Baltimore County
Department of Health

Bureau of Behavioral Health
Core Service Agency

FY 2011
Annual Report
&
FY 2013-FY 2015

3-year
Comprehensive Mental Health Plan
and Budget

Baltimore County Department of Health

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Mental Health Association of Maryland
Mosaic Community Services, Inc.
NAMI of Baltimore
On Our Own, Inc.
People Encouraging People, Inc.
Prologue, Inc.
Villa Maria of Catholic Charities

FY 2011 Annual Report
&

FY 2013 Comprehensive Mental Health Plan and Budget

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Acronym List

Every effort has been made to spell out each acronym used in this report at least once. A glossary has been included for the benefit of the reader.

ACT	Assertive Community Treatment
ADAA	Alcohol and Drub Abuse Administration
ASO	Administrative Services Organization
ASP	After-school program
BCCRS	Baltimore County Crisis Response System
BBH	Bureau of Behavioral Health
BCDH	Baltimore County Department of Health
BSFT	Brief Strategic Family Therapy
C & A	Child and Adolescent
CAFAS	Child and Adolescent Functional Assessment Scale
CARF	Commission on Accreditation of Rehabilitation Facilities
CCP	Community Conferencing Project
CEI	Community Enhancement Initiative
CHIPS	Children's Hospital In-Patient Program (Franklin Square)
CISM	Critical Incident Stress Management
CON	Certificate of Need
CSA	Core Service Agency
CSI	Community Services Initiative or Community Solutions, Inc.
CQT	Consumer Quality Team
DHMH	Department of Health and Mental Hygiene
DHR	Department of Human Resources
DJS	Department of Juvenile Services
DORS	Division of Rehabilitation Services
DSS	Department of Social Services
EBP	Evidence-Based Practice
ED	Emergency Department
ECMH	Early Childhood Mental Health
EIDP	Employed Individuals with Disabilities Program
EOP	Explanation of Payment
FEMA	Federal Emergency Management Agency
FIS	Family Intervention Specialist
FPE	Family Psychoeducation
FTE	Full Time Equivalent
GOC	Governor's Office of Children
GOCCP	Governor's Office on Crime Control and Prevention
GST	Geriatric Service Team
HIPAA	Health Insurance Portability and Accountability Act
IAP	Intensive Aftercare Program
ICM	Intensive Case Management
IEP	Individual Education Plan
IHIP	In-home Intervention Program
IHIT	In-home Intervention Team
ISP	Immediate Services Program
JCAHO	Joint Commission on Accreditation of Hospital Organizations
LEA	Local Education Agency
LCT	Local Care Team
LMB	Local Management Board

MA	Medical Assistance/Medicaid
MACRO	Maryland Mediation Conflict Resolution Office
MACSA	Maryland Association of Core Service Agencies
MCCJTP	Maryland Community Criminal Justice Treatment Program
MCO	Managed Care Organization
MCT	Mobile Crisis Teams
MFR	Managing For Results
MHA	Mental Hygiene Administration
MHAM	Mental Health Association of Maryland, Inc.
MHP	Maryland Health Partners
MST	Multisystemic Therapy
MOU	Memorandum of Understanding
NACo	National Association of Counties
NAMI	National Alliance for Mental Illness
OHCQ	Office of Health Care Quality
OMHC	Outpatient Mental Health Center
OPS	Operations Center for the Baltimore County Crisis Response System
PATH	Projects Assisting Transition from Homelessness
PHMS	Public Mental Health System
PRP	Psychiatric Rehabilitation Program
QA	Quality Assurance
QMB	Qualified Medicare Beneficiary
ROSC	Recovery Orientated System of Care
RFP	Request for Proposals
RRP	Residential Rehabilitation Program
RSP	Regular Service Program – FEMA grant
RTC	Residential Treatment Center
SAMHSA	Substance Abuse Mental Health Services Administration
SBS	School Based Services
SCYFIS	State Children, Youth and Family Information System
SE	Supported Employment
SED	Serious Emotional Disorder
SEP	Supported Employment Program
SLMB	Special Low-Income Medicare Beneficiary
SMI	Serious Mental Illness
SOAR	Supplemental Social Security, Outreach, Access and Recovery
SPC	Shelter Plus Care
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSP	Successful Schools Program
SST	Student Services Team
TAMAR	Trauma, Addictions, Mental Health and Recovery
TAPA	Technical Assistance and Policy Analysis Center
TAY	Transitional Age Youth
TBI	Traumatic Brain Injury
TBS	Therapeutic Behavior Support
UCC	Urgent Care Clinic
VAAN	Vulnerable Adults Assistance Network
VO	ValueOptions®
VPA	Voluntary Placement Agreement
WRAP	Wellness Recovery Action Plan
Youth MOVE	Youth Motivating Others through Voices of Experience

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Executive Summary

Attached is the Baltimore County Annual Report for Fiscal Year 2011 and the Plan for Fiscal Years 2013-2015.

The first part of the report is the Fiscal Year 2011 Annual Report. The most significant highlights of this year is the continued merging of the local Baltimore County mental health and substance abuse programs into an integrated behavioral health system of care. This merger is an ongoing process and is anticipated to take several years to be fully realized. Some benefits that have been achieved since the first year of this process are:

1. More efficient use of resources
2. The development of innovative programming
3. Blending of program philosophies and values
4. Cost Effectiveness and increased quality

The merger of mental health and substance abuse services reflects state and national trends. It is expected to enhance our ability to serve individuals with these co-occurring disorders, help us refine our internal management practices, be in a better position adapt to future budgetary challenges, and respond to the systemic changes which are anticipated from health care reform.

The Departments of Health and Social Services will merge in FY 2012 to form the Department of Health and Human Services. It is anticipated that this initiative will create additional opportunities for cross-system collaboration.

Other **highlights** from Fiscal Year 2011 include:

1. The continuation of our Public Forums for both Adult Consumers and Children and Families
2. The re-direction of existing funds to support the expansion of two evidence based practice programs; Assertive Community Treatment (ACT) and Brief Strategic Family Therapy (BSFT).
3. Expanding the availability of housing vouchers for individuals with mental illnesses through increased collaboration with the local Office of Community Conservation and the Local Housing Office.
4. Maintaining a positive working relationship with local stakeholders and partners to advance the needs of individuals with serious mental illnesses.

There have been several **challenges** for the Baltimore County Core Service Agency (CSA) during the past fiscal year:

1. The CSA also experienced reductions to its State budget during FY 2011. Most of these reductions were absorbed within the CSA's administrative budget to minimize the impact on direct services to consumers. Although no employees were dismissed, as positions became vacant they were left unfilled increasing the workload for the existing staff.

2. Affordable housing continues to be an ongoing need for consumers in our community. Although we are fortunate to have over 330 residential rehabilitation housing slots available for individuals with serious mental illnesses, there is a lack of affordable

alternatives available for individuals who may no longer require that level of support and supervision. During FY 2011, we were able to continue our collaboration with local housing officials and advocates to increase utilization of supported housing programs by individuals with mental illnesses.

The review of the data **trends** for Baltimore County for FY 2011 indicates that the patterns of utilization and expenditure within the local public mental health system are generally consistent with the trends observed throughout the State as a whole.

1. Overall there was a 13% increase in the number of persons served and a 1% increase in expenditures compared to Fiscal year 2010.
2. There has been a 13.6% increase in the number of individuals with Medicaid and a 4% decrease in the number of uninsured individuals served.
3. In FY 2011, Baltimore County has a penetration rate of 14.3%, similar to the statewide rate of 13.8%.
4. Baltimore County is spending about 25% more per person on services to children and adolescents and about 12% less per person on services to adults than the statewide average in FY 2011. This is consistent with data from FY 2010.

The CSA had **four primary goals** for FY 2011:

1. The CSA, in partnership with local stakeholders, will develop strategies and programs to guide mental health consumers to an array of clinically appropriate and cost effective services.
2. The CSA will oversee implementation of fiscal, operational, and policy changes within the public mental health system with consideration to local best interests.
3. The CSA will develop and manage targeted services and initiatives to serve specific needs populations.
4. The CSA will monitor, evaluate, and analyze public mental health services in Baltimore County.

The Annual Report discusses the progress in meeting these goals and the projections for FY 2013.

Section I of this document contains the Plan for FY 2013-15

The plan discusses the Mission and Vision for the Department of Health and the Bureau of Behavioral Health.

The Mission of the Bureau of Behavioral Health is:

"To strengthen and sustain a safe and effective behavioral health system of care that promotes wellness and recovery."

The Vision of the Department of Health is:

" Healthy people living, working, and playing in Baltimore County"

The organizational structure of the CSA is presented as an integrated mental health/substance administrated entity within the Bureau of Behavioral Health

The plan was developed by a workgroup comprised of both mental health and substance abuse staff within the Bureau of Behavioral Health as well as representatives from the Mental Health Advisory Council. The group met weekly to review goals and objectives, analyze data, and develop the document format. The goals and objective were discussed at several meetings of the Advisory Council along with a presentation of the data. The needs assessment process involved the review of material from several sources including, MHA PMHS data, and review of Help Call Data' from calls received by the CSA from throughout the previous year, and consumer concerns and feedback offered at the annual Mental Health Town Meeting.

The CSA has established five goals for FY 2013:

Goal 1.
The CSA in partnership with local stakeholders (e.g. consumers, family members), will develop strategies and programs to guide behavioral health consumers to an integrated array of clinically appropriate services.

Goal 2.
The CSA will oversee implementation of fiscal, operational, and policy changes within the Public Mental Health System with consideration to local best interests.

Goal 3.
The CSA will develop and manage targeted services and initiatives to serve special needs populations.

Goal 4. The CSA will monitor, evaluate, and analyze public behavioral health services in Baltimore County.

Goal 5.
The CSA will promote system of integrated care where prevention of substance abuse and mental illness is common practice across the life span.

Section II contains the budget for FY 2013. Our budget for FY 2013 is essentially level funded from FY 2012.

Section III of the report includes the roster for the Baltimore County Mental Health Advisory Council and the Council's letter of support. The Council has been an active partner with the CSA in promoting and advocating for mental health issues in the County.

Baltimore County
FY 2011
Annual Report

Baltimore County Core Service Agency Annual Report FY 2011

Introduction:

Fiscal Year 2011 was a very busy year of highlights and challenges for the Baltimore County CSA.

The CSA continued to move forward with the integration of mental health and substance abuse services as a component of the Bureau of Behavioral Health. This merger, which was initiated two years ago, has continued to create opportunities for administrative efficiency and service enhancement. Quarterly Provider Meetings now include both mental health and substance abuse providers and a shared agenda. Additional integration challenges and opportunities lie ahead with the local merger of the Departments of Health and Social Services to form the Department of Health and Human Services in FY 2012. This new administrative structure will provide behavioral health staff and social service staff with opportunities for a closer working relationships and greater possibilities for collaboration.

The CSA has closely monitored efforts at the Department of Health and Mental Hygiene (DHMH) to integrate behavioral health system and services. As a stakeholder in the integration process, the CSA will participate in the ongoing efforts of the DHMH to develop a system of integrated care, based on the Department's, "Principles for Integrated Care" as listed below:

1. A new system should provide the greatest value to Maryland consumers. Individuals and families should be able to access the right services at the right time to remain as healthy and productive as possible.
2. A new system should support effective models of integrated care. These models include health homes, where medical treatment and behavioral health care not only are provided at the same location, but as components of a single treatment plan for the whole person.
3. A new system should prioritize the needs of the seriously ill. Special attention must be paid to assure coordinated care for especially vulnerable Marylanders who experience severe mental illness or substance abuse disorders.
4. A new system should integrate financing for substance abuse and mental health treatment services. Given the high degree of comorbidity, our financing system should not fracture along the lines of diagnoses within behavioral health.
5. A new system should provide payment on the basis of performance, value and outcome, not just volume. Such payment reform transformations are occurring throughout the health care financing and delivery systems for all payers and services, and the behavioral health system must join this movement to align incentives with prevention and health for Marylanders.
6. A new system should include a strong role for local oversight and engagement. The financing system should provide comprehensive and outcome data to localities. Currently, localities receive only a fraction of important data about the care of their residents. More full information will allow for the identification of unmet needs and the design of programs to address them.
7. A new system should be able to coordinate well with other systems, including the criminal justice, education and child welfare systems, to promote social outcomes

such as successful community reintegration, adoptions and permanent placements, school achievement, and others.

From a procurement perspective, there were seven programs with contracts scheduled to expire at the end of the Fiscal Year and two new programs launched. The contracts scheduled to expire included geriatric services, homeless services, Wellness and Recovery programs, jail based services, and services provided through Consumer Flex Funds. All programs were successfully re-bid with no disruption in services. Two new evidence based practice programs were started, Assertive Community Treatment (ACT), and Brief Strategic Family Therapy (BSFT). Both of these programs are a welcome addition to the local continuum of services.

The Co-Occurring Disorders Workgroup continued to meet during FY 2011, offering training and technical assistance to the mental health and substance abuse provider networks. This group has focused on issues such as comparing and contrasting the Recovery Oriented System of Care (ROSC) initiative promoted by the State Alcohol and Drug Abuse Administration, and the Recovery Movement in the mental health community. The group has also spent time learning more about the development of Federal Health Care Reform and the potential impact on behavioral health services.

The lack of affordable housing for individuals with serious mental illnesses continues to be an ongoing challenge in Baltimore County. In FY 2011, the CSA reviewed and revised its procedures for reviewing applications for residential rehabilitation programs (RRP) in order to increase efficiency and parity in the placement process. There is very little turnover in the RRP programs and a need to create more housing alternatives. The CSA is working closely with local partners in the County Housing Office and Office of Planning to develop additional affordable options.

The CSA has been actively involved in the development of services for children and adolescents. The Child and Adolescent Coordinator promoted the local development of evidence based services for this population, including Multisystemic Therapy, Brief Strategic Family Therapy, and Functional Family Therapy. CSA staff work closely with our provider network and the staff in our Local Management Board, and have been active in statewide policy initiatives through MHA and the Maryland Association of Core Service Agencies (MACSA).

The CSA oversees a broad network of grant funded sub-vendor programs. These programs have had a successful year and their accomplishments are listed in this Annual Report.

This Annual Report also lists the four goals established for the CSA in FY 2011 and the progress achieved and the projections for FY 2013.

Highlights:

1. The CSA continued to **comply with all aspects of our Memorandum of Understanding (MOU)** with the Mental Hygiene Administration (MHA). The agency has been noted for its excellent contract and fiscal management and monitoring systems, and successfully completed all of its quarterly reviews from MHA.

2. We are fortunate to have an active and engaged **Mental Health Advisory Council**, which has a good working relationship with the CSA. The Council has had strong representation from our provider, consumer, and partner agency networks.

3. **Public Forums**: In October 2010 the CSA sponsored the 13th Annual Town Hall Meeting and Mental Health Fair. The event, which is targeted to adult consumer audiences, drew over 250 attendees and provided a forum for consumers to learn about local mental health and related resources and get answers to individual questions regarding mental health services and issues. The Fourth Annual Children's Mental Health Fair was held in April and attracted over 200 participants. This event offered important information regarding available services and service coordination to families and professionals in the County and included break out sessions on topics of special interest including Access to Low Cost & No Cost Service, DORS Services and Enhancing the Family-Provider Relationship. Both of these forums have become important venues for community education regarding local mental health services and resources.

