment, medical care, pharmacy assistance, job training, educational legal assistance, and assistance with security deposits.

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<b>SERVICE AREA OF PROJECT</b>	<b>ADMINISTRATIVE ENTITY</b>	<b>PATH SFY 2008 FUNDING</b>	<b>PROJ. # SERVD. SFY 2008</b>	<b>SERVICES PROVIDED UNDER PATH</b>
Frederick County	Frederick County CSA	\$77,400	450	FREDERICK COMMUNITY ACTION AGENCY – Outreach, case management, referrals for health care, job training, alcohol and substance abuse treatment, transportation, housing coordination, supportive and supervisory services, and the development of Medbank services to link PATH clients to free prescription medications made available through patient assistance programs.
Garrett County	Garrett County CSA.	\$24,500	27	GARRETT COUNTY CSA. - Screening, housing coordination, security deposits, one - time only rental assistance linkage to permanent housing, and referrals for mental health and other services.
Harford County	Harford Co CSA	\$71,524	95	CORE SERVICE AGENCY IN COLLABORATION WITH ALLIANCE, INC. – Outreach, case management, linkage to housing, assessments, and referrals, substance abuse and assertive treatment services, services to prevent re-incarceration and improve access to services upon release from incarceration.

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<b>SERVICE AREA OF PROJECT</b>	<b>ADMINISTRATIVE ENTITY</b>	<b>PATH SFY 2008 FUNDING</b>	<b>PROJ. # SERVD. SFY 2008</b>	<b>SERVICES PROVIDED UNDER PATH</b>
Howard County	Howard County CSA	\$35,478	25	GRASS ROOTS CRISIS INTERVENTION CENTER – Case management, psychiatric services, referral, housing assistance, assistance with entitlements.
Mid-Shore (Caroline, Dorchester, Kent, Queen Anne’s, and Talbot Counties)	Mid-Shore Mental Health Systems, Inc.	\$52,624	125	MIDSHORE MENTAL HEALTH SYSTEMS, INC. – Contracts with vendors to provide homeless outreach to all five counties, assessments, housing security deposits assistance, case management, conduct needs assessment, one - time only rental payments.
Montgomery County	Montgomery County CSA	\$115,588	300	MONTGOMERY COUNTY DETENTION CENTER-  Outreach, engagement, linkage to mental health, case management, and housing.  Oversight and program linkages to community advisory group including Volunteers of America Chesapeake, Inc.
Prince George’s County	Department of Family Services, Mental Health Authority Division	\$62,872	80	QUALITY CARE INTERNET BEHAVIORAL HEALTH – Outreach, screening, assessment, case management, supportive services in residential settings, housing assistance, referrals to mental health services, medical, housing, rehabilitation, and vocational training, one-time only rental assistance and security deposits.

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<b>SERVICE AREA OF PROJECT</b>	<b>ADMINISTRATIVE ENTITY</b>	<b>PATH SFY 2008 FUNDING</b>	<b>PROJ. # SERVD. SFY 2008</b>	<b>SERVICES PROVIDED UNDER PATH</b>
Somerset County	Somerset County CSA	\$10,000	8	SOMERSET COUNTY CORE SERVICE AGENCY-Outreach, housing services, i.e. one-time only rental assistance to prevent eviction, security deposits, planning of housing, and minor renovations to existing housing.
St. Mary's County	St. Mary's County CSA	\$45,950	120	DETENTION CENTER MENTAL HEALTH - to serve homeless, detention center inmates with mental illness, screening, assessment, linkage to community resources. Two hours per week of telepsychiatry in a mental health clinic to assist with aftercare planning.  THREE OAKS SHELTER – Outreach and case management services and aftercare which includes housing are its goals.
Washington County	Washington County CSA	\$37,000	320	TURNING POINT – Case management outreach, job training, supportive and supervisory services, screening and diagnostic services. 2 positions: homeless outreach worker and outreach assistance.

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<b>SERVICE AREA OF PROJECT</b>	<b>ADMINISTRATIVE ENTITY</b>	<b>PATH SFY 2008 FUNDING</b>	<b>PROJ. # SERVD. SFY 2008</b>	<b>SERVICES PROVIDED UNDER PATH</b>
Wicomico County	Wicomico County CSA	\$22,000	40	WICOMICO COUNTY CSA-Assessment, service planning, linkage to mental health, housing, medical, employment, outreach, and case management.
Worcester County	Worcester County CSA	\$33,281	50	HEALTH DEPARTMENT – MENTAL HEALTH PROGRAM – Mobile assessments, assertive outreach, training one - time only rental payments, security deposits, minor renovation, expansion and repair of homes, mental health and case management.
<b>TOTAL Maryland</b>		\$1,053,000	2,183*	

In previous years, data on the number of persons served included those served through outreach and those receiving ongoing PATH services. Due to changes in definition, PATH consumers who are engaged through outreach are no longer included in the number of persons to be served. PATH providers are currently counting only those who are considered enrolled (client file opened and service plan developed) as the number served in FY 2007.

(Additional grants have also been used to support needed services. PATH supported services are linked with Shelter Plus Care, which provides tenant-based or sponsor-based rental assistance. MHA has adopted a strategy to target individuals for Shelter Plus Care who are homeless and being discharged from detention centers. However, several of the small Shelter Plus Care grants target those without criminal justice involvement. The success of the program is measured not only by enhancement in the quality of life to consumers but also by the reduction in readmission to detention centers and hospitals or the return to homelessness. During the past several years, recidivism across the system has been limited to 3 % - 7% to jails, 1% to hospitals, and 1% to homelessness.

In 1995, the U.S. Department of Housing and Urban Development (HUD) first awarded MHA a five-year, \$5.5 million Shelter Plus Care grant to provide housing for individuals who are homeless with serious mental illnesses and their dependents who are being released from the detention center, or are in the community on intensive caseloads of

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parole and probation. Last year, the FY 2007 Shelter Plus Care Housing grant was renewed for \$2,580,217, the renewal grant was increased largely due to increases in the Fair Market Rental Values determined by HUD. Additionally, in FY 2007 MHA received \$759,236 through eleven small grants targeted to specific jurisdictions. The jurisdictions awarded new five-year grants over the past years through MHA included Allegany, Anne Arundel, Baltimore, Cecil, Frederick, Harford, and Prince George's counties. [NFC 2]

For FY 2008, MHA was awarded funding in the total amount of \$3,186,648 for 14 Shelter Plus Care renewal grants. Currently, MHA is serving a total of 642 persons, 149 single individuals with mental illness, 157 families with 268 children and 68 other family members through all of the Shelter Plus Care grant programs.

Since 1995, the process for applying for funding through the U.S. Department of Housing and Urban Development (HUD) has changed. In 1996, HUD introduced to communities the Continuum of Care model to address the problems of housing and homelessness in a more coordinated, comprehensive, strategic fashion. The model required local communities to develop a strategic plan to address the use of HUD resources and this also became the application process for obtaining HUD funding. As a result of this change, MHA lost its ability to directly apply for Shelter Plus Care Housing grant funds to HUD and to apply for funding using a single statewide application. The new process requires MHA and other State and local entities to apply for funding through the local Continuum of Care Planning group. In FY 2008, MHA submitted 15 renewal grants to thirteen Continuum of Care Planning groups as a part of their application for HUD funding. Each local Continuum of Care of Plan must incorporate MHA's Shelter Plus Care application into its local plan annually.

Advocates for the homeless and for housing for people with disabilities in Maryland have expressed concern with proposed changes in the Housing Choice Voucher Program. If fewer vouchers are available for individuals with disabilities, then it will be more difficult to advance consumers from Shelter Plus Care to other housing choice programs.

Individuals who are homeless are also served by traditional mental health treatment and support programs, including existing psychiatric rehabilitation programs, case management entities, crisis service providers, and mobile and on-site clinic services. In addition, outreach and eviction prevention services, as well as coordination with needed mental health services are provided to homeless individuals. In Baltimore City, Baltimore Mental Health Systems, Inc. obtained grant funds to provide case management and other services for homeless individuals with mental illnesses. State general funds and mental health block grant funds support additional services and programs for the homeless population. Additionally, the Maryland Community Criminal Justice Treatment Program (MCCJTP) supports specific programs targeted at individuals with serious mental illnesses, many of whom are homeless and in detention centers. In FY 2006 the MCCJTP operated in 23 Maryland counties and served approximately 5,591 individuals with approximately 5,565 units of service being provided.

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On June 30, 2005 SAMHSA announced 30 grants to provide substance abuse and mental health services for homeless people. The grants were to enable communities to expand and strengthen their treatment services for homeless individuals with substance abuse disorders, mental illnesses, or co-occurring substance abuse disorders and mental illness. In Maryland, People Encouraging People, long a leader in mental health services and outreach to the homeless in Baltimore City, was awarded \$400,000 per year for five years to create a comprehensive dual diagnosis treatment program for persons who are homeless and have substance abuse and mental health problems. [NFC]

Training regarding issues related to homelessness and mental illness has been a MHA priority for several years. These training programs include consumers and representatives from many agencies. MHA works in collaboration with CSAs and/or PATH providers to develop training to address issues related to individuals who are homeless in hospitals, shelters, on the street, in jails, or detention centers. In FY 2007, MHA provided an annual conference targeted to PATH, housing, homeless, mental health, consumers, and advocates. The conference, "From Homelessness to Housing: The Heart of the Matter", "A Place to Call Home: Challenges and Alternatives" was attended by 150 persons. In FY 2008, MHA will provide a 2 day Shelter Plus Care 101 Training and a three day Housing Quality Standards Training for housing inspectors and residential specialist training for homeless services providers to increase knowledge of emerging best practices, i.e. SSI outreach training.

In FY 2007 MHA continued to meet on a quarterly basis with community service providers that receive PATH funds. MHA staff also attends the Continuum of Care Planning group meetings on a regular basis. Since December 2004, MHA has been participating in the development of the State's Interagency Council on Homelessness Ten-year Plan to End Homelessness in Maryland. This planning committee is chaired by the Department of Human Resources and co-chaired by DHMH. MHA also participated on the State's SSI/SSDI, Outreach, Access and Recovery Technical Assistance Initiative, and work group which will provide training to case managers working with individuals who are homeless on strategies to expedite processing of SSI/SSDI applications. Additionally, MHA collaborates with other agencies and departments that provide services or have resources to meet the needs of individuals who are homeless with psychiatric disorders, including the Department of Human Resources, the Department of Housing and Community Development, and the Department of Economic and Employment Development. Within DHMH itself, MHA collaborates with the Alcohol and Drug Abuse Administration, Family Health Administration, Medical Care Policy Administration, and the AIDS Administration. MHA encourages and provides technical assistance on request to encourage similar interaction at the local level to facilitate effective service provision for homeless individuals of all ages with psychiatric disorders.

**TARGETED SERVICES TO OLDER ADULTS**

During 2006, approximately 1200 persons aged 65 and older were served through the PMHS fee-for- service system. Services rendered included case management, crisis, inpatient, mobile treatment, outpatient, inpatient, psychiatric rehabilitation, residential rehabilitation, respite care, supported employment. Older adults access services in the PMHS in the same way as other age groups. Access to outpatient services can be challenging due to the reduced fees paid by Medicare. Providers are, at times, reluctant to provide this service to large numbers of Medicare recipients. The PMHS also provides non-Medicare covered services to older adults who meet the eligibility and medical necessity criteria for the service.

In addition to these services in the fee-for-service system, MHA funds specialized services for elderly individuals through the CSAs. Since 1988 MHA has utilized a team of psychogeriatric nurse specialists and social workers to provide consultation services to nursing homes and community programs which serve older adults with mental illnesses. These positions are mentored by MHA's geropsychiatric nurse specialist in their efforts support older adults with psychiatric disabilities maintain and improve quality of life. The goal is to continuously increase the knowledge base and skills of community providers in managing the somatic and psychiatric needs of older adults. MHA's Coordinator of Services to Older Adults, MHA's R.N. consultant, and the local consultants are each affiliated with the Maryland Gerontological Association as well as the Mental Health Association of Maryland's "Coalition on Mental Health and Aging". MHA also contracts with CSAs to fund MHA Residential Rehabilitation Programs in Anne Arundel County, Prince George's County, and Baltimore City to provide nursing services and additional supports for residents with complex medical conditions and those who are elderly. Approximately 150 persons were served through these programs. [NFC 4]

Additional programs funded by MHA, through the CSAs, include senior outreach in public housing in Baltimore City, a senior peer support mentoring project in Baltimore County, a senior case management and assistance program in Washington County; and elderly outreach in Calvert, Frederick, and Prince George's Counties. Additional MHA funded services that elderly individuals may access include mobile crisis teams, client support, peer support, and emergency psychiatric services. CSAs also participate with other county agencies in sponsoring some specific services. The list below provides some highlights on these MHA funded/CSA sponsored programs:

- Baltimore City:  
"PATCH" program (Psycho-geriatric Assessment, Treatment in City Housing)- sponsored by the Johns Hopkins and Bayview Hospitals is an outreach program available to older adults with serious mental illness, residing in East Baltimore City "high-rise" housing developments at 17 sites, and offers an alternative for seniors unable to access traditional out-patient treatment services, including medication management and assessments. During the year 2006, approximately 110 persons were served through this program.

"SOS" program-sponsored by the University of Maryland Hospital, is an out-reach program similar to the "PATCH" program available to older adults with serious mental illness, throughout Baltimore City neighborhoods not covered through the

## **MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

“PATCH” program. In the year 2006, approximately 180 persons were served under this program.

“Harbel” -psychogeriatric out-reach, out-patient mental health program offers services to older adults with mental illness in the Harford/Belair Road catchment area of Baltimore City.

- Baltimore County:  
“Peers” program, peer support for older adults with mental illness, served 65 persons in 2006. Services include “face-to-face” visits and telephone support.
- Garrett County:  
“OATS” Program (Older Adult Transition Service) provides outreach services, counseling services, information and referral services to persons transitioning from adult to older adult status. Approximately 90 persons were served in the year 2006.  
  
“Partnership for Optimal Aging” -inter-agency committee on aging and health planning that includes representatives of key agencies in the county which serve older adults with mental illness.
- Washington County:  
“Case Management Program” for older adults, served approximately 86 persons during the year 2006.
- Worcester County:  
“Maryland Access Point-” single point of entry program available to all older adults in the county which provides information, referral and access to all county-wide services. It is jointly sponsored with the local Area on Aging.

The State-wide PASRR Program (Pre-Admission Screening/Resident Review Program) is a federally mandated pre-admission screening process for nursing home candidates who are diagnosed with major mental illness and whose symptoms required in-patient psychiatric hospital services within the last two years. The law requires that these individuals are evaluated by an independent review team to ascertain that medical necessity criteria for Nursing Facility placement is present, and that the individual’s continued psychiatric needs can be adequately met outside of an in-patient setting, and that the Nursing Facility is the least-restrictive, most appropriate program to address the individual’s medical needs.

Since the inception of the Pre-Admission Screening/Resident Review (PASRR) program in the 1980’s, Maryland continues to see a decrease in the numbers of Level II evaluations submitted to the MHA for review and signature. This is due, in part, to a process that allows for potential PASRR candidates to be evaluated for appropriateness of admission to less restrictive settings at the time of referral for a Level II screen. Additionally, quarterly trainings are provided to nursing facility staff and hospital staff by the PASRR reviewers regarding the criteria necessary for a person to require a Level II evaluation. Intense efforts are made to divert persons from nursing home placement and toward alternative settings.

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There is no data regarding the number of persons who are diverted from requiring Level II evaluations.

MHA maintains a yearly information base for PASRR candidates regarding dispositions. For calendar year 2006, a total of 584 Level II PASRR evaluations were completed and reviewed by the MHA. Of that number, 20 persons were found to not meet the criteria for Level II screens and were therefore, exempted from continuation of the process, and 3 records remained incomplete in that additional information requested to continue the process was not produced. Statistics for calendar year 2006 show that approximately 108 persons required from 2-6 PASRR evaluations, while 476 persons received only 1 PASRR evaluation for the year. Of the remaining persons evaluated, 419 were persons over the age of 55, with 334 persons who met the definition for eligibility for nursing facility services found in Maryland COMAR 10.09.11 "Nursing Facility Services" regulation and the Federal PASRR regulations. 53 persons over the age of 55 were identified as meeting medical necessity criteria for short-term nursing facility admission. Some of these persons were diverted to Medicaid waivers for community alternatives. The remaining persons over age 55 were found to not meet medical necessity criteria and were recommended for community placement. One hundred and sixty-five (165) persons under the age of 55 were also evaluated. Of this number, 112 persons were found to meet medical necessity criteria for long-term care in a nursing facility, and 32 persons were found to meet medical necessity criteria for short-term placement. The remaining persons were recommended for community placement. [NFC]

During FY 2007, the MHA sponsored a state-wide conference on mental health and aging which was video cast live to groups in four regions in Maryland, providing an opportunity for key stake holders throughout the state to participate. The audience included representatives from state and local agencies that serve older adults in the general population and older adults with mental illness. The keynote speaker, Dr. Stephen Bartels, Director of the Dartmouth Psychiatric Research Center, addressed "Evidenced Based Practice in Geriatrics" as well as an update on the development of the emerging tool-kit on geriatric mental health. In addition, Dr. Bartels delivered an address on his research on "Integrating Somatic and Psychiatric Treatment." Approximately 100 persons participated statewide. Following the conference, Dr. Bartels consulted with senior staff of the Mental Hygiene Administration and staff of the Maryland Transformation Grant Team, in addition to key stakeholders from the Maryland Department on Aging, the Maryland Mental Health Association, and representatives from various advocacy groups regarding older adult issues.

In FY 2008 training will continue to focus on workforce development in the field of geriatric mental health, and the integration of somatic and psychiatric treatment through the provision of regional cross-trainings for key players in the State Public Mental Health System and in other agencies that serve the same populations by identifying procedures to enhance the ability to navigate the medical and psychiatric systems in order to access appropriate supports for consumers aging in place and older adult consumers. These training strategies reflect goals prioritized by the NASMHPD Commissioners. During FY 2008, MHA plans to conduct a survey regarding the complexity and extent of somatic conditions facing consumers residing in psychiatric residential treatment programs within the Public Mental Health System. Results from these surveys will be incorporated into these trainings. [NFC 5]

## **MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

In addition, MHA representatives participate on committees concerned with aging issues. The Mental Health Association of Maryland's "Coalition on Mental Health and Aging" which is a group of specialists and advocates who represent the fields of aging and mental health. The Coalition's meetings are a vehicle to share information from the local, state and national levels regarding policies, procedures, regulations, and legislation that affect older adults. The Coalition on Mental Health and Aging has produced a resource guide titled: *Mental Health in Later Life: A Guidebook for Older Marylanders and the People Who Care for Them*. MHA's Coordinator of Services to Older Adults continues to work closely with the National Association of State Mental Health Program Directors' (NASMHPD's) Older Persons Division by participating in the monthly conference calls, through volunteering on various committees, and through attending the division's annual 2007 meeting held in Indianapolis.

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### **SFY 2008 OBJECTIVES FOR CRITERION 4:**

#### **SERVICES FOR ADULTS**

- Utilize Projects for Assistance in Transition from Homelessness (PATH) funds to develop innovative services that support state transformation goals; continue to apply for federal support to enhance services; provide technical assistance to CSAs to support statewide provision of services for homeless individuals. **[NFC 3]**  
MHA Monitor: Marian Bland, Office of Special Needs Populations
- Provide formal training and technical assistance for case managers and other mental health professionals who refer homeless consumers to Housing and Urban Development (HUD) funded Supportive Housing Programs, i.e. Shelter Plus Care Housing. **[NFC3]**  
MHA Monitor: Marian Bland, Office of Special Needs Populations
- Provide training for the Projects for Assistance in Transition from Homelessness (PATH) homeless services providers to increase current knowledge of emerging best practices including Supplemental Security Income (SSI) outreach. **[NFC 3]**  
MHA Monitor: Marian Bland, Office of Special Needs Population
- Develop best practices for improving integration of somatic and psychiatric treatment and service needs for individuals in residential rehabilitation programs (RRPs) with complex medical needs or who are older adults. **[NFC 4]**  
MHA Monitor: Lissa Abrams and Marge Mulcare, Office of Adult Services
- Develop guidelines and explore potential financing for use of telemedicine within the PMHS for direct services, consultation, and education. **[NFC 3]**  
MHA Monitor: Lissa Abrams, MHA Office of Adult Services

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### **ADULT & CHILD PLAN**

#### **CRITERION #5: Management Systems**

**This Criterion applies to both adult and children and adolescents. It is not duplicated in the Child Plan section.**

**Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.**

#### **FUNDING FOR MENTAL HEALTH SERVICES**

The MHA budget currently contains funding (federal Medical Assistance and State general funds) for specialty (or non-primary) mental health services. This includes funding for services traditionally offered by the PMHS such as outpatient clinics and psychiatric rehabilitation, as well as inpatient psychiatric hospitalization, residential treatment center placement, services rendered by individual practitioners, mental health-related Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services, and mental health related laboratory services. Funding for the pharmacy benefit was formally transferred back to the Medical Assistance budget in FY 2001. This change promotes better coordination of care by utilizing the same pharmacy benefits manager for all prescription drugs. [NFC 4]

In FY 2008 a total of \$897.7 million has been appropriated for the MHA. Of this amount, \$609.2 million (\$497.1 million MA service funds) is for community services, \$281.3 million for State-operated institutions, and \$7.2 million for program administration. Federal grants including this block grant, PATH, Shelter Plus Care, emergency response capacity, Data Infrastructure Grant (DIG), and other CMHS and CMS grants account for \$15.4 million in federal funds. Sixty-eight percent (68% ) of the FY 2008 funds are targeted for community services. In addition, several local jurisdictions contribute mental health funding, which is not included in these budget numbers.

With the closure of Crownsville Hospital Center, there are now six State-operated psychiatric hospitals that provide acute, intermediate, and long-term care for adults. Two of these facilities have inpatient units for adolescents, and one offers services for individuals who are deaf. In addition, MHA operates one psychiatric forensic facility and three residential treatment facilities for youth. The Administration also collaborates with the Maryland Psychiatric Research Center, which is operated by the University of Maryland and is located on the grounds of a major State hospital. This facility coordinates with State facilities and community hospitals to provide innovative research in new medications and treatments for individuals whose mental health symptoms have not been relieved by traditional medication regimens. The Center also conducts physiological research regarding schizophrenia and other psychoses. [NFC 5]

Vendors are reimbursed for pre-authorized services using a fee-for-service system based on a mental health benefits package. This package is the same for MA 1115 Waiver Medicaid recipients, for non-waiver Medicaid eligible recipients, and for those individuals

## MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008

who, because of the severity of their illness and their financial need, qualify for State subsidized services.

Eligibility requirements for uninsured/MA ineligible individuals to qualify for State subsidized services in the fee-for-service system include uninsured consumers that have received services in the prior two years. Individuals discharged from psychiatric facilities or released from incarceration within the prior three months, on conditional release from a State hospital, who receive SSDI due to psychiatric impairment, or who are homeless do not have to meet these eligibility requirements. In addition, individuals presenting with an urgent need may obtain services upon approval of the appropriate CSA. In FY 2007 many previously uninsured individuals were enrolled in the Primary Adult Care waiver and now have Medical Assistance coverage for most mental health care (excluding hospital emergency, inpatient and outpatient hospital-based services).

In addition, MHA continues to contract directly with CSAs to support those programs that provide specialized services that are either not included in the standard benefit package or do not lend themselves to payment through the fee-for-service system. This amount is approximately \$30 million in State general funds.

In the past, MHA expenditures have exceeded its appropriations. MHA received an FY 2003 deficit appropriation of \$30 million and an additional \$36 million in its FY 2004 budget. Several cost containment measures were instituted in FY 2003 and continued in FY 2004. These included increased utilization review and management of service authorization, intensified efforts to retract paid claims that proved to be ineligible for one reason or another, and increased auditing of provider billing. However, these measures alone were insufficient to control expenditures. Legislative budget language in 2004 required MHA to control its expenditures within its appropriation by the end of FY 2005. Examination of the data clearly showed more than a 50% growth on spending for rehabilitation services over the past four years. The number of people served increased and the cost per person increased as well. Medical necessity criteria for child and adolescent PRP services were revised and authorization and utilization management activity was heightened for both MA reimbursed and State only funded PRP services. Working with stakeholders, MHA developed a plan to help contain costs, targeting residential and psychiatric rehabilitation programs. Reimbursement for PRP and RRP services changed, effective February 1, 2004, to a monthly rate, rather than reimbursement for each visit/service. The monthly rate was designed to allow flexibility (both in service time and frequency of visits) to enable providers to provide services based on the needs of individuals while reducing overall costs. This financing methodology included conversion of some services funded with State general funds to Medicaid reimbursed services. Other changes, as of February 1, 2004, included some changes in outpatient mental health rates and availability of certain codes. **[NFC 1]**

With continuing vigilance throughout FY 2004 and FY 2005, MHA was able to meet the legislative mandate to control expenditures. This was accomplished during a year of transition to a new ASO, while consumers continued to receive services and providers were paid in a timely fashion. Costs for FY 2005 and FY 2006 were significantly lower than prior years and MHA's expenditures were within its appropriations. MHA's FY 2008 appropriation showed an increase of \$33 million over FY 2007 for community services. This increased appropriation included funds for a provider rate increase, utilization increase, and an increase in the number of people being served. There is a projected structural deficit by

## **MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

FY 2009. The state is taking steps in FY 2008 to reduce commitments; as yet the extent of reductions in the MHA budget is not known.

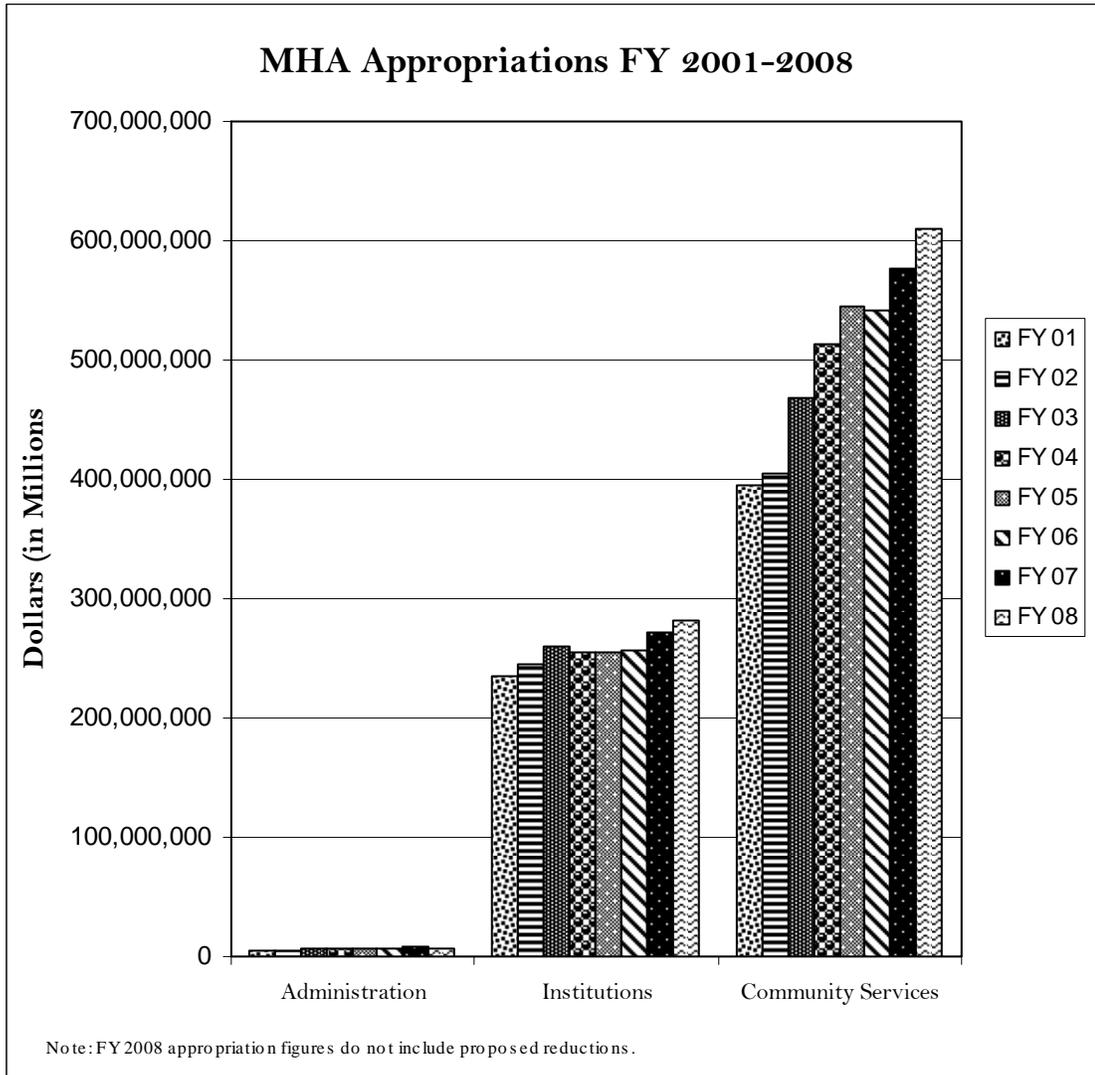
### **FINANCIAL DATA**

The MHA has contracted with MAPS-MD (APS Healthcare) to assist in the operation of the PMHS. MAPS-MD authorizes services based on medical necessity, processes claims payments, and provides management information services. Data are provided to the MHA, local CSAs, service providers, and the Maryland Medical Assistance program.

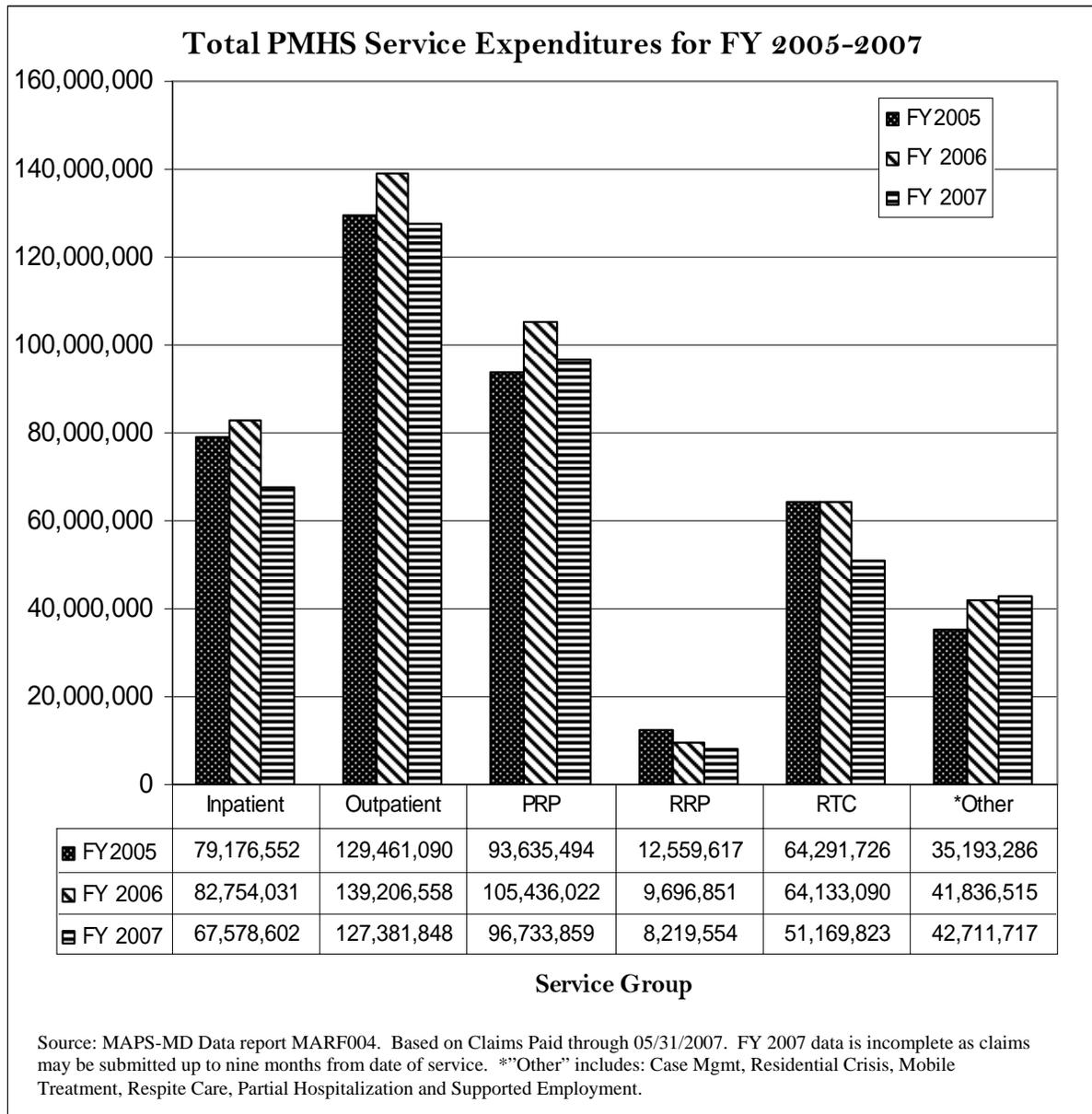
Data available from MAPS-MD are the source for the community-based fee-for-service information. Data sets are not routinely compiled for those non-fee-for-service services that are funded through contracts. Other unavailable data are statistics on services provided to Medicare-only recipients and on Medicare-only reimbursed services. Medicare-eligible services are not subject to authorization and are processed through a federal intermediary, not through MAPS-MD. Information on individuals that are both Medicare and Medicaid eligible was previously captured by the PMHS. Beginning July 1, 2003, claims for individuals who are qualified for federally matched MA and have Medicare began to be processed by Medical Assistance and the data are no longer in the ASO data system.

The MHA relies on the data from MAPS-MD to monitor the expenditures and federal Medicaid attainments of the PMHS. MHA further analyzes the data for trends in service delivery and/or spending. This information is used to develop strategies for managing the budget, amending current MHA policies as needed, development/implementation of new services, and correcting any problems that may be identified. In addition, the information is used to prepare budgets and budget presentations; to track the number of services and expenditures by consumer age, diagnostic and eligibility categories; and to set rates in subsequent years.

**MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

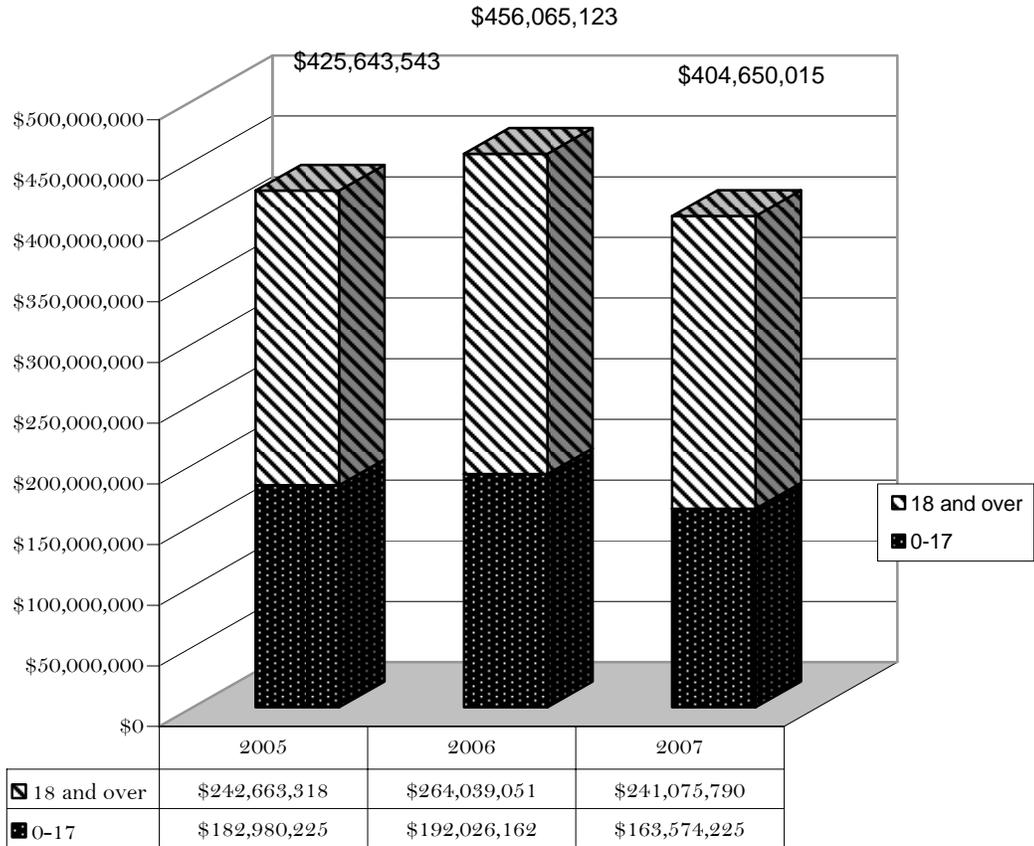


**MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**



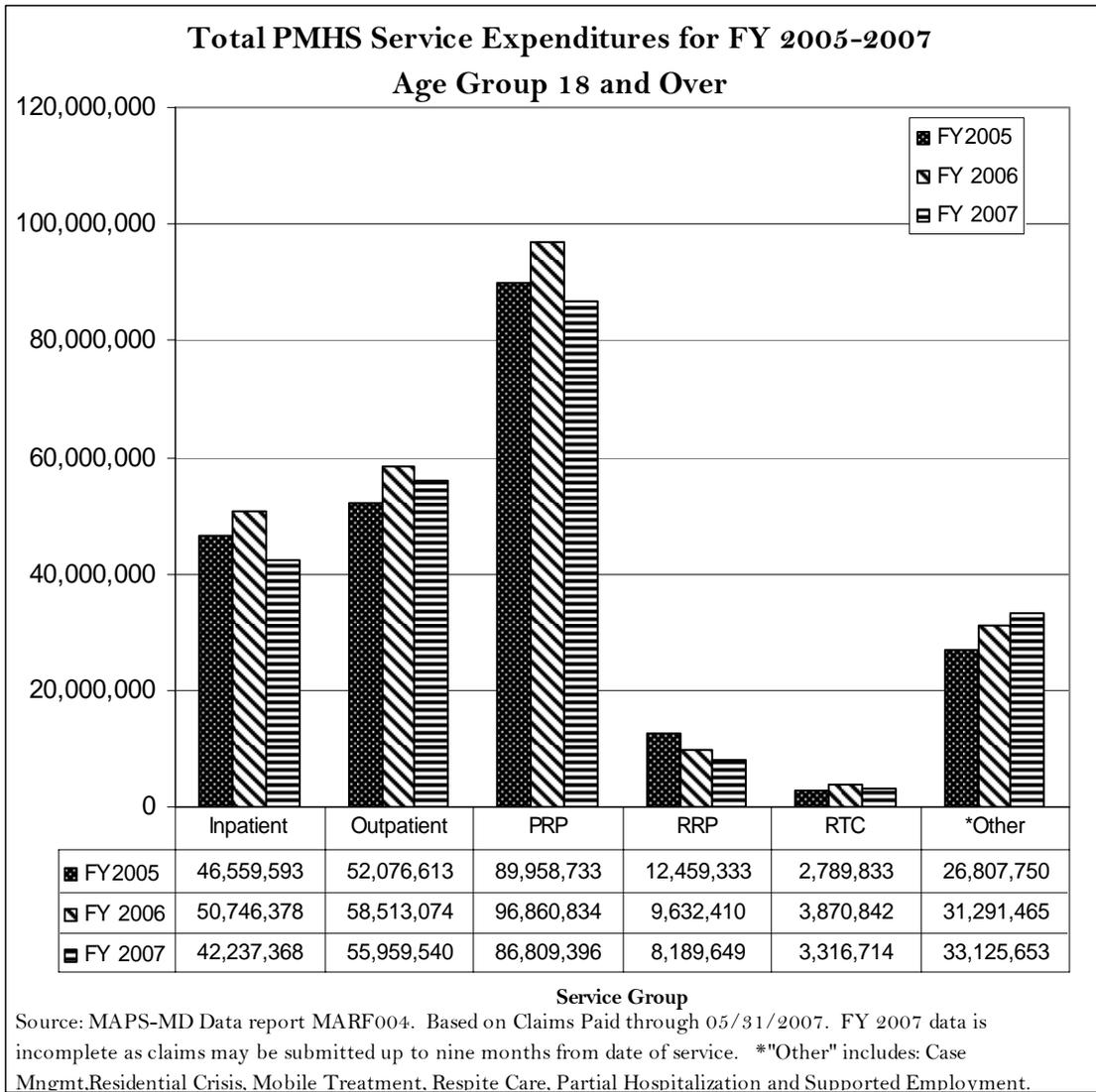
**MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

**Total PMHS Service Expenditures for FY 2005-2007  
by Age Group**

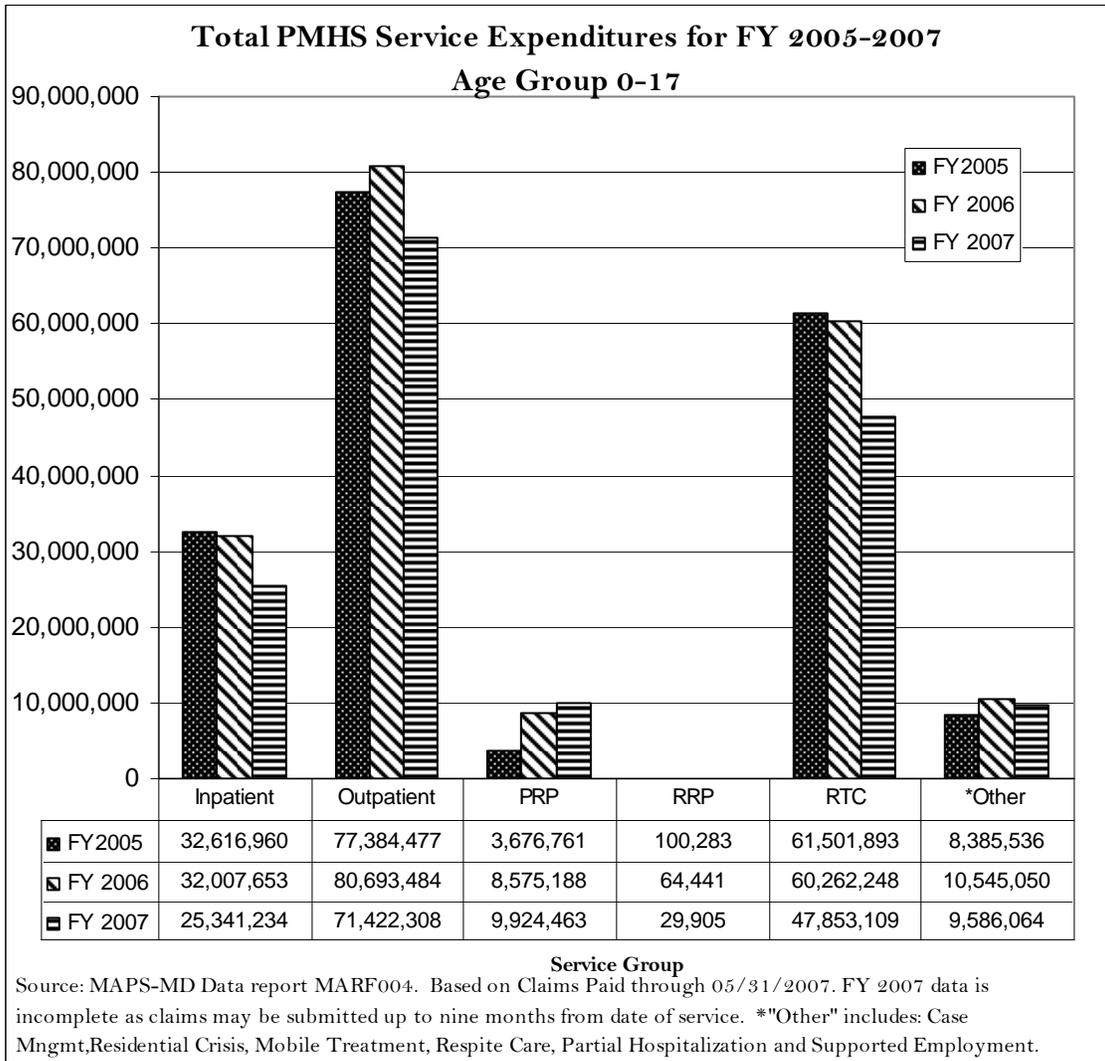


Source: MAPS-MD Data report MARF004. Based on Claims Paid through 05/31/2007. FY 2007 data is incomplete as claims may be submitted up to nine months from data of service.

**MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**



**MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**



**MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

**Total Expenditure By County for FY 2005 - 2007**

<b>County</b>	<b>FY 2005</b>	<b>FY 2006</b>	<b>FY 2007</b>
ALLEGANY	\$6,483,566	\$6,936,812	\$6,617,951
ANNE ARUNDEL	\$24,673,039	\$25,018,066	\$23,369,542
BALTIMORE CITY	\$146,235,483	\$161,356,555	\$143,381,289
BALTIMORE COUNTY	\$62,075,851	\$68,471,517	\$62,163,440
CALVERT	\$3,140,087	\$3,557,776	\$3,929,280
CARROLL	\$8,343,075	\$9,319,090	\$7,913,576
CECIL	\$7,754,315	\$8,308,704	\$7,350,868
CHARLES	\$5,770,936	\$5,647,546	\$4,430,359
FREDERICK	\$15,122,338	\$15,292,402	\$13,250,759
GARRETT	\$2,516,198	\$2,985,944	\$3,180,512
HARFORD	\$12,790,656	\$14,544,742	\$11,578,023
HOWARD	\$8,991,281	\$9,164,904	\$8,217,341
*MIDSHORE	\$15,329,972	\$15,184,277	\$13,212,675
MONTGOMERY	\$35,150,484	\$38,855,049	\$32,742,502
PRINCE GEORGES	\$40,498,799	\$38,606,586	\$35,762,378
SOMERSET	\$3,820,278	\$3,152,446	\$2,653,406
ST. MARY	\$4,746,886	\$5,468,909	\$4,606,871
WASHINGTON	\$9,250,617	\$10,098,809	\$9,008,142
WICOMICO	\$8,454,363	\$9,343,115	\$8,202,119
WORCESTER	\$2,982,351	\$2,858,482	\$2,693,391
OUT OF STATE			
<b>Total</b>	<b>\$424,130,575</b>	<b>\$454,171,731</b>	<b>\$404,264,424</b>

\*Midshore includes: Caroline, Dorchester, Kent, Queen Anne, and Talbot counties.

Source: MAPS-MD Data report MARF004

Based on Claims Data Through 05/31/2007

Note: FY 2007 data is incomplete as claims may be submitted up to nine months from date of service.

Includes dollars spent in Baltimore Capitation Services.

**MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

**Total Expenditure By County for FY 2005-2007  
for Age Group 18 and Over**

<b>County</b>	<b>FY 2005</b>	<b>FY 2006</b>	<b>FY 2007</b>
ALLEGANY	\$4,479,463	\$4,824,984	\$4,618,574
ANNE ARUNDEL	\$15,722,463	\$16,364,991	\$15,449,511
BALTIMORE CITY	\$82,148,739	\$91,109,063	\$85,590,306
BALTIMORE COUNTY	\$31,632,274	\$35,825,040	\$32,748,416
CALVERT	\$1,869,347	\$2,235,727	\$2,642,493
CARROLL	\$5,637,817	\$6,349,690	\$5,148,959
CECIL	\$3,904,128	\$3,710,784	\$3,564,561
CHARLES	\$2,854,479	\$2,967,967	\$2,650,238
FREDERICK	\$8,582,909	\$8,397,028	\$7,991,929
GARRETT	\$1,585,591	\$1,718,972	\$1,650,984
HARFORD	\$7,164,005	\$8,186,322	\$7,207,599
HOWARD	\$6,204,347	\$6,308,388	\$5,781,263
*MIDSHORE	\$9,098,664	\$7,059,490	\$6,430,063
MONTGOMERY	\$22,735,093	\$25,378,558	\$21,342,078
PRINCE GEORGES	\$24,595,947	\$25,660,640	\$22,947,930
SOMERSET	\$1,173,608	\$1,244,054	\$949,331
ST. MARY	\$3,097,153	\$3,718,218	\$3,189,734
WASHINGTON	\$4,685,181	\$5,005,001	\$4,422,359
WICOMICO	\$5,081,723	\$5,524,799	\$4,905,458
WORCESTER	\$1,460,308	\$1,461,611	\$1,270,675
<b>Total</b>	<b>\$243,713,239</b>	<b>\$263,051,327</b>	<b>\$240,502,461</b>

\*Midshore includes: Caroline, Dorchester, Kent, Queen Anne, and Talbot counties.

Source: MAPS-MD Data report MARF004

Based on Claims Data Through

05/31/2007

Note: FY 2007 is incomplete as claims may be submitted up to nine months from date of service.

Includes dollars spent in Baltimore Capitation Services.

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**Total Expenditure By County for FY 2005 -2007  
for Age Group Under 18**

<b>County</b>	<b>FY 2005</b>	<b>FY 2006</b>	<b>FY 2007</b>
ALLEGANY	\$2,004,103	\$2,111,828	\$1,999,377
ANNE ARUNDEL	\$8,950,576	\$8,653,075	\$7,920,031
BALTIMORE CITY	\$64,086,744	\$70,247,492	\$57,790,983
BALTIMORE COUNTY	\$30,443,577	\$32,646,477	\$29,415,024
CALVERT	\$1,270,740	\$1,322,049	\$1,286,787
CARROLL	\$2,705,258	\$2,969,400	\$2,764,617
CECIL	\$3,850,187	\$4,597,920	\$3,786,307
CHARLES	\$2,916,457	\$2,679,579	\$1,780,121
FREDERICK	\$6,539,429	\$6,895,374	\$5,258,830
GARRETT	\$930,607	\$1,266,972	\$1,529,528
HARFORD	\$5,626,651	\$6,358,420	\$4,370,424
HOWARD	\$2,786,934	\$2,856,516	\$2,436,078
*MIDSHORE	\$6,231,308	\$8,124,787	\$6,782,612
MONTGOMERY	\$12,415,391	\$13,476,491	\$11,400,425
PRINCE GEORGES	\$15,902,852	\$12,945,946	\$12,814,448
SOMERSET	\$2,646,670	\$1,908,392	\$1,704,075
ST. MARY	\$1,649,733	\$1,750,691	\$1,417,137
WASHINGTON	\$4,565,436	\$5,093,808	\$4,585,783
WICOMICO	\$3,372,640	\$3,818,316	\$3,296,661
WORCESTER	\$1,522,043	\$1,396,871	\$1,422,716
<b>Total</b>	<b>\$180,417,336</b>	<b>\$191,120,404</b>	<b>\$163,761,964</b>

\*Midshore includes: Caroline, Dorchester, Kent, Queen Anne, and Talbot counties.

Source: MAPS-MD Data report MARF004

Based on Claims Data Through

05/31/2007

Note: FY 2007 data is incomplete as claims may be submitted up to nine months from date of service.

Includes dollars spent in Baltimore Capitation Services.