4. The CSA has **positive relationships with other stakeholders** in the local mental health community. Regular service coordination meetings are held with the provider and consumer networks. There are strong interagency relationships with the Police, criminal justice system, Local Management Board, Departments of Juvenile Services (DJS) and Social Services (DSS), Homeless Services, Baltimore County Public Schools, and the Department of Aging. CSA staff members have participated in providing an overview of mental health intervention issues for homeless shelter staff and police to improve interactions between these groups and our target population.

5. The CSA has been able to make progress this year in **expanding the pool of housing resources** available to our consumers. The CSA and Local Housing Authority collaborated and jointly led an effort to respond to a Notice of Funding Availability (NOFA) from the Department of Housing and Urban Development (HUD) to expand the number of housing vouchers available to individuals with disabilities. This workgroup continues to meet to review policies and resources available to increase access to supported housing vouchers for individuals with disabilities, including psychiatric disabilities. The CSA has also developed a collaborative relationship with the Baltimore County Office of Community Conservation (OCC). This office oversees the local implementation of the Homelessness Prevention and Rapid Re-Housing Program (HPRP). The program provides rental subsidies for individuals who agree to participate in case management services. The CSA was able to have 25 of the 125 slots in the program set aside for individuals with psychiatric disabilities and has been successful in referring individuals to that program. The CSA was also an active member of the planning committee for the Charrette process used to establish the County's ten year plan to eliminate homelessness.

6. As part of the local health department, CSA staff participated in several **activities as a response to local community health needs**. These activities included the flu vaccination campaign, including providing support in the planning and conducting of vaccination clinics.

7. In FY 2011, staff from the CSA provided **leadership in many aspects of the Public Mental Health System.** The CSA director served on the Executive Committee of the Maryland Association of Core Service Agencies (MACSA) the statewide network of CSA directors, and was a representative from that group to the Maryland Mental Health Coalition. Our Child and Adolescent Services Coordinator chaired a subcommittee of MACSA, and several staff participated in other subcommittees and work groups for that organization. Baltimore County CSA participated with MHA as a member the Mental Health Blueprint Committee for Children, Youth, and their Families.

Needed services:

Affordable housing continues to be one of the main consumer needs. There is a perceived bottleneck of clients in the Residential Rehabilitation Program (RRP) who may no longer need the intensive service offered, but cannot move to more independent housing due to due to lack of affordable options. This lack of affordable housing also affects homelessness. The CSA responded by collaborating with local stakeholders, including the Local Housing Office, the Office of Community Conservation, and local homeless advocates through an intensive planning process to identify and develop additional housing alternatives. A survey of current RRP placements is planned for FY 2012 to identify participants who could have the potential to transition to more independent housing.

Data trends:

The Mental Hygiene Administration has provided the CSA with standardized data tables for FY 2011. These tables are primarily a presentation of Public Mental Health System utilization in the County by age group, type of coverage, and type of service utilized. A review of the trends identified is included in section two of this document, the FY 2013 Plan section.

There are several data trends that can be summarized for this Annual Report:

1. The data trends in Baltimore County are very consistent with the data trends that reflect the entire state. This has been true for at least the past three years. The distribution of services and expenditures among the age groups is very similar to the statewide trend.
2. The number of people receiving public mental health services in Baltimore County increased by 13% from FY 2010 to FY 2011.
3. Overall, expenditures on Public Mental Health Services remained stable in Baltimore County, increasing by less than 1 percent from FY 2010 to FY 2011.
4. Baltimore County overall spends about 16% more than the State average per person on public mental health services. This is primarily due to a higher cost per person for child and adolescent services and may be attributable to the rich array of children's services available in the County.

Annual Report of Activities

CSA Sub Vendor Programs (organized alphabetically by project title)

This section details all sub vendor programs annual performance and CSA flexible funds outcomes. Each CSA administered program, those programs staffed by CSA special payroll employees and funded through various funding resources, is described and program performance is detailed. The subsequent program descriptions represent the outcomes for services provided under contract; grant agreement and/or Memorandums of Understanding during FY 2011.

Three grids are provided to detail the following:

- **CSA Service Matrix** by service provided and population served. A page number is provided, which references the location of the program report in the report.
- **CSA Sub Vendor Program** chart details services provided by provider
- **CSA Flexible Funds Matrix** describes each fund and services provided through the fund

Table8: FY 2011 CSA Service Matrix

CSA Service Matrix							
Service (Alphabetical by Service)	**Population Served**					**FY 20011 Program Report**	
	Children & Adolescents	**Transition Age**	**Adults**	**Aging**	**All**	**Table #**	**Page #**
Case Management					✓	Table 11	Page 18
Deaf Differential			✓			Table 12	Page 20
Family Intervention Specialist	✓					Table 14	Page 22
Family-to-Family					✓	Table 15	Page 23
Geriatric Service Team (GST)				✓	✓	Table 16	Page 25
Homeless Outreach					✓	Table 17	Page 26
In-home Intervention (state-wide)	✓					Table 26	Page 39
Mental Health Crisis Service					✓	Table 19	Page 30
Multisystemic Therapy (MST) Program	✓					Table 20	Page 33
Projects Assisting Transition from Homelessness (PATH)					✓	Table 17	Page 26
Re-Entry			✓			Table 17	Page 26
Seniors in Partnership/Education Program (PEERS)				✓		Table 24	Page 36
Shelter Plus Care					✓	Table 18	Page 29
Special Population RRP			✓	✓		Table 13	Page 21
Therapeutic After School Program (2 sites)	✓					Table 26	Page 39
Therapeutic Respite Care (state-wide)	✓					Table 26	Page 39
Transition Age Youth (TAY) Program		✓				Table 25	Page 37
Trauma, Addictions, Mental Health and Recovery (TAMAR)			✓			Table 17	Page 26
Wellness & Recovery Center (4 sites)		✓	✓			Table 27	Page 42

Table 9: FY 2011 CSA Sub-Vendor Programs

CSA Sub-Vendor Programs			
Provider (Alphabetical by Provider)		**Contract**	**Service Provided**
1	Affiliated Santé Group	**1**	Mental Health Crisis Service
2	Alliance, Inc.	**2**	Case Management
			Re-Entry Program (New vendor for FY'12)
			TAMAR, Trauma, Addictions, Mental Health and Recovery (New vendor for FY'12)
3	Bay Life Services	**3**	GST (Geriatric Service Team)
4	Community Solutions, Inc	**4**	MST (Multisystemic Therapy)
5	Community Support Services for the Deaf, Inc. (CSSD)	**5**	Deaf Differential
			Special Population RRP
6	Mental Health Association of Maryland	**6**	PEERS
7	Mosaic Community Services, Inc.	**7**	FIS (Family Intervention Specialist)
8	NAMI	**8**	Family-to-Family
9	On Our Own, Inc	**9**	Wellness & Recovery Center
10	People Encouraging People, Inc. (PEP)	**10**	TAY (Transition Age Youth) Program
		11	ACT (Assertive Community Treatment)
11	Prologue, Inc.	**12**	Wellness & Recovery Center
		13	Homeless Outreach
			PATH
		14	Shelter Plus Care
12	Villa Maria	**15**	Brief Strategic Family Therapy (BSFT)
		16	Therapeutic After School Program (2 sites)
		17	Therapeutic Respite Care (state-wide)Therapeutic After School Program (2 sites)
			In-home Intervention (state-wide)Therapeutic Respite Care (state-wide)
TOTALS =	**12 Vendors**	**17 Contracts**	**21 Services Provided**

Table 10: FY 2011 CSA Flexible Funding

CSA Flexible Funding	
Child & Adolescent Flex Fund	
Provider	**Service**
IFCS	In-home Intervention and Day Care Consultation
Mosaic	In-home Intervention
Villa Maria	In-home Intervention/Institutional Respite
Adult Flex Fund	
Provider	**Service**
Various vendors	Adult Flex Fund
Various vendors	Medical/Dental Fund

Table 11: FY 2011 Case Management Outcomes

Program:	**CASE MANAGEMENT**	
Project Title:	Case Management	
Vendor:	Alliance Inc., under grant system only from August 2007 through August 2009, converted to fee-for-service for remainder of FY 10 and beyond	
Population:	All	
	TARGET:	**OUTCOME:**
Number of referrals received	-----	**478**
Number of adults served	326	**214**
Number of children served	282	**190**
% of consumers remaining free from hospitalizations	95%	**99%**
% of consumers remaining free from incarcerations	95%	**95%**
% of consumers successfully discharged	90%	**65%**
% of consumers reporting satisfaction with services	95%	**95%**

Program Description

Case managers assist consumers, both children and adults, throughout the county, in many ways. Contacts between consumers and case managers occur in many settings: home, community, hospital, homeless shelters. Alliance also has one staff assigned to the County Detention Center pro bono, to establish links with prisoners who could be served post-discharge. Individuals with a mental health diagnosis, insured by MA or uninsured, may request Alliance case management services. Referrals may be initiated by the consumer or may be referred by an individual working with the consumer. Case managers are also present in the homeless shelters and accept referrals from the CSA, the Department of Social Services, the public school system, and other governmental agencies. Thus, Alliance was responsive to a wide variety of referral sources.

Case managers partner with and assist the consumer to access appropriate services and supports in order to function as independently as possible in the community. In conjunction with the consumer and family or significant others, an assessment of the consumer's needs is made, and an action plan aimed at recovery is developed. Services may be traditional mental health clinic-based services, or specialized supplementary, counseling-oriented or substance-abuse treatment services provided by an array of community agencies. The case manager also helps clients in need seek stable housing and financial benefits or emergency funds. Despite the variation in the type of services, the length of case management service is time limited to approximately six months.

Highlights

Alliance is working with consumers to access and maintain housing through a variety of special programs. In FY 11 Alliance was able to help at least 60 consumers with voucher programs, as well as additional consumers with some one time flex fund assistance for security deposits or eviction prevention. The vouchers included 25 vouchers for the County's Homeless Prevention and Rapid Re-housing program, 30 vouchers for the County's Rental Allowance Program, and 5 Shelter Plus vouchers from Prologue. In November and December 2010, Alliance assisted over 50 families with food or clothing for the holidays.

Challenges

The consumers face an abundance of challenges such as lack of insurance, SPMI, co-occurring disorders, acute and chronic physical health issues, homelessness, and possible incarceration or victimization. The problems Alliance encounter while trying to assist this group are mainly lack of resources such as insurance, affordable housing, transportation and medical and psychiatric services.

Table 12: FY 2011 Deaf Differential & Sign Language Interpreter Outcomes

Programs:	**DEAF DIFFERENTIAL SIGN LANGUAGE INTERPRETER**
Projects:	Signing Therapist Services in PMHS programs American Sign Language Interpreters
Vendor:	Community Support Services for the Deaf (CSSD)
Population:	Consumers who are deaf and/or hard of hearing and receive services within the Public Mental Health System

TARGET:	**OUTCOME:**
12 consumers served in outpatient mental health	**12 consumers served**
23 consumers served in psychiatric rehabilitation	**23 consumers served**
5 consumers served in residential rehabilitation	**5 consumers served**
143 hours of sign language interpretation	**143 hours**

Program Description

CSSD has a Psychiatric Rehabilitation Program (PRP), which consumers attend during the day. A signing Rehabilitation Specialist provides interpretation services. Twenty-three consumers this year utilized these services. Consumers in this program reside in supervised living programs. In order for the consumers to reside in this structured program, they must meet priority population criteria for residential care.

The Deaf Differential project pays for sign language interpretation for consumers receiving outpatient, psychiatric rehabilitation, and residential rehabilitation services. The public mental health system covers the cost of the mental health services, and the grant covers the cost of the sign language interpreter.

Highlights

The program provides a specialized service for individuals who are both deaf and/or hard of hearing and have a mental illness. We are fortunate to have this resource available in our continuum of care. The program successfully met its targeted performance goals in each category.

Challenges

The number of individuals served is limited by the availability of funding.

Table 13: FY 2011 Special Population RRP Outcomes

Program:	**SENIOR CENTER FOR RETIREMENT SERVICES (Special Population RRP**
Project Title:	Special Needs Clients
Vendor:	Community Support Services for the Deaf (CSSD)
Population:	Consumers with a mental health diagnosis who are deaf and/or hard of hearing, and require multiple, intensive, and specialized services to remain in the community

TARGET:	**OUTCOME:**
Provide specialized RRP services for 3 consumers to remain in the community	**3 consumers served**

Program Description

CSSD, Inc. served three individuals in the Senior Center for Retirement Services. CSSD provides a continuum of services for individuals who are deaf and/or hard of hearing and have a mental health diagnosis. CSSD provides an intensive level of service through the Retired Service Program. Individuals in this program have severe medical needs along with hearing loss and mental illness. A nurse provides medical services, which include medication management, wound care, administration of medications by injection, and acute medical care issues, ex. diabetes, cancer, heart attack, stroke, etc.). Funds are provided for three individuals to be served in this program each year.

Highlights

The program successfully maintained its clients in a stable community setting. The participants continued to develop their community living skills and their ability to cope with their mental illness through participation in the residential and psychiatric rehabilitation programs or in the Senior Center.

Challenges

The program has had some challenges in managing some of the behavioral issues of their most challenging residents. The program has discussed the possibility of adding additional awake overnight staff to address these issues.

Table 14: FY 2011 Family Intervention Specialist Outcomes

Program:	**FAMILY INTERVENTION SPECIALISTS (FIS)**	
Project Title:	Family Intervention Specialist – Team Based	
Vendor:	Mosaic Community Services, Inc.	
Population:	Adolescents in the Dept. of Juvenile Services Violence Prevention Initiative	
OUTCOME MEASURES:	**TARGET:**	**OUTCOMES:**
Number of referrals received	20	**19**
Each FIS will serve at least 10 cases, for a total of 20 youth served per fiscal year.	20	**22**
60% of the youth on caseload will avoid re-arrest.	60%	**89%**
60% of youth in school will regularly attend	60%	**89%**
60% of youth who do not attend school will be engaged in employment or volunteer work.	60%	**61%**
60% of youth will be substance free.	60%	**76%**
60% who have been referred for any type of mental health services will participate on a regular basis.	60%	**70%**
60% of youth will be compliant with Court and IAP Team aftercare conditions.	60%	**66%**
90% of youth will avoid readmission to residential placement.	90%	**92%**

Program Description

The Family Intervention Specialist program is part of the Department of Juvenile Service's Violence Prevention Initiative (VPI). The VPI is for youth who are in the community and have exhibited violent behaviors, and are deemed at risk for further violent behaviors. Two Family Intervention Specialists provide mental health support and family interventions, as part of an interdisciplinary team with DJS staff; each is assigned to either a West Side or East Side team.

Highlights

Positive experience has been a strong partnership between the CSA, DJS, and the provider at the local level.