**EVALUATION SERVICES**

MHA's most significant evaluation initiative in FY 2007 was full-scale implementation of an Outcomes Measurement System (OMS). MHA, in collaboration with the University of Maryland's Systems Evaluation Center (SEC) and ASO, instituted the OMS statewide for individuals ages six to sixty-five who are receiving outpatient mental health services in Outpatient Mental Health Clinics (OMHCs), Federally Qualified Health Centers (FQHC's), and hospital-based outpatient mental health clinics. The five outcome domains that are being implemented for adults are psychiatric signs and symptoms and symptom distress; functioning, including employment; living situation; criminal justice system/legal involvement; and alcohol and substance use. The six outcome domains that are being implemented for children, adolescents, and their caregivers are psychiatric signs and symptoms and symptom distress; functioning, including school performance and employment; living situation; social connectedness of the caregiver; juvenile justice system/legal involvement; and alcohol and substance use. Now that initial OMS data are available, the next phase will include developing a structure for outcomes reporting. [NFC 5]

Another significant evaluation project in FY 2007 was to finalize the proposal for implementation of a Consumer Quality Team (CQT) initiative in Maryland through the Maryland Mental Health Association, including the CQT's role in the continuum of other evaluation, compliance, and consumer activities. Activities for FY 2007 included finalizing decisions regarding target programs in the three pilot jurisdictions, developing interview protocols (e.g., questions and format of consumer interviews), developing a staffing model, hiring consumer/family member interviewers, developing and implementing staff training, conducting initial announced visits to all target community-based programs, and developing and implementing a monthly feedback loop for the information that is gathered during the interviews. An FY 2007 annual report, which will describe the visits that were conducted and the issues that were identified, will be written by the CQT in the first quarter of FY 2008. [NFC2]

In addition to the two major initiatives described above, MHA, through its contract with the ASO, continues to conduct annual consumer surveys. As with previous survey efforts, the survey tools were based on the most recent versions of the Mental Health Statistics Improvement Project (MHSIP) consumer survey tools for both adults and children and adolescents and their families. Analyses of the results of the telephone surveys of consumers' satisfaction with and outcomes from PMHS services were completed (surveys were administered in spring 2006 with individuals who received outpatient mental health services in 2005). An Executive Summary Report and tri-fold pamphlets detailing the results of the survey were prepared and widely disseminated. In order to continue to comply with annual federal URS requirements, the consumer surveys were conducted again in the fourth quarter of FY 2007. Through this most recent survey, Maryland has continued to incorporate the new federal reporting requirements for functioning, social connectedness, criminal/juvenile justice involvement, and school performance (i.e., attendance and suspensions/expulsions). Analyses of the current survey results will be completed in FY 2008, and reports and tri-fold brochures will be generated and distributed.

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Finally, MHA continued to contract during FY 2007, with the Systems Evaluation Center (SEC) within the University of Maryland, School of Medicine, Department of Psychiatry, Center for Mental Health Services Research, and Mental Health Systems Improvement Collaborative (MHSIC) for a variety of PMHS evaluation projects and activities. This Center is funded through this block grant. The SEC, now in its sixth year of operation, began its work in August 2001 (FY 2002), and is one of three centers within the MHSIC. The others are the Training Center and the Evidence-Based Practice (EBP) Center. The SEC was created to increase MHA's capacity for a methodical and systematic approach to measuring PMHS performance. Overall goals of the SEC are to design systems/program evaluation questions, methods, and studies; analyze existing data; identify cost-effective practices with positive outcomes for consumers; and develop realistic performance measures and indicators for the PMHS and programs. In doing so, MHA obtains information that greatly enhances its ability to plan, manage, monitor, and evaluate PMHS efficiency and effectiveness. [NFC 5]

Highlights of SEC projects and activities during FY 2007 included:

- participating in the process for Statewide implementation of the OMS, including finalizing OMS instruments, assisting in the clarification of scoring and programming issues related to the instruments, assisting in the on-line testing of the new system, developing training materials and an interview guide, and participating in provider training sessions;
- participating in ongoing OMS monitoring meetings, including planning for analysis of the Statewide data and reporting of the data;
- participating in the implementation of the Mental Health Transformation State Incentive Grant (MHT SIG), including assuming the primary role in the completion of the Resource Inventory and Needs Assessment, attending and participating in a variety of meetings and conference calls related to the grant, developing evaluation materials for stakeholder meetings, developing an overview of an evaluation plan for the entire MHT SIG process, and preparing summaries of the year's evaluation activities for inclusion in the SAMHSA reapplication submission;
- continuing to participate in the evaluation component of a SAMHSA-funded State project on implementation of the Assertive Community Treatment (ACT) EBP, including program monitoring and outcome data collection activities, as well as training and providing technical assistance to a consumer advocacy organization that is conducting consumer satisfaction interviews;
- continuing to implement the Data Infrastructure Project (DIP)/PMHS Data Analysis Project, including assisting MHA to complete all basic and developmental Uniform Reporting System (URS) tables; refining the data repository and integrating eligibility, authorization, OMS, provider, and pharmacy data into that repository; providing analyses for NOMS submissions that are required as part of the FY 2008 FBG application; and supporting efforts to continue the administration of the PHQ-8 for inclusion in the 2007 BRFSS in Maryland;
- continuing activities related to the Cultural Competence survey project, including data analysis, report writing, and presentation of findings to MHA administrators and the Cultural Competency Advisory Committee (CCAC);
- participating in an oversight workgroup that is responsible for providing guidance to the implementation of the CQT initiative, including assisting in the development of an evaluation plan for that project; and

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- Conducting a survey to assess workforce issues related to the implementation of the EBP in Supported Employment (SE), in particular the perceived impact of SE on staff satisfaction and retention.

During FY 2008, the SEC will be involved with the following evaluation projects and activities:

- Outcomes Management System (OMS) Statewide Implementation, Monitoring, and Data Analysis – continuing to collaborate with MHA and the ASO to identify analyses and report formats for OMS Statewide data, conducting focus groups with consumers and clinicians as a “process evaluation,” developing analysis protocols and reporting formats for OMS outcomes data, creating a Web-based training program for providers, re-reviewing the full OMS plan as developed by the OMS Steering Committee and identifying plans for revising as needed, and producing final OMS Adult Pilot Phase reports.
- Mental Health Transformation State Infrastructure Grant (MHT SIG) – continuing to participate in MHT SIG activities, including revising and implementing the evaluation plan including both local and national evaluation activities; collaborating with transformation leadership and the MHT SIG team to identify specific strategies in the Comprehensive Mental Health Plan (CMHP) to be evaluated; participating in national evaluation activities; forming a “Consultant Panel” composed of consumers, family members, providers, and other stakeholders who will provide feedback and guidance to the evaluation team; conducting evaluation activities specifically to assess the effects of leadership transitions on transformation; and continuing to provide formative evaluation feedback to the MHT SIG team regarding stakeholder participation. [NFC 2]
- Evidence-Based Practice (EBP) Implementation Evaluation – continuing to collaborate with the EBP Center and MHA to develop methodologies for monitoring and evaluating evidence-based practices as they are implemented more broadly throughout the State; continuing to conduct evaluation activities specific to the Assertive Community Treatment (ACT) EBP grant, including finishing the collection of consent and contact information for the consumer satisfaction methodology, collecting consumer satisfaction survey data, collecting the final round of consumer outcomes data; and participating in planning meetings and activities related to implementation of an EBP for co-occurring disorders treatment.
- Data Infrastructure Project (DIP)/PMHS Data Analysis Project – continuing to collaborate with MHA regarding its strategies and objectives related to the analysis and presentation of PMHS data; continuing to respond to specific data analysis requests; initiating analyses of PMHS population dynamics; continuing training activities regarding data utilization; analyzing DSM IV-TR Axis 3 (Somatic Conditions) data from PMHS authorization data and Medicaid data; and planning BRFSS, financing, and morbidity/mortality training for PMHS stakeholders.
- Cultural Competence Survey Project – completing data analysis, conducting another presentation to MHA’s Cultural Competency Advisory Committee (CCAC), preparing final reports, and conducting a study of the validity of the instrument.
- Consumer Quality Team (CQT) Initiative – continuing to participate in the CQT oversight workgroup with an emphasis on consultation regarding evaluation of the initiative and conducting interviews with CQT interviewers.

## **AVAILABILITY OF HUMAN RESOURCES**

MHA recognizes that well-trained staff is a critical component of providing mental health services. Currently, there are 134 outpatient mental health programs and 142 psychiatric rehabilitation programs, many in multiple locations. In FY 2006, there were 3,287 State hospital and residential treatment center full-time equivalent employees and 88 employees in MHA headquarters. In FY 2007, there were 3,287 budgeted positions in the facilities and 88 in Headquarters.

## **WORKFORCE DEVELOPMENT**

Training continues to be a priority and primary responsibility of MHA, directly and indirectly through a collaborative agreement with the University of Maryland Mental Health Systems Improvement Collaborative (MHSIC) Training Center. During the past year, training continued over systems issues, services to specific age and special needs populations and to support the implementation of a variety of initiatives (e.g. early childhood interventions, older adult issues, TAY services, trauma sensitive care, etc.). Training was presented in large group settings, in focus groups, and through teleconferences targeted at specific populations or providers. MHA's annual conference, held in May 2007, focused on "The Behavioral Health Workforce: Working Together to Promote Recovery". The first keynote presentation, "The National Plan for Behavioral Health Workforce Development: Implications for Maryland", was presented by John Morris, MSW, Executive Director of the Annapolis Coalition on the Behavioral Health Workforce. The second keynote, "Person Centered Planning: From Concept to Practice", was presented by Janis Tandora, Psy. D., Assistant Clinical Professor at the Yale University School of Medicine, and Kevin Johnson, a Peer Recovery Mentor from the Yale Program for Recovery and Community Health. Twenty workshops focused on different aspects of the behavioral health workforce. [NFC 5]

MHA has a unique relationship with the University of Maryland, Division of Mental Health Services Research, headed by Howard Goldman, M.D., Ph.D. Since the 1990's, the University has been providing technical assistance and training on systems development for MHA and the PMHS. In 2002, this partnership was expanded to assist MHA in its efforts to disseminate and ensure that excellent mental health care was being implemented and that evaluative research into the effectiveness of mental health care delivered could be meaningfully assessed through measurable outcomes. The Evidence-Based Practice Center (EBPC) and Systems Evaluation Center (SEC) were established, joining the pre-existing Training Center to form the Mental Health Systems Improvement Collaborative (MHSIC).

Through the block grant, MHA funds the EBPC and the SEC at the MHSIC. The EBPC continues to implement family psychoeducation, supported employment, and assertive community treatment in agencies throughout the State. MHA is promoting the evidence-based practice model of supported employment for implementation throughout all of the mental health vocational programs, and in 2006 piloted a new mechanism for training and implementation activities. Two sites which had previously been trained, and were maintaining high fidelity to the evidence-based practice of supported employment, were contracted by the EBPC to train additional sites around the state. Under the supervision of an expert at the EBPC, training of trainer activities were held, and they began working with

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three sites each. This model has been a very successful way of expanding the number of sites which can be trained, and was continued and expanded in 2007. This approach will be continued in FY 2008 to complete training/consultation to the sites involved.

In 2007 another new mechanism for training and implementation of evidence-based practices began; called The CLiP (Collaborative Learning/implementation Process), This method is being used to train additional supported employment programs that want to become EBP programs. The training involves five programs at a time, in a series of sessions that occurs over three months, all facilitated by the EBPC's supported employment consultant/trainer. During the first month an "Executive Round" is held, specifically designed for agency leadership and local Department of Rehabilitation Services (DORS) leadership. In the second month the "Treatment Team Round" is held, designed for all agency staff and the DORS counselors as well as mental health clinicians external to the agency who provide mental health services to SE program consumers. The third month is the "Technical Assistance Round", with the consultant/trainer conducting an on-site visit to each program to assist them with their individual implementation efforts. This includes looking at each of the fifteen items on the fidelity scales and identifying what steps the program needs to take to meet high fidelity. The first series of the CLiP began in October 2006; a second began in February, 2007. This mechanism for training will continue in FY 2008.

Additionally, in FY 2007, the EBPC and SEC staff continued with implementation and evaluation activities on Assertive Community Treatment (ACT), subsequent to MHA receiving a CMHS EBP Training and Evaluation grant in FY 2004. This grant, which is ending its final year, trained four existing mobile treatment programs and two new ACT teams in the practice. These teams adhere to the evidence-based practice model and are evaluated according to the Dartmouth Assertive Community Treatment Scale (DACTS) fidelity scales. As of FY 2008 two of these teams are now ready to serve as ACT Training Resource Programs and, under the supervision of the EBPC's ACT consultant/trainer, will begin training other programs on the ACT model of service delivery throughout the state. Additionally, under this grant, the partnership established with a statewide mental health consumer advocacy group continues. Through this partnership, consumers have been hired and trained, and are administering a survey to ACT clients to assess consumer satisfaction, including cultural competency. These evaluation activities will continue in FY 2008, concluding in September, 2007. [NFC 5]

MHA, in coordination with the Department of Child and Adolescent Psychiatry at the University of Maryland, received a SAMHSA grant in FY 2005 to reduce seclusion and restraint in the child-serving mental health facilities. A trainer for this grant was hired and is located and receives supervision at the MHSIC. Utilizing NASMHPD-prepared materials, the trainer continues to work with the child-serving mental health inpatient state facilities to address a culture change aimed at reducing and eventually eliminating seclusion and restraint. The Maryland-developed training manual S.T.A.R.T. (Systematic Training Approach for Refining Treatment) finalized in FY 2007, which emphasizes prevention, is now being used to train front-line staff at all five of these facilities. During FY 2008, the project director, a doctor ally prepared mental health nurse, will continue working 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 achieving facility-wide training, using the S.T.A.R.T. manual. [NFC 2]

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For a number of years MHA has sponsored a collaboration initiative with the University of Maryland and the Johns Hopkins schools of medicine and the Maryland Coalition of Families for Children's Mental Health called the Maryland Youth Practice Improvement Committee (MYPIC). This group has provided a forum for addressing research and practice issues of importance to the mental health of Maryland's children, youth and their families. In June 2007, this group was formalized as the Maryland Child and Adolescent Mental Health Institute (the Institute), with funding from the FBG. The goals of the Institute are to further evidence-based practice for children and adolescents in Maryland through research, practice and education. [NFC 5]

Training in Maryland is facilitated by strong public-academic partnerships. Executive staff at MHA and university leaders collaborate regularly on system and program development. Since the 1970's, the Maryland Plan, a program for training and recruitment of psychiatrists into the public sector has been in place between MHA and the University of Maryland School of Medicine. Other professional schools (nursing, social work, psychology, rehabilitation) at the university campuses have been involved as well. Additionally, a collaborative program for training of child psychiatrists is in place between MHA and Georgetown University. The University of Maryland and Johns Hopkins Department of Psychiatry and the Georgetown University are partners with MHA in the planning and development of child and adolescent services, providing regular technical assistance and consultation. [NFC 5]

MHA continues to co-chair with the Maryland State Department of Education (MSDE) the Maryland Mental Health Workforce Development Steering Committee which is developing strategies to increase the number and develop the competencies of the child and adolescent mental health workforce. Products under development are: 1) core competencies for child and adolescent mental health professionals; 2) pre-service curricula based on competencies developed; and, 3) a white paper on the importance of child and adolescent mental health workforce development. The core competencies will be shared with colleges and universities in Maryland to be integrated into pre-service and professional training programs.

The Early Childhood Mental Health Certificate Program will begin in September 2007 as a way to increase the number of providers with specialized training in the knowledge, skills and attitudes necessary to practice in the field of early childhood mental health. The program includes eight full-day sessions offered one day per month over the September to May time period plus readings and on-line activities with all activities required to be awarded the certificate. The first class of 40 participants is already fully subscribed. [NFC 3, 4, 5]

Additionally, Maryland has been selected by the Center on the Social Emotional Foundations for Early Learning (CSEFEL) to participate in a training and technical assistance project to foster the professional development of the early care and education workforce. The Maryland State Department of Education and the MHA are jointly sponsoring this project. The introduction to the project's conceptual model, the *Teaching Pyramid Model for Supporting Social and Emotional Competence* will be offered September 7, 2007. CSEFEL will work with Maryland to accomplish the following goals: convene a collaborative workgroup to develop policies that sustain the model; train trainers and coaches to build the

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capacity of the workforce and support local implementation; identify 3 to 4 local programs to service as demonstration sites; and, evaluate outcomes. [NFC 4, 5]

MHA also funds the Maxie Collier Scholars Program (MCSP) in which minority undergraduate students are provided with scholarships and mentoring to encourage them to pursue graduate education towards a career in mental health. The undergraduate disciplines participating include nursing, natural sciences (pre-med), psychology, and social work. During academic year 2006-2007, ten (10) students were enrolled as scholars in the MCSP. The program sponsors a mental health seminar entitled: "Emerging Issues in Mental Health and Well-being," which meets a general education requirement and it is open to all students. Other program elements include: internship in a mental health setting; access to a network of career placement resources; general academic advisement; individualized graduate school preparation and support plan for each scholar; and enrichment activities, i.e. mental health seminars, workshops, conferences. [NFC 3]

MHA, in collaboration with law enforcement agencies, offers training for officers, other public safety officials and community providers regarding the management of crises involving persons who appear to have a mental disorder and who may or may not have committed an offense. Training is provided through the MHA Office of Forensic Services, as well as by the local crisis response systems. Presentations include use of emergency petitions, approaching persons with mental disorders, the field interview of the person with a mental disorder, dealing with the suicidal individual, coverage of post traumatic stress disorder (PTSD) and treatment resources for active duty personnel and veterans. These presentations concentrate on the practical decisions that police officers have to make in the field, and are in plain, non-technical language. MHA will continue to participate in meetings with judges, State's attorneys, public defenders, and public safety officials regarding availability of mental health services for individuals with criminal justice involvement. Meetings focus on diversion, services for inmates with mental illness, and discharge planning for pre/post release inmates. Training for judges, state's attorneys, defense council, and local agencies will be provided on the new reporting requirements of the statute (Criminal Procedure Article, §§ 3-108) for individuals committed as Incompetent to Stand Trial.

In March 2005, then Governor Ehrlich issued an executive order stating that the National Incident Management System (NIMS) should be the state standard for incident management and that all state governmental agencies will adopt this system. MHA has developed an All Hazards Disaster Plan that includes the development of state and local infrastructure, communications systems, interagency coordination, and enhanced crisis response. A drill was held in April 2006 to test the effectiveness of the plans. In collaboration with ADA and the Bureau of Governmental Research (BGR), MHA has developed an automated tracking system called the Hotline Online Tracking System (HOTS). This tracking system is being used by the statewide crisis hotlines and allows for the collection of data to track trends in calls. In times of crisis/emergency, the HOTS system has the capacity to broadcast messages to all of the hotlines so that callers may receive the appropriate information. MHA continues to work closely with DHMH's Professional Volunteer Corps Coordinator to recruit and train licensed behavioral health professionals for a Statewide Behavioral Health Volunteer Corps. In addition, MHA provides workshops for all the Professional Volunteer Corps volunteers on disaster stress management and crisis counseling in the event of a crisis/disaster. Over 1,500 volunteers have been trained. Fifteen mental health professionals from the Volunteer Corps were deployed to New Orleans to

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assist with the recovery from Hurricane Katrina. The mental health volunteers were deployed through a partnership between DHMH, the Maryland Defense Force and the American Red Cross. In order to reduce responder stress, MHA instituted check-in calls for all 165 DHMH volunteers who were deployed to the Gulf Coast area so they could discuss their feelings related to their response. Over twenty mental health volunteers were given forms with questions to ask, referral information and data logs. Behavioral Health volunteers, who had not been deployed, instituted these calls. Additionally MHA crisis hotlines provided crisis intervention, information and referral for Katrina related calls. [NFC 1] [NFC 6]

In September, 2005, MHA hired a Director of Behavioral Health Disaster Services (BHDS). On October 1, 2007, MHA hired an Assistant Director of Behavioral Health Disaster services. The purpose of these positions is to provide facilitation, support and technical assistance to enhance Maryland's ability to respond to the behavioral health needs that arise in the event of natural or man-made crises/disasters as well as enhance MHA and ADAA's planning and preparedness. The Director and Assistant Director have reviewed and are revising MHA and ADAA's All-Hazards Disaster plans to ensure collaboration and consistency in these plans. All-Hazards Plans are also being compiled, reviewed and revised for all Core Service Agencies (CSAs) in the State. The Director and Assistant Director are providing CSAs with a template to design and conduct drills of their All-Hazards Plans. Both MHA and ADAA's Plans have been drilled once, with plans to continue these drills twice per year. NIMS trainings have been conducted for MHA and ADAA Incident Command staff. In addition, CISM and NIMS trainings are being provided to Maryland's CSAs. These positions will continue to work with MHA and ADAA management to insure that all staff trained in the NIMS model.

MHA also supports training through its CSAs. Local/regional trainings are provided dependent on local needs. Consumer, family, and advocacy groups receive funding to provide community education and training targeting adult consumers, minorities, family members, children's mental health, and stigma issues.

The following list includes training and technical assistance activities that have been approved by MHA, which will be coordinated through the University of Maryland Training Center in FY 2008. Training events include projects for children and adolescents, adults and elderly consumers, as well as a multitude of special populations. [NFC 1] [NFC 5]

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### **DESCRIPTION OF MHA FY 2008 TRAINING**

1. Annual MHA conference. This 2 day event brings together stakeholders from the Public Mental Health System (PMHS) to address issues related to the direction of the system and the delivery of mental health services in Maryland. Projected attendance: 450-500
2. CSA Training/Technical Assistance: Provides for training related to system management including such topics as planning, mental health finance systems, service development, consumer relations, emerging populations, Evidence-Based Practices, etc. Training and technical assistance is targeted to relevant CSA, MHA and ASO staff. Projected attendance: 3 training activities @ 100 per activity = 300 + technical assistance to individual CSA's as requested.
3. Interpreters: Provides funding for interpreter services at training events, to ensure ADA compliance.
4. The Training Center: Continuation of the relationship with the Department of Psychiatry at the University of Maryland School of Medicine to coordinate planning, development and evaluation of the herein described training projects.
5. Adult Services-Aging: This annual training will focus on strategies for change and meeting the needs of older adults with mental illness, and will feature a speaker on evidence-based practices in geriatric mental health. Projected attendance: 100
6. Adult Services-Case Management: Annual MHA Case Management Conference which offers training, education and resources to approved targeted mental health case management programs throughout the state. Projected attendance: 200
7. Adult Services-TAY conference: This annual training focuses on services for transition-aged youth as they move from child/adolescent services into the adult public mental health system. Projected attendance: 100
8. Adult Services-TAY cross-training: This training responds to the call to action of the Interagency Transition Council for Youth with Disabilities to blend the resources of designated State agencies to coordinate cross-training for major stakeholders. This amount represents MHA's co-sponsorship of that effort. Projected attendance: 100
9. Adult Services- MHA/DORS conference: This required annual training will provide information to vocational rehabilitation professionals and community mental health agency staff on issues of mutual concern. Special focus will be directed toward the design and implementation of Evidence-Based Practice initiatives in Supported Employment. Projected attendance: 150
10. Adult Services-Supported Employment Training: This two-day competency-based, experiential training will cover supported employment leadership and team management topics, tool and strategies for Executive Directors, program managers and team leaders of Evidence-Based Practice in Supported Employment program sites selected in FY2006. Projected attendance: 70
11. Forensic conference: This Annual Symposium on Mental Health and the Law will address DHMH services for children adjudicated incompetent to proceed in juvenile court. It will include a focus on mental health diversion from the criminal justice system, addressing choices and options available to individuals facing (or potentially facing) criminal charges, such as crisis response services, jail diversion programs, and mental health courts. Projected attendance: 175
12. OCA- Leadership Empowerment Advocacy Project (LEAP): These funds will be utilized by the Office of Consumer Affairs to assist individuals with mental illness to learn empowerment and advocacy strategies. Projected attendance: 200

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13. Emergency Evaluation/Involuntary Admission: This seminar will provide information to community providers on these issues. Projected attendance: 125
14. Facilities Retreat: This 2-day session addresses system-wide issues affecting Mental Health Facilities within the public mental health system. Projected attendance: 35
15. Special Populations- There will be a special presentation on “Lessons Learned since Vietnam: Promoting Resilience in Today’s Soldiers and Families”, offered to a variety of individuals interested in veterans’ mental health. Projected attendance: 100
16. Special Populations-Homeless Training: This day-long training will provide hands-on strategies for preventing homelessness and assisting consumers with sustaining permanent housing. Projected attendance: 100
17. Cultural Competence Conference: Planned and presented by the MHA Cultural Competence Advisory Group, this one day conference will focus on us of the new consumer assessment tool to help improve mental health services. Projected attendance: 150
18. Child & Adolescent Services-Suicide Prevention Conference: This annual conference which informs providers, agency personnel, youth and families on issues related to suicide prevention will be held October 3, 2007. This year’s conference, entitled “Linkages to Life”, will feature nationally recognized keynote speaker Michael Trout. Projected attendance: 450
19. Child & Adolescent Services Annual Conference: This two-day annual conference serves as the vehicle to update consumers, family members and providers on activities related to the Child and Adolescent statewide Blueprint Committee and its recommendations. Projected attendance: 400
20. Child & Adolescent Services-Workforce Development: These funds will support regional conferences targeted at CSAs, providers, families, youth, advocates and local and state agency staff, to continue the work of the C&A Workforce Development Committee on retention, recruitment and core competency issues. Projected attendance: 200
21. Child and Adolescent Services-Early Childhood Regional Conferences: These regional conferences to include CSAs, LMBs, early childhood providers, families, advocates and local and state agency staff, will provide follow-up on promoting local early childhood mental health system of care development through jurisdiction plans. Projected attendance: 200
22. Child and Adolescent Services-Early Childhood Certificate Program: These funds will serve as seed money for training on early childhood mental health treatment issues, leading to a Certificate. Projected attendance: 40
23. Child and Adolescent Services-Case Management: This conference will address the issues unique to case management services with children and adolescents. Projected attendance: 100
24. On Our Own of Maryland: Employment Project: OOOMD will revise currently available materials regarding the new Employed Individuals with Disabilities (EID) Program to ensure that it is consumer-friendly, and will provide training on the EID Program to all of the OOOMD-affiliated Wellness and Recovery Centers throughout the state, and to the consumers currently served by Supported Employment programs around the state. Projected attendance: 900
25. On Our Own of Maryland (OOOMD)-Recovery Project: Continuation of MHA funding for “The Recovery Process: Reel to Real”, intended for consumers, and “The Recovery Paradigm: Collaboration, Partnership, Results” intended for providers. Projected attendance: 375
26. On Our Own of Maryland (OOOMD) -Summer Conference: funding continues historical MHA support for this annual statewide consumer conference; Projected attendance: 50

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### **SFY 2008 OBJECTIVES FOR CRITERION 5:**

#### **SERVICES FOR ADULTS AND CHILDREN AND ADOLESCENTS:**

- Monitor implementation of the Outcome Measurement System (OMS) (including provider completion of questionnaires, service utilization and expenditures and resolution of identified issues) and complete design of initial set of data reporting/dissemination mechanisms for public, provider, and government stakeholders. [NFC 5]  
MHA Monitor: Sharon Ohlhaber and Stacy Rudin, Office of Planning, Evaluation, and Training
- Maintain and update disaster mental health response plan that includes: the development of statewide and local infrastructures (including Core Service Agency (CSA) All-Hazards plans), communication systems, interagency coordination, enhanced crisis response capacity in the areas of clinical services/supports through maintaining a centralized database, providing assistance with designing and reviewing training for volunteers, and expanding the Statewide Behavioral Health Professional Volunteers Corps Program for crisis/disaster response. [NFC 1]  
MHA Monitor: Laura Copland and Charles Bond, MHA Office of Special Needs Populations
- Collaborate with the Maryland National Guard and the Pro Bono Counseling Project to develop, maintain, and update behavioral health programs for military personnel, family members, and community to include: 1) continued development of Maryland National Guard Outreach (MNGO) pilot program; 2) trainings and conferences specific to military and combat issues; and 3) provision of pro bono individual, couples, and family treatment to military personnel and family members. [NFC 1]  
MHA Monitor: Laura Copland and Charles Bond, MHA Office of Special Needs Populations
- Provide training designed for specific providers, consumers, family members, and other stakeholders, to increase the effectiveness of service delivery within the PMHS. [NFC 5]  
MHA Monitor: Carole Frank, Office of Planning, Evaluation, and Training
- Continue to provide direction, funding and ongoing consultation to the Mental Health Association of Maryland (MHAM) in implementing a series of public education and training activities. [NFC 1]  
MHA Monitor: Jean Smith, Office of Public Relations

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- Participate in oversight of the implementation of the Consumer Quality Team (CQT) pilot project and plan for further expansion, as feasible. **[NFC 2]**  
MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs
  
- MHA will collaborate with the Mental Health Transformation Office, the Mental Health Association, and the DHMH Office of Minority Health and Health Disparities to convene a Workgroup on Cultural Competency and Workforce Development to examine barriers to access to appropriate mental health services provided by health care professionals who are culturally competent to address the needs of Maryland's diverse population. **[NFC 3]**  
MHA Monitor: Daryl Plevy, Mental Health Transformation Office
  
- Support, in collaboration with Mental Health Transformation Office (MHTO) and CSAs, the implementation of a web-based platform which provides information, resource directories, and on-line availability of personal health record information for consumers at the county-level. **[NFC 6]**  
MHA Monitor: Daryl Plevy, Mental Health Transformation Office
  
- Routinely monitor for system growth and expenditures, identify problems, and implement corrective actions as needed. **[NFC 5]**  
MHA Monitor: Susan Steinberg, Office of the Deputy Director for Community Programs and Managed Care

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### **SERVICES FOR ADULTS**

- Continue the annual statewide telephone survey of consumer satisfaction and outcomes of PMHS services for adults. **[NFC 5]**  
MHA Monitor: Sharon Ohlhaber, Office of Planning, Evaluation, and Training
- Offer training for law enforcement officers, other public safety officials, and agencies regarding, (1) Post Traumatic Stress Disorder (PTSD), (2) treatment resources for military personnel and veterans, and (3) the management of crises involving individuals who appear to have a mental disorder and who are charged with offenses or suspected of criminal involvement. **[NFC 1]**  
MHA Monitor: Larry Fitch, Office of Forensic Services
- Continue to support NAMI MD's implementation of public education and training efforts. **[NFC 1]**  
MHA Monitor: Carole Frank, Office of Planning, Evaluation, and Training
- Provide training to consumers in development of advance directives and encourage the use of electronic personal health records when available. **[NFC 2]**  
MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs
- MHA, in collaboration with CSAs and stakeholders will develop a plan to implement evidence-based practices (EBPs) for individuals with co-occurring disorders. **[NFC 5]**  
MHA Monitors: Lissa Abrams, MHA Office of Adult Services

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### **SERVICES FOR CHILDREN AND ADOLESCENTS**

- Implement year three activities under the Substance Abuse and Mental Health Services Administration (SAMHSA) Seclusion and Restraint grant which will lead to the reduction, with the intent of elimination, of seclusion and restraint in the state-operated facility system and other inpatient settings to include child, adolescent, and adult inpatient programs. [NFC 2]  
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services and Sheilah Davenport, Office of the Deputy Director for Facilities and Administrative Operations
- Develop curricula for child and adolescent mental health providers, in collaboration with the Maryland State Department of Education (MSDE), the Department of Human Resources (DHR), the Department of Juvenile Services (DJS), and the Mental Health Workforce Development Steering Committee, based on the established core competencies. [NFC 5]  
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services
- Apply, in collaboration with Medical Assistance, for a 1915(c) psychiatric residential treatment demonstration waiver to provide services to up to 150 children and youth as mandated in Senate Bill 748 (2006 Legislative Session) - *Psychiatric Residential Treatment Demonstration Waiver Application*. [NFC 5]  
MHA Monitor: Al Zachik and Susan Russell Walters, MHA Office of Child and Adolescent Services
- Continue the annual statewide telephone survey of parents/caretakers' satisfaction and outcomes of PMHS services for children and youth. [NFC 5]  
MHA Monitor: Sharon Ohlhaber, Office of Planning, Evaluation, and Training
- Support the DHMH Center for Maternal and Child Health in increasing public awareness of fetal alcohol spectrum disorders (FASD) and its effects on both mothers and children. [NFC 1]  
MHA Monitor: Joyce Pollard, MHA Office of Child and Adolescent Services
- In collaboration with the University of Maryland, the Johns Hopkins University, and the Maryland Coalition of Families for Children's Mental Health, implement the *Child and Adolescent Mental Health Institute* to research and develop child and adolescent focused evidence-based practices in mental health and to assist in the planning and implementation of EBPs.[NFC 5]  
MHA Monitor: Al Zachik and Joan Smith, MHA Office of Child and Adolescent Services

**SECTION III**

**PERFORMANCE GOALS AND ACTION PLAN**

**TO IMPROVE THE SERVICE SYSTEM**

**Children's Mental Health Plan**

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### **CHILDRENS PLAN**

#### **CRITERION #1: Comprehensive Community–Based Mental Health Service System for Children and Adolescents**

**Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.**

#### **AVAILABLE SYSTEMS OF TREATMENT, REHABILITATION, AND SUPPORT SERVICES**

##### **Services Available**

At this time, community-based services in the fee-for-service benefits package for children and adolescents include:

- Psychiatric hospitals
- Psychiatric units of acute care general hospitals
- Residential treatment centers (RTCs)
- Psychiatric day treatment (also called partial hospitalization)
- Outpatient mental health clinics, many of which provide school-based and after-school treatment programs
- Psychiatric rehabilitation programs
- Mobile treatment services
- Supported employment and vocational services
- Respite care
- Residential crisis services
- Therapeutic behavioral aides
- Mental health related laboratory services

Additionally, MHA provides funds through contracts to programs that provide specialized services (e.g., mobile crisis) that do not fit the fee-for-service model. These programs are eligible to apply for funds, as are consumer support programs such as peer support programs, family support groups, consumer-run businesses, protection and advocacy services, juvenile court evaluation programs, and early childhood mental health consultation.

Any provider who meets appropriate licensing, certification, accreditation, or other applicable standards is eligible to become a provider in the fee-for-service system. Eligible providers include facilities, programs, and individual practitioners. Individual practitioners include physicians, psychologists, nurse psychotherapists, clinical social workers, occupational therapists, and certified professional counselors who are allowed to practice independently under their Practice Acts. This increase in the provider community offers consumers an expanded choice of providers.

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In addition to the above services, coordination with a number of other service types is provided within the system of care. These include:

### **Educational and Vocational Opportunities**

**School-Based Services.** MHA continues its extensive work with the Maryland State Department of Education (MSDE), both in regard to strengthening student support services for students in regular classrooms and in special education settings governed by the requirements of the Individuals with Disabilities Education Act (IDEA). MHA and MSDE collaborate to provide services to children and youth and to recruit qualified mental health providers for schools and the community. An extensive array of school-based mental health services are available for students enrolled in regular education and in special education. There has been a considerable increase in school-based mental health services over the past several years. For example, mental health services are available in one hundred and twenty public schools in Baltimore City and in six schools in Baltimore County. There are currently 61 school-based health centers (SBHCs) across the state, each of which provides somatic services. Approximately half of the SBHCs also provide mental and behavioral health services. [NFC 1]

Consistent with the Children's Cabinet's continuing emphasis on reducing violence, MHA, in concert with MSDE and the Governor's Office for Children, is funded to implement and maintain a school-based mental health violence prevention initiative. Maryland law requires elementary schools with suspension rates over 18% to implement the Positive Behavioral Interventions and Supports (PBIS) program or an alternative behavioral modification program to reduce suspensions. Additionally, an increasing number of schools are choosing to use this program because of its success in improving school climate. The program has been successful in decreasing the number of suspensions and expulsions as well as behavioral referrals to special education. During the 2006-07 school year, 465 schools across the state implemented PBIS with support from MSDE, the Johns Hopkins Bloomberg School of Public Health's Mental Hygiene Department, and other groups. An additional 123 schools were trained in using PBIS in summer 2007. [NFC 1]

MSDE in collaboration with MHA, DJS, the Center for School Mental Health Assistance, the Johns Hopkins University's Center for Prevention and Early Intervention, the Mental Health Association of Maryland, the Maryland Coalition of Families for Children's Mental Health, and the Maryland Assembly on School-Based Health Care received a School Mental Health Integration grant from the U.S. Department of Education. The Maryland Mental Health Alliance, composed of these interested groups helped MSDE pursue the integration of a full continuum of effective mental health promotion, prevention, early intervention, treatment, and crisis intervention services into Maryland schools. Using the work of the Alliance as a jumping off point, MSDE in collaboration with MHA submitted another USDE Integration Grant application focused on providing support, consultation, resources, and training to a rural jurisdiction (Dorchester County). The grant will support and develop further the infrastructure to integrate universal, secondary, and tertiary prevention and intervention in the county's eleven schools. [NFC 1]

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**Early Childhood Mental Health.** The goal of the Maryland Early Childhood Mental Health Initiative is to integrate mental health services into existing early childhood programs (children 0 to 5 years), to incorporate supports into existing early childhood programs, and to promote and support the integration of early childhood mental health services within other settings. The mental health component of the Maryland Infant and Toddler Program which provides services for young children governed by IDEA is strengthened by the activities of the Early Childhood Mental Health Initiative. Additionally, the Initiative supports the provision of mental health services in day care services provided through DHR as well as federally-funded Head Start programs. [NFC 4]

The Maryland State Early Childhood Mental Health Steering Committee provides direction to the Initiative. The Steering Committee is composed of a wide variety of organizations including: MHA's Office of Child and Adolescent Services; Maryland Coalition of Families for Children's Mental Health; MSDE; Governor's Office for Children; DJS; Maryland Insurance Administration; Mental Health Association of Maryland; CSAs; Local Management Boards; University of Maryland Training Center; and, other child serving agencies. [NFC 4]

Findings from the 2005 evaluation of the pilot of early childhood mental health consultation with childcare providers indicated that that on-site consultation to child care programs delivered by interventionists who were knowledgeable about child development, individualized consultation for children at risk of being expelled from their child care programs, and consultation to providers about classroom-wide behavior management strategies had a number of positive effects. These effects included substantial decrease in expulsion for at-risk children, strong gains in social skills, reductions in children's problem behaviors, changes in teachers' behaviors, and improvement in the classroom environment. Based on the results of the pilot project and evaluation, support from agencies, providers and families, and the success of the FY 2007 expansion of early childhood mental health consultation MSDE received \$2.5 million for state FY 2008 to further early childhood mental health screening, prevention and intervention for preschool children at risk of developing emotional and mental health disorders. This will ensure that consultation is available in all jurisdictions. [NFC 4, 5]

**Services for Transitional Age Youth.** Employment services are considered a priority for the "school to work" transition efforts listed on students' Individual Treatment Plans (ITPs) required by the Individuals with Disabilities in Education Act (IDEA). The desire for a job may be a motivating force for older teens and young adults to keep them involved in their overall plan of care and movement toward self-determination. Outpatient and psychiatric rehabilitation mental health service providers, including school-based mental health services, can support the activities of the schools in transitioning students with mental health needs into the world of further training, education, or work. Many of MHA's transition age youth (TAY) initiative projects (see Criterion #3) focus on assisting youth to obtain and maintain employment. Supported employment services, as described under Criterion #1 of the adult plan, are available for older adolescents as well. MHA and the Department of Rehabilitation Services (DORS) collaborate on employment activities for adults with mental illness and their efforts to increase vocational counselors' understanding of the needs of individuals with psychiatric disabilities. This effort has fostered an increased understanding of the needs of youth with psychiatric disorders as well. [NFC 1, 5]

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For older youth requiring ongoing mental health services in the adult services sector, access and linkage to educational services are primarily managed through psychiatric rehabilitation programs (PRPs). The rehabilitation assessment includes review of the individual's strengths, skills, and needs for education and vocational training. Based upon the assessment, the individual rehabilitation plan includes a description of needed and desired program services and interventions and identification of, recommendations for, and collaboration with other services to support the individual's rehabilitation, as appropriate. Some PRPs offer GED programs within their own service continuum, while others refer consumers to classes offered elsewhere. Community colleges and local universities in many counties provide opportunities for higher education. A spectrum of low cost/ subsidized programs (both federal and State subsidies) are available to individuals with disabilities. Many PRPs utilize a "supported education" model, supporting the consumer in his/her choice and pursuit of education in the community at large. [NFC 1, 5]

### **Housing Services**

There are two primary housing concerns for children and youth with mental health needs: 1) out-of-home placement, and 2) affordable, adequate housing for the family as a support to keep the child or adolescent in their community. Most housing, or "out-of-home placements", in the child and adolescent service system are provided by the child welfare and juvenile justice systems. An array of kinship care, foster care, treatment foster care, group homes, therapeutic group homes, and residential treatment centers are available. Family preservation is a key objective of the system along with keeping the child in the least restrictive environment possible. However, the full range of housing options are available to enable the most appropriate placement for each child. Mental health services, including outpatient, psychiatric rehabilitation, respite, and therapeutic behavioral aides are used to meet the mental health needs of children and adolescents in these out-of-home placements. In four jurisdictions, high fidelity wraparound services called Wrap-MD are available to assist in keeping children with their families. These services are funded through a combination of Medicaid and state funds. [NFC 1]

MHA's activities in the broader housing arena may affect families as well. Housing that is affordable, accessible, and integrated into the community is a major factor in enhancing the well-being and stability of children and adolescents and their families. MHA actively collaborates with both the Maryland Department of Housing and Community Development (DHCD) and the federal Department of Housing and Urban Development (HUD) to promote access and receipt of affordable housing through specialized government-supported housing opportunities. DHCD is represented on the Joint Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council. [NFC 1]

MHA encourages the CSAs to work with local housing authorities and affordable housing developers to maintain awareness of opportunities in their regions. To access housing, many local mental health providers have helped consumers, some with children, successfully pursue HUD Housing Choice Voucher Programs and rental assistance services. Several CSAs have also supported their local housing authorities in their applications for HUD Housing Choice Voucher Program vouchers for persons with disabilities and their families. Additionally, MHA has encouraged and provided some financial incentives to establish non-profit housing development entities. Many of these entities, as well as mental

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health provider organizations, have developed affordable housing through community bond grants through Maryland's DHMH's Administration-Sponsored Capital Program. MHA has identified housing as its priority for receipt of these bond monies. Several of this year's Capital Program awards addressed this priority. [NFC 1]

In 1995, the U.S. Department of Housing and Urban Development (HUD) awarded MHA a five-year, \$5.5 million Shelter Plus Care grant to provide housing for individuals who are homeless with serious mental illnesses (with or without accompanying substance abuse) and their dependents, who are being released from the detention center or are in the community on the intensive caseloads of parole and probation. Last year, the FY 2007 Shelter Plus Care Housing grant was renewed for \$2,580,217 due to increases in the Fair Market Rental Values determined by HUD. Additionally in 2007, MHA received \$759,236 through eleven small grants targeted to specific jurisdictions. The jurisdictions awarded the five-year grants were Allegany, Anne Arundel, Baltimore, Cecil, Frederick, Harford, and Prince George's Counties. Effective July 1, 2007 (FY 2008), MHA was awarded funding in the total amount \$3,186,648 for 14 Shelter Plus Care renewal grants. Currently, MHA is serving a total 642 persons, 149 single individuals with mental illnesses and 157 families with 268 children and 68 other family members. [NFC 1]

### **Medical, Dental, and Pharmacy Services**

**Medical and Dental Services.** Medicaid is the joint federal and state program that provides health and long term care coverage to low-income individuals. The main low-income populations covered under Medicaid include children and their parents, pregnant women, older adults, and individuals with disabilities. Medicaid also covers Medicare cost-sharing for certain low-income Medicare enrollees.

Federal Medicaid requires coverage of the following services: inpatient and outpatient hospital, physician, nurse midwife and certified nurse practitioner, laboratory and x-ray, nursing home and home health care, rural health and federally qualified health centers, and early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21. EPSDT requires coverage of all medically necessary services, including dental services, for children under age 21. Maryland Medicaid also covers "optional" services, such as drugs, therapies, medical day care, and personal care.

In Maryland, about 80% of Medicaid beneficiaries are in HealthChoice, Maryland Medicaid's mandatory managed care program. Individuals choose a primary care provider (PCP) and enroll in one of seven HealthChoice managed care organizations (MCOs). MCOs provide almost all Medicaid benefits, except for certain "carved-out" services that are provided on a fee-for-service basis. Specialty mental health is a key carve-out service. HealthChoice regulations require that MCOs provide medically necessary and appropriate dental services to enrollees who are younger than 21 years old. Of the 682,189 individuals enrolled in Medical Assistance in May 2007, 408,843 (59.9%) were 18 years or younger. Maryland's Children's Health Program (MCHP) provides recipients with the Medical Assistance benefit package and their care is provided through the MCOs as well. In June 2007, children enrolled in MCHP numbered 93,949. [NFC 1, 5]

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In FY 2006, 21,221 children under age 13 and a total of 42,990 children from age 0-18 were served through the fee-for-service system. In FY 1998, this number under age 13 was about 16,300. Special provisions are made for youth in out-of-home placement to assure better access to care. The needs of the child and adolescent population with co-occurring mental illness and substance abuse are a special concern for the system. Special efforts to coordinate care when these young people are encountered by the system are made by MHA, Alcohol and Drug Abuse Administration (ADAA), Developmental Disabilities Administration (DDA), and the special needs coordinators of the various MCOs. In particular, the juvenile justice population has a high rate of co-occurring disorders and efforts to integrate mental health treatment within the juvenile justice system places a high premium on the integration of mental health and substance abuse treatment approaches. [NFC 1]

DHMH promotes coordination of MCO and fee-for-service specialty mental health services. Enrollees can self-refer to the Specialty Mental Health System, and Medicaid regulations state that an MCO or an MCO primary care provider shall refer an enrollee to the Specialty Mental Health System when the MCO PCP cannot meet the enrollee's needs. The regulations also state that an MCO shall cooperate with the Specialty Mental Health System in developing referral procedures and protocols. The requirement that MCOs provide primary mental health care provides a clear linkage between a child's pediatric medical care and mental health treatment plan. The mental health benefits provided under the Early and Periodic Screening Diagnostic and Treatment (EPSDT) program are managed by the PMHS. Carving out this mental health benefit has facilitated identification and referral of youth for mental health intervention, particularly young children. [NFC 1, 5]

Meetings among Medicaid and MHA staff, MCO medical directors, and MAPS-MD medical directors promote coordination. Special needs coordinators at the MCOS currently have access to identified care managers at the ASO, who are specifically commissioned to fulfill this coordinating function. In addition, information on pharmacy utilization is shared across systems. Medicaid receives real-time information on MCO and fee-for-service pharmacy claims in order to prevent drug contraindications at the point of sale. On a monthly basis, Medicaid sends reports to each MCO of their enrollees' fee-for-service mental health drug use, so MCOs and PCPs have information on the mental health drugs their enrollees are taking. In a new initiative, MHA, MA, and the ASO have worked together to include pharmacy data within the ASO's web-based authorization system. Beginning July 1, 2007, mental health providers will be able to access information on prescriptions filled by consumers for psychotropic drugs and medications paid for through the MCOS. A 12 month rolling history of filled prescriptions will be maintained. Plans include developing access to the information for primary care providers for the MCOs later this year.

**Pharmacy Services.** In ongoing efforts to manage pharmacy costs, Medical Assistance (MA) developed a Preferred Drug List (PDL) to make better use of less expensive, but equally effective medications. Cooperating drug manufacturers have offered the State additional revenue in the form of supplemental rebates for purchasing some of the brand name drugs. Fifty-three classes of drugs currently fall under the preferred drug list. According to PDL regulations, for each therapeutic class where there are three or fewer drugs, the PDL may be limited to only one drug; for each therapeutic class in which there are four or more drugs, at least two drugs must be included on the PDL. Prescribing of non-preferred drugs requires a preauthorization. The PDL affects all fee-for-service recipients and those HealthChoice and Primary Adult Care (PAC) recipients who take certain mental

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health drugs. The PDL impacts nearly all MA fee-for-service prescribers, and since mental health drugs are “carved out” from the MCOs’ formularies, it affects MCO prescribers of mental health drugs. Atypical antipsychotics and antiretroviral agents have been excluded from the PDL and can be prescribed without preauthorization; however, atypical antipsychotic agents are limited to U.S. Food and Drug Administration (FDA) recommended quantities. Preauthorization phone numbers and fax are available for prescribers who prefer to use non-PDL drugs. Preauthorizations for non-preferred drugs are granted upon request and require no justification or criteria at this time. There is also a hotline for recipients to use if they feel they are having difficulty getting their medications. However, due to budget reductions, the atypical antipsychotic carve-out from the PDL is scheduled to end in January 2008.

The Maryland General Assembly established the Maryland Health Insurance Plan under the Health Insurance Safety Act of 2002. A Board of Directors governs the plan, which operates as an independent unit of Maryland Insurance Administration. Individuals who are not eligible for group health coverage, COBRA, government – sponsored health insurance programs and some other special categories, may be eligible. The MHIP includes in its benefits coverage for mental health services. MHIP also has a Prescription Drug program which provides coverage at different levels and includes a deductible. [NFC 5]

Some individuals who receive services through the PMHS are not Medicaid or waiver-eligible and not enrolled in MCOs, and some of these individuals do not have a regular PCP. CSAs have found innovative ways to promote somatic and dental care for uninsured adults in their jurisdictions, e.g., through pro bono initiatives, medical and dental school clinics or pharmaceutical companies. Additionally, CSAs have been provided with some funds to purchase needed medical/pharmacy/laboratory services for uninsured individuals who cannot afford their costs and for whom no other source of funds or access to the service/drugs are available. These funds are frequently used to prevent the need for more intensive levels of service or reduce the risk of hospitalization. Another resource is the Maryland Medbank Program, which assists low-income, uninsured persons in gaining access to free medicines available through pharmaceutical manufacturers’ patient assistance programs. Individuals are referred by their physicians and must meet income and other eligibility criteria set by the supplying drug companies. Only brand name drugs are available and are subject to supply.