Challenges

The DJS Office of Technical Support has not provided computer access to the FIS staff, regarding DJS client records, DJS department-wide or branch-wide e-mails, and access to DJS hookups for printers supplied by the provider for each FIS staff. Mosaic FIS staff continues to feel that this lack of access impacts efficient service delivery. FY 2012 will be the last year the FIS program funds will be routed through MHA to the CSA. Beginning in FY 2013; DJS will procure its own vendor for the program.

Table 15: FY 2011 Family-to-Family Education Program Outcomes

Program:	**FAMILY-TO-FAMILY EDUCATION**
Project Title:	Family-to-Family Education
Vendor:	National Alliance for the Mentally Ill of Baltimore (NAMI
Population:	All

TARGET:	**OUTCOME:**
30 press releases	**Distributed press releases to over 30 media outlets to announce: winter/spring Family-to-Family classes**
2,500 course announcements distributed	**Course announcements were mailed to over 2,500 people on mailing lists and 3,000 people via email.**
140 family members of a person with a mental illness enrolled in 12 week education courses	**207 family members were enrolled in the Family-to-Family course**
75% of graduates will rate the course "good" or above	**Over 94% of graduates rated the course "good" or above.**
Maintain statistics including attendance, race/ethnicity and residency for 90% of participants	**Teachers have collected data for over 95% of participants.**
Maintain records for family members referred to support groups with a target of maintaining 90% of participants	**Over 95% of records are maintained for family members that are referred to support groups**
80% of family members attending support groups will rate the experience as "moderately helpful" or above	**90% of participants surveyed stated they found the groups to be "moderately helpful" or above.**
100% of family members attending family education courses will receive weekly education resources	**100% of course attendees were provided resources at no cost**
100% of family support group attendees will receive crisis materials	**100% of course participants receive a crisis file along with other resource materials**

Program Description

Family-to-Family Education is a free program of the National Alliance for the Mentally Ill of Baltimore (NAMI). This program provides a structured, copyrighted curriculum facilitated by trained family members that includes a 12-week course of Psycho-education, skills training and support for families impacted by a mental illness. In addition, free weekly 90 minute peer support groups are provided to share resources, materials and support in emotionally trying times.

Highlights

This year NAMI was able to partner with 4 new sites to host programs. Family to Family Education courses were implemented at the following sites: Baltimore City Department of Recreation, - Alliance, Inc (Rosedale, Baltimore County), Mount Olive United Methodist Church (Randallstown, Baltimore County), and St. Luke's Lutheran Church (Parkville, Baltimore County). A new weekly support group was sponsored at Baltimore Hebrew Congregation (Pikesville, Baltimore County). The NAMIWALKS fundraiser event was relocated to the Baltimore Inner Harbor with over 1,500 people in attendance.

Challenges

There was a significant period of change/transition as the former Executive Director of NAMI for the past 10 years took a position with the state NAMI organization. There were no challenges experienced during this fiscal year that effected the success of the programs and services provided as evidenced by the successful expansion and development of the new program sites.

Table 16: FY 2011 Geriatric Service (GST) Program Outcomes

Program:	**GERIATRIC SERVICE PROGRAM**
Project Title:	Outreach – Elderly Services Initiatives
Vendor:	Bay Life Services
Population:	Aging

TARGET:	**OUTCOME:**
200 Pre-Screenings	**228 Pre-Screens**
150 Admissions	**68 Admissions**
1,200 Home Visits	**1,245 Home Visits**
1,000 Senior Center Discussion	**1,017 participants**

Program Description

The Geriatric Service Team (GST) is a coordinated and comprehensive geriatric service program for seniors aged 60 and over with mental health needs. The GST, consisting of a physician, a nurse, and social workers, is available to work with seniors and their families concerning age related issues impacting older persons with mental illness and other life changes. Services offered include pre-screening evaluations, consultations, counseling, and discussion groups at the local senior centers.

Highlights

The GST pre-screened 228 persons for possible services; however not all of these referrals resulted in an admission to the program. The program was able to meet this outcome goal by attending the Senior Expo and providing anxiety education and screenings at the local senior centers. There are senior groups in 8 of the senior centers and attendance has increased at the Catonsville and Pikesville Senior Centers. The program was able to exceed their goal of 1,000 senior center participants with a reported 1,017 participants.

All of the GST staff attended the Senior Expo and assisted with 80 depression screenings. This provided a great opportunity for the program to interface with the public and other community providers that serve the senior adult population. Staff presence in the aging professional community now includes the Mental Health Coalition for the Aging, Vulnerable Adult Assistance Network, the Maryland Transformation Act Group meetings, Bureau of Behavioral Health Provider meetings and Franklin Square Advisory Council meetings.

Challenges

The program faced several challenges this fiscal year due to funding changes: closing of the satellite clinic at Painter's Mill and the reduction in staff psychiatrist hours. However; despite these challenges, the GST program made necessary programmatic changes and now operate from one location at the Eastern Family Resource Center. The number of admissions increased to 68 this fiscal year and the program has met or surpassed all other performance measures. After reviewing supporting documentation, MHA has now changed the Condition of Award from 150 to 100 unduplicated enrollments

Table 17: FY 2011 Homeless Outreach, PATH, Re-Entry, and TAMAR Program Outcomes

Programs:	**HOMELESS OUTREACH** **PATH** **RE-ENTRY** **TAMAR**
Project Titles:	Outreach to Homeless Projects For Assistance in Transition from Homelessness (PATH) Jail Mental Health Program (MCCJTP) Trauma Treatment (TAMAR Program)
Vendor:	Prologue, Inc.
Population:	Adult

PROGRAM:	TARGET:	OUTCOME:
Homeless Outreach	45 individuals served	**48 individuals served**
	20 individuals housed	**14 individuals housed**
PATH (Projects Assisting in Transitioning from Homelessness)	150 Adults and/or Families will be served	**164 Adults and/or Families will be served**
	90% of caseload will have a service plan within 30 days	**85%**
	60% of caseload will be placed in permanent housing	**40%**
	45% placed in permanent will still be housed after one year	**See "Challenges" section under PATH**
	90% of caseload will be connected to mental health services	**76% were connected with mental health or substance abuse services**
Re-Entry	71 individuals served	**71 served**
	26 individuals housed	**26 housed**
TAMAR	80 individuals served	**79 served**

Homeless Outreach

Program Description

Prologue is the provider for the Homeless Outreach Program. They provide direct services to homeless individuals who suffer from mental illness and/or have substance abuse problems. Their outreach teams work with the homeless shelters and the detention center, as well as known locations where homeless persons on the street are known to congregate to engage with the targeted population. They also take referrals from providers, hospitals and governmental social service organizations.

Prologue reported that in FY 2011, it served collectively forty eight individuals. Prologue linked fourteen individuals to housing in FY11; they did not meet their performance outcome of

housing twenty individuals. Last year, fourteen individuals served by this grant were placed in permanent housing.

Highlights

Prologue surpassed the number of individuals that they were projected to serve in FY11.

Challenges

Prologue reported that shortages of affordable low-income housing created barriers to housing more clients. Additionally, Prologue reported that the limited number of housing subsidies, and the dollar amount of benefits received, are often not enough to support a client's housing needs.

PATH

Program Description

The PATH Program (Projects for Assistance in Transition from Homelessness) is a federally funded, MHA administered, program aimed at assisting individuals who have a serious mental illness or a co-occurring disorder. Participants are linked to services to aid them in applying for entitlements and finding appropriate housing.

Highlights

PATH was able to provide linkages, through making an initial contact, to a greater number of adults and families than projected this fiscal year.

Prologue staff was trained in submitting SSI/SSDI Outreach, Access and Recovery (SOAR) applications. SOAR is a national project designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are homeless or at risk of homelessness and have a mental illness and/or a co-occurring substance use disorder.

Prologue staff members were also trained in Supported Employment.

Challenges

Prologue reports they are serving a greater number of co-occurring consumers, who present unique challenges in engagement and service provision. Due to the transient nature of this population, there has been a challenge in tracking participants subsequent to their involvement in the program. This issue will be further reviewed in FY 2012.

Re-Entry

Program Description

Re-Entry is a case management program contracted to Prologue through the Baltimore County CSA. The purpose of the program is to identify those individuals in the criminal justice system, who have severe and persistent mental illnesses and are at risk for re-institutionalization. The program is designed to assist the detention center staff with identifying those individuals who are in need of mental health treatment while incarcerated, assist in discharge planning, and provide case management services upon release. Additionally, the assigned case manager follows the individual with mental illness for about six months in the community. They will advocate for appropriate mental health treatment in the community and monitor post-release compliance with

treatment. Prologue's staff is responsible for educating detention center staff and parole and probation officers about mental illnesses.

Highlights

The Conditions of Award from MHA, Office of Special Needs Populations has expanded the targeted diagnostic criteria to allow the provision of services to a broader population. The existing case manager left employment with the vendor, but a new half-time case manager was hired to fill that position shortly thereafter. The program is now fully staffed.

Challenges

The program case managers report that their clients are in need of more than just an over night shelter when they are released from incarceration. Most of the transitional housing shelters have long waiting lists and their clients become lost to follow-up before adequate housing becomes available. There is a need for more permanent housing.

Trauma, Addiction, Mental Health and Recovery (TAMAR)

Program Description

TAMAR provides counseling and case management support for female inmates at the Baltimore County Detention Center, who have been identified as victims of emotional or physical trauma.

Highlights

In FY 2011 the TAMAR program will became part of a new pilot project and therapeutic community for women at the Baltimore County Detention Center. The program is conducted in a separate housing unit and will accommodate up to 16 inmates. These inmates must be sentenced for at least nine months. As such, they will have the opportunity to be in the TAMAR program for an ample amount of time to complete the entire ten-week psycho-educational program. All 16 of the female inmates will meet the eligibility requirements for participation in TAMAR.

Challenges

The housing unit in which TAMAR is now conducted is shared with female work release inmates who are not participants in the new pilot project and therapeutic community. As a result the continuity of the overall therapeutic community is sometimes disrupted. Program and detention center staff are working to address this issue.

Table 18: FY 2011 Shelter Plus Care Outcomes

Program:	**SHELTER PLUS CARE**
Project Title:	Shelter Plus Care
Vendor:	Prologue, Inc.
Population:	Adult

TARGET:	**OUTCOME:**
51 individuals served	**53 Individuals served**

Program Description

The Shelter Plus Care Program in Baltimore County is a permanent housing tenant based rental subsidy program. The Shelter Plus Care Program was designed as the housing component of the Maryland Community Criminal Justice Treatment Program for homeless individuals who have a mental illness and forensic background. The Shelter Plus Care Program is very successful in maintaining people in the community and preventing them from being re-institutionalized. The CSA's vendor for the Shelter Plus Care Program is Prologue, Inc.

Highlights

Prologue Inc. has met the performance measures for consumers served this year. The program was able to expand and develop two additional housing units to increase capacity from 49 to 51 units. It should be noted that in addition to single adults, the program serves a significant number of homeless families with children.

Challenges

Despite meeting performance measures, the Shelter Plus Care program has experienced challenges in securing affordable housing that meets the federally mandated Fair Market Rent Values in the communities in which the consumers prefer to live. Fortunately, Prologue Inc. has cultivated relationships with property owners and realtors to support the fidelity and efficacy of the program.

The program has also worked with the CSA to streamline the scheduling of the annual apartment inspections to avoid delay in administrative processing of reports and payments.

Table 19: FY 2011 Baltimore County Crisis Response System (BCCRS) Outcomes

Program:	**BALTIMORE COUNTY CRISIS RESPONSE SYSTEM (BCCRS)**
Project Title:	Mental Health Crisis Response System Emergency Services Hotline
Vendor:	Affiliated Santé Group, Inc.
Population:	All

PROGRAM:	**TARGET:**	**OUTCOME:**
Hotline	Adults: 8,000	**Adults: 13,592**
	Youth: 1,200	**Youth: 2,063**
Mobile Crisis Team (MCT) interventions	1000	**2,436**
In-home Intervention Team, East Side	350	**423**
In-home Intervention Team, West Side	350	**436**
Urgent Care Clinic, East Side	500	**617**
Urgent Care Clinic, West Side	500	**518**
Community Education presentations	50	**55**

Hours and Operation of BCCRS:	
Hotline	24/7/365
IHIT	M, W, F 10 AM-6 PM Tues & Thurs 1 PM–9 PM (East and West Side)
UCC	7 days/week, 6 PM-10 PM weeknights, 2 PM–6 PM weekends (East and West Side)
MCT	365 days/year 10AM-1AM

Staffing:	
Director:	1 FT LCSW-C
Hotline operators to staff OPS:	4 FT 4 PT (Bachelors Level Counselors–3 in graduate school programs)
Supervisor:	1 FT Clinical Coordinator LCSW-C
Clinical Coordinator:	1 FT & 1 PT LCSW-C
IHIT East:	1 FT Clinical Coordinator LCSW-C 1 PT Masters Level Clinician
IHIT West:	1 FT PhD and 1 FT LCSW-C
MCT:	1 FT LGSW 1 FT Masters Level Clinician 1 FT Masters Level Clinician 4 FT PhD. Candidates 4 FT Masters Level Clinicians
UCC West:	1 Board Certified Psychiatrist 3 LCSW-C
UCC East:	1 Board Certified Psychiatrist 3 LCSW-C

Program Description

The Baltimore County Crisis Response System (BCCRS) is a partnership between The Affiliated Santé Group (ASG), the Baltimore County Department of Health, Bureau of Behavioral Health, and the Baltimore County Police Department. BCCRS serves as the provider of emergency mental health services for all Baltimore County residents. BCCRS offer seven distinct levels of service as follows: Operations Center (24/7 hotline), police/clinician staffed Mobile Crisis teams, clinician staffed In-Home Intervention Teams, Urgent Care Clinics for face to face appointments within 48 hours, Critical Incident Stress Management for response to natural and manmade disasters, Community Education, and Hotline Volunteers. FY 2011 was the program's tenth year of operation.

Highlights

The overall strength of BCCRS is its ability to adapt to ever increasing needs in the Mental Health system and respond to identified barriers to care. The expansion dramatically increased our accessibility to Baltimore County residents. Our ongoing efforts to work with community providers and increase our visibility have paid off. BCCRS continues to try to develop ongoing communication with community providers in efforts to increase service utilization.

BCCRS was able to launch our Electronic Medical Record (EMR) during this fiscal year. The long awaited EMR has dramatically increased accessibility to client records for all service components. The EMR functions in live time which allows various service components to track the status of a client no matter where the service is being provided.

BCCRS also continues to offer the Foster Care Stabilization Program. BCCRS is meeting the State need for crisis intervention accessibility for targeted Foster Care children. BCCRS will provide services to this population through our CRS services as well as the additional after hours on call service. BCCRS was able to staff this on call PRN position with existing internal staff who are familiar with our program, and the services available in the community.

Challenges

An ongoing challenge for our unique system is the ability to recruit and retain the specialized staffing needed for our program. Recruitment during this fiscal year proved to be once again a challenge. Staffing shortages are extremely difficult when operating 24 services and vacancies require that existing staff often go above and beyond their job requirements. BCCRS has been very fortunate in that staff have demonstrated their dedication going above and beyond in order to avoid service disruption. This fiscal year brought forth many challenges for staffing as we had absences and a turnover due to licensing requirements. Retaining quality personnel, who meet the requirements of the position and have been through extensive training in our program with level funding in a competitive market, remains a challenge.