### **Case Management**

Over the past several years, MHA has increased both the availability and comprehensiveness of case management services and has created a variety of mechanisms for funding case management activities. MHA has emphasized implementing the strengths model of case management, which recognizes the individual’s assets and promotes access to services that optimize the individual’s quality of life. The FY 2006 annual Child and Adolescent Services Conference, *Nurturing Resilience in Youth* increased providers and parents knowledge about this important focus. [NFC 1, 5]

MHA policy has mandated that children and adolescents with SED in MHA’s priority population be targeted for publicly funded case management. Case management is critical in the development of interagency coordination for community-based mental health care of

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young people with serious emotional disturbances. Providers have indicated that they utilize various formats in delivering case management. For autonomous case management programs, the broker model, case management services which coordinate and link consumers to community resources, is prescribed by MHA policy. [NFC 4]

Maryland funds case management activities for children and youth in three ways. The first way in which case management for children and adolescents has been funded is through Medical Assistance intensive mental health case management. Persons of all ages who meet certain diagnostic and functional criteria were eligible for these services. Case management programs operated in 24 jurisdictions throughout the state. Through recent communications with the Center for Medicaid and Medicare Services (CMS) regarding Maryland's option for mental health case management within the state's MA Plan, several changes necessary for the state to continue Medicaid reimbursement for this service were identified. These changes included a new rate setting methodology and more stringent instructions, which would have resulted in significant reductions in current rates. After considerable analysis, a decision was reached to withdraw Maryland's Medicaid state plan option for mental health case management. Utilizing the historical State match funds, MHA will contract with the CSAS, who in turn, will contract with case management providers for the service. Funds for general case management, as described above, will be incorporated into the contracts. While overall there will be a decrease in funding available, this strategy allows the service to be preserved. Some administrative burden will be reduced, creating greater flexibility in the provision of the service. Priority populations for the service will remain the same. At a later date, Maryland plans to reevaluate case management services, and if feasible, reapply to CMS for a state plan amendment for mental health case management. [NFC 4]

Second, mobile treatment programs are conceptually defined as combined clinical and case management treatment programs for a specific subset of the MHA priority population, i.e., those individuals who have not engaged in traditional treatment and rehabilitation activities. As of July 1, 2007, nineteen mobile treatment programs were operating throughout the State. Although most mobile treatment programs focus on the treatment of adults, 232 children and adolescents were served in FY 2006 through this modality. [NFC 5]

Third, psychiatric rehabilitation programs (PRPs) are expected to provide case management activities as an integral part of the care they provide. The rate paid to PRP providers under the PMHS is intended to support this level of activity. Many individuals with serious emotional disturbances receive case management services in this way. In FY 2004, a case rate for psychiatric rehabilitation was instituted. Along with this, the dramatic growth in these services between FY 2001 and FY 2003 resulted in MHA re-examining the guidelines for child and adolescent psychiatric rehabilitation in FY 2004 and FY 2005 to ensure that the services were being utilized correctly for the appropriate children and adolescents. Medical necessity criteria were revised to include targeting the provision of psychiatric rehabilitation services to those children and adolescents who were showing significant dysfunction. The new criteria state that psychiatric rehabilitation services are for children and adolescents with serious mental illnesses or emotional disturbances who have been referred by a licensed professional of the healing arts based on screening, assessment, or ongoing treatment of the individual. The services must be goal directed and outcome focused. The services are time-limited interventions provided only as long as they continue to be medically necessary to reduce symptoms of the individual's mental illness and to

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restore the individual to an appropriate functional level. A clinical evaluation and the ongoing mental health treatment plan must indicate that the individual has a primary DSM-IV TR diagnosis that is causing the significant symptoms or serious functional behavioral impairment to be addressed by the rehabilitation services. Exceptions for children and adolescents who do not meet the criteria can be considered, based on the facts and circumstances offered by the referring professional. [NFC 5]

Under the PMHS, the ASO collects and reports on data regarding utilization and costs of mental health services. CSAs can review this information and determine whether those individuals with high volume and costly service utilization are receiving appropriate services or whether another strategy, including use of case management, will be helpful in bringing about utilization of the most effective constellation of services. [NFC 6]

During FY 2007, the Community Support Leadership Network (CSLN), which is composed of directors and case managers of case management units, continued to meet quarterly to discuss issues related to policy and program development. In addition, the CSLN assisted in planning the annual State-approved case management training, which is required by the State regulations governing intensive case management. [NFC 5]

### **Substance Abuse Services for Persons with Co-occurring Disorders**

DHMH is the agency responsible for mental health, substance abuse, developmental disabilities, AIDS, maternal and child health, and all the programs offered through the State Medical Assistance Plan. There is an ongoing need for coordinating mechanisms within the Department itself in order for DHMH to fulfill its role as an interagency partner with the other Departments of the Children's Cabinet. The coordination of services for substance abuse, as well as developmental disabilities, with services offered to children and youth for mental health problems, is a critical issue within the DHMH coordination process. These needs all fall under the category of youth with special health care needs, and the primary systemic coordinating effort is the Special Needs Advisory Committee. Staff coordinators from MHA and ADAA and the special needs coordinator from the child's HealthChoice MCO work together when a child with co-occurring diagnoses requires enhanced coordination efforts. [NFC 5]

In the past, Maryland has emphasized cross training of staff and coordination of services as a means of providing access to services by individuals needing both mental health and substance abuse services. A number of existing mental health treatment and rehabilitation programs, as well as programs established through the DHMH Alcohol and Drug Abuse Administration (ADAA), have developed dual diagnosis capability and are able to offer substance abuse treatment services to individuals with mental illness. In FY 2007, the Department of Juvenile Services (DJS) continued to work with the MHA to implement two pilot programs in two juvenile detention centers, in which professionals trained in both mental health and substance abuse will work with youth who are diagnosed with co-occurring mental health and substance abuse problems. [NFC 4, 5]

MHA continues to address the challenge of how to implement evidence-based practices to improve services for children and adolescents, with co-occurring disorders of mental illness and substance abuse. In FY 2007 MHA continued its involvement in multiple

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collaborations with ADAA in its efforts to provide integrated treatment for youth with co-occurring disorders at the local level. A statewide conference was convened which attracted stakeholders from Maryland's public behavioral health community. Attendees of this conference were provided with a clear understanding of the core values and principles of integrated care for co-occurring mental health and substance abuse use disorders in children and adolescents from the perspective of system, program, and clinician. In FY 2008 MHA will continue multiple collaborations with ADAA to promote integrated treatment for consumers with co-occurring disorders at the local level. Currently representatives from MHA and ADAA regularly meet with county leaders to provide assistance and support for regional initiatives. Currently representatives from MHA and DHMH regularly meet with county leaders to provide assistance and support for regional initiatives. This includes initiatives at the county level to implement the Comprehensive, Continuous, Integrated Systems of Care (CCISC) for Consumers with Co-occurring Mental Health and Substance Use Disorders model. Worcester County, Montgomery County, Anne Arundel County, Baltimore County, Prince George's County, and St. Mary's County are currently involved in strategic planning processes. In FY 2008 MHA will assist up to eight jurisdictions to initiate or complete consensus documents, local action plans and train local staff in implementing CCISC. [NFC 5]

The Secretary of the Department of Health and Mental Hygiene has also demonstrated commitment to co-occurring disorders by appointing an administrative officer from his office to work with MHA and ADAA. As a result of coordination through this newly formed position, a State-level leadership team has been convened to provide leadership toward enhanced service coordination across systems. There is now a State Charter, reflecting the State's ongoing development toward service integration across the systems. Maryland was selected by SAMHSA to attend the National Policy Academy on Co-Occurring Disorders in 2005. This policy academy was attended by the Director of MHA, Director of ADAA, the Medical Director of ADAA, the DHMH Program Administrator for Co-Occurring Disorders, a state delegate from the Maryland House of Representatives, the Health Officer from Worcester County, along with representatives from the Department of Public Safety and Correctional Services, Department of Juvenile Services, Maryland Medicaid, and the Maryland Mental Health Association. A state action plan has been created as a result. MHA's FY 2008 State Mental Health Plan includes a strategy to work on items within that action plan (including data collection, workforce development, screening and assessment) to support county initiatives and assure that policy and regulatory changes be reflected in state and local level plans. [NFC 5]

The majority of the women with co-occurring disorders in the justice system have children and a smaller population is pregnant while incarcerated. MHA was instrumental in developing and implementing the TAMAR's Children Program. In FY 2006, MHA continued to partner with federal, State, local, and private agencies to coordinate mental health services and housing for the TAMAR's Children Program. This program was for pregnant women who were incarcerated or at risk of incarceration in local detention centers and the Maryland Correctional Institute for Women (MCIW). The TAMAR's Children Program was initially funded through a SAMHSA Targeted Capacity Expansion grant program known as Building Healthy Communities, the Department of Housing and Urban Development (HUD) program (additional Shelter Plus Care), a Department of Justice Residential Substance Abuse Treatment grant, local and State in-kind service commitments, and private foundation funding. The aim of this holistic program was to provide appropriate

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treatment to women with mental health, substance abuse, and trauma related disorders as well as mother/child intervention to enhance capacity for secure attachments. The program provided services during the period of incarceration, in a community rehabilitation setting, and re-entry to community with housing and case management services. The program as originally constructed ceased operation near the close of FY 2006. Involved agencies remained committed to serving this population. [NFC 2, 3]

In 2007, MHA collaboratively worked with the Department of Public Safety and Correctional Services, the Administrative Office of the Courts, the Alcohol and Drug Abuse Administration, the Family Health Administration, Baltimore Mental Health Systems, Inc. and the Archdiocese of Baltimore to create a new statewide diagnostic and transitional program for pregnant women who are at least 18 years of age who might otherwise be incarcerated. As a result of this collaborative partnership, a new program, the Chrysalis House Healthy Start Program, was created. This program, funded through state general funds will consist of a 16-bed diagnostic and transitional facility (in the former location of the Tamar's Children Program) and will serve pregnant and post partum women and their babies. Pregnant women may be referred by the Court, the State or defense, or DHMH. A comprehensive assessment will be conducted by a licensed clinician and an individualized treatment plan will be developed between each woman and the treatment team. [NFC 2]

After the newborn's birth, the mother and baby will remain in the residential facility and receive a comprehensive array of services. Services will include medical care through contract with a health care organization, mental health treatment which includes trauma and attachment-based treatment interventions, substance abuse treatment and co-occurring treatment services, legal services, parenting and childcare services which includes involvement from the Healthy Start and Family Tree Programs, housing, after hours residential support, health education, and other support services. This program has started accepting referrals and is expected to open in August 2007. [NFC 2]

Also in FY 2007, MHA continued to offer and/or provide consultation to state and local agencies serving pregnant and post-partum women and their children on mental health and trauma. MHA continued to fund outreach, case management, and housing assistance to graduates of the Tamar's Children Program through funding provided to Prisoner's Ad Association. [NFC 2]

### **Juvenile Services**

There are a number of continuing activities underway to enhance the linkages and accessibility to behavioral health care for youth in Maryland's juvenile justice system. Over the past several years, NASMHPD Research Institute's post doctoral fellowship program and the Mental Health Association of Maryland have conducted studies to look at the needs of youth in the juvenile justice system. These studies initiated the development of a pilot project, based in part on the successes of the Maryland Community Criminal Justice Treatment Program for adults in jails, which is discussed in Adult Criterion 1. The Maryland Juvenile Justice Mental Health Treatment Program, initiated with funds from the CMHS Mental Health Block Grant, has fortified the collaboration among juvenile justice officials, educators, and health and mental health professionals. The program initially provided for behavioral health screening for youth detained from Baltimore City and the rural Eastern

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Shore and expanded to four detention centers Statewide. It also provides mental health treatment to the youth while detained and post discharge case management and treatment for those youth who return to a community living situation after detention and court disposition. [NFC 5]

In FY 2005, the program underwent a reconfiguration with both additional funding for mental health treatment from the Department of Juvenile Services (DJS) budget and the openings of the new Baltimore City Juvenile Justice Center, the Lower Eastern Shore Children's Center, and the Western Maryland Children's Center. The program now focuses on the needs of juvenile offenders in six detention centers prior to adjudication and disposition by the juvenile court (J. DeWeese Carter Youth Center, Alfred D. Noyes Children's Center, Cheltenham Youth Detention facility, Thomas J. S. Waxter Children's Center, Western Maryland Children's Center, and the Baltimore City Juvenile Justice Center). DJS, with its additional mental health funding, will build upon these existing services in FY 2008. [NFC 1, 5]

The time period covered by an extensive three year plan for integrating behavioral health in the juvenile justice system has come to an end, however many of the changes instituted continue, particularly the collaboration with MHA Child and Adolescent Services to provide training and consultation with DJS staff. Juvenile justice intake officers have received initial training on behavioral health screening for all youth who come before juvenile justice. The goal is to identify possible mental health problems and refer families for assistance. These screenings are administered to approximately 30,000 youth per year. Additionally, behavioral health services have been incorporated into facilities operated by DJS and those operated under contract. These facilities include detention centers, shelter care programs, residential drug treatment programs, and youth challenge camps. [NFC 1]

The MHA budget includes funds for a mental health component for aftercare services. In FY 2007, slightly less than \$1.8 million was transferred to MHA through an interagency memorandum of understanding to continue implementation of the mental health component for youth discharged from State juvenile correctional facilities. Mental health professionals, called Family Intervention Specialists (FISs), participate in 26 specialized DJS Intensive Aftercare Teams to conduct assessments, make referrals for treatment, and facilitate groups. In FY 2006, the Family Intervention Specialists provided mental health services to over 543 youth who came in contact with the juvenile justice system and were in need of services. In order to meet each jurisdiction's needs, the FIS work in collaboration with DJS area directors and supervisors and participate in meetings and trainings. The CSAs have been designated lead agencies at the local level, assuring coordination with other mental health services. [NFC 1]

The MHA Child and Adolescent staff provide training for DJS direct care staff on an as needed basis, but at least four times annually. In addition, one of the staff will be assisting the DJS Director of Professional Development and Training to create training for DJS direct care staff which will be offered on an ongoing basis. If requested, MHA will assist in conducting this training. Additionally, the MHA Child and Adolescent staff provide ongoing consultation to DJS as the new Secretary and his staff are moving toward more community-based services for juvenile offenders. [NFC 1]

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### **Family Involvement**

The continuing value placed on family member participation and involvement has been retained and strengthened in the new system. MHA encourages the input of consumer and family members at all levels. A concerted effort is made to include families in the planning, development, and monitoring of the PMHS. In FY 2008, MHA will continue to fund the Maryland Coalition of Families for Children's Mental Health, a statewide child and family advocacy group, to develop local family support activities with a mission to inform families of children and adolescents about policy, to teach them about becoming participants in the policy and decision-making process, and to provide feedback about the operations of the public mental health system. The Coalition participates on more than 22 state and local policy shaping committees. [NFC 2]

In addition to the custody relinquishment study discussed in Child and Adolescent Criterion 3, the Coalition has conducted other research including a series of focus groups of parents involved with the juvenile justice system, an evaluation of the State's Respite Care Initiative, and concerns of families of transition-age youth. A series of focus groups with families of young children engaged with the early childhood education system was completed in FY 2005. The Maryland Coalition of Families for Children's Mental Health conducted six focus groups in early summer 2006 regarding the delivery of services for the TAY population. Participants included more than 60 youth and families with slightly more adults than youth involved in the groups. An additional 10 families who were unable to attend submitted input via written survey. The information garnered from this will help to inform future policy and program planning for this population. [NFC 2]

Themes which emerged included: 1) the transition age (roughly 16 to 24 years) is an especially difficult time for youth with mental health needs and their families with families continuing many of the roles they had assumed when the child was younger due to lack of services; 2) structure provided by school is over and a number of decisions must be made about housing, employment or college requiring learning about a new set of agencies that families indicated they knew little about and in which youth did not wish to participate due to perceived stigma; 3) youth expressed a strong desire for independence and yet lacked the experience, skills or emotional stability to work, manage their own finances and have a "normal" life; 4) youth had career aspirations but felt that work was a major issue; 5) there was a gap between the youth's cognitive development and social and emotional development which impeded their ability to meet their goals for independence; and, 6) families were frustrated that when their children turned 18, parents were legally no longer able to be involved in their child's treatment although they were always the ones called upon in time of crisis. [NFC 1, 2]

In FY 2004, the Coalition established a Family Leadership Institute which provides a six-month training program for families in becoming advocates in their communities and the state. Twenty families participated in the first Institute. The fourth Family Leadership Institute was held this year with 34 graduates increasing the total number of trained family advocates to 94. The Youth Leadership Group had its third weekend retreat in July 2007 and will also be the kickoff for the statewide Youth MOVE initiative. [NFC 2]

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In June 2007, Maryland initiated its Youth MOVE (Youth Motivating Others through Voices of Experience) program which provides training for youth to be active participants and leaders in seeking services for themselves and for the community of youth. Maryland's effort is 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. [NFC 2]

The Coalition also hosts training sessions for family members and professionals on selected topics and co-sponsors a major annual conference. In June 2007, the Coalition collaborated with MHA and the University of Maryland to sponsor the two-day 4<sup>th</sup> Annual Child and Adolescent Mental Health Conference, *Connecting Families and Youth with Evidence-Based Practice, Practice-Based Evidence and Promising Practices*. Finally, the Coalition provides information and referral services, provides one-to-one support for families in 14 counties, and facilitates five support groups across the State. [NFC 2]

On Our Own of Maryland (OOOMD) and MHA continue to collaborate to fight stigma within the mental health system through the Anti-Stigma Project (ASP). The ASP uses workshops to help participants identify stigmatizing behaviors and attitudes as well as possible solutions, communication techniques, and actions as vehicles for change. Workshops may be designed and tailored to address specific populations and situations, such as issues related to cultural competency, substance abuse, and juvenile justice. One major focus this year was to connect to other constituencies, such as law enforcement, government, education and somatic healthcare. Workshops were presented in many educational settings, as well as to the National Naval Medical Center. OOOMD continues to receive requests for the teaching videotape, "Stigma...in Our Work, in Our Lives," which has gained national and international attention and is now being used in more than 30 states and four other countries. Additionally there are several requests for "Stigma: Language Matters" posters. This poster will be translated into Spanish in an effort to reach out to an even wider audience. In FY 2006, the Anti-Stigma Project presented 50 workshops throughout the State with over 3,000 people reached. [NFC 2]

### **Activities to Reduce Hospitalization**

MHA has directed efforts at reducing the numbers and length of inpatient admissions, both in hospitals and in residential treatment centers (RTCs) for children and adolescents.

**Hospitals:** The ongoing impetus of the Lisa L. et al Settlement Agreement continues the reduced inpatient utilization of the two MHA-operated hospital units for adolescents. The average daily population (ADP) of these two units was 25 in FY 2007. MHA has not operated beds for children under age 12 since FY 1994. Beds are purchased from the private sector, when necessary. As noted previously, the state is projecting a structural deficit, with expenditures projected to outpace revenues by FY 2009. In response, there are initial budget reductions to occur in FY 2008 to begin to address the problem. MHA's budget was reduced by \$13 million, which will be taken from the facilities. One of the two adolescent units, which operated under capacity, will be converted to an adult unit. Each of the three RICAs will be reduced by eight beds. It is anticipated that excess capacity in the private RTC sector, the 1915(B) waiver, and the dollars for wraparound in the state budget will be sufficient to

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absorb the need. Currently it is projected that these changes in hospital configuration will be in place by January 2008. [NFC 2, 5]

Under the Lisa L. et al Settlement Agreement, the State continues to address the requirements for the timeliness of discharges for youth who are clinically ready to leave the hospital setting. At the end of FY 2004 Crownsville Hospital Center was closed, although bed capacity was maintained within the system. The adolescent unit located at Crownsville was relocated to Spring Grove Hospital Center. Four million dollars from the closure of the hospital was reallocated for community-based services in the five counties largely affected by the closure. These counties have developed a variety of services, focusing on diversion from and alternatives to State hospitalization. Assertive community treatment teams, in-home intervention programs for adults and children and adolescents, and services in the jails are examples of the types of services developed. [NFC 1, 5]

MHA has altered the previous centralized admission and referral process for emergency departments (ED) to use in locating and accessing State hospital beds. The process now relies heavily on using local systems of care. This change began with the Eastern Shore Hospital managing the requests for admission from eastern shore emergency departments (EDs) to Eastern Shore and Upper Shore State hospitals. Finan Center in Western Maryland now directly manages the referral and state hospital admissions for individuals presenting in EDs in Frederick, Washington, Garrett and Allegany counties. Through changing the locus of the admission system to the state hospitals to the region where the service is located, better coordination of care has developed between the community mental health system, core service agencies, local hospitals and the state hospitals. The collaboration will better promote use of alternative services to hospital levels of care and facilitate the discharge of long stay state hospital patients. MHA continues to operate a centralized admission referral center (CARC) in the Central Region to assist emergency rooms in locating and accessing State hospital beds. This center receives referrals of uninsured individuals for State hospital beds, 24 hours per day, 7 days per week. Specialists in child and adolescent mental health and developmental disabilities are available to work with the center when youth with complicated diagnoses or multi-agency involvement present in the emergency rooms. [NFC 4, 6]

Fiscal year 2006 data (obtained from claims paid through 5/31/07) show 2,524 children under age 18 served in acute psychiatric units in general hospitals and private psychiatric hospitals. Claims data for FY 2007 data (claims paid through 5/31/07; providers have up to nine months to submit bills) show there were 2,062 children and adolescents served. [NFC 1]

An issue of concern within the hospital system is the number of children and adolescents who are in acute inpatient beds, ready for discharge, without adequate insurance coverage and whose parents, without additional supports, are unable to care for them. In many instances, the child's insurance will cover acute inpatient care, but not the range of community-based services that the child requires to successfully return home or to an interim placement. Often, a recommendation is made for more restrictive RTC placement in order to access MA eligibility as a "family of one". The Council on Parental Custody Relinquishment to Obtain Health Care Services issued a report containing numbers of recommendations to address this problem. See Criterion #3 for a more detailed discussion of efforts to reduce the Unnecessary Relinquishment of Parental Custody. [NFC 2]

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**Residential Treatment Centers:** The ADP for the State-operated RTCs in FY 2007 was 90. In response to budget reductions, each of the three RICAs will be reduced by eight beds. It is anticipated that excess capacity in the private RTC sector and the dollars for wraparound in the state budget will be sufficient to absorb the need. Currently it is projected that these changes in configuration will be in place by January 2008. [NFC 2, 5]

**Wraparound:** Wraparound services (MD-Wrap) to support efforts to treat children and adolescents in their home and community are being piloted in two large jurisdictions. In October 2003, Maryland received a Real Choice Systems Change Feasibility and Development grant, *Community-based Treatment Alternatives for Children (CTAC)*, to study the feasibility of implementing a demonstration project of wraparound community services as an alternative to psychiatric residential treatment. Based on the grant findings and other activities in the state, \$1 million in State monies in FY 2006 was designated to fund two high-fidelity wraparound pilot programs for children up to 18 years of age. These began in January 2006; both are using the Milwaukee Wraparound Model. In FY 2007 \$2.5 million in State funding budgeted through the Governor's Office for Children to expand the program to two more jurisdictions who are able to provide high-fidelity services. Both of these counties are rural with one located on the Eastern Shore and the other in Southern Maryland. [NFC 5]

In December 2006 Maryland was awarded one of 10 CMS demonstration projects for alternatives to psychiatric residential treatment facilities (PRTF) allowing the designated states to apply for a 1915(c) Medicaid Home and Community-Based Services waiver to serve children and youth at risk of out-of-home placement in the community. This project will serve children who meet the medical necessity criteria for PRTF admission, who are not eligible for MA Home and Community-Based services, for whom MD-Wrap is an appropriate alternative treatment, and who live in a jurisdiction with MD-Wrap available (currently four jurisdictions). There will be up to 150 children enrolled per year by the end of the project in 2011. [NFC 5]

In February 2006, Maryland Medical Assistance in collaboration with MHA submitted a request for an amendment to its 1115 waiver to expand these wraparound services to up to 750 children and youth who meet the medical necessity criteria for residential treatment. On the advice of CMS, this waiver was withdrawn with the expectation that these children can be served in a manner similar to those children in the PRTF Waiver Demonstration Project, although with MA funding outside the waiver grant mechanism. [NFC 5]

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### **SFY 2008 OBJECTIVES FOR CRITERION 1:**

#### **SERVICES FOR CHILDREN AND ADOLESCENTS**

- Continue implementation of wraparound and community-based care pilots in Baltimore City and Montgomery, St. Mary's, and Wicomico counties for youth who meet residential treatment center (RTC) level of care. **[NFC 5]**  
MHA Monitor: Al Zachik, Office of Child and Adolescent Services
- Apply, in collaboration with Medical Assistance, for a 1915(c) psychiatric residential treatment demonstration waiver to provide services to up to 150 children and youth as mandated in Senate Bill 748 (2006 Legislative Session) - *Psychiatric Residential Treatment Demonstration Waiver Application*. **[NFC 5]**  
MHA Monitor: Al Zachik and Susan Russell Walters, MHA Office of Child and Adolescent Services
- Provide support for the Child and Adolescent Mental Health Institute with its partner, the Maryland Coalition of Families for Children's Mental Health, to assist in the implementation of Youth MOVE (Motivating Others through Voices of Experience), a youth peer support program, in conjunction with the National Youth MOVE. **[NFC 2]**  
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services
- Collaborate with Maryland State Department of Education (MSDE) to advance and monitor school-based mental health services through advocacy for expanding existing services and increasing the number of participating schools. **[NFC 4]**  
MHA Monitor: Al Zachik and Cyntrice Bellamy, MHA Office of Child and Adolescent Services
- In collaboration with the Department of Health and Mental Hygiene (DHMH) and the Mental Health Transformation Office (MHTO), adapt from Australia and Scotland and begin to implement the Mental Health First Aid program which provides training in basic understanding and appropriate responses to mental health disorders, with special focus on training individuals in education settings. **[NFC 1]**  
MHA Monitor: Brian Hepburn, MHA Office of the Executive Director
- In collaboration with the administrative services organization (ASO) and managed care organizations (MCOs) improve utilization of existing systems of care delivery across agencies and organizations to improve coordination of care between somatic and mental health care. **[NFC 1]**  
MHA Monitor: Gayle Jordan-Randolph, Office of the Clinical Director
- Collaborate with On Our Own of Maryland, Inc. (OOOMD) to continue the implementation of the statewide anti-stigma campaign through the Anti-Stigma Project. **[NFC 1]**  
MHA Monitor: Cynthia Petion, Office of Planning, Evaluation, and Training

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- Collaborate with the DPSCS, ADAA, Family Health Administration, the Judiciary, and the Archdiocese of Baltimore to implement the new women's transitional program (Chrysalis House Health Start Program) which is targeted to serve pregnant and post-partum women and their babies. **[NFC 3]**  
MHA Monitors: Marian Bland, MHA Office of Special Needs Populations
- MHA, in collaboration with Maryland Department of Health and Mental Hygiene (DHMH) and CSAs, will continue to support initiatives at the county level to implement integrated systems of care for consumers with co-occurring mental health and substance use disorders. **[NFC 5]**  
MHA Monitor: Tom Godwin, MHA Office of the Clinical Director and Pat Miedusiewski, DHMH
- Promote 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. **[NFC 2]**  
MHA Monitor: Marcia Andersen and Al Zachik, Office of Child and Adolescent Services

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### CHILDRENS PLAN

#### CRITERION #2: Child Mental Health System Data Epidemiology

**Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.**

#### PMHS DATA SYSTEM

The primary PMHS data system is currently managed by an administrative services organization, MAPS-MD (*APS Healthcare*). Historical data from the previous vendor have been transferred to MAPS-MD. Historical data have also been placed at the University of Maryland Systems Evaluation Center (SEC). The SEC provides enhanced capacity for analysis of the data, particularly in relation to evaluation and outcome efforts.