Plans for the coming year

- Continue cross training for MCT officers and clinicians
- Continue to increase CRS visibility locally and regionally as crisis services increase nationally
- Ongoing training to community providers for Crisis Intervention and Suicide Prevention Strategies

- Increased cross training for current staff with regards to co-occurring mental health and substance abuse clients
- Training offered to larger Baltimore County Police Department

Table 20: FY 2011 Multisystemic Therapy (MST) Outcomes

Program:	**MULTISYSTEMIC THERAPY (MST)** ***(Evidence-Based Program)***
Project Title:	Multisystemic Therapy (MST)
Vendor:	Community Solutions, Inc.
Population:	Adolescents

TARGET:	**OUTCOME:**
Serve 47 youth per fiscal year	**68 youth served**
50% of youth will be living at home at discharge	**85% at home**
50% will demonstrate success in school/work	**85% successful**
50% will have no new arrests	**93% no new arrests**

Program Description

Multisystemic Therapy (MST) is an intensive, home-based intervention for identified children and their families employing a standardized, structured methodology. The treatment strategy focuses on reducing antisocial behavior of adolescents by addressing the various systems that influence their behavior, including family members, peers, schools and neighborhoods. MST is a treatment that strives to change how youth function in their natural settings (home, school and neighborhood) in ways that promote positive social behavior while decreasing antisocial behavior. MST therapists focus on empowering parents by using identified strengths to develop natural support systems (e.g., extended family, neighbors, friends, and church members) and remove barriers (e.g., parental drug abuse, high stress, and poor relationships with mates) to improve their capacity to function as effective parents. This process is viewed as collaboration between the family and therapist, with the family taking the lead in setting treatment goals and the therapist suggesting ways to accomplish these goals.

Highlights

Fiscal year 2011 has been significant for the ongoing positive outcomes the MST program and the youth and families involved have achieved and the increase in the number of youth and families served.

There is a measure that is not defined in the county's contract, but is an important measure to MST Services. This is the number of youth completing treatment. A case is considered completed at discharge if the MST Team and the family agree that there is evidence that some or all of the overarching goals have been met and progress sustained over a period of three to four weeks. The standard set by MST Services is a completion rate of 85%.

Below is a table reflecting the outcomes in this category for the past eight years:

Table 21: MST Completion Rate by Fiscal Year

MST Completion Rate by Fiscal Year		
FISCAL YEAR	**COMPLETION PERCENTAGE**	**MST STANDARD**
2003	57.89%	85%
2004	78.95%	85%
2005	70%	85%
2006	93.33%	85%
2007	55.56%	85%
2008	86.06%	85%
2009	95%	85%
2010	72%	85%
2011	**88%**	**85%**

MST measures goals in two overall categories: Instrumental Outcomes and Ultimate Outcomes. The ultimate outcomes are determined by three categories: 1) the youth is at home; 2) the youth is having success at school or work; and 3) no new arrests while in MST therapy. In FY 2011, the program has seen an increase in the percentage of youth living at home at the close of treatment. Additionally, there has been a slight decrease in the number of youth who are experiencing success at school/work at the time of discharge; although the outcome exceeds the target by 35% and a slight increase in the number of youth with no new arrests at the time of discharge.

Table 22: MST Comparison of Ultimate Outcomes by Fiscal Year

Comparison of Ultimate Outcomes By Fiscal Year - MST			
FISCAL YEAR	**LIVING AT HOME**	**SUCCESS IN SCHOOL/ WORK**	**NO NEW ARRESTS**
2003	73.68%	68.42%	68.42%
2004	76.32%	68.42%	78.95%
2005	86.67%	80%	80%
2006	93.33%	86.67%	86.67%
2007	61.11%	72.22%	55.56%
2008	93.03%	79.81%	82.94%
2009	88.09%	85.71%	92.86%
2010	72%	91%	91%
Contract	50%	50%	50%

The other category involves the Instrumental Outcomes, which measure changes that have occurred within the youth's ecology. Do the parents have increased parenting skills to handle future challenges? Have they increased their informal and formal support systems? Are their interpersonal relationships improved? Is the youth being successful in school or at work? Is the youth involved in pro-social activities and peers? Have these changes been sustained for 3-4 weeks? FY 2011 was remarkable for these measures as they all increased from the previous year and all either tied or reached an all time high for the particular measure.

Table 23: MST Comparison of Instrumental Outcomes by Fiscal Year

Comparison of Instrumental Outcomes By Fiscal Year - MST						
FISCAL YEAR	**IMPROVED PARENTING SKILLS**	**IMPROVED FAMILY RELATIONS**	**NETWORK OF SOCIAL SUPPORTS**	**SUCCESS AT WORK/ SCHOOL**	**PRO-SOCIAL ACTIVITIES/ PEERS**	**SUSTAINED CHANGES 3-4 WEEKS**
2003	47%	47%	47%	47%	42%	47%
2004	58%	63%	61%	61%	52%	53%
2005	57%	53%	53%	63%	57%	53%
2006	73%	70%	67%	70%	77%	77%
2007	61%	56%	56%	50%	44%	44%
2008	86%	89%	87%	78%	83%	82%
2009	95%	95%	95%	81%	88%	88%
2010	93%	93%	98%	78%	80%	76%
2011	**100%**	**100%**	**100%**	**93%**	**90%**	**88%**

Challenges

FY 2011 has been significant for the positive outcomes the MST program has achieved. In addition to the excellent outcomes there has been no staff turnover during this fiscal year. The tenure for an MST therapist nationally is between 18-24 months. Each of the current County MST therapists has been in their position for at least 36 months. This stability has contributed to the outstanding outcomes and services this team is able to achieve and provide.

Table 24: FY 2011 Seniors in Partnership/Education Program (PEERS) Outcomes

Program:	**SENIORS IN PARTNERSHIP/EDUCATION PROGRAM**
Project Title:	PEERS
Vendor:	Mental Health Associations of Maryland, Inc. Baltimore Region
Population:	Aging

TARGET:	**OUTCOME:**
70 Community Education Groups	72
1460 Seniors attending Community Education Groups	1,942
60 Senior enrolled in home visitation	64
1200 visits to Seniors	1,264
25 Volunteers matched with clients	27

Program Description

The PEERS program is a program of the Mental Health Association of Maryland, which provides community education, outreach, and volunteer support to people, age 60 or older, who have late onset mental health needs. This program works to reduce and eliminate stigma associated with mental illness in the aging population. The mission of this program is to empower older adults with support and education, which promote independence, well-being, and social connection.

Highlights

PEERS continues to meet or exceed all performance measure goals, and for fiscal year 2011, this program has been invited to participate in the "Senior Safety Initiative" sponsored by the Department of Aging. PEERS will be speaking at all of the Baltimore County Senior Centers on the importance of "Emotional Safety" in successful aging. The PEERS Program also helped to organize as well as participate in the Baltimore County Town Hall Meeting and the Baltimore County Senior Expo/Depression screenings in the fall of 2011.

Challenges

There are no remarkable challenges for this program. The PEERS Program staff and volunteers make this a very valuable and successful program.

Table 25: FY 2011 Transition Age Youth (TAY) Program Outcomes

Program:	**TRANSITION AGE YOUTH (TAY) PROGRAM**
Project Title:	Transition Age Youth (TAY)
Vendor:	People Encouraging People, Inc. (PEP)
Population:	Transition Age Youth

TARGET:	**OUTCOME:**
Number of referrals received	**25**
Number of consumers served	**10**
50% Reduction in # psychiatric hospitalizations	**100%**
30% Reduction in substance abuse involvement/ relapse	**100%**
50% Rate of attendance at purposeful daily activities	**100%**
50% Retention rate of clients in stable housing	**100% (10 clients in residence; 3 discharged to stable housing)**
30% Reduction in encounters with the legal system	**100%**
50% Improvement in activities of daily living and independent skills	**100%**
50% Clients report satisfaction with quality of life/ services of program	**100%**

Program Description

The Transitional Age Youth program was implemented in Baltimore County by PEP via an MHA grant to the CSA, beginning in 2001. It is similar to an adult, apartment based RRP program. Activities and supports are tailored to the age group, 18-23, and also to individual needs. Unlike adult residential programs, the TAY program can serve consumers without a "Priority Population" diagnosis. The program has 10 beds: 4 male and 2 female at intensive RRP level; and 2 male and 2 female at supported housing level. All apartments are located in a single, small building owned by the provider, with staff on premises 24/7. A day rehabilitation program, used by consumers not attending school or a job, is available at PEP's on-site PRP nearby. PEP, a multi-service agency, also provides an OMHC, a drug rehabilitation program (for youth with minor issues), vocational services, access team for public benefits, GED class, and art class. The community at large provides some services, like components of education and employment.

Highlights

Despite significant behavior problems presented by many of the consumers, PEP staff remained dedicated to helping these young adults. While the funding is far less for the supported beds, PEP staff serves these consumers to the same extent as the RRP bed consumers. Usually CSA inspection of the apartments finds them in good condition, clean and well furnished, despite problem behaviors of the consumers (See *"Challenges"*).

Challenges

One challenge is finding consumers who can function at the level of independence hoped for by the program. Most referrals come from DSS clients in RTC or group home programs. These facilities are very structured, and the transition of some youth from these programs to TAY, which is more loosely structured and supervised, under a different model, has not been smooth.

Some problem issues: consumers often do not keep their apartments neat and clean to safety standards; and sometimes destroy property due to lack of impulse control, resulting in loss of income to provider (for subsidy of repairs/replacement). Another challenge is that, while SSI funds are the main source of income for the supported beds, it is hard to find consumers who have SSI in place at the time of referral. This results in vacancies in this category, engendering loss of income for the provider.

A number of youth referred, especially from other Counties, had very low IQ and autism spectrum disorders. The program is not equipped to serve this population. Indeed this is a major service gap in the state: a number of fully supervised group homes are needed to serve the more complex young adults in this age range.

Table 26: FY 2011 After-school Program, In-home Services and Respite Services Outcomes

Programs:	**AFTER-SCHOOL PROGRAM IN-HOME SERVICES RESPITE SERVICES**		
Project Title:	Children's Wrap Around Services		
Vendor:	Villa Maria of Associated Catholic Charities		
Population:	Child & Adolescents		
PROGRAM:		TARGET:	**OUTCOME:**
Therapeutic After-School, Lansdowne		35 unduplicated children	**87**
		2,736 sessions will be provided	**3,737**
Therapeutic After-School, Timonium		24 unduplicated children	**61**
		2,311 sessions will be provided	**1,462**
Therapeutic Respite Care (Statewide)		17 unduplicated children will be served	**25**
		163 days of service will be provided	**163**
Behavioral In-Home Intervention (Statewide)		27 unduplicated children will be served	**32**
		304 weeks of intervention	**329**

Program Description

Villa Maria operates two after school programs in Baltimore County. One of the programs is located on the grounds of Villa Maria's main campus in Timonium and the other in the Lansdowne area of the county. Each of these programs provides multi-modal therapy, PRP and psychiatric services to children and their families.

Therapeutic After School Programs

Timonium Therapeutic After-School Program (TTASP)

TTASP now routinely implements the CANS assessment at admission and again at six months or discharge. The scores are used to guide the treatment planning as well as to measure outcomes. TTASP is currently putting procedures in place for all CANS scores to be entered into a database routinely, so that both programmatic and individual data can be evaluated.

TTASP had another successful year. The program exceeded all performance measures with the target for total sessions being exceeded by over 470 sessions. The target for unduplicated children was nearly tripled. Client satisfaction and CANS data showed that children and families

get effective intervention for their presenting problem, and feel included and engaged in the process. Plans are being solidified to add a half-time supervisor at the Timonium site to oversee After School Program Counselors and work in coordination with Suzie Fisch-Templeton, the Program Supervisor.

Lansdowne Therapeutic After School Program (LTASP)

LTASP had an extremely busy year. Community schools actively sought out the program for their students, as did families and area pediatricians. The special project for the staff team this year was to develop specific month-long curriculum plans to use for groups, working on the areas of affect management, problem solving and family. This was successfully completed and is being used for planning purposes. Families continue to rate the program very high on client satisfaction surveys and often attend monthly parent support groups held on site, in addition to family therapy sessions. The program targets for total sessions and unduplicated clients were far exceeded this year. The target for unduplicated children served was exceeded by over fifty and the number of sessions was exceeded by over 1,000. The expectation is that the program can continue to grow. The program plans to add a half-time After School Program Counselor in the next few months due to increased referrals and need in the community.

Challenges

TTASP faced staffing challenges, mostly with regards to the program Psychiatrist, but this is now remedied. LTASP had several setbacks this year regarding two program vehicles; however, options are being explored on how to address this problem in an affordable way.

Summary

Both of the Therapeutic After-School Programs had a busy and productive year. Overall staffing patterns were stable and great effort was put into three areas: Implementation of the CANS outcome measure, curriculum development and increasing the communication between staff that deliver services to the children in the programs. Significant progress was made in all three areas.

Both programs have long-standing and well-developed relationships with community schools. These have been further improved as Villa Maria has developed its school-based partnerships. The summer component of TASP continues to thrive as many of the schools eagerly refer children at the end of the school year, aware of the need for structure and intervention during the summer.

Client satisfaction data for the programs continues to show that the programs provide effective intervention with a family focused approach. Parents rate the programs' effectiveness a 4.5 on a scale of 5, on average. Many of the parents in TASP also participate in our Parent Support Groups that are on site, and provide childcare and transportation.

In-Home Intervention Program (IHIP) – Statewide

The In-Home Intervention Program served 32 unduplicated children during FY2011.

The In-Home Intervention Program of Villa Maria Continuum provided services to identified families to ensure that those who received psychiatric rehabilitation services achieved stabilization, behavioral modification enhancement, social skill development, and successful integration of coping and conflict resolution skills. While the identified consumers presented

with significant psychosocial stressors and chronic mental illness, significant gains were achieved. Baltimore County Bureau of Behavioral Health supported the aforementioned and supported Villa Maria's assessment of consumers' needs relative to length of stays warranted to ensure stabilization.

Many of the families served by the program presented with children who were positive for the following:

- High levels of psycho-emotional stress of the identified client
- Parent/Child relationship difficulties
- Peer conflict relationship difficulties
- Unstable family dynamics
- The presence of substance abuse related issues with significant family members
- High levels of anxiety in response to the crisis situations being presented in the home

Therapeutic Respite Care- - Statewide

The weekend respite program had a successful year. Due to a decreased budget, the program's performance measures were lowered. Number of unduplicated children served was lowered from 20 to 17, and number of days of service was lowered from 261 to 163. With these changes, the program was able to exceed the target number of children served by eight, and the number of days of service was met exactly on target. As usual, the program served children from various jurisdictions and from populations both waiting for admission and discharging from the St. Vincent's Villa RTC (formerly known as Villa Maria RTC). The program reports that satisfaction survey feedback given is always very positive for the program. Both families and referring parties report feeling that the support the program offers is significant in helping children remain at home. Parents of discharged children often do not want to terminate, stating that services are so helpful and valuable. The only complaints have to do with wanting more access to respite services. Many parents have asked for and have received additional respite days, funded by Bureau of Behavioral Health C & A diversion funds or through the local Department of Social Services.