The data system collects information on those who receive services in the fee-for-service system. The system is driven by a combination of authorizations and claims for mental health services. Inherent in the implementation of the PMHS is a series of extremely comprehensive data sets. Data sets on client's service authorization and events and the provider community are available. Client information is accumulated through either the Medical Assistance (MA) eligibility file or the subsidized client data forms. Unduplicated counts are calculated by using MA numbers, Social Security numbers and/or unique identifiers. Authorizations are made on-line and added to available data. Provider data come from provider enrollment files, which are used both for referral and for payment of claims. Finally, event and cost data are derived from claims files.

MAPS-MD's basic platform is CareConnection®, a proprietary system that currently meets a number of external mental health management standards, as well as internal standards required by internal operations and the State of Maryland (via extensive customization) of both care management and claims applications. MAPS-MD's CareConnection® system is supported by ACHIEVE, a claims processing and payment platform. This system allows MAPS-MD to be responsive to the MHA's evolving data analysis and program evaluation needs. [NFC 5]

CareConnection® is specifically designed to support mental health services access, utilization review, and care coordination tasks. CareConnection® collects and displays demographic, clinical service, provider and outcome information relative to an episode of care, and also links multiple consumer records into useful "episodes of care." Consisting of a series of interrelated databases and software routines, this system stores and can report over 200 elements for both inpatient and outpatient care. Also included among the numerous data fields, care management elements, and outcome indicators are:

- service authorizations and referrals
- services utilized by level of care and service
- treatment service lengths and number of units provided
- site visits, including record reviews and second opinion (peer) reviews of authorization

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All stored data can be retrieved and reported either in standard form, using an automated reporting system or by way of custom programming or ad hoc reports. The data may be formatted to produce monthly, quarterly or fiscal reports. Maryland operates on July-June fiscal year. Currently over 50 standard reports are generated to assist in general planning, policy, and decision making. The data may also be accessed to produce an unlimited range of reports via ad hoc requests.

In FY 2008, information on drug prescriptions filled by consumers in the PMHS will become available through CareConnections. This will be made accessible first to providers of mental health services. It will only be available to those providers with existing open authorizations to treat the consumer. The pharmacy data will be refreshed monthly and will include prescriptions filled during the 12 months prior to the refresh date. Later this year, information will be made available to MCOS, who can then communicate it to their primary care physicians. The availability of this new module will enhance service quality and will provide a rich resource to enhance data analysis efforts. [NFC 6]

An unanticipated problem resulting from PMHS implementation contributes to an undercount of persons with mental illness. The MAPS-MD Management Information System (MIS) does not capture data for individuals who receive no services reimbursed by MA and have Medicare as their only payer source. These Medicare reimbursed services cannot be subject to authorization and claims are not paid by MAPS-MD, the two mechanisms for capturing data. Additionally, beginning July 1, 2003, claims for individuals who are qualified for federally matched MA, and have Medicare, began to be processed by Medical Assistance and the data on their utilization of Medicare reimbursed services is no longer in the ASO data system. Therefore, the data on those served in the PMHS represents an undercount.

Tables on the following pages provide data on consumers served by age and number of consumers accessing care in FY 2006 since this is the last full fiscal year for which claims have been processed. However, FY 2007 data, based on claims paid through 5/31/07, shows that thus far, 87,048 individuals had claims submitted for mental health services through the fee-for-service system, with fifty-five percent (55%) being adults. Sixty-six percent (66%) of adults treated met the diagnostic categories selected for SMI.

The MAPS-MD MIS was utilized to produce most of the data included as performance indicators in this application. Data for FY 2005, 2006, and 2007 are based on claims paid through May 31, 2007. For FY 2005 and 2006, this produces reliable numbers. Since claims can be submitted up to nine months following the date of service, the data for FY 2007 is still incomplete. Full year projections were not made for FY 2007. Specific diagnoses were used to define SMI. An individual was categorized as SMI if, at any time during the fiscal year, a diagnosis in the specific categories was submitted on a claim.

The MHA submitted its application to SAMHSA/CMHS for a third round of Data Infrastructure Grant in June 2007. The required Basic and Developmental Tables were submitted in December 2006. All tables will be submitted this year, including developmental tables based on new consumer survey items. Data for these come from three sources. Community data are obtained from data that results from claims, authorizations, and Outcomes Measurement Systems (OMS) which are within the MAPS-MD system. Some data, such as employment status and residential status, along with detailed racial and

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ethnicity data, are not available from either standard claims or MA eligibility data sets. Efforts are made to obtain this information in the MAPS-MD system through requirements for registration and authorization by providers for services. The MAPS-MD information is supplemented by an annual Consumer Satisfaction Survey for many NOMs measures, though the newly implemented OMS may allow MHA to move to client level reporting for some of these measures. Data from State operated inpatient facilities are obtained from a Hospital Management Information System (HMIS). Currently, information is abstracted from the HMIS and integrated into data from the community system to complete all required URS and NOMs reporting. While this system does not use the same consumer identifiers at the ASO data system, there are elements common to both which MHA has used to establish a nearly unique identifier based on demographic variables. This identifier has been used to link data from the two systems. This system, which has been in place since 1986, is scheduled for replacement. Data for those tables reporting on individuals served and services provided are collected and reported at the person level. [NFC 5]

In addition to MAPS-MD, MHA contracts with the Systems Evaluation Center (SEC), a component of the Mental Health Services Improvement Collaborative of the University of Maryland School of Medicine, Department of Psychiatry, Division of Services Research to assist with evaluation and data infrastructure activities. As MHA's strategic partner, SEC maintains a copy of the community service's data repository which extends back to 1999. The University of Maryland SEC has accepted responsibility for the oversight of the effort to collect the data necessary to complete the Uniform Reporting System (URS) tables required to be included with Maryland's Mental Health Block Grant application. The SEC, MAPS-MD, and MHA are working jointly to develop an outcomes measurement system, described more fully in Criterion #5. In this coming year the SEC will continue to collaborate with MHA and key stakeholders to identify areas of interest related to the PMHS that could be analyzed using multiple databases. These databases include claims, authorization, the consumer satisfaction survey, the Outcomes Measurement System, the hospital management information system (HMIS), Medicaid, and other State databases, as available.

### **INCIDENCE AND PREVALENCE FOR CHILDREN AND ADOLESCENTS**

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For children and adolescents, the recalculated Maryland poverty level changed the prevalence rates to be used in calculating number of children and adolescents with SED. Two estimates were used based upon the most recent information available. The estimates utilized were tied to the child poverty rate and the lowest and most upper limits of levels of functioning in the federal calculation. This translates to 5% up to 11% of the population under 18. The performance indicator under this criterion provides data for both the 5% and 11% prevalence rates. The population under 18 for each county was multiplied by the two rates cited in the federal definition.

Estimates of treated prevalence, however, were of necessity based upon a somewhat stricter definition of SED. Specific Axis I and II diagnoses codes were selected to identify the SED treated in the system. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. Slight modifications were made this year to the list of diagnoses included under the SED category. Specific pervasive

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developmental disorder and learning disorder diagnoses were further restricted. All data have been updated to reflect this change. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

"Priority population" means those children and adolescents, and for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared priority for publicly-funded services. MHA's Priority population includes a child or adolescent, younger than 18 years old, with serious emotional disturbance, which is a condition that is:

- Diagnosed with a mental health diagnosis, according to a current diagnostic and statistical manual of the American Psychiatric Association (with the exception of the "V" codes, substance use, and developmental disorders unless they co-exist with another diagnosable psychiatric disorder); and
- Characterized by a functional impairment that substantially interferes with or limits the child's role or functioning in the family, school, or community activities.

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities.

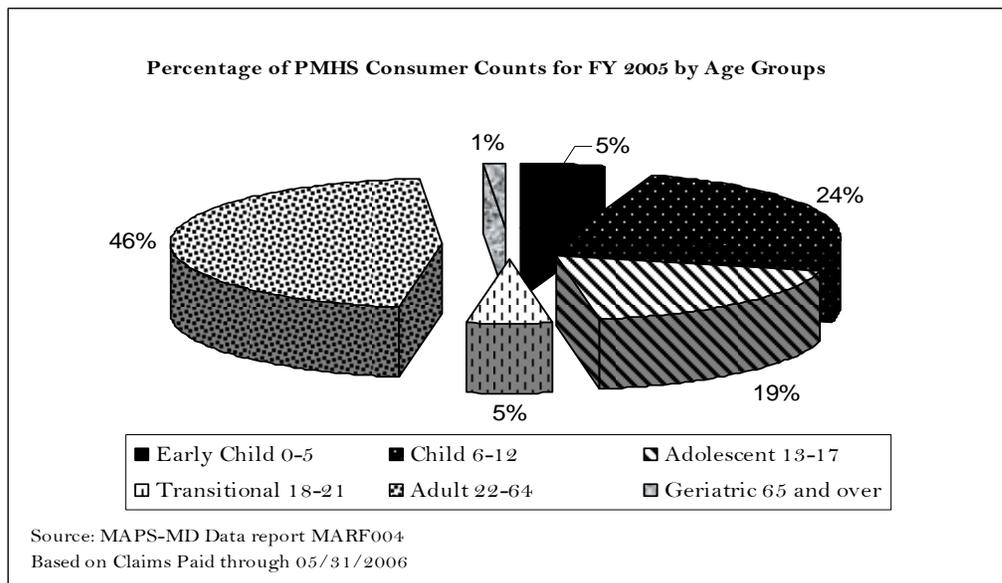
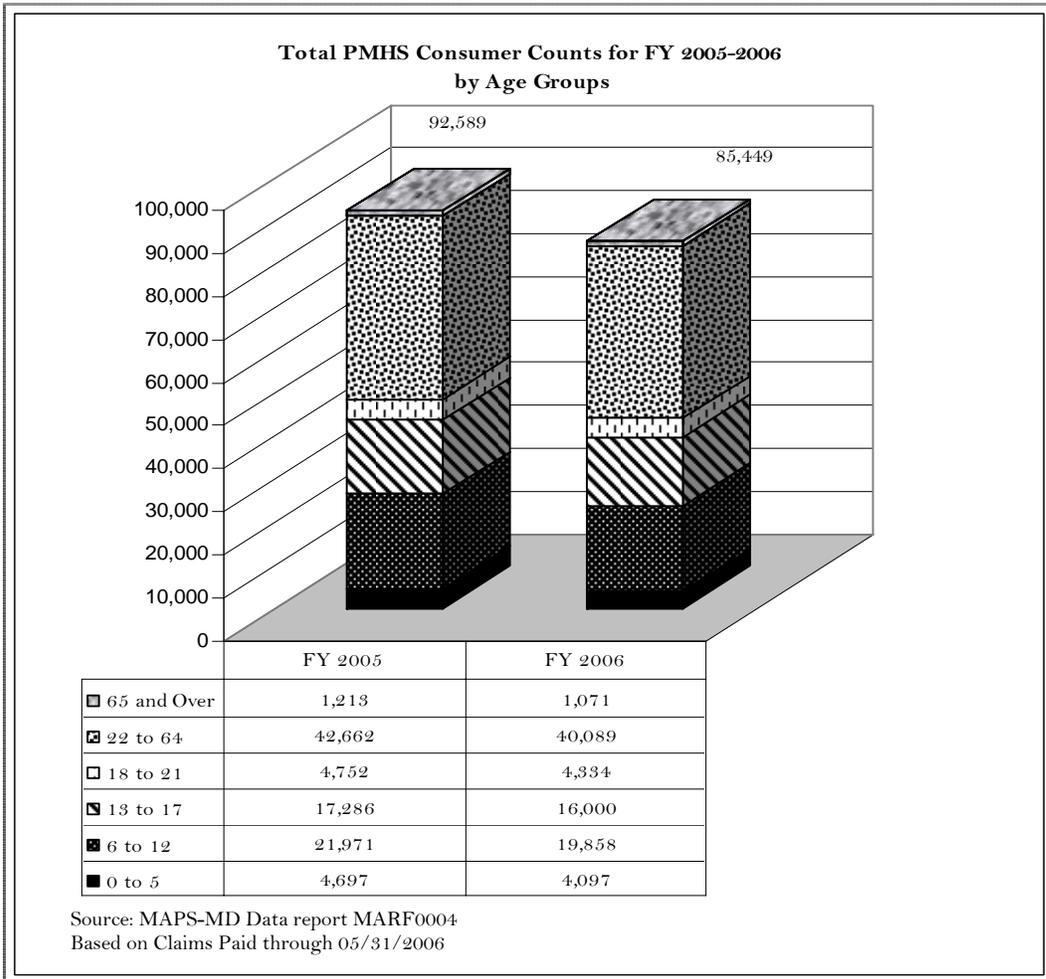
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**Mental Hygiene Administration  
Prevalence Estimates for Serious Emotional Disorder (SED) by County  
Child and Adolescent  
Population**

<b>County</b>	<b>Under 18 Population</b>	<b>Low Prevalence 5%</b>	<b>High Prevalence 11%</b>
Allegany	14,830	742	1,631
Anne Arundel	125,915	6,296	13,851
Baltimore County	180,698	9,035	19,877
Calvert	22,571	1,129	2,483
Caroline	7,719	386	849
Carroll	41,868	2,093	4,605
Cecil	24,178	1,209	2,660
Charles	36,674	1,834	4,034
Dorchester	6,790	340	747
Frederick	57,213	2,861	6,293
Garrett	6,814	341	750
Harford	61,100	3,055	6,721
Howard	70,976	3,549	7,807
Kent	3,880	194	427
Montgomery	230,090	11,505	25,310
Prince George's	226,547	11,327	24,920
Queen Anne's	10,719	536	1,179
St. Mary's	25,313	1,266	2,784
Somerset	5,233	262	576
Talbot	7,098	355	781
Washington	31,659	1,583	3,482
Wicomico	21,695	1,085	2,386
Worcester	9,469	473	1,042
Baltimore City	162,093	8,105	17,830
<b>Statewide Total</b>	<b>1,391,142</b>	<b>69,557</b>	<b>153,026</b>

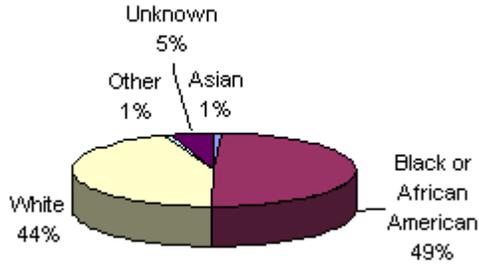
Data Source:  
July 1, 2004 Estimated Maryland Total Population by Age Group, Region and Political  
Subdivision

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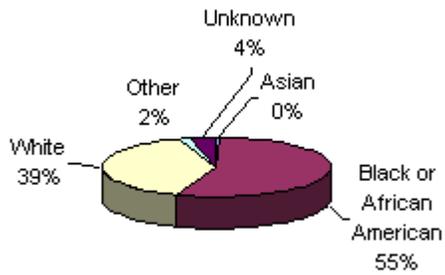


**MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

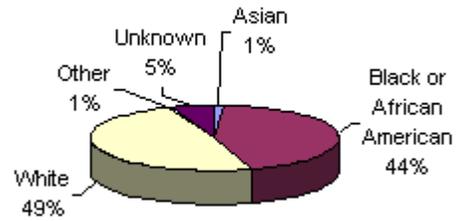
**Total Consumers Served  
in FY 2005 by Race and Age Group**



**Age 0-17**



**Age 18 and over**



Source: FY 2005URS Table 2A

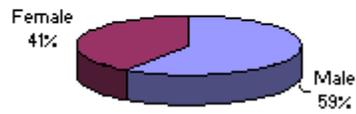
Note: Other includes: American Indian, Native Hawaiian, Pacific Islander and those consumers with more than one race.

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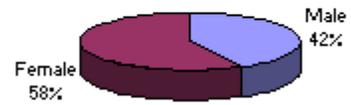
**Total Consumers Served  
in FY 2005  
by Gender and Age Group**



**Age 0-17**



**Age 18 and over**



Source: FY 2005 URS Table 2A

## **MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2008**

### **SFY 2008 OBJECTIVES FOR CRITERION 2:**

#### **SERVICES FOR CHILDREN AND ADOLESCENTS**

- Continue to serve identified priority populations, maintaining an appropriate level of care for at least the same number of individuals in the populations who have historically utilized the PMHS. **[NFC 5]**  
MHA Monitor: Stacy Rudin, Office of Planning, Evaluation, and Training
- Continue activities to develop and/or refine management information systems, including the new State hospital information systems – Computerized Hospital Records Information Systems (CHRIS). **[NFC 6]**  
MHA Monitor: Robin Jacobs, MHA Office of Management Information Systems
- Collaborate with the Department of Human Resources (DHR), CSAs, ASO, and local homeless boards regarding the integration of local Homeless Management Information System data on the number of homeless individuals with mental illnesses who are served by Housing and Urban Development (HUD) funded programs into a State data base system. **[NFC 6]**  
MHA Monitor: Marian Bland and Jacqueline Powell, MHA Office of Special Needs Populations

**CHILDRENS PLAN**

**CRITERION #3: Integration of Children's Services**

Many of the items in this section appear in Criterion #1. They are repeated here to meet the Block Grant application instructions.

**Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.**

**PROVISION OF INTEGRATED CHILDREN'S SERVICES**

Maryland's integrated system of care is organized at the state and jurisdictional (local) levels with the goal of each child and his/her family experiencing appropriate and smoothly coordinated service delivery. Maryland views the requirement for an integrated system of care as the appropriate way for services to be available to all children, youth and families while having particular benefit for children with emotional disorders. This is particularly the case when children and families who have relationships with more than one agency have problems with access and coordination. Having a strong emphasis on coordination increases the likelihood that the needed services from multiple agencies will be delivered to families with varying combinations of disorders and multiple problems beyond emotional disturbance.

At the state level, the Children's Cabinet is the coordinating body which brings together the child-serving agencies to develop and implement data driven state policies and make policy recommendations to the Governor to improve the health and welfare of children and families. This group, which convenes on a regular basis, is composed of the Secretaries of all the major executive departments which provide services to youth: education, health, juvenile justice, housing, and social services. A working subgroup of the Children's Cabinet, the Children's Cabinet Results Team (CCRT), meets more frequently to move the work of the Cabinet forward. The CCRT membership includes members from the same agencies as the Cabinet. The director of MHA's Child and Adolescent Services is a major participant in the CCRT's work, providing mental health input into policy decisions and programs. The Cabinet collaborates to promote the vision of the State for a stable, safe and healthy environment for children and families. The Children's Cabinet also assesses need, establishes budget priorities, and develops interagency initiatives to address these specific priority needs.

The work of the Children's Cabinet is based on up to 10 years of data for an established set of results and indicators that monitor the broad well-being of children and families in Maryland and its 24 jurisdictions (23 counties and Baltimore City). Based on observable data trends over time and across departments, the Children's Cabinet selects specific areas in need of development or improvement and sets forth budgetary and programmatic priorities to obtain the desired results. One of the areas selected for Maryland in FY 2008 is serving children more effectively in the community. The consequent Children's Cabinet budget supported MHA's interest in using high fidelity wraparound following the Milwaukee model (called MD-Wrap) to increase the availability of less restrictive services to children and youth.

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At the jurisdictional or local level, Local Management Boards (LMB) have been created in each of the 24 jurisdictions with the responsibility for coordinating a wide variety of services provided to children, youth, and families. These entities operate in ways similar to the CSA function described under Section I, Regional/sub-State Programs. In many jurisdictions the LMB has a member on the CSA and vice versa, resulting in the integration of the efforts of LMBs and CSAs, who are responsible for mental health which is an essential component of the child and adolescent service system in Maryland. In one county, the CSA and LMB functions are merged into one entity and one individual serves as both the LMB director and the CSA director.

Maryland also has additional interagency mechanisms for sustaining and improving an integrated system of care for children, youth, and families with social services, education including early childhood and special education, juvenile services, substance abuse services, and suicide prevention. [NFC 1, 2, 5]

### **Social Services**

Collaboration with social service providers is particularly important given the high prevalence of mental health disorders among children who are in state custody. In Maryland, social services are provided primarily by the Department of Human Resources (DHR) through its Social Services Administration, the State's child welfare agency, and its local agencies in each jurisdiction, the Departments of Social Services. MHA tracks the percentage of selected categories of youth in the child welfare system who receive services via the public mental health system as a performance indicator.

MHA and DHR work together in a number of venues. The NIMH funded "Science to Service" evidence-based practice initiative, which is briefly described in Criterion 5 Adult and Child, focuses on implementation of treatment foster care. This is a service that falls into the nexus of mental health treatment and social services (or juvenile services) housing placement for youth unable to remain with their families. In FY 2006 MHA, in conjunction with DHR, the University of Maryland – Baltimore, and treatment foster care providers across the state completed Maryland's NIMH Science to Service grant assessing the use of evidence-based treatment foster care (TFC) in the state. Based on this work, a Treatment Foster Care Roundtable was convened in June 2007 to discuss approaches to promote the development and utilization of innovative treatment foster care in Maryland. Almost 50 participants representing a broad variety of stakeholders explored issues and developed a draft white paper with recommendations to be made to CCRT to move treatment foster care toward evidence-based practice with identified funding and/or reimbursement.

Joint ventures with DHR also include using the Federal Child Care Development Fund's (CCDF) earmarked dollars for quality expansion activities to support pilot programs on the Eastern Shore and in Baltimore City in early childhood mental health consultation. In addition, the major system improvement activities taking place in the Governor's Task Force on Custody Relinquishment represent a substantial interface with the social service and juvenile service sectors. DHR and MHA also collaborate on respite care activities for biological and foster families. Finally, MHA and DHR, in conjunction with the Mental Health Transformation Office are developing a joint project to address mental health needs of

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foster care youth. All of these activities are more fully discussed later in this Criterion. [NFC 1, 5]

### **Educational Services, including Special Education Provided under IDEA**

MHA continues its extensive work with the Maryland State Department of Education (MSDE), both in regard to strengthening support services for students in regular classrooms as well as in special education settings governed by the requirements of the Individuals with Disabilities Education Act (IDEA). MHA and MSDE collaborate to provide services to children and youth and to recruit qualified mental health providers for schools and the community.

There has been a considerable increase in school-based mental health services over the past several years. For example, mental health services are available in 120 public schools in Baltimore City and in six schools in Baltimore County. There are currently 61 school-based health centers across the state, each of which provides somatic services. Approximately half of the centers also provide mental and behavioral health services.

Consistent with the Children's Cabinet's FY 2006 emphasis on reducing violence, MHA, in concert with MSDE and the Governor's Office for Children, is funded to implement and maintain a school-based mental health violence prevention initiative. Additionally, Maryland law requires elementary schools with suspension rates over 18% to implement the Positive Behavioral Interventions and Supports (PBIS), or an alternative behavioral modification program, to reduce suspensions. Additionally, there are schools that are choosing to use this program because of its success in improving school climate. The program has been successful at decreasing the number of suspensions and expulsions as well as behavioral referrals to special education. During the 2006-07 school year, 465 schools across the state implemented PBIS with support from MSDE, the Johns Hopkins Bloomberg School of Public Health's Mental Hygiene Department and other groups. An additional 123 schools received team training in July 2007 for implementation in the coming school year.

A Maryland Mental Health Workforce Development Steering Committee was convened by DHMH and MSDE. It is comprised of 38 members and includes consumers, families, trainees, and providers of services. MHA's Director of the Office of Child and Adolescent Services co-chairs the committee with the MSDE. The committee is focusing on recruitment and retention issues and developing core competencies in child and adolescent mental health to be utilized in Maryland colleges' and universities' curricula as well as in-service training for the existing workforce. The certificate program based on the core competencies will enroll its first class this fall at the University of Maryland, Baltimore. The committee's work mirrors the recommendations of the Annapolis Coalition's Report on workforce development. Maryland is receiving national attention for its efforts, including MHA's unique collaboration with MSDE. [NFC 1, 2, 4, 5]

### **Early Childhood Mental Health**

The goal of the Maryland Early Childhood Mental Health Initiative is to integrate mental health services into existing early childhood programs (children 0 to 5 years), to incorporate supports into existing early childhood programs, and to promote and support the

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integration of early childhood mental health services within other settings. The mental health component of the Maryland Infant and Toddler Program which provides the services for young children governed by IDEA is strengthened by the activities of the Early Childhood Mental Health Initiative. Additionally, the Initiative strengthens the provision of mental health services in day care services provided through DHR as well as federally-funded Head Start programs.

Based on the results of the pilot project and evaluation, support from agencies, providers and families, and the success of the FY 2007 expansion of early childhood mental health consultation MSDE received \$2.5 million for state FY 2008 to further early childhood mental health screening, prevention and intervention for preschool children at risk of developing emotional and mental health disorders. This will ensure that consultation is available in all jurisdictions. [NFC 4, 5]

### **Juvenile Services**

The Maryland State Early Childhood Mental Health Steering Committee provides direction to the Initiative. The Steering Committee is composed of a wide variety of organizations including: MHA's Office of Child and Adolescent Services; Maryland Coalition of Families for Children's Mental Health; MSDE; Governor's Office for Children; DJS; Maryland Insurance Administration; Mental Health Association of Maryland; CSAs; Local Management Boards; University of Maryland Training Center; and other child serving agencies.

Findings from the 2005 evaluation of the pilot of early childhood mental health consultation with childcare providers indicated that that on-site consultation to child care programs delivered by interventionists who were knowledgeable about child development, individualized consultation for children at risk of being expelled from their child care programs, and consultation to providers about classroom-wide behavior management strategies had a number of positive effects. These effects included substantial decrease in expulsion for at-risk children, strong gains in social skills, reductions in children's problem behaviors, changes in teachers' behaviors, and improvement in the classroom environment.

There are a number of continuing activities underway to enhance the linkages and accessibility to behavioral health care for youth in Maryland's juvenile justice system. Over the past several years, NASMHPD Research Institute's post doctoral fellowship program and the Mental Health Association of Maryland have conducted studies to look at the needs of youth in the juvenile justice system. These studies initiated the development of a pilot project, based in part on the successes of the Maryland Community Criminal Justice Treatment Program for adults in jails, which was discussed in Criterion 1. The Maryland Juvenile Justice Mental Health Treatment Program, initiated with funds from the CMHS Mental Health Block Grant, has fortified the collaboration among juvenile justice officials, educators, and health and mental health professionals. The Program initially provided for behavioral health screening for youth detained from Baltimore City and the rural Eastern Shore and has been expanded to four detention centers Statewide. It also provides mental health treatment to the youth while detained and post discharge case management and treatment for those youth who return to a community living situation after detention and court disposition.