Table 27: FY 2011 Wellness and Recovery Centers Outcomes

Program:	**WELLNESS AND RECOVERY CENTERS** ***(Formally Consumer Drop-In Centers)***	
Project Title:	Peer Support	
Vendors:	On Our Own, Inc. (3 sites) Marty Log, Inc. (1 site)	
Population:	Adult	
PROGRAM	**TARGET:**	**OUTCOME:**
On Our Own, Inc.	260	**320**
Marty Log, Inc.	100	**100**

Program Description

The Wellness and Recovery Centers provide a safe and supportive setting for persons with mental illness to gather and enjoy socialization, peer support, advocacy and education. Members are treated with dignity and respect as they search for community integration, supportive relationships and information about mental illness.

Highlights

Baltimore County currently has two providers that offer Wellness and Recovery programs at various sites throughout the County. Both vendors have increased the hours of operation, and expanded program activities that promote and support wellness and recovery. On Our Own, Inc. (OOO) is now able to offer a network of care, advanced directives, peer employment specialist resources, Mental Health First Aid and WRAP. The TAY (Transitional Age Youth) center is thriving and is operating a mobile peer support unit. Marty Log at Prologue has been involved in several projects related to helping consumers throughout the state. The Director of Marty Log at Prologue was part of a workgroup that developed the "Peer Employment Resource Training" that is currently being taught around the state. She has also co-authored the Maryland Certified Peer Specialist Manual and Training Program, which will be piloted on the Eastern Shore FY2011.

Members at the various Centers have embraced the Recovery Model, and have been at the forefront lobbying on local, state, and national levels to address disparities in the mental health communities. Overall, memberships are increasing at the various sites due to outreach presentations, referrals or individuals accessing the website. A total of 420 unduplicated consumers were served at the centers in FY 2011. Of these consumers, 320 were served at On Our Own, Inc. and 100 at Marty Log, Inc. Both providers continue to offer exceptional program activities that promote and support wellness and recovery.

Challenges

There were significant program challenges for Prologue Inc. and On Our Own during the past fiscal year; the Wellness and Recovery Director of Prologue Inc. (of 6 years) accepted another position as Wrap Project Coordinator for On Our Own of Maryland Inc. and OOO dealt with leasing management issues concerning building repairs. Despite these challenges, both providers continue to offer exceptional program activities that promote and support wellness and recovery.

CSA Flexible Funds

Table 28: FY 2011 Adult Client Support and Medical/Dental Flexible Funds Outcomes

Programs:	**ADULT CLIENT SUPPORT & MEDICAL/DENTAL FLEXIBLE FUNDS**
Project:	Client Support Services
Vendor:	Multiple vendors (pharmacies, apartment complexes, etc.)

TARGET:	**OUTCOME:**
100 individuals with a mental health illness will receive financial assistance for psychiatric medications	**62**
5 individuals will receive support for lab tests	**0**
126 individuals will receive other client support services (eviction prevention, security deposit or utility assistance)	**185**

Program Description

The MHA of Maryland designates the Baltimore County Department of Health, Bureau of Behavioral Health as the Core Service Agency (local mental health authority) for the Baltimore County region. MHA grants a limited amount of funding to our agency each fiscal year to assist adult County residents who are current members of the public mental health system with needs related to remaining stable in the community.

It is the intent that these funds will help prevent homelessness and deterioration of symptoms related to mental illness. The funds should be used in combination with other community, private, and/or public and family resources and should be linked to the consumer's clinical and rehabilitation plans.

The MHA requires that an **Uninsured Eligibility form** be completed for each consumer requesting financial assistance for psychiatric medications. In addition, the MHA audits the usage of funds for appropriateness and adherence to MHA regulations.

Highlights

There are currently two discretionary funds available for adult consumers with mental illness in the Public Mental Health System: The Adult Flex Fund and Medical Flex Fund. The Adult Flex Fund can be used for eviction prevention, security deposits and for utility turn off prevention. The Medical Flex Fund is used to assist consumers without insurance to pay for psychiatric medication and/or laboratory fees.

In FY 2011, **247** consumers were able to access or remain stable in the community because of these Adult and Medical Flex Fund programs. Of that number, **57** were assisted with **rent/eviction prevention** funds, **100** with **BG&E bills,** and **28** with **security deposits**. This fiscal year, the client support funds made a great impact on the lives of 4 hearing impaired consumers needing services through the Public Mental Health System. With the support of the

MHA, the CSA was able to work closely with Providers around the needs for interpreting services for psychiatric and therapy appointments. The flex funds also provided the opportunity for another consumer to leave a shelter after more than a year and secure stable housing in the community. Funds were used to provide basic household needs for a very happy and grateful consumer. As for the Medical Flexible Fund, a total of 62 consumers received financial assistance to pay for psychiatric prescriptions. There was one request for lab work this fiscal year , but the consumer received medical assistance prior to appointment. Referral sources have been very diligent about applying for the Primary Adult Care Program when submitting applications for prescription assistance.

Challenges

While this fund has been a great resource to alleviate many problems for consumers in the Public Mental Health System, this fiscal year presented challenges of a reduced budget and increase in the number of referrals for interpreters and eviction prevention etc. Consumer's often needed help in excess of the $500.00 threshold allowable amount. It was often challenging to coordinate the necessary resources with other community providers. However; despite these challenges, the funds were able to assist many consumers to remain stable in the community.

Table 29 Y 2011 Child and Adolescent Flexible Funds

Program:	**CHILD AND ADOLESCENT FLEXIBLE FUNDS (MHA)**	
Project Title:	C & A Diversion	
Vendors:	Various providers of service for in-home intervention, therapeutic respite care, mentoring, camp and transportation	
PROGRAM:	**TARGET:**	**OUTCOME:**
Respite Services (Institutional Weekend Respite)	3 children will be served	2 children were served
In-home Services (Home-based Intervention)	24 children will be served	18 children were served
Behavioral Consultation (Day Care)	5 children will be served	45 children were served
Therapeutic Camp	8 children will be served	14 children were served
Recreational Camp and Activities/Parent Respite	No target	63 children were served

A. Institutional Weekend Respite (St. Vincent's Villa)

Program Description

St. Vincent's Villa (SVV), formerly known as Villa Maria RTC, provides weekend respite to children in the community, ages 6-12. The program allows for a child to spend between 24 and 48 hours in the facility. During this time, the child participates in various activities in a therapeutic setting and is supervised by trained residential treatment center (RTC) staff. This type of respite is used to serve children with intensive needs, but who do not meet the medical necessity criteria for hospitalization. The services are used to reduce parent-child stress, and allow the child to engage in appropriate social activities with peers. The CSA can fund up to 6 days per fiscal year for approximately 3 children.

Highlights

The program received 2 referrals in FY 2011. Both youth used the full six nights available to them during the fiscal year.

B. In-home Services (Home-Based Intervention)

Villa Maria

Program Description

Villa Maria is a PRP-type service, utilizing a twice-weekly, in-home model to serve families. The model focuses on the parent-child relationship; helping parents to understand their child's needs develop age-appropriate expectations, and appropriate discipline. The in-home specialist works with the child to develop appropriate coping skills, anger management, and improved self-esteem. The specialist is available for 24/7 crisis support and also performs a limited amount of case management duties.

Highlights

Demand for the program remains high, and there is often a greater demand for the service than there is open slots; however, referrals the first two quarters of the fiscal year started slow. When demand picked up in the third and fourth quarters, the budget allowed for the program to be able to serve ten children at a time, instead of eight. This made up for the slower first and second quarters.

Institute for Family Centered Services (IFCS)

Program Description

IFCS is a similar program to Villa Maria. Services are provided in the home to both the parent and the child. A PRP worker is assigned to the child, who teams with a family counselor assigned to work with the parent. Some case management duties are performed as necessary. Staff is also available for 24/7 crisis support.

Highlights

IFCS served a total of 8 school age youth for the fiscal year, plus 5 young children as shown in the next section. It is advantageous to consumers and to the CSA that we have a choice of two vendors for in-home intervention.

C. Behavioral Consultation (Day Care*)*

Institute for Family Centered Services (IFCS)

Program Description

IFCS provides twice-per-week; in-home service to families of children ages 2-5. A behavior specialist meets with the family over a 12-week period, sometimes longer, to assist the parents in understanding their child's needs, age-appropriate expectations, and appropriate discipline.

Highlights

Project ACT, partnered with the Villa Maria Continuum, provides behavioral consultation services to day care centers in the county for the last few years. Therefore, the IFCS program has focused on providing behavioral consultation to parents of young children in the home, rather than providing this to day care centers.

D. Other Programs Funded By Flex Fund

Therapeutic Camp

Program Description

Camp New Horizons is a therapeutic camp on the grounds of the Chatsworth School, which provides a continuum of special education services for children who are seriously emotionally disturbed. The camp serves children in grades K-5 with diagnosis of Attention Deficit Disorder (ADD) and other mild disabilities. Activities include arts and crafts, sports, social skills, swimming, day trips, etc.

Highlights

In FY 2011, the CSA funded tuition for 5 children and transportation for 9 children who attended the camp in summer 2010.

Recreational Camps/After-School Programs/Parent Respite

Program Description

Recreation: This category could include such activities as karate, YMCA, and Boys and Girls Club membership, and social and educational classes and activities at the Community College of Baltimore County (CCBC), among other things. These activities are geared toward helping children develop appropriate social skills, build self-esteem, and learn self-discipline. In addition, the time spent at activities serves as brief respite for the parents, thus reducing parent-child stress.

Recreational Camp: This category could include such camps as nature camps, sports camps, cheerleading camps, and enrichment camps. As with the recreational activities funded throughout the year, recreational summer camps also serve the purpose of building the child's social skills, self-esteem, and self-discipline, while also serving as a form of respite.

Highlights

The CSA funded services for 63 youth. The majority of the requests for such funding came from Alliance case managers. The case managers were able to identify and register children for such low-cost programs as the Salvation Army, YMCA and CCBC.

FY 2011 C & A Flex Fund Highlights

The Child and Adolescent Flexible Funds continue to be a valuable resource to children and their families in Baltimore County. This funding diverts children from higher cost services such as inpatient hospitalization or out-of-home placement such as residential treatment centers.

FY 2011 C & A Flex Fund Challenges

An ongoing challenge in monitoring the Child and Adolescent Flexible Fund is predicting the use of services during a given fiscal year. All services must be pre-approved by the CSA prior to service provision.

FY 2011 Bureau of Behavioral Health/Core Service Agency Report of Progress on FY 2011 Goals, Objectives, and Strategies

Projections for FY 2013 -2015 Goals, Objectives, and Strategies

Our Goals, Objectives and Strategies have remained substantially unchanged for FY 2011. Each strategy has a specific team or lead assigned for implementation. This designates primary responsibility for achieving the specific strategy. The re-organization of the Bureau of Behavioral Health, as noted previously, broadens the pool of staff available to address these items. Ongoing focus on these goals, objectives and strategies will be the continuing responsibility of the CSA Director.

The key to the staff abbreviations in the following tables is listed below.

All	All staff
Admin	Administrative Team
Adult	Adult Team
C & A	Child and Adolescent Team
Director	Core Service Agency Director
MHAC	Mental Health Advisory Council
QA	Quality Assurance/Consumer Advocacy

Goal 1	The Core Service Agency (CSA), in partnership with local stakeholders, (e.g. consumers, family members) will develop strategies and programs to guide mental health consumers to an array of clinically appropriate and cost effective services.

Goal 1 Objective 1		**The CSA will work with the local stakeholders to identify and address fiscal, policy and treatment challenges and develop alternatives to costly hospital admissions.**
		Strategies
Adult	1.1.1	**Collaborate with the Emergency Departments that operate in Baltimore County to explore and develop alternative, less restrictive treatment options to hospital admissions (e.g. through referral to emergency health teams and crisis beds).**
FY '11 Result		The Mobile Crisis Team and the Assertive Community Treatment Team have worked closely with the local County Emergency Departments regarding the disposition of individuals in psychiatric crisis to implement alternatives to inpatient hospitalization. The Mobile Crisis Team and the Assertive Community Treatment (ACT) Team will continue to serve as a community based referral resource for individuals identified in the County Emergency Departments. Outreach efforts will continue to engage the Emergency Departments to promote least restrictive treatment options for local consumers.
All	1.1.2	**Build community capacity through the Crisis Response Service and interagency collaboration to divert admissions from the Emergency Departments and maintain community placements.**
FY '11 Result		The Mobile Crisis Team (MCT) reports significant success in diverting individuals from the emergency petition process and subsequent inpatient admissions through treatment intervention at the community level. MCT services are available countywide, seven days a week, 15 hours a day. The CSA has continued to use funding received from the State Department of Human Resources (DHR) to increase capacity of on-call clinicians to be available 24/7 for targeted DHR family foster care youth. Training of DSS staff has occurred around the full continuum of Baltimore County Crisis Response Service (BCCRS) services. Promotional materials have been provided to participating families. Several jurisdictions ceased their diversion activities in FY 2011 as a result of funding cuts. In FY 2012 MHA re-launched this initiative in selected counties. Baltimore County remains open to implementing additional diversion activities pending available funding. Maintain strategy.
Adult	1.1.3	**Collect relevant aggregate information on individuals who use the emergency room to access psychiatric treatment to develop strategies that divert individuals to more appropriate and cost effective services.**
FY '11 Result		The CSA data committee met on a monthly basis to develop data review priorities and review the best options to pro-actively collect and use available data. As ED diversion funding was cut in FY 2011, review of this specific data was assigned a lower priority. Maintain strategy pending the availability of additional diversion funding in FY 2013.
Adult	1.1.4	**Monitor the use of crisis beds and crisis bed providers to reduce the length of stay per occupancy to the shortest, but safest stay possible.**

FY '11 Result		Adult team social workers review and approve requests for extensions of crisis bed services. In FY11, the team completed authorizations. FY 2011 data indicates a reduced length of stay in the crisis bed program. The CSA will continue to collaborate with crisis bed staff to reduce the length of stay and discharge to the appropriate placement and least restrictive environment.
Adult	1.1.5	**Promote the utilization of a fixed number of crisis beds to be set aside for diversion from hospitalization.**
FY 11 Result		The Adult Team has worked with the crisis bed vendor to facilitate admissions for individuals as an alternative to hospitalization. The strategy will be maintained.
All	1.1.6	**Use available funding to ensure the stability of our outpatient mental health center (OMHC) network.**
FY '11 Result		Grant funds from MHA for this purpose expired in FY 2010. The CSA provided a grant to Mosaic to facilitate services for uninsured individuals in the Northwestern portion of the County. In FY 2010, 719 consumers were served, 42 of who were uninsured. These funds were re-directed in FY 2011 for the development of evidence based practice programs. The CSA will Monitor provision of services for consumers in County OMHCs. Track funding and payment policy mechanism changes to determine impact on the availability and quality of services
Goal 1, Objective 1		Objective Accomplished

Goal 1 Objective 2		**The CSA will collaborate with public, private and local community inpatient facilities and hospitals to improve consumer discharges into the community.**
		Strategies
All	1.2.1	**Collaborate with key staff at the state, private, and community hospitals and Residential Treatment Centers (RTC).**
FY '11 Result		The CSA Adult team meets quarterly with the social work staff at Spring Grove Hospital to coordinate patient discharges from the hospital. Child & Adolescent staff collaborates regularly with RTC staff by attending treatment team meetings and assisting with admission and discharge processes. RRP occupancy rates continue to at approximately 98%. The CSA will maintain the strategy.
Adult	1.2.2	**Promote regular participation of key state hospital staff at the residential directors meeting to increase providers' understanding of the treatment and discharge procedures at the state hospital.**
FY '11 Result		CSA staff continued to act as a liaison between the hospital and community providers. CSA will continue quarterly meetings with social work staff at Spring Grove Hospital to facilitate referrals and placement.
Adult	1.2.3	**Promote an annual tour of state hospitals and residential rehabilitation programs by respective staff to enhance discharges to the community.**
FY '11 Result		RRP staff from the CSA continued to perform this liaison duty. No tour was conducted due to provider familiarity and scheduling issues. CSA will continue to facilitate communication and collaboration between hospital and community-based staff.

Adult	1.2.4	**Develop resources for those populations who have historically been challenged in acquiring stable community housing, focusing particularly on the needs of homeless and uninsured persons.**
FY '11 Result		The CSA served on the board of Baltimore County Communities for the Homeless to expand homeless day resources and develop a nursery for homeless infants. The CSA partnered with the County Housing Office in a week-long charrette process to develop a long term plan to reduce homelessness in the County in accordance with new Federal guidelines. Maintain strategy by working in collaboration with stakeholders to implement the long term plan.
C & A	1.2.5	**Collaborate with hospital and Residential Treatment Center (RTC) staff to return children to their homes with appropriate support services.**
FY '11 Result		Staff regularly collaborates with RTC staff and families of youth to plan for their return to the community with appropriate services and supports. Baltimore County will continue to access and refer youth and families to the RTC Waiver as a diversion to RTC placement or as an alternative means to return youth to their home and community while maintaining an RTC level of care.
Goal 1, Objective 2		**Strategy Accomplished**

Goal 1 Objective 3		**The CSA will collaborate with county and state human service and education agencies in the provision of services to individuals with mental behavioral health needs.**
		Strategies
All	1.3.1	**Provide education and assistance regarding the Public Mental Health System services (PMHS), CSA resources, and access to mental health services to partner agencies upon request (e.g. OMHCs, schools, Department of Juvenile Services, public health nursing, etc).**
FY '11 Result		CSA collaborated with local public and private agencies to provide public forums on MH resources. Notable events in FY 2011 included the 13th Annual Town Hall Meeting, Senior Expo, and the 4th Annual Children's Mental Health Fair, which attracted over 450 participants combined. These events are very well received by the community and help to promote the CSA mission. Maintain strategy
All	1.3.2	**Maintain collaborative meetings with partner agencies (e.g. Department of Social Services Housing Division, the Department of Juvenile Services, Baltimore County Public Schools, the Local Management Board, Vulnerable Adult Assistance Network (VAAN), Local Coordinating Team).**
FY '11 Result		CSA staff has attended a variety of collaborative meetings with all the partner agencies listed above to advance initiatives to improve and strengthen the local system of care. Maintain strategy
All	1.3.3	**Provide case consultations for consumers who receive services from multiple systems (e.g. public health nursing, shelters, etc.)**

FY '11 Result		CSA staff regularly offer assistance to providers, consumers, local public and private agency staff to help ensure mental health consumers and families have access to a broad range of related services. The CSA collaborated with the County Office of Community Conservation to provide significant technical assistance and training to homeless shelter staff to increase their capacity to serve individuals with behavioral health needs. The CSA initiated quarterly collaboration meetings with the director of the central region office of the Developmental Disabilities Administration to address the needs of individuals with co-occurring needs. Maintain strategy.
C & A	1.3.4	**Assist families and children to access wraparound services through the 1915 c RTC Waiver**
FY '11 Result		The CSA will continue to work with families and community agencies to access wraparound services through the CME for children and youth who are eligible.
Goal 1, Objective 3		**Strategy Accomplished**

Goal 1 Objective 4		**The CSA will collaborate with consumers, families, providers, local and state leaders and related advocacy agencies in all phases of system development.**
		Strategies
C & A	1.4.1	**Collaborate with the Local Management Board on a wide array of child and adolescent issues and initiatives.**
FY '11 Result		The C & A staff collaborate with LMB staff on a regular basis. The CSA receives funding from the LMB to support several evidence based practice programs including Multi-systemic Therapy (MST) and Brief Strategic Family Therapy (BSFT). The Bureau of Behavioral Health also offers Functional Family Therapy (FFT) as evidence based practice available to youth and their families. Maintain strategy.
All	1.4.2	**Collaborate with MHA on system transformation activities both as an individual CSA and through the Maryland Association of Core Service Agencies (MACSA).**
FY '11 Result		CSA staff continued to participate in the Transformation Project through monthly meetings of MACSA. Transformation Project staff provided consultation and were very helpful in enhancing the CSA's relationship with the Local Housing Authority which resulted in expanded local housing opportunities for individuals with psychiatric disabilities. Transformation funding has expired. The CSA will continue to implement advances achieved through this project.
Goal 1, Objective 4		**Strategy Accomplished**

Goal 1 Objective 5		**The CSA will use flexible funds to support and improve consumers' quality of life and enhance treatment alternatives.**
		Strategies
C & A	1.5.1	**Support a comprehensive array of wrap around services including behavioral in-home intervention, home-based and out of home respite, therapeutic after school program, school-based mental health, therapeutic summer camp, case management, pre-school age in-home/day care services through grant funded programs and the child**

		and adolescent flexible fund.
FY '11 Result		In FY 2011, In-home Intervention services served 62 youth, (Villa :32 statewide/18 Flex and IFCS 12); Home based and out of home respite served 19 OOH/37 HB youth with the Tri-County Respite Grant; Therapeutic After-School program served 86 youth; and 63 youth were funded for recreational/summer activities with County flex funds. Maintain strategy as funding allows.
Adult	1.5.2	**Provide funds, through the client services adult flexible account and medical account, to support the needs of consumers with mental illness that are not covered under the fee-for-service system.**
FY '11 Result		The CSA has provided services for 247 consumers to access flex funds and to remain stable in the community in FY 2011. Maintain strategy as funding allows.
All	1.5.3	**Streamline the use of adult flexible account and medical account by accessing a county procurement card and the county's accounting department and monitor to ensure maximum effectiveness.**
FY '11 Result		Bureau of Behavioral Health fiscal staff used procurement cards to process flex fund payments when applicable. Procedures were established to streamline the processing of flex fund requests and increased accountability. Continue to monitor procedures and expenditures, and maintain strategy.
Goal 1, Objective 5		**Strategy Accomplished**

Goal 1 Objective 6		**The CSA will promote wellness and recovery, self-determination, consumer access to resource information and peer support.**
		Strategies
Adult/ QA	1.6.1	**Promote consumer participation in the Wellness and Recovery Centers (formerly Drop-in Centers).**
FY '11 Result		The CSA sponsors four (4) Wellness and Recovery Centers throughout Baltimore County and a total of 420 unduplicated consumers received services at these Centers. Wellness and Recovery Centers will increase the number of operation hours at each site. The On Our Own site in Dundalk will expand its hours and services to include individuals with substance abuse and co-occurring disorders.
Adult/ QA	1.6.2	**Maintain collaborative relationships with the consumer Wellness and Recovery Centers through conducting regular meetings with program staff and managers to monitor programs, and facilitate collaboration between managers of the centers and community.**
FY '11 Result		The CSA program liaison hosts quarterly meetings with the Center Directors and Peer Counselors of the Wellness and Recovery Centers to provide consultation and technical assistance to the programs. The existing contracts for these services expired in FY 2011 and were re-bid. New contracts were issued to the incumbent vendors who were the successful bidders. Maintain strategy.
C & A	1.6.3	**Provide consultation to Family Navigators and family advocacy programs on obtaining treatment resources.**
FY '11 Result		Provided consultation upon request. The C & A staff received a total of 286 help calls throughout the year. Maintain strategy.

All/ MHAC	1.6.4	**Organize and sponsor a yearly Countywide Mental Health Fair in partnership with the Mental Health Advisory Committee.**
FY '11 Result		The CSA co-sponsored the 13th Annual Mental Health Fair and Town Hall Meeting. Outcomes from this meeting are described in Annual Plan. Maintain strategy.
C & A/ MHAC	1.6.5	**Organize and sponsor a yearly Countywide Children's Mental Health Fair in collaboration with public and private child serving agencies, community stakeholders, and families).**
FY '11 Result		The CSA was a lead sponsor of the 4th Annual Child & Adolescent Mental Health Fair. C & A staff was involved in the planning and implementation of the fair. Maintain strategy.
QA	1.6.6	**Fund and monitor the Family-to-Family Education Program**.
FY '11 Result		The Family-to-Family Education program run by the National Alliance on Mental Illness (NAMI) is funded and monitored by the CSA. They continue to meet or exceed all conditions of award. Maintain strategy.
All	1.6.7	**Promote access to care for uninsured or under insured individuals through providing resource information to available services.**
FY '11 Result		The CSA continues to maintain and update a roster of community resources available to uninsured individuals. This information is made available to the public through "help calls" received by our office and at community health fairs and events. Maintain strategy.
Goal 1, Objective 6		**Goal Accomplished**

Goal 1 Objective 7		**All Baltimore County residents will have access to all components of the crisis response service.**
		Strategies
Adult	1.7.1	**Fund and monitor a countywide emergency mental health program with the following components: hotline, mobile crisis team, in-home intervention team, urgent care clinic, and critical incident stress management (CISM) team.**
FY '11 Result		As a result of program expansion in FY 2010, all the above listed services are fully funded and available to all County residents. Maintain strategy.
All	1.7.2	Promote community provider use of the Emergency Mental Health Crisis hotline as an alternative resource to emergency rooms for after hours support/crisis.
FY '11 Result		Utilization of the crisis hotline continues to exceed program performance measures. Crisis program staff continue to promote the hotline through both provider and community contacts. Maintain strategy.
Adult	1.7.3	**Require the provider to expand the network of referral sources to ensure community agencies are knowledgeable of available resources.**
FY '11 Result		Crisis service provider has met with numerous community and professional leaders to promote expansion of MCT. Maintain strategy.
Goal 1, Objective 7		**Strategy Accomplished**

Goal 1 Accomplished

Goal 2	**The CSA will oversee implementation of fiscal, operational and policy changes within the public mental health system (PMHS) with consideration to local best interests.**

Goal 2 Objective 1		**The CSA will manage fiscal operations in a manner that ensures internal financial controls with maximum benefit received from funds expended.**
		Strategies
Adult	2.1.1	**Review, document, and if appropriate, authorize the extension of crisis bed services (beyond the initial 10 days of treatment) for the crisis bed providers in the county.**
FY '11 Result		CSA staff has continued to perform this function. In FY 2011 the CSA authorized extensions beyond the initial 10 days of treatment. Maintain strategy, continue to track this data.
Adult	2.1.2	**Review, authorize, and monitor requests for non-Medicaid eligible consumers who need outpatient mental heath treatment.**
FY '11 Result		CSA staff performed this function.
Adult	2.1.3	**Authorize, reauthorize, and monitor expenditures for enhanced client support services.**
FY '11 Result		Adult team staff was available to perform this function in FY 2011
All	2.1.4	**Maintain collaborative relationship with the Administrative Services Organization (ASO) to ensure clinical and fiscal responsibility with all service authorizations.**
FY '11 Result		CSA staff has been able to maintain an effective relationship with the ASO vendor. ASO staff has provided ongoing training and support. Maintain strategy.
C & A	2.1.5	**Participate in the Certificate of Need (CON) process with the ASO to review, approve, and monitor RTC admissions.**
FY '11 Result		C & A staff reviewed 90 CON requests in collaboration with the ASO to determine eligibility for RTC admission (77 for standard RTC, 13 for RTC Waiver services). Maintain strategy.
Admin	2.1.6	**Ensure accountability by managing resources properly in compliance with applicable laws and regulations.**
FY '11 Result		CSA Quality Assurance and Fiscal staff performed this function. CSA staff have established procedures for monitoring and review of programs and have worked collaboratively with MHA and OHCQ staff. A weekly budget management meeting has been established to review expenditures. Additional staff has been added to the Quality Assurance Team.
All	2.1.7	**Identify opportunities to improve staff resources within the local PMHS through staff training and advocacy for personnel at all levels.**
FY '11 Result		The BBH sponsored several training programs for professionals and para-professionals in FY 2011, including In-service training for Bureau staff, Behavioral Health training for Homeless Shelter personnel, and a monthly Friday afternoon Seminar Series on relevant topics. Maintain strategy and continue to develop staff training opportunities as needed.
Admin	2.1.8	**Provide annual internal fiscal controls by testing the effectiveness of sub-vendors risk management and accountability systems.**
FY '11 Result		CSA Quality Assurance and Fiscal staff performed this function in FY 2011 through program monitoring and fiscal auditing of contracted vendors.
All	2.1.9	**Assign a CSA contract monitor to all grant-funded contracts to monitor contract performance measures and expenditures.**

FY '11 Result		A contract liaison, quality assurance staff member, and a fiscal monitor regularly review performance measures and expenditures for all CSA contracts.
C & A	2.1.10	**Monitor the use of Therapeutic Groups Homes under the directives and guidelines of MHA, Governor's Office of Children (GOC)/State Children Youth and Families Information System (SCYFIS); participate in OHCQ site visits of the programs.**
FY '11 Result		Conducted site visits with OHCQ to insure adequate services are in place, collaborated with therapeutic group homes to assist them with challenging cases, and assisted MHA with the completion of the Levels of Intensity forms needed for the re-licensing and rate setting processes.
Goal 2, Objective 1		**Strategy Accomplished**

Goal 2 Objective 2		**The CSA will collaborate with MHA in the development of state mental health policy and legislation and will partner with consumers, providers and stakeholders regarding operational changes within the public mental health system (PMHS).**
		Strategies
All	2.2.1	**Participate in the MHA Meetings (e.g. crisis beds, supported employment, residential rehabilitation, etc.) to keep informed of changes within the PMHS.**
FY '11 Result		CSA attended all MHA meetings to keep current with new policies and initiatives.
All	2.2.2	**Conduct semiannual provider meetings with OMHCs, psychiatric rehabilitation, residential rehabilitation, and supported employment programs to review system changes, goals, and policies.**
FY '11 Result		As a part of the BBH, the CSA participates in a quarterly meeting with all providers.
All	2.2.3	**Develop training to address system and clinical changes to assist providers in remaining current.**
FY '11 Result		As a part of the Bureau of Behavioral Health, the CSA has sponsored and co-sponsored several trainings in FY 2011. The quarterly all-provider meeting has included presentations from the ASO and other sources on procedural issues within the PMHS. In addition, the Bureau of Behavioral Health holds monthly seminars on a variety of clinical issues for staff and their provider network.
Director	2.2.4	**Update the Bureau of Behavioral Health/CSA web page within the Baltimore County Health Department and within the Network of Care to include information on training, policy changes, program changes, etc.**
FY '11 Result		The CSA webpage is managed through the Public Information Office of the Health Department. Staff for the CSA has collaborated on updates and refinements.
MHAC	2.2.5	**The Mental Health Advisory Council will work with the CSA to identify consumer needs and concerns and develop lines of communication between consumers and the CSA.**
FY '11 Result		The MHAC met monthly throughout FY 2011 with support and guidance from the CSA director. The Council was active in the development of the Town Hall Meeting and Children's Mental Health Fair along with other projects and offers regular feedback to the CSA on local behavioral health issues.
C & A	2.2.6	**Participate in Local Management Board Family Advisory Committee.**

FY '11 Result	Strategy completed. As a result of budget cuts to the LMB the committee was suspended in FY 2009 and remains suspended. When this changes the CSA will resume its participation on this committee.
Goal 2, Objective 2	**Strategy Accomplished**

Goal 2 accomplished

Goal 3	**The CSA will develop and manage targeted services and initiatives to serve specific special needs populations.**

Goal 3 Objective 1		**Promote social-emotional development, positive family relationships, stable enrollment in day care, and school readiness, for the early childhood population with intensive needs (through age 5).**
		Strategies
C & A	3.1.1	**Collaborate with the Abilities Network/Project ACT consultation to day care centers regarding children who present significant behavior problems.**
FY '11 Result		C & A staff takes an active role with Project ACT through the Abilities Network and attend committee meetings and monitoring the program.
C & A	3.1.2	**Contract for provision of day care site-based and home-based services for this population and their families, with priority given to Project ACT referrals**.
FY '11 Result		Project ACT continued to respond to day care referrals, perform evaluations and offer consultation and intervention to families. The CSA participates in utilization reviews and oversight committee. Maintain strategy.
Goal 3, Objective 1		**Goal Accomplished**

Goal 3 Objective 2		**Coordinate access to Residential Treatment Centers (RTC) for children with intensive needs, monitor treatment progress, and assist with discharge planning.**
		Strategies
C & A	3.2.1	Assist with referral/admission process.
FY '11 Result		C & A staff reviewed 77 CON's for new admission to RTC's. 13 CONs were reviewed for RTC Waiver admissions. The CSA was lead agency for 43 youth (25 new admissions and 18 carry over from FY 2010). Continue strategy; anticipate a decrease in the number of new RTC referrals with the implementation of the RTC Waiver services.
C & A	3.2.2	**Assist in all phases of the Local Coordinating Team (LCT) process**.
FY '11 Result		C & A staff participated in 38 weekly LCT meetings; reviewing the initial placement, annual review of placement and CSI services for 112 cases. The LCT has transitioned in regulation from LCT to the Local Care Team (LCT) In Baltimore County the LCT and the Multi-D processes have been combined. This process allows for families and /or agencies to refer cases for technical assistance. Most often families/agencies are seeking treatment resources for very challenging youth with a wide variability of needs.
C & A	3.2.3	**Track RTC utilization of County residents.**
FY '11 Result		C & A staff monitored RTC cases for which the CSA was the lead agency. Case monitoring includes participation in treatment team meetings, being available to parents and RTC staff for case consultation, and participating with discharge planning. (See strategy 3.2.1 for the number of cases served). Maintain strategy.
C & A	3.2.4	**Monitor treatment progress of CSA lead agency youth by reviewing monthly treatment plans, attending treatment team meetings, discharge-planning meetings, and other inter-agency meetings.**
FY '11 Result		Strategy completed
Goal 3, Objective 2		**Goal Accomplished**

Goal 3 Objective 3	**Coordinate services to assist transition age youth (TAY) ages 18 to 23 years old in transitioning from the Child PMHS to Adult PMHS.**

		Strategies
Adult	3.3.1	**Monitor the contracted provider to ensure the delivery of residential rehabilitation, supported housing, and case management to TAY clients.**
FY '11 Result		People Encouraging People (PEP) is the contracted provider of residential TAY services. Ten TAY clients were served in the program in FY 2011. All seven outcome measures were successfully achieved. Maintain strategy.
Adult	3.3.2	**Collaborate on interagency committees with other agencies and providers serving this population.**
FY '11 Result		Strategy completed.
Goal 3, Objective 3.		**Goal Accomplished**

Goal 3 Objective 4		**Supported Employment services will continue to be promoted to consumers and providers.**
		Strategies
Adult	3.4.1	**Participate in the MHA quarterly Supported Employment Program meetings.**
FY '11 Result		The CSA has assigned a clinical team staff person to over see supported employment activities, including participating in these quarterly meetings.
Adult	3.4.2	**Conduct joint meetings with Supported Employment and Psychiatric Rehabilitation providers to promote supported employment services within the psychiatric rehabilitation programs.**
FY '11 Result		CSA has met with these providers on a quarterly basis. Maintain strategy and look to broaden employment opportunities for local consumers.
Goal 3, Objective 4		**Goal Accomplished**

Goal 3 Objective 5		**Broaden housing options for adults who require program support to live independently and for adults re-entering the community.**
		Strategies
Adult	3.5.1	**Collaborate with MHA Office of Special Populations and County Agencies to oversee, supervise, and explore opportunities for the expansion of Projects for Assistance in Transition from Homelessness (PATH), Homeless Outreach Services, Shelter Plus Care and Re-Entry programs.**
FY '11 Result		CSA staff has met quarterly with the Office of Special Populations for the oversight of these projects. Shelter Plus Care funding expanded in FY 2011.
Adult	3.5.2	**Monitor the Residential Rehabilitation waiting list quarterly to ensure that consumers who are priority population are placed into residential rehabilitation in an expeditious manner.**
FY '11 Result		The CSA Residential Specialist in FY 2011 performed this function. Placement policies and procedures were reviewed and updated to ensure rapid placement and a accurate waiting list.
Adult	3.5.3	**Collaborate with Department of Social Services "Back Home" and "Housing First" programs and other agencies to explore housing options.**
FY '11 Result		CSA staff has worked with DSS and other County agencies to expand housing resources. Twenty-five housing slots in the Rapid Rehousing program were reserved for individuals with psychiatric disabilities. CSA staff also collaborated with DSS staff in the submission of a proposal to HUD for additional Housing Choice vouchers, and an ongoing workgroup continues to meet to address these issues.

Adult	3.5.4	**Establish a work group of advocacy members, etc. to work with agencies outside the mental health field to identify possible housing solutions**.
FY '11 Result		The CSA has continued to work with partners in the local Housing Office and Planning Office to identify new housing opportunities. The CSA participates in the local quarterly Housing Roundtable, and the Charrette Planning process. Maintain strategy; continue to participate on the housing committee.
Goal 3, Objective 5		**Goal Accomplished**

Goal 3 Objective 6		**The CSA will actively work to ensure a wide range of services is available to meet the needs of persons who are homeless in the county.**
		Strategies
Adult	3.6.1	**Participate on the Baltimore County Communities for the Homeless, Inc. (BCCH).**
FY '11 Result		The CSA continued to work with this local homeless advocacy organization.
Adult	3.6.2	**Participate in the bi-monthly PATH and Shelter Plus Care Coordination meetings led by the MHA Special Needs Population Division.**
FY '11 Result		CSA staff regularly attends these meetings along with our subcontracted vendor. Maintain strategy.
Adult	3.6.3	**Conduct mental health training for providers of homeless services (e.g. homeless shelter staff, etc.), as requested.**
FY '11 Result		CSA staff developed and offered training on mental health and coordinated a training on substance abuse issues for shelter personnel. Approximately 40 shelter staff participated
Adult	3.6.4	**Serve as a resource for case consultation and training to the Baltimore County homeless service providers, as requested.**
FY '11 Result		The CSA staff have performed this function on request.
Goal 3, Objective 6		**Goal Accomplished**

Goal 3 Objective 7		**The service needs of individuals with co-occurring disorders; both mental illness/substance abuse will continue to be a focus of improvement.**
		Strategies
Director & Adult	3.7.1	**Participate with MHA and local stakeholders, to develop and implement services for individuals with co-occurring disorders.**
FY '11 Result		The CSA, as part of the BBH chairs a Countywide Co-Occurring Steering Committee to address the needs of and services available to consumers with co-occurring disorders. The group met bi-monthly during FY 2011 and sponsored provider forums and training on co-occurring issues. Maintain strategy and expand the group to include developmental disabilities stakeholders.
Director	3.7.2	**Promote the implementation of a welcoming treatment environment, in partnership with the Co-occurring Disorders Steering Committee.**
FY '11 Result		Co-Occurring Disorders Steering Committee met regularly in FY 2011. The committee expanded membership and sponsored several training activities. Under guidance from the committee both mental health and substance abuse providers have worked to develop a welcoming treatment environment for their clients.
Goal 3, Objective 7		**Goal Accomplished**

Goal 3 Objective 8		**The CSA through collaboration, education, and outreach efforts will increase awareness of the mental health needs of the aging population.**
		Strategies
Adult	3.8.1	**Participated in the Vulnerable Adult Assistance Network (VAAN), an interagency committee formed to address the needs of older adults with mental health concerns.**
FY '11 Result		This committee meets bimonthly with representatives from various county agencies to address the needs of the older adult consumer with mental health concerns. Issues related to hoarding have become a particular focus. The County has established a Hoarding Task Force to address emerging cases. The CSA provides clinical consultation to the Task Force.
Adult	3.8.2	**Participate in the Mental Health Coalition on Aging and Mental Health to explore and advocate for alternative funding resources for seniors.**
FY '11 Result		The GST coordinator participates in these meetings and the CSA participation has been via electronic communications and collaboration with the GST program staff.
Adult	3.8.3	**Fund and monitor services that support the Geriatric Service Team (GST).**
FY '11 Result		CSA funds and monitors vendor (Bay Life) to operate a county-wide Geriatric Program. This contract expired in FY 2011 and was rebid: Bay Life continues to operate the program.
Adult	3.8.4	**Collaborate with the Department of Aging, Social Services, Baltimore County Crisis Response Service, and Adult Evaluation Services to explore ways to identify, educate and treat seniors with a mental illness.**
FY '11 Result		Collaborative partnerships continue to exist with these agencies and the CSA frequently provides consultation for seniors with a mental illness.
Adult	3.8.5	**Fund and monitor the PEERS Senior Outreach program.**
*FY '11 R*esult		CSA contracts with Mental Health Association of Maryland (Baltimore Region) to train and match volunteers to meet the needs of isolated older adults with mental health concerns. This contract expired in FY2011 and was rebid. The Mental Health Association continues to operate this program.
Goal 3, Objective 8		**Goal Accomplished**

Goal 3 Objective 9		**The CSA will collaborate with agencies in serving the behavioral health needs of consumers in the criminal justice system.**
		Strategies
Adult	3.9.1	**Collaborate with MHA Office of Forensic Services to develop services for consumers who have mental illness and are involved in the forensic system.**
FY '11 Result		CSA maintained positive working relationship with this office in FY 2011.
FY '13 Projection		Maintain strategy
Adult & Director	3.9.2	**Participate in the monthly Criminal Justice Coordinating Council established through the County Executive's Office.**
FY '11 Result		The CSA Director and BBH Chief are appointees to this Council, which is now being held bi-monthly.
Adult	3.9.3	**Convene a bi-monthly forensic/mental health meeting, including the court mental health services, the detention center administration and mental health staff to improve the overall services for consumers who have become involved in the criminal justice system.**

FY '11 Result		The Forensic/Mental Health Workgroup met bi-monthly with strong participation from both mental health and criminal justice agencies. The group has reviewed and addressed issues related to coordination of care with the State Hospital, aftercare services for individuals released from the detention center, and coordination with the courts. Maintain strategy. The group has expanded during FY 2012 to include representatives from the regional office of the Developmental Disabilities Administration.
Adult	3.9.4	**Provide medication and flexible funding to consumers being released from the detention center.**
FY '11Result		Resources for this purpose were made available by the CSA and the Crisis Response Service.
Adult	3.9.5	**Provide linkage to the crisis response system for individuals released from the detention center to improve treatment options.**
FY '11 Result		Crisis Response System is represented on the Forensic/Mental Health Workgroup and part of the available service continuum.
Adult	3.9.6	**Provide consultation on the protocols of completing and executing Emergency Petitions to local police and family members.**
FY '11 Result		Consultation is provided as requested
Adult/ QA	3.9.7	**Maintain and enhance mental health and trauma services (TAMAR) for clients upon release from the Baltimore County Detention Center.**
FY '11 Result		TAMAR program operated with multiple funding sources (state and local) in FY 2011. The case management contract for this service was re-bid in FY 2011 and awarded to Alliance, Inc.
Adult	3.9.8	**Provide clinical consultation services for the police department (e.g. forensic cases, mental health cases, workplace violence case, etc.).**
FY '11 Result		Consultation has been provided upon request.
Adult	3.9.9	**Provide specialized mental health training to Baltimore County Police Officers.**
FY '11 Result		Affiliated Santé Group, the CSA-funded vendor for crisis response, provides regular trainings for the Baltimore County Police Department to aid officers in recognizing and responding to individuals in mental health crises. An annual 3-day seminar entitled "Police Response to the Mentally Ill" was presented at the Police Academy which included training scenarios involving individuals with mental health issues portrayed by the Mental Health Players of the Mental Health Association of MD.
Adult	3.9.10	**Serve as a facilitator between mental health providers and the Police Department to resolve procedural barriers to quality care.**
FY '11 Result		Through the bimonthly meeting of the Crisis Response Program Steering Committee, CSA staff met with police representatives to address issues related to barriers to quality care. The Police Department holds an appointed position on the Mental Health Advisory Council which also serves as a forum to address quality of care issues.
C & A	3.9.11	**Provide consultation to Department of Juvenile Services (DJS) staff to provide appropriate community resources/referrals.**
FY '11 Result		CSA staff continued to collaborate with DJS regional office staff providing treatment resources and community based services information.