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In FY 2005, the program underwent a reconfiguration with both additional funding for mental health treatment from the Department of Juvenile Services (DJS) budget and the openings of the new Baltimore City Juvenile Justice Center, the Lower Eastern Shore Children's Center, and the Western Maryland Children's Center. The program now focuses on the needs of juvenile offenders in six detention centers prior to adjudication and disposition by the juvenile court (J. DeWeese Carter Youth Center, Alfred D. Noyes Children's Center, Cheltenham Youth Detention facility, Thomas J. S. Waxter Children's Center, Western Maryland Children's Center and the Baltimore City Juvenile Justice Center). DJS, with its additional mental health funding, will continue to build upon these existing services in FY 2008.

The time period covered by an extensive three-year plan for integrating behavioral health in the juvenile justice system has come to an end. However, many of the changes instituted continue, particularly the collaboration with MHA Child and Adolescent Services to provide training and consultation with DJS staff. Juvenile justice intake officers have received initial training on behavioral health screening for all youth who come before juvenile justice. The goal is to identify possible mental health problems and refer families for assistance. These screenings are administered to approximately 30,000 youth per year. Additionally, behavioral health services have been incorporated into facilities operated by DJS and those operated under contract. These facilities include detention centers, sheltered care programs, residential drug treatment programs, and youth challenge camps.

The MHA budget includes funds for a mental health component for aftercare services. In FY 2007, slightly less than \$1.8 million was transferred to MHA through an interagency memorandum of understanding to continue implementation of the mental health component for youth discharged from State juvenile correctional facilities. Mental health professionals, called Family Intervention Specialists (FIS), participate in 26 specialized DJS Intensive Aftercare Teams to conduct assessments, make referrals for treatment, and facilitate groups. In FY 2007, the Family Intervention Specialists provided mental health services to over 376 youth who came in contact with the juvenile justice system and were in need of services. In order to meet each jurisdiction's needs, the FIS work in collaboration with DJS area directors and supervisors and participate in meetings and trainings. The CSAs have been designated lead agencies at the local level, assuring coordination with other mental health services.

The MHA Child and Adolescent staff provide training for DJS direct care staff on an as needed basis, but at least four times annually. In addition, one of the staff will be assisting the DJS Director of Professional Development and Training to create training for DJS direct care staff which will be offered on an ongoing basis. If requested, MHA will assist in conducting this training. [NFC 4, 5]

### **Substance Abuse Services**

Since DHMH is the agency responsible for mental health, substance abuse, developmental disabilities, AIDS, child and maternal health, and all the programs offered through the State Medical Assistance Plan, there is an ongoing need for coordinating mechanisms within the Department itself in order for DHMH to fulfill its role as an

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interagency partner with the other Departments of the Children's Cabinet. The coordination of services for substance abuse, as well as developmental disabilities, with services offered to children and youth for mental health problems, is a critical issue within the DHMH coordination process. These needs all fall under the category of youth with special health care needs, and the primary systemic coordinating effort is the Special Needs Advisory Committee. Staff coordinators from MHA and ADAA and the special needs coordinator from the child's HealthChoice MCO work together when a child with co-occurring diagnoses requires enhanced coordination efforts. Efforts to support initiatives at the county level to implement the Integrated Systems of Care for Consumers with Co-Occurring Mental Health and Substance Use Disorders model of best and evidence-based practices and the State's involvement in the SAMSHA National Policy Academy are discussed under Criterion 1. [NFC 4]

### **Suicide Prevention**

The Maryland Suicide Prevention program works with a broad spectrum of professionals and survivors on activities which include prevention, intervention, and postvention services. In FY 2008 MHA continues statewide activities for suicide prevention, hot-line assessment, resource retrieval, and referral services through the Maryland Youth Crisis Hotline Network. As part of monitoring the statewide program, MHA reviews monthly reports from the Maryland Youth Crisis Hotline Network. The system managed 9,047 calls in CY 2006.

Additionally, in FY 2007 MHA chaired a working group to update the state's suicide prevention plan for children and youth. Multiple subcommittees comprised of stakeholders from other state agencies, providers and family members participated. In FY 2008 this plan will be integrated into the state's comprehensive suicide prevention plan which is under development. [NFC 1, 2]

## **INTERAGENCY INITIATIVES FOR FY 2008**

### **Efforts to Reduce the Unnecessary Relinquishment of Parental Custody**

The issue of children and adolescents who are unable to be discharged from hospitals in a timely way and may be at risk of unnecessary relinquishment of custody to access mental health services has been a significant concern in Maryland for the past several years. Based on a series of national reports by the Bazelon Center for Mental Health Law, the Maryland Coalition of Families for Children's Mental Health's 2002 study, *Relinquishing Custody—An Act of Desperation*, and the Governor's Executive Order 01.01.2003.02 of 2003 which created the Council on Parental Custody Relinquishment to Obtain Health Care Services, Maryland developed and is currently implementing a plan to address these issues. The plan provides funding with State resources from DHR and mechanisms for voluntary placement agreements in order to avoid change of custody when possible.

In the first half of CY 2006, the Systems of Care Initiative coordinated by the Governor's Office for Children (GOC), reviewed the recommendations from the Custody Relinquishment and Access to Services for Children Final Report to update their status and refine the focus for the group's continued work. In FY 2007, MHA, in collaboration with GOC, DHR, other interagency representatives, families, hospital and RTC representatives,

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addressed the following areas: fiscal strategies; services assessment and development; wraparound; training, technical assistance and education; data collection; and, local access mechanisms for families to locate and receive services. The Innovations Institute of the University of Maryland, Department of Child and Adolescent Psychiatry provided extensive training for providers and families in high fidelity wraparound (MD-Wrap) and local access mechanisms with funding from GOC. This process will continue in FY 2008. [NFC 2, 5]

### **Center for Medicaid/ Medicare Services' Waiver Applications**

Maryland has been working toward receiving two waivers or waiver amendments for home and community-based services for children and youth at risk of out-of-home placement. In October 2003, Maryland received a Real Choice Systems Change Feasibility and Development grant, *Community-based Treatment Alternatives for Children (CTAC)*, to study the feasibility of implementing a demonstration project of wraparound community services as an alternative to psychiatric residential treatment. Based on the grant findings and other activities in the state, \$1 million in State monies in FY 2006 was designated to fund two high-fidelity wraparound pilot programs for children up to 18 years of age who were enrolled in Medicaid. These began in January 2006; both are using the MD-Wrap Model. State funding was received through the GOC to expand the program in FY 2007 to two jurisdictions that are able to provide high-fidelity services.

In February 2006, Maryland Medical Assistance in collaboration with MHA submitted a request for an 1115 amendment waiver to expand these wraparound services to up to 750 children and youth who meet the medical necessity criteria for residential treatment. The waiver was withdrawn at Medicaid's request pursuant to the awarding of the 1915(c) demonstration projects.

Maryland received one of the ten 1915(c) federal Medicaid demonstration waivers to divert youth from psychiatric residential treatment and provide them with community-based services. Maryland has submitted the waiver application and is working with CMS toward waiver approval. The target population for the waiver are children who meet the medical necessity criteria for psychiatric residential treatment facility (PRTF) admission, who live in a jurisdiction with MD-Wrap services available, whose needs can be met in the community, and who are not currently eligible for Medicaid home and community-based services. The demonstration project will serve up to 150 children per year phased in over the five years of the project. Fidelity monitoring will be conducted at least three times per year. Children may remain in the waiver for up to 24 months with annual review. [NFC 2, 5]

### **Respite Care Initiative**

MHA offers respite care as a support service for the parents and caregivers of children with psychiatric disorders. Respite care is designed to provide temporary relief for the young person's caregiver from the often rigorous and stressful routine of caring for the child at home. There are three respite initiatives that the MHA is involved in with respect to child and adolescent respite services. They are: 1) the Maryland Caregivers Support Coordinating Council (MCSCC); 2) the respite services expansion feasibility study; and, 3) state grant-funded respite programs at the local level.

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MCSCC was created by the General Assembly through Senate Bill 567 in July 2001. Its charge was to examine the availability of respite care for caregivers of all ages and of all disability groups and to develop and coordinate a statewide system of family caregiver support services. The Council is composed of people appointed by the Governor's office and consists of family caregivers, advocates, and state agency representatives. MHA has played a significant role in development of the Council and the mental health community has good representation among appointees. In bringing together a diverse set of constituents, many of whom have not previously worked together, a number of key issues have emerged. For example, a central issue for representatives of the Department of Aging is the burden placed on grandparents caring for children with disabilities. Delivery of respite care and other caregiver supports is a key issue. The Council has promoted the use of a Maryland Lifespan Respite Model approach to the needs of caregivers, which includes all age groups and disabilities.

In 2003 the federal Centers for Medicaid and Medicare Services (CMS) awarded MHA a grant to do a feasibility study for the expansion of respite services for children in Maryland. The MCSCC serves in an advisory and oversight capacity for this project. The study has been conducted in partnership with the Center for Health Program Development and Management at the University of Maryland, Baltimore County. The study included provider and caregiver surveys, as well as a review of all regulations in Maryland that govern the provision of respite care. The final report (August 2006) analyzed the variety of regulations governing respite in Maryland, outlined findings from provider and family surveys, and developed a preliminary model as if respite were a Medicaid service. Considerable challenges to implementation of the model were noted. If funding becomes available, a demonstration project, based on the study, could be implemented. The initial priority population is youth with SED, but if funded there would be the requirement that the respite needs of families of youth with other disabilities would be addressed.

The MHA currently funds respite through state-only dollars. The MHA has recognized the need for respite care for families in reducing caregiver stress and considers it to be a critical family support service. There are seven contract-funded respite programs in Maryland which cover 15 counties statewide. Respite providers have contracts through the local CSAs but receive authorization to provide services through MAPS-MD, the Maryland ASO. Providers may provide either in-home or out-of-home (residential) respite or both. The CSAs submit bi-annual reports of the number of youth served, types of respite provided, and how respite was used as a way of reducing caregiver burden.

Most residential respite providers are treatment foster care or group home providers and all meet licensing requirements as a child placement agency. There continues to be interest in expanding respite services beyond current capacity. MHA meets quarterly with the CSAs, respite providers and family advocates. The purpose of these meetings is to discuss barriers and successes, as well as to have the group discuss ideas for how to expand respite options. Additionally, the programs meet on a quarterly basis with family groups to plan and advocate for respite expansion. [NFC 1, 2, 5]

**Services for Transitional Age Youth**

MHA received funding starting in FY 2000 to provide services for youth moving from the child to the adult system. MHA fully implemented competitively awarded grant-funded Transition Age Youth (TAY) projects, as of year four of the initiative. Initiatives in ten jurisdictions (Baltimore County, Worcester County, Washington County, Garrett County, Charles County—in a tri-county project involving St. Mary's and Calvert Counties, Prince George's County, Anne Arundel County, Baltimore City, Montgomery County, and Howard County) are fully operational at maximum service capacity. No additional funding was appropriated for the last several years; however, MHA continues to support existing grantees through its system of Core Service Agencies (CSAs). These projects are supported with State general funds provided through contracts to CSAs and with Medical Assistance (MA) through the fee-for-service system. These projects utilize different service approaches and target diverse and specialized populations (i.e. pregnant and parenting TAY with children; TAY transitioning from RTCs; supported education). MHA continues to review local CSA Plans for inclusion of services to TAY individuals and to identify diversionary strategies for supporting TAY in the community and preventing institutional placement. [NFC 2]

MHA partnered with the University of Maryland School of Medicine, Department of Psychiatry, Innovations Institute and Evidence - Based Practice Center to develop an application for a National Institute of Mental Health (NIMH) research demonstration grant to provide evidence for the effectiveness of a composite service delivery intervention model, entitled Supported Transition through Action and Resource Teams (START). START integrates three components targeting critical needs of TAY and their families: 1) the widely used, promising practice of MD-Wrap designed to provide coordinated and individualized care planning; 2) the EBP of supported employment to help youth obtain desired and meaningful employment and further their education; and, 3) a prominent youth and family empowerment component to support the key transitions for youth and family members associated with the period of emerging adulthood complicated by the complex mental health needs of the youth. These components will be tailored to address the developmental challenges experienced by transition age youth, the discontinuities in service delivery systems as youth move from the child-serving to the adult mental health system and the changing role of the family and the youth in accessing and participating in supportive services and making life decisions. The intervention is designed to facilitate movement toward positive adult development, to enhance adaptive outcomes following the end of secondary education, and to empower families to provide needed support. [NFC 5]

In FY 2008 MHA plans to utilize input from focus groups conducted by the Maryland Coalition of Families for Children's Mental Health to identify best practices in the delivery of services for transition-age youth (TAY) and begin dissemination activities. Focus groups with parents and transition age youth were conducted by the Coalition and a report, identifying recommendations for best practices, was provided to MHA. A conference is planned to begin dissemination to interested stakeholders.

MHA also collaborates with other agencies to address services to the TAY target group. MHA participates through the Governor's Interagency Transition Council (ITC) for Youth with Disabilities, in working with designated State agencies to coordinate cross-

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training and integration of initiatives that may impinge on systems reform for TAY-serving agencies. In FY 2007, MHA jointly sponsored an annual statewide conference on TAY with the Interagency Transition Council for Youth with Disabilities (ITC).

MHA continues to collaborate with the Maryland Department of Disabilities (MDOD) and with the ITC in the development and implementation of a cross-agency, multi-year strategic plan based on a recently completed statewide resource mapping process. This process identified existing and needed services and resources to improve post school outcomes for Maryland youth with disabilities, ages 16-25. The goal is to: 1) to align and coordinate existing TAY services across state agencies and to identify new services to develop, enhance, and sustain TAY outcomes; 2) to enhance coordination and collaboration among stakeholders with relevant services; and, 3) to develop new policies and legislation to better meet goals and objectives. [NFC 5]

### **Local Access Plans and Mechanisms**

Maryland is continuing to promote a systems of care philosophy and framework for children and youth, particularly those with, or at-risk for, intensive service needs. This process encourages local jurisdictions to strengthen local capacity by developing structural changes that: 1) create better access to service and service coordination for all families through a *Local Access Mechanism*; 2) provide accountable care coordination for children with the most intensive multi-system needs through designated care management units or entities; 3) employ the wraparound approach as a fundamental practice model in children's services; and, 4) develop new service capacity, particularly evidence-based and promising practices.

MHA and the CSAs have been active participants in the *Local Access Mechanism* project spearheaded by the Governor's Office for Children to develop a local infrastructure that helps families access and coordinate available services and supports, both public and private, to address the full range of needs encountered by families with children. These efforts improve coordination and utilization of existing resources and supports and assist in the identification of needed services. The state is supporting this initiative with \$2.295 million in the FY 2008 budget with the expectation that each jurisdiction will have a plan using the single point of access and family navigation philosophy tailored to the locale's needs and resources. Local agencies including the CSAs are partnering with families and youth at both the case plan and policy levels. An additional \$2.76 million of state funds is available in FY 2008 to extend the Wraparound pilot sites that provide accountable care coordination for Community Medicaid-Eligible children through designated care management entities. [NFC 1, 2, 3, 4, 5]

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**SFY 2008 OBJECTIVES FOR CRITERION 3:**

**INTEGRATION OF CHILDREN’S SERVICES**

- Continue to interface with other agencies and administrations to support a comprehensive system of mental health, somatic health, and other services and supports. The following is a listing of the agencies with which a liaison is maintained and the responsible MHA monitor. [NFC 1]

<b>Maryland State Government</b>	<b>MHA Monitor</b>
Maryland Department of Disabilities	Brian Hepburn MHA Office of the Executive Director
Governor’s Office for Children	Al Zachik and Marcia Andersen MHA Office of Child and Adolescent Services
Maryland State Department of Education	Al Zachik, Cyntrice Bellamy, and Joyce Pollard MHA Office of Child and Adolescent Services
Division of Rehabilitation Services	Lissa Abrams and Steve Reeder MHA Office of Adult Services
Department of Human Resources	Lissa Abrams MHA Office of Adult Services Al Zachik MHA Office of Child and Adolescent Services Marian Bland MHA Office of Special Needs Populations
Department of Housing and Community Development	Penny Scrivens MHA Office of Adult Services Marian Bland MHA Office of Special Needs Populations
Maryland Department on Aging	Lissa Abrams and Marge Mulcare MHA Office of Adult Services
Department of Public Safety and Correctional Services	Larry Fitch MHA Office of Forensic Services Marian Bland MHA Office of Special Needs Populations
Department of Juvenile Services	Al Zachik and Cyntrice Bellamy MHA Office of Child and Adolescent Services Larry Fitch MHA Office of Forensic Services
Judiciary of Maryland	Larry Fitch

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	MHA Office of Forensic Services
Alcohol and Drug Abuse Administration	Tom Godwin MHA Office of the Clinical Director
Family Health Administration	Al Zachik and Joyce Pollard MHA Office of Child and Adolescent Services
Developmental Disabilities Administration	Stefani O’Dea MHA Office of Adult Services Lisa Hovermale MHA Office of the Executive Director
Maryland Health Care Commission	Brian Hepburn MHA Office of the Executive Director
Health Services Cost Review Commission	Randolph Price MHA Office of Administration and Finance
Children’s Cabinet Results Team	Al Zachik MHA Office of Child and Adolescent Services
Office of Health Services (Medical Assistance)	Brian Hepburn MHA Office of the Executive Director Susan Steinberg MHA Office of the Deputy Director for Community Programs and Managed Care Gayle Jordan-Randolph MHA Office of the Clinical Director
Office of Operations and Eligibility (Medical Assistance)	Brian Hepburn MHA Office of the Executive Director Susan Steinberg MHA Office of the Deputy Director for Community Programs and Managed Care
Office of Health Care Quality	Sharon Ohlhaber MHA Office of Planning, Evaluation, and Training
Office of Planning and Capital Financing	Cynthia Petion MHA Office of Planning Evaluation, and Training
AIDS Administration	Marian Bland MHA Office of Special Needs Populations
Maryland Emergency Management Administration	Laura Copland MHA Office of Special Needs Populations

- Support the CSAs and Local Management Boards (LMBs) in their ongoing collaborations to implement Local Access Plans to assist children, youth, and their families obtain needed services. [NFC 1]

MHA Monitor: Al Zachik and Marcia Andersen, MHA Office of Child and Adolescent Services

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- Continue efforts, through the activities of the Maryland State Early Childhood Mental Health Steering Committee, to promote and support early childhood mental health services and to integrate mental health services within all settings where all young children and families grow and learn. **[NFC 4]**  
MHA Monitor: Al Zachik and Joyce Pollard, MHA Office of Child and Adolescent Services
- Continue statewide activities for youth suicide prevention, intervention, and postvention. **[NFC 4]**  
MHA Monitor: Henry Westray, MHA Office of Child and Adolescent Services
- Create an interagency project to better serve mental health needs of children in the child welfare system. **[NFC 4]**  
Monitor: Daryl Plevy, Mental Health Transformation Office
- Develop a plan, in collaboration with stakeholders, to improve services for transition-age youth (TAY) with disabilities. **[NFC 4]**  
MHA Monitor: Lissa Abrams, MHA Office of Adult Services, and Al Zachik, MHA Office of Child and Adolescent Services
- Support the efforts of the Department of Juvenile Services (DJS) to provide mental health clinical care in all DJS detention centers and residential facilities statewide and for children and adolescents receiving informal community-based supervision from DJS. **[NFC 4]**  
MHA Monitor: Al Zachik and Cyntrice Bellamy, MHA Office of Child and Adolescent Services
- Continue implementation of wraparound and community-based care pilots in Baltimore City and Montgomery, St. Mary's and Wicomico counties for youth who meet residential treatment center (RTC) level of care. **[NFC 5]**  
MHA Monitor: Al Zachik, Office of Child and Adolescent Services
- Apply, in collaboration with Medical Assistance, for a 1915(c) psychiatric residential treatment demonstration waiver to provide services to up to 150 children and youth as mandated in Senate Bill 748 (2006 Legislative Session) - *Psychiatric Residential Treatment Demonstration Waiver Application*. **[NFC 5]**  
MHA Monitor: Al Zachik and Susan Russell Walters, MHA Office of Child and Adolescent Services
- Collaborate with the Maryland Defense Force, the Maryland Army National Guard Family Assistance Program to implement a pilot program designed to provide psychosocial, psychoeducational, and referrals for mental health services to returning soldiers of the Maryland National Guard and their families throughout the deployment cycle. **[NFC 1]**  
MHA Monitor: Laura Copland and Charles Bond, MHA Office of Special Needs Populations

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- Support the DHMH Center for Maternal and Child Health in increasing public awareness of fetal alcohol spectrum disorders (FASD) and its effects on both mothers and children. [NFC 1]  
MHA Monitor: Joyce Pollard, MHA Office of Child and Adolescent Services

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### **CHILDRENS PLAN**

#### **CRITERION #4: Rural Populations and Services to the Homeless**

**Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.**

### **TARGETED SERVICES FOR RURAL POPULATIONS**

#### **Definition of Rural Areas**

Rural counties have historically been defined in Maryland as those with a population of 35,000 or less. Six counties continue to meet this criterion. (Source: U.S. Census Bureau, Estimated Maryland Total Population by Political Subdivision, July 1, 2005, as reported in Maryland Vital Statistics Annual Report 2005).

Maryland's definition was reviewed relative to the more complicated definitions of rural used by the U.S. Census Bureau. For Census 2000, the Census Bureau's classification of "rural" consists of all territory, population, and housing units located outside of urbanized areas (UAs) and urban clusters (UCs). The Census Bureau also looks at the population density with core census blocks of at least 1,000 people per square mile or surrounding census blocks with an overall density of at least 500 people per square mile. Many counties and metropolitan areas are split with UAs and UCs, often mixed with more rural areas. Based on population density alone, several other counties in Maryland, beyond the six, might be considered rural. However, other factors, including growth rate and proximity to major metropolitan areas (emerging bedroom communities), make these counties appear less rural. Based upon this, the six counties with populations under 35,000 will remain Maryland's defined rural areas for purposes of this application, while recognizing that pockets of "rural" areas exist in other counties.

Of the six Maryland counties that qualify under this definition, one rural county – Garrett – is the western-most jurisdiction in the state, and the other five – Caroline, Dorchester, Kent, Somerset, and Talbot Counties – are on the Eastern Shore. In recent years, several Eastern Shore counties have developed past the 35,000 threshold. Typically, as a rural county develops beyond the 35,000 threshold, it experiences growth in housing, commerce, and average household income that makes it more similar to the rest of the state.

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<b>Rural County Population</b>
Caroline 31,822
Dorchester 31,401
Kent 19,899
Somerset 25,845
Talbot 35,683*
Garrett 29,909

Source: U.S. Census Bureau, Estimated Maryland Total Population by Political Subdivision, July 1, 2005  
Maryland Vital Statistics Annual Report 2005

Talbot County is an excellent example of a county that is undergoing transformation from a rural to non-rural area. On July 1, 2003 the county's population was 34,670. On July 1, 2005, the last year for which official age-specific population data were available, the number increased to 35,683, barely exceeding Maryland's self defined "rural" threshold of 35,000. Projections indicate that the population of Talbot County will continue to increase to an estimated 36,062 in 2006. For purposes of this year's block grant application we will continue to include Talbot County among the six rural counties. (Utilization data from all six counties are used in the block grant performance indicator.) Talbot County now has an average per capita personal income of \$50,872 up from \$46,144 in 2005.

The five Eastern Shore rural counties have personal per capita incomes ranging from a low of \$23,125 in Somerset County to the high of \$50,872 in Talbot County, compared to a statewide average per capita personal income of \$41,972. The demographics of Somerset County and most of the Eastern Shore counties also reflect issues affecting rural areas. For example, Somerset has experienced little growth in recent years. Somerset County's 2004 household median income was one of the lowest in the State at \$34,000. Statewide household median income that year was \$64,450. Additionally, over the past five years, the number of Medical Assistance Program enrollees has risen.

Garrett County, in Western Maryland, provides a useful example of how rural communities differ from jurisdictions in more rapidly developing areas of the State. Garrett County has one of the lowest per capita incomes (\$27,843) of the State's 24 subdivisions. In 2004, the median household income was \$37,050 (Maryland Department of Business and Economic Development). The unemployment rate in Garrett County is generally double that of the state. Garrett County adults with less than a twelfth grade education comprise 20.7% of the population. 16.6% of the County residents, among the highest of Maryland jurisdictions, are enrolled in Medical Assistance. In its FY 2008-2009 plan, Garrett County is described as an isolated, rural, mountainous county in the northwestern most corner of Maryland. Availability of public transportation, access to health care and health information

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is limited for a number of socioeconomic, geographic, educational, and cultural reasons. Low education levels create a barrier to seeking and understanding health information. [NFC 4]

### **Available Services**

At present, the range of children's mental health and support services in rural counties is similar to those available in urban and suburban jurisdictions. Some services in contiguous counties are provided by programs that provide services at multiple sites throughout the area served. Mental health providers in rural areas have a history of cooperation and coordination as well as a history of sharing resources with each other and with other service related agencies, to address the service needs of specific populations. Through this cooperation, providers have developed innovative services that are tailored to the unique needs of their areas.