C & A	3.9.12	**Fund and monitor Family Intervention Specialist (FIS) programs for high-risk DJS involved youth.**
FY '11 Result		Funding for the FIS program will no longer be directed through MHA, therefore the CSA will no longer have a direct role in the FIS program.
C & A	3.9.13	**Fund and monitor the Multisystemic Therapy (MST) program for high-risk DJS involved youth.**
FY '11 Result		The MST program received 68referrals for service (target – 47). The CSA maintains an active role with this program. All referrals come to the CSA for review and acceptance before they are forwarded to the MST vendor. Performance measures have all been achieved.
C & A	3.9.14	**Participate on the Countywide committees to address delinquency prevention and services to DJS youth.**
FY '11 Result		C & A staff participates in the Baltimore County Delinquency Prevention Committee and the Disproportionate Minority Contract Committee with the local judiciary, juvenile justice, and law enforcement agencies.
Goal 3, Objective 9		**Goal Accomplished**

Goal 3 Objective 10		**Case Management services will be provided Countywide for adults with a chronic and persistent mental illness and children with intensive needs.**
		Strategies
Adult/ C & A	3.10.1	**Monitor the case management services program to ensure the appropriateness and adequacy of those services.**
FY '11 Result		Strategy completed 214 Adults, 190 children served
Adult/ C & A	3.10.2	**Collaborate with the provider of case management services to guarantee the delivery of case management services to the special needs population.**
FY '11 Result		The Case management vendor received referrals for service and served adults and children/adolescents. The number of C & A referrals was significantly lower than expected thereby decreasing the vendor's ability to meet the average census target. In addition, the program was limited in its ability to serve clients incarcerated in the Baltimore County Detention Center (BCDC) due to policy changes as a result of converting from a grant funded to a Medicaid reimbursed service. The program maintained a pro bono presence at the BCDC, but served fewer clients from the source.
Goal 3, Objective 10		**Goal Accomplished**

Goal 3 Objective 11		**The CSA will manage specialized services for mental health consumers who have unique treatment needs.**
		Strategies
Adult	3.11.1	**Grants will be available for a limited number of individuals identified by the MHA who have a mental illness and are deaf and/or hard of hearing to enable the deaf and/or hard of hearing consumers to live in the community with additional support services not available through the PMHS.**
FY '11 Result		The CSA, through Community Support Services for the Deaf, has meet performance measures in serving this population in the community.
Adult	3.11.2	**Fund and monitor the provider of deaf and/or hard of hearing services for the provision of signer/interpreter fees not covered under the PMHS for clients served in those programs.**

FY '11 Result		During FY 2011, CSSD met all performance measures for serving deaf and/or hard of hearing clients living with mental illness. They have served consumers in OMHC, PRP, RRP, and through sign language interpreting.
Adult	3.11.3	**Fund and monitor the Community Enhancement Initiative (CEI) to support eight consumers living in the community.**
FY '11 Result		Funding for this program was re-allocated within the CSA to absorb budget reductions for the fiscal year. Strategy may be re-established in FY 2013 to support Spring Grove Hospital ALU census reduction initiative.
Adult/ C & A	3.11.4	**Explore opportunities to expand Evidence-Based Practice projects to serve special populations (e.g. Assertive Community Treatment (ACT), MST, BSFT, etc.).**
FY '11 Result		The CSA continues to implement Supported Employment and Multisystemic Therapy, and assisted the LMB in implementing Multidimensional Treatment Foster Care. The BBH also provided Functional Family Therapy. In FY 2011, the CSA successfully bid for vendors to operate a Assertive Community Treatment Team and a Brief Strategic Family Therapy program. The CSA will continue to operate these services and look for potential program expansion. BSFT will be fully implemented and will be available countywide as a home based service. The BSFT will continue to work toward certification through the University of Miami BSFT Training Institute. The ACT program will achieve fidelity to the model status.
Adult	3.11.5	**Maintain membership on the County returning veterans' workgroup to address the unique treatment needs of returning veterans and their families.**
FY '11 Result		CSA staff continued to participate in this bi-monthly workgroup representing the behavioral health needs of veterans and their families.
Adult/ C & A	3.11.6	**Collaborate with developmental disability stakeholders to identify gaps in services and potential strategies to address the needs of individuals with both a mental illness and developmental disability.**
FY '11 Result		In FY 2011 the central region CSAs (Howard, Harford, Anne Arundel, Baltimore City, and Baltimore County) established a quarterly meeting with the Central Regional Director of the Developmental Disabilities Administration to review policies, procedures, review cases, and coordinate services. This has been a positive process and has helped with the integration of these services.
Goal 3, Objective 11		**Goal Accomplished**

Goal 3 Objective 12		**The CSA will ensure that mental health needs of citizens in Baltimore County will be met in the event of a man-made or natural disaster.**
		Strategies
Director	3.12.1	**Assist in the development and implementations of the Health Department's Disaster Plan and participate in the County's initiative to educate citizens with special needs in emergency preparedness.**
FY '11 Result		CSA staff is included in the Department's Incident Command structure and have responded as needed. The CSA maintains a roster of emergency personnel and coordinates the local mental health response.
Director	3.12.2	**CSA staff designated as essential personnel will receive training and other necessary information in the event of a disaster.**

FY '11 Result		BBH staff participated in NIMS training to refresh their disaster response skills The CSA Director has been trained and serves as a liaison to the County's Emergency Operations Center.
Director	3.12.3	**The Emergency Mental Health Crisis response service will provide CISM and other training and will maintain a list of volunteers trained to respond to an event.**
FY '11 Result		The Baltimore County Crisis Response Service (BCCRS) maintains a list of volunteers and provides specialized training to volunteer emergency responders. In FY 2011 the team responded to 55 CISM and Community Education requests.
Director	3.12.4	**Encourage providers to develop emergency plans in the event of a man made or natural disaster.**
FY '11 Result		The QA team reviews emergency procedures with residential providers during regularly scheduled site visits.
Goal 3, Objective 12		**Goal Accomplished**

Goal 3 accomplished

Goal 4	**The CSA will monitor, evaluate, and analyze public mental health services in Baltimore County.**

Goal 4 Objective 1		**The CSA will continue to refine and improve the methods of monitoring and evaluating the appropriateness and outcome of services rendered to assure quality programs.**
		Strategies
QA	4.1.1	**Review Program Improvement Plans (PIP) for programs inspected by the Office of Health Care Quality.**
FY '11 Result		The Quality Assurance (QA) team reviews PIPs for programs inspected by the Office of Health Care Quality.
QA	4.1.2	**Communicate with the MHA regarding deemed status programs.**
FY '11 Result		The QA team communicates with MHA regarding deemed status programs.
QA	4.1.3	**Evaluate and educate on the need for advanced directives for psychiatric emergencies.**
FY '11 Result		The QA team will continue to review the policies and procedures related to advance directives during site visits.
QA & Adult	4.1.4	**Collaborate with Consumer Quality Team (CQT) consumers to assist in developing monitoring mechanisms.**
FY '11 Result		The QA team collaborates with the Consumer Quality Team (CQT). A representative participates in monthly feedback meetings and works closely to address the consumer concerns expressed in interviews with the CQT team.
QA	4.1.5	**Receive education and direction from the MHA regarding statewide satisfaction surveys and review and monitor satisfaction surveys conducted by programs with contracts.**
FY '11 Result		The QA team reviews and monitors satisfaction surveys conducted for programs with contracts at the time of their site visits. The contract liaisons also participate in monitoring the surveys on an ongoing basis.
QA	4.1.6	**Review applications for new programs in Baltimore County to comply with COMAR and directive of the MHA, in collaboration with the DHMH Office of Health Care Quality and continue to seek clarity on respective agency roles and responsibilities.**
FY '11 Result		The QA team reviews applications for new programs in Baltimore County to assure that the programs comply with COMAR regulations and the directives from MHA and the Office of Health Care Quality. There were 10 new program applications in FY 2011. Some are still in progress. This is down considerably from the 100 applications that were processed several years ago. We continue to seek clarity on the respective agency roles in this task.
QA	4.1.7	**Conduct periodic focus groups or other needs assessments in collaboration with the Mental Health Advisory Council and other groups to identify priorities, outcome measures, and formulate goals for the CSA.**
FY '11 Result		The data team has analyzed quantitative and qualitative data from, MHA and ASO reports, HELP calls, site visits and grievances. The outcomes of data analysis will be used to formulate goals for the CSA.
All	4.1.8	**Participate with the Mental Hygiene Administration (MHA) and the Administrative Services Organization (ASO) in the monitoring of provider compliance with system billing and fiscal requirements.**
FY '11 Result		The BBH and the CSA do participate with the MHA and ASO in the monitoring of provider compliance with system billing and fiscal requirements. The QA team does participate in this activity.

FY '13 Projection		Maintain strategy
All	4.1.9	**Perform site visits and report results for grant funded programs and provide technical support and education to address weaknesses in programs receiving grant dollars.**
FY '11 Result		The County QA team maintains an active schedule of site visits across the spectrum of services for mental health and substance abuse consumers in our jurisdiction including grant funded programs and RRP sites. We are providing cross training to the staff in the Bureau of Behavioral Health to orient them to CSA QA procedures.
		Goal Accomplished

Goal 4 Objective 2		**The CSA will monitor and maintain compliance with Memorandum of Understanding (MOU) with the Mental Hygiene Administration (MHA) with regard to contract providers.**
		Strategies
Admin	4.2.1	**Monitor contract deliverables and expenditures as outlined in the MOU with MHA.**
FY '11 Result		The CSA assigns a staff member as the contract monitor for each of our contracted programs. The monitor is responsible for collecting quarterly performance reports form the program, providing technical assistance to the program, and reporting any issues to the CSA QA program manager.
Admin	4.2.2	**Monitor contract expiration dates to assure that sufficient time is allowed for the Request for Proposal (RFP) process and development of a new contract.**
FY '11 Result		Several programs had contracts expire during FY 2011. All contracts were successfully re-bid and program services continued uninterrupted.
Admin	4.2.3	**Submit RFPs, which outline project expectations and funding, to Purchasing Office at least six months prior to the current contract expiration.**
FY '11 Result		All RFPs submitted during FY 2011 were completed within the required timeframe.
Admin	4.2.4	**The CSA will not execute contracts prior to approval by The Baltimore County Council.**
FY '11 Result		All contracts issued in FY 2011 were completed within County Charter guidelines
Admin	4.2.5	**Incorporate current language required by the MHA into contracts as renewed**.
FY '11 Result		Complete
Admin	4.2.6	**Utilize the County procurement process to respond and develop new contracts with providers and work with the County grants, purchasing and law offices to streamline those functions to be responsive and timely.**
FY '11 Result		The CSA successfully rebid all contracts in FY 2011.
		Goal Accomplished

Goal 4 Objective 3	**The CSA will work with the Administrative Services Organization (ASO), the MHA, providers and consumers to help track, monitor, analyze and resolve grievances, complaints and appeals.**
	Strategies

QA	4.3.1	**Resolve grievances, complaints and appeals through the Quality Assurance Coordinator, the Consumer Advocate, the team of Program Managers and CSA Director.**
FY '11 Result		The QA team has dedicated additional resources to oversee the provision of services in Baltimore County. The CSA continues to conduct site visits and resolve complaints, grievances, and appeals with input from the Bureau of Behavioral Health staff and Chief of Mental Health Services. Additionally; the CSA is developing new tools to standardize and document this process for internal analysis and reporting to funding sources and OHCQ. There were 45 complaints or grievances investigated in the past year.
QA	4.3.2	**Review available data for trends, patterns, and quality assurance and include this analysis in the Annual Report.**
FY '11 Result		The data management team has been formed and QA team members will participate. The team has begun to develop strategies to analyze the available data collected from MHA, Value Options, site visits, the CQT, and consumer complaints/grievances. This analysis will be used to evaluate the need for services in our jurisdiction.
		Goal Accomplished

Goal 4 Objective 4		**The CSA will analyze relevant data to identify problems, gaps in service or irregularities.**
		Strategies
Admin	4.4.1	**Utilize data available through the ASO, CSA, MHA and other data resources to track, monitor, and analyze service utilization and expenditures.**
FY '11 Result		The data team tracks service utilization and expenditures and identify irregularities and gaps in services.
Admin	4.4.2	**Periodically review consumer demographic information to analyze service utilization patterns by County residents.**
FY '11 Result		Members of the data team reviewed this information in preparation for the Plan and Budget.
All	4.4.3	**Review HELP call patterns to aid in identifying system service gaps**.
FY '11 Result		An analysis of Help Calls received in FY 2011 has bee used as part of the data analysis and needs assessment for FY 2011. The Help Call form has been converted to an online tool which now assists with tracking and data collection.
Goal 4, Objective 4		**Goal Accomplished**

Goal 4 accomplished

Section II:

FY 2013-2015 Plan

Section II Plan Fiscal Year 2013-2015

Introduction

There are multiple challenges facing the Baltimore County Core Service Agency for FY 2013 and beyond. These challenges include anticipated budget reductions, the restructuring of behavioral health care at the State level, and the impact of Federal Health Care reform. As discussed in our Annual Report, our Bureau of Behavioral Health has become an entity that is well structured and positioned to address the needs of our community. A comprehensive review of the goals, objectives, and strategies for FY 2011 and the projections for FY 2013 is combined and contained within the Annual Report in this document. Subsequent progress on these goals will be addressed in future Plan Updates.

Mission and Vision Statements

Baltimore County Department of Health Vision Statement:
"Healthy people living, working, and playing in Baltimore County"

Baltimore County Department of Health Mission Statement:
"To promote health and prevent disease through Education, Advocacy, Linkage to resources and Treatment to improve the quality of life for Baltimore County residents"

Bureau of Behavioral Health Mission Statement:
"To strengthen and sustain a safe and effective behavioral health system of care that promotes wellness and recovery.

Organizational Structure of the CSA

The **Bureaus of Mental Health and Substance Abuse officially merged in July 2009 to form the Bureau of Behavioral Health.** Throughout Fiscal Years 2010 and 2011 there has been an ongoing process of merging staff functions, refining administrative procedures, and reviewing fiscal management to implement the new Bureau of Behavioral Health's mission. The new bureau has embraced the team concept to address many of these challenges. This process continues to be very helpful as it promotes cross educating the staff and facilitates understanding of our programmatic philosophies and the full scope of responsibilities of the new bureau. Several new teams have been established to address content specific issues:

Management Team: Comprised of program managers from both of the previous bureaus, this team meets weekly to review bureau operations, system challenges, and implementation of program practices.

Budget Team: Comprised of key program managers and fiscal staff, this team meets weekly to track expenditures, review budgetary policies, and prepare fiscal reports.

Clinical Team: This team is comprised of program managers and staff from the CSA and meets bi-weekly to review service provision issues related to the public mental health system. The team reviews service delivery issues related to adult, and child and adolescent services.

Data Team: This team is comprised of program managers and staff, and the bureau statistical analyst. This team meets monthly. Its mission is to review the various sources of system data available to bureau staff, develop new data collection mechanisms, and analyze available data.

The behavioral health care landscape at the national and state level is in a process of change and redefinition. The Bureau of Behavioral Health intends to position itself to best be able to respond to system changes as a result of future federal health care reform and continued budgetary constraints in order to meet the needs of Baltimore County residents.

In FY 2012, Baltimore County Government offered a Retirement Incentive Initiative. As a result, several positions in the Bureau of Behavioral Health will become vacant and will remain so for FY 2013. The Bureau Management Team will review re-organization strategies to ensure continuity of CSA functions.

There have been several benefits that have already resulted from this integration:

1. **More efficient use of resources**:
As a result of blending our bureaus, we have realized some administrative cost savings that have helped us respond to budget reductions. As staff positions have become vacant, they have remained unfilled. We have been able to draw on the resources of our blended staff to fill some of these gaps. As a result, we have been able to absorb reductions to our administrative budget while preserving services for consumers and minimizing reductions to our provider network.

2. **Innovative programming**
Two examples of program innovations that have occurred as a result of merging our mental