School-based services have been an effective way to improve accessibility to mental health services for children and adolescents. This approach helps overcome rural transportation issues and provides for better service coordination with other agencies. Three recent significant MHA projects, in which the rural counties have participated, are the Maryland Juvenile Justice Mental Health Treatment Program, the Respite Care Initiative, and as a pilot site for activities under the Early Childhood Mental Health Consultation Project (one of two pilot sites supporting child care centers). *Project Right Steps* is a partnership that includes four rural counties in the Mid Shore CSA, integrating early childhood mental health consultation services into existing early childcare and educational settings. The Juvenile Justice program provides mental health screening and treatment in the juvenile detention center on the Eastern Shore and intensive aftercare services for those youth eligible for services through the PMHS. Five of the rural counties participate in MHA's child and adolescent respite initiative. Each of these is also discussed in Criterion #3. [NFC 4]

MSDE in collaboration with MHA, DJS, the Center for School Mental Health Assistance, the Johns Hopkins University's Center for Prevention and Early Intervention, the Mental Health Association of Maryland, the Maryland Coalition of Families for Children's Mental Health, and the Maryland Assembly on School-Based Health Care received a School Mental Health Integration grant from the U.S. Department of Education. The Maryland Mental Health Alliance, composed of these interested groups helped MSDE pursue the integration of a full continuum of effective mental health promotion, prevention, early intervention, treatment, and crisis intervention services into Maryland schools. Using the work of the Alliance as a jumping off point, MSDE in collaboration with MHA submitted another USDE Integration Grant application focused on providing support, consultation, resources, and training to a small, rural -like jurisdiction (Dorchester County). The grant will support and develop further the infrastructure to integrate universal, secondary, and tertiary prevention and intervention in the county's eleven schools. [NFC 1, 4]

The maintenance of effective Core Service Agencies (CSAs) is a key statewide strategy to meet rural needs. The Mid-Shore Mental Health Systems, Inc. (MSMHS) is the CSA responsible for public mental health services in Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties, located on Maryland's Eastern Shore. MSMHS is currently the only regional CSA in Maryland. In its two year Community Mental Health Plan, MSMHS

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discussed the rural nature of four of the five counties in the region. Population per square mile ranges from 55.4 persons per square mile in Dorchester County to 130.1 per square mile in Talbot County, with a regional average of 89.9 persons per square mile. The plan emphasizes that in “planning processes to improve the system of care to assure consumer focus and one (system) that is recovery oriented, it is apparent that the unique needs of the rural jurisdictions must be given a priority.” [NFC 2, 4]

In its FY 2008 Community Mental Health Plan Update, the MSMHS reported the following special initiatives and collaborative efforts in FY 2007:

- Continued to partner with local education agencies, local management boards, and others in exploring various funding approaches and models of school-based mental health service delivery resulting in the Department of Education Integration grant application for Dorchester County;
- Continued to participate in the regional anti-stigma consortium;
- Continued to partner with the Department of Juvenile Services Intensive Aftercare Team through inclusion of a Family Intervention Specialist on the team; and,
- MSMHS collaborated with the Local Management Boards (LMBs) to develop local access plans. Through a negotiation process with the Governor’s Office for Children (GOC), the LMBs were awarded \$251,543 to implement a single point of access, through an Adult Review and Evaluation Services (ARES) accredited warm line and to hire three full-time family navigators for the region.[NFC 2, 4]
- MSMHS developed various components of crisis services and expanded Intensive Support Services, which are in-home intervention services available to families in the region. Approximately 354 children and their families were identified who required intensive services through the Intensive Support Services (ISS) initiative.
- The eight counties that comprise the mid and lower Eastern Shore were awarded \$500,000 through negotiations with GOC to develop a group home on the lower shore. It is hoped that the group home will have the capability to provide diagnostic services, crisis respite as well as typical services of a therapeutic group home.

After several years of moderate expansion, Somerset County Core Service Agency (SCCSA) has worked to maintain the array and number of services available. As the second smallest county in the State, Somerset County has only seen a 5.6% growth in population in the past 10 years, with little of that growth in recent years. It also has one of the lowest median income rates in the State. These factors make it important to avoid duplication of effort and to acknowledge the need for collaboration with both in-county and tri-county (Somerset, Worcester, and Wicomico) stakeholders on planning, service expansion, and coordination of activities and efforts. The Tri-County Provider Forum continues to meet to discuss issues regarding the PMHS and to increase provider knowledge. In FY 2007 Somerset County CSA reported the following accomplishments:

- Partnered with the Family Services Division of the Circuit Court to update and re-distribute the county resource guide;
- Partnered with the local Department of Social Services to provide Applied Suicide Intervention Skills Training for 30 professional and paraprofessional staff providing services in the county;

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- Continued working in partnership with the two other CSAs on the lower shore and received a HUD grant to provide 62 slots in the tri-county region to address permanent housing and case management needs;
- Provided leadership and management for the Salisbury Homeless Outreach Project that was funded by the City of Salisbury through Community Development Block Grant monies; and,
- Partnered with Seton Center, local affiliate of Catholic Charities to provide mental health educational information in the Spanish language. [NFC 2, 3, 5]

The Garrett County Core Serve Agency (GCCSA) Fiscal Year 2008-2009 mental health plan included accomplishments for the prior years. The key highlight for children and adolescents was the GCSCA’s continued support of the Adventure Sports Institute (ASI) of Garrett College, which operates the Transition Age Youth (TAY) project. TAY graduates now act as mentors to incoming TAY participants. The ASI applied for a \$20,000 Consolidated Technical Assistance Grant from the Appalachian Rural Commission (ARC) to support year-round adventure sport therapeutic activities for high school students in the TAY programs. If the grant is received, the Garrett County Commissioners and Garrett College have agreed to provide the \$20,000 match. [NFC 3, 4]

The following table provides an overview of the six rural counties and the major programs available. Not included in the table is the broad array of individual providers in these rural communities.

<b>CONTINUUM OF MENTAL HEALTH SERVICES</b>	<b>Mid-Shore Mental Health Systems</b>	<b>Somerset County CSA</b>	<b>Garrett County CSA</b>
Advocacy- Adult and Child	X	X	X
Community Support Funds(pharmacy, lab, transportation, other needs)	X	X	X
Detention Based Mental Health Services	X	X	X
Inpatient Services Adult Adolescents Child	X X X	X (youth and family services in Crisfield)	Emergency Room only
Intensive Outpatient Services	X		X
Intensive In-Home Services	X	X	X
Outpatient Mental Health Adult Child and Adolescent	X X	X X	X X

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Peer Support Services	X	X	X
Psychiatric Rehabilitation Program			
Adult	X	X	X
Child and Adolescent	X	X	X
Respite Care			
Adult	X	X	X
Child	X	X	
Supported Employment Services	X	X	X
Transition Age Youth Programs	X	Go-Getters committed six residential slots	X
Targeted Case Management			
Adult	X	X	
Child and Adolescent	X	X	X

**Service Needs**

In order to best assess local service needs and implement services to meet those needs, MHA strongly supported the development of CSAs in rural counties. As noted previously, all rural counties in Maryland are served by CSAs. The rural CSAs are challenged to plan, both independently and collectively, for their residents' needs and the most efficacious use of resources. All CSAs are required to include a description of their needs assessment process and findings, including gaps in services in their local mental health planning documents. The consistent and recurring service needs identified are: adequate number and mix of providers, need for specialty service providers, transportation, crisis treatment services, and efforts to address the needs of individuals with co-occurring disorders.

One of the major challenges for a rural area is the recruitment, retention, and ongoing training of mental health professionals. The number of qualified professionals in the Mid-Shore area has increased over time. This may be attributed to the growth of some of the Mid-Shore counties. Conversely, in its FY 2007 Plan Update, the Garrett County Core Service Agency reports that there are only 1.6 full-time equivalents of psychiatrist time available in the county. The need for psychiatric care for the child and adolescent population is acute. Garrett County and Kent County (as well as a number of very urban census tracts in Baltimore City with special needs related to the homeless population) are designated by the Federal Department of Health and Human Services, Bureau of Primary Health Care as mental health professional shortage areas (MHPSA). This designation may provide needed assistance in the recruitment of physicians. [NFC 3]

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CSAs, in both Western Maryland and on the Eastern Shore, have identified the need to travel to adjacent counties for some services as a significant rural issue. Due to the lower population density and greater distances to all types of services, rural mental health programs have acquired and operate vehicles to link individuals to services, both through mobile services and by transporting consumers to needed services. Local health departments and Community Action Agencies also provide some publicly supported transportation in rural counties. Additionally, CSAs have some funding in their budgets for transportation services for eligible individuals. Stigma also plays a significant role as a barrier to accessing mental health services, particularly in rural settings. The CSAs on the Eastern Shore and Lower Shore Counties work collaboratively with stakeholders to address stigma through workshops and public awareness activities.

Mid-Shore Mental Health Systems, Inc., in collaboration with other community programs, has recognized the need for mental health services for those Hispanic consumers that are uninsured. The Mid-Shore Council on Family Violence has two bi-lingual client advocates. For All Seasons, an outpatient mental health center, applied for a grant to obtain funding for a bilingual interpreter and MSMHS will provide the cost of the therapist, and limited psychiatrist time.

In the Fiscal Year 2008 Update of the Community Mental Health Plan, Mid-Shore Mental Health Systems, Inc. continues to focus on:

- Development of a system that is consumer and family driven and moves towards recovery and resiliency;
- Defeating the stigma of mental illness;
- Utilizing private/public partnerships to improve access;
- Maximizing existing resources by utilizing best practices with proven outcomes; and
- Improving access to care in the rural region through the use of developing technology.

Additionally both the Board of Directors and the Regional Mental Health Advisory Committee has given a priority to improve:

- Interagency communication and collaboration that maximizes resources and eliminates duplication and unnecessary expenditures in order to develop a rural model of delivery that better serves the consumers in need;
- Collection and reporting of recovery-oriented outcomes measurement data

In FY 2008-2009 Plan, the Somerset County Core Service Agency identified the following areas of need it will concentrate upon which include:

- maintaining collaborative initiatives locally, regionally and statewide;
- increasing awareness and public knowledge about mental illness and mental health resources;
- developing strategies that address ending chronic homelessness in the mentally ill population;
- addressing the need for integrated services for mentally ill, substance abusing and developmentally delayed individuals; and

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- developing and implementing outcomes management objectives for all contractual obligations. [NFC 1, 2]

The CSA analyzed the growth in the number of children and adolescents served and noted a significant increase in services provided. The CSA also put forth several innovative approaches specific to meeting the needs of child and adolescent residents of Somerset County during the coming year which include:

- Partnering with the LMB and DSS to plan a Community Awareness Fair to provide both professional and community stakeholders the opportunity to gather important information about services;
- Collaborating with the LMB, the Board of Education, the Department of Juvenile Services, and the Health Department's Prevention Program to secure funding, through a competitive State grant process, to develop a comprehensive school-based mental health and violence prevention program; and,
- Working with other county child-serving agencies to implement a countywide Local Access Plan (Somerset Family Links) which hired its family-systems navigator in January 2007. [NFC 4]

GCCSA's 2008-2009 Mental Health Plan focuses on solidifying and enhancing the existing programs. Efforts will focus on:

- Coordination and collaboration with consumers, family members, providers, and other county and state stakeholders to assure accessibility to quality mental health services.
- Identification of funds and programs which are targeted to increasing evidence-based practices for children/adolescents and their families, including suicide prevention activities.
- Maintaining numerous local and interagency collaborative efforts focused on children and youth, including collaborations surrounding school mental health issues, early childhood/preschool needs, and overall coordination of services.
- Working with graduates of TAY program to act as mentors to incoming TAY participants.
- Maintaining availability of school-based mental health services, now available in every school in Garrett County. [NFC 4, 5]

### **Use of Technology**

There have been several preliminary efforts in telemedicine over the past few years. Since 2004, through a child and adolescent best practices project funded by MHA, in collaboration with the directors of the departments of child and adolescent psychiatry at the University of Maryland and the Johns Hopkins Hospital, seminars have been held once per month and are video-conferenced to seven sites across the State. The goal is to provide state of the art information (best practices) on child psychiatry psychopharmacology and treatment to the child practitioners in Maryland. It is a live, interactive seminar that offers slide presentations, didactic material and interactive discussion. This project keeps State providers informed of the latest developments in their field without needing to travel many hours and at great expense.

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In 2003, Sheppard Pratt was awarded a grant from the U.S. Department of Agriculture (USDA) to install and furnish telemedicine equipment at several public and private mental health facilities in the State. Three units were set up in Worcester County in conjunction with the grant. Worcester County Health Department Core Services Agency, with funding from the Mental Hygiene Administration, contracted with Sheppard Pratt to provide telepsychiatry services to clients who were homeless, with mental illnesses and substance abuse problems. The Worcester County Core Services Agency has since expanded on these services by funding mental health treatment to children and adolescents. Additionally, a population of pregnant and post-partum women at the Center for Clean Start in Salisbury are served under the USDA grant. Sheppard Pratt was also awarded a grant in 2006 by the Health Resources Services Administration (HRSA) to purchase equipment, train providers and establish a telepsychiatry disaster network at several general hospitals and community mental health clinics in Maryland.

Sheppard Pratt has also completed a telepsychiatry inpatient attending physician demonstration project, one of the first in the country, with a general hospital on the Eastern Shore. The general hospital was in need of psychiatric coverage during a time of staff turnover, a common problem for rural general hospitals in Maryland as well as most other states. The hospital funded the professional fees portion of the pilot project as a demonstration of inpatient telepsychiatry utilization. Finally, a twice-monthly mental health grand rounds professional education program is provided via interactive videoconferencing to a number of hospitals and mental health clinics in Maryland.

Correctional Mental Health Services (CMHS) began utilizing telepsychiatry in 2004 at the St. Mary County Detention Center as part of a comprehensive program to provide mental health services to incarcerated individuals. CMHS currently provides telepsychiatry services at the St. Mary's, Charles and Wicomico County Detention Centers. CMHS provides both live and telepsychiatry services in all sites at which CMHS utilizes telepsychiatry.

MHA in collaboration with CSAs is now working to develop parameters for telemedicine, including its use to address access issues for remote locations, specialty services, and special needs groups. The Maryland Association of Core Service Agencies (MACSA) has applied for grants, USDA and HRSA, to obtain funding for the purchase of equipment and has partnered in this grantsmanship effort with the Mental Hygiene Administration and the University of Maryland Department of Psychiatry. Unfortunately, funding has not been awarded to date. MHA is working with the former clinical director of telebehavioral services at Sheppard Pratt, who is now at the University of Maryland. [NFC 3, 6]

### **TARGETED SERVICES TO THE HOMELESS**

The exact number of children and youth in Maryland who are homeless and who have mental health problems is unknown. MHA has been participating in the efforts of the Maryland Department of Human Resources (DHR) and local communities to implement the Homeless Management Information System statewide. All of the Maryland counties have established a system and most of the counties have trained shelters staff and providers on utilizing the Homeless Management Information System. Some counties are still working to

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resolve issues regarding providers' resistance to using the Homeless Management Information System due to concerns about client confidentiality. Data are not broken out by age as a part of the survey. Efforts are also underway to develop a statewide data warehouse so that local homeless data may be accessed at the state level. [NFC 6]

DHR's Office of Transitional Services gathers information about people who have stayed in emergency shelters, transitional housing programs, or who have been given a motel placement. Therefore, the estimate provided reflects only the number of homeless people who receive shelter as reported by local agencies on the Office of Transitional Services Homelessness Survey and is an underestimate of the actual number of homeless individuals. The total number of people who were served by Maryland's homeless shelters in Fiscal Year 2006, the latest year for which data are available, was 37,432 (all ages). This is a 2,661 person increase from the number served in FY 2005. Almost one-quarter (24.5% or 8,506) of those served in shelters in FY 2005 were children and youth between birth and 17 years. Shelters also reported that on 34,191 occasions, people were refused shelter or motel placements because of a lack of space or lack of funds during FY 2006. This is a decrease from FY 2005 and may reflect providers not collecting information on numbers of persons turned away. [NFC 6]

Only a portion of homeless individuals and families use shelters; MHA estimates that at least another 25% (8,692) of the homeless are unsheltered. Based on the National Resource Center on Homelessness and Mental Illness, 20-25% of the homeless population has a mental illness. Therefore it is estimated that there are 10,865 homeless persons who have a mental illness in Maryland. Because the age distribution of homeless persons is unknown, MHA cannot easily estimate the number of homeless children and adolescents.

The strategy of outreach and services for children and youth with serious emotional disturbance who are homeless continues to have a two-pronged focus: 1) children and adolescents who have run away from home for extended periods or who are otherwise homeless and on their own; and 2) children who are members of homeless families. These are two very different populations who are served by different service networks. [NFC 2, 5]

**Services for Runaway and Homeless Youth.** The unmet needs of youth that are homeless are extensive, particularly the needs of the runaway and homeless adolescents with serious emotional disturbance. A special project, for runaway and homeless youth, continues in Ocean City, Maryland, the state's major beach resort area. Located in Worcester County on the Eastern Shore, Ocean City increases from a relatively small community to a population of close to 400,000 in the summer. Many runaway and homeless youth frequent the resort, some experiencing serious psychiatric disorders, almost all involved, in some way, in drug and alcohol abuse. The agencies in the community have formed a successful collaborative consortium to coordinate shelter, primary health, substance abuse, mental health, and other human services for this population. The project serves youth from all areas of the rest of the Maryland and large numbers of youth from other surrounding states in the region. This program receives a federal grant from the Administration for Children, Youth and Families (ACYF) to sustain its efforts. In addition, federal community mental health block grant funds have been allocated for mobile crisis services in Worcester County. This project is intensively staffed. [NFC 5]

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**Services for Children in Homeless Families.** MHA has funded and provided technical assistance to a project for young children who are homeless because their mothers and other family members live in family shelters throughout Baltimore City. The Parents and Children Together (PACT) program provides a therapeutic nursery at the YWCA shelter in Baltimore City, and extensive consultation at The Ark, a day care program that serves many of the children who reside in family shelters across the entire city. This population is reported to experience significant developmental delays, particularly in language acquisition.

Children and adolescents with serious emotional disturbance in families that are homeless can access Maryland's Projects for Assistance in Transition from Homelessness (PATH) and Shelter Plus Care programs for services. PATH funds are used for outreach, engagement, case management, screening and diagnostic services, consultation to shelters, training, housing assistance, supportive services in residential settings, and mental health and substance abuse services. PATH funded case managers are located in shelters, detention centers, and service agencies, facilitating outreach and access to services in a timely manner. PATH provides outreach and access in urban, suburban, and all of the rural areas in Maryland. These services also link individuals and families to the fee-for-service system. The PATH Program is targeted to homeless consumers who have serious mental illnesses or co-occurring substance use disorders, who are disconnected from the community and lack the necessary supports to obtain permanent housing.

In FY 2007, the PATH program provided services in 22 of 24 jurisdictions in Maryland. The FY 2005 funding level was \$956,000. Local PATH supported agencies identified 2,932 homeless individuals with mental illnesses. Of these, 1,943 actually enrolled for PATH services. In FY 2006, the PATH funding level was increased to \$1,065,000. However due to federal cuts in the PATH Program, MHA received \$1,053,000 in PATH funding in FY 2007. The \$12,000 reduction in funding for FY2007 did not affect direct services to PATH-eligible consumers. It was taken from funds used in previous years to provide statewide training and to provide scholarships for consumers and/or PATH providers to attend national, state, and local conferences to enhance skills administered through Baltimore City. In FY 2008, PATH will be funded at \$1,053,000. The PATH programs are projected to provide services to an estimated 2,237 individuals and families.

In FY 2005, several counties received an increase in funding, including Baltimore, Harford, Frederick, and St. Mary's counties and Baltimore City. Increases were awarded to counties which proposed to use PATH funding for activities consistent with SAMHSA's mental health transformation goals. Through the increased funding, a consumer advocate was hired as a part of the Assertive Community Treatment Team in Harford County. Frederick County added a Medbank Program to their PATH Program to assist consumers to obtain free medications through the Patient Assistance Programs operated by pharmaceutical manufacturing companies. Additionally a PATH Outreach Worker/Case Manager was hired as a part of the TAMAR Community Project, a program funded by the AIDS Administration in partnership with MHA to provide psychosocial support services to HIV positive, female prostitutes involved in the criminal justice system in Baltimore City. Also in Baltimore City, funding was awarded to Health Care for the Homeless (HCH) to partially fund a new SSI Project at their site in Baltimore City. An SSI Outreach Specialist is housed at HCH to assist consumers with applying for SSI/ SSDI presumptive eligibility. In St. Mary's County, the additional funding has contributed to the purchase of two dedicated two-hour blocks of telepsychiatry per week in a mental health clinic which serves homeless persons who have

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serious mental illnesses who are transitioning out of the detention center. For a comprehensive review of PATH supported programs see the Adult Plan, Criterion 4.

In previous years, data on the number of persons served included those served through outreach and those receiving ongoing PATH services. Due to changes in definition, PATH consumers who are engaged through outreach are no longer included in the number of persons to be served. PATH providers are currently counting only those who are considered enrolled (client file opened and service plan developed) as the number served in FY 2007.

Additional grants have also been used to support needed services. PATH supported services are linked with Shelter Plus Care, a service which provides tenant-based or sponsor-based rental assistance. For FY 2008, MHA was awarded funding totaling \$3,186,648 for 14 Shelter Plus Care renewal grants. In FY 2007, MHA served a total of 642 persons in Shelter Plus Care, 149 single individuals with mental illnesses, as well as 157 families with 268 children, and 68 other family members. This program has proven very significant for the children and adolescents by providing housing to mothers with psychiatric disorders. It enables them to keep their children out of the child welfare system and avoid the resulting loss of custody.

MHA has had a U.S. Department of Housing and Urban Development (HUD) award for Shelter Plus Care since 1995, to provide housing for individuals who are homeless with serious mental illnesses and their dependents who are being released from the detention center, or are in the community on intensive caseloads of parole and probation. In FY 2007 the Shelter Plus Care Housing grant was renewed for \$2,580,217 largely due to increases in the Fair Market Rental Values determined by HUD. Additionally, in FY 2007 MHA received \$759,236 through eleven small grants targeted to specific jurisdictions. The jurisdictions awarded new five-year grants over the past years through MHA included Allegany, Anne Arundel, Baltimore, Cecil, Frederick, Harford, and Prince George's counties.

Since 1995, the process for applying for funding through the U.S. Department of Housing and Urban Development (HUD) has changed. In 1996, HUD introduced to communities the Continuum of Care model to address the problems of housing and homelessness in a more coordinated, comprehensive, and strategic fashion. The model required local communities to develop a strategic plan to address the use of HUD resources and this also became the application process for obtaining HUD funding. As a result of this change, MHA lost its ability to directly apply for Shelter Plus Care Housing grant funds to HUD and to apply for funding using a single statewide application. The new process requires MHA and other state and local entities to apply for funding through the local Continuum of Care Planning group. In FY 2007, MHA submitted 15 renewal grants to 13 Continuum of Care Planning groups as a part of their application for HUD funding. Each local Continuum of Care plan must incorporate MHA's Shelter Plus Care application in its local plan annually.

Advocates for the homeless and housing for people with disabilities in Maryland have expressed concern with proposed changes in the Housing Choice Voucher Program. If fewer vouchers are available for individuals with disabilities, then it will be more difficult to advance consumers from Shelter Plus Care to other housing choice programs.

Children and adolescents and their families who are homeless are also served by traditional mental health treatment and support programs, including existing psychiatric

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rehabilitation programs, case management entities, crisis service providers, and mobile and on-site clinic services. In addition, outreach and eviction prevention services, as well as coordination with needed mental health services, are provided to homeless individuals. State general funds and mental health block grant funds also support services and programs for the homeless population.

Training regarding issues related to homelessness and mental illness has been a MHA priority for several years. These training programs include consumers and representatives from many agencies. MHA works in collaboration with CSAs and/or PATH providers to develop training to address issues related to individuals who are homeless in hospitals, shelters, on the street, or in jails or detention centers. In FY 2007, MHA provided an annual conference targeted to PATH, housing, homeless, mental health, consumers, and advocates. The conference "From Homelessness to Housing: The Heart of the Matter" was attended by 150 persons. In FY 2008, MHA will provide a two-day Shelter Plus Care 101 Training and a three-day Housing Quality Standards Training for housing inspectors and residential specialist training for homeless services providers to increase knowledge of emerging best practices, i.e. SSI outreach training.

In FY 2007 MHA continued to meet on a quarterly basis with community service providers that receive PATH funds. MHA staff also attends the local Continuum of Care Planning group meetings on a regular basis. Since December 2004, MHA has been participating in the development of the State's Interagency Council on Homelessness' Ten-Year Plan to End Homelessness in Maryland. This planning committee is chaired by the Department of Human Resources and co-chaired by DHMH. MHA collaborates with other agencies and departments that provide services or have resources to meet the needs of individuals who are homeless with psychiatric disorders, including the Department of Human Resources, the Department of Housing and Community Development, and the Department of Economic and Employment Development. Within DHMH itself, MHA collaborates with the Alcohol and Drug Abuse Administration, Family Health Administration, Medical Care Policy Administration, and the AIDS Administration. MHA encourages and provides technical assistance on request to encourage similar interaction at the local level to facilitate effective service provision for homeless individuals of all ages with psychiatric disorders. [NFC 2, 4, 5]

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### **SFY 2008 OBJECTIVES FOR CRITERION 4:**

#### **SERVICES FOR CHILDREN AND ADOLESCENTS**

- Develop guidelines and explore potential financing for use of telemedicine within the PMHS for direct services, consultation, and education. **[NFC 3, 6]**  
MHA Monitor: Lissa Abrams, MHA Office of Adult Services
- Utilize Projects for Assistance in Transition from Homelessness (PATH) funds to continue services or leverage funding for additional services that support state transformation goals; continue to apply for federal support to enhance services; provide technical assistance to CSAs and homeless providers to support statewide provision of services for homeless individuals.**[NFC 3]**  
MHA Monitor: Marian Bland and Jacqueline Powell, MHA Office of Special Needs Populations
- Develop guidelines and explore potential financing for use of telemedicine within the PMHS for direct services, consultation, and education. **[NFC 3]**  
MHA Monitor: Lissa Abrams, MHA Office of Adult Services

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**ADULT & CHILD PLAN**

**CRITERION #5: Management Systems**

**This Criterion applies to both adult and children and adolescents. It is not duplicated in the Child Plan section.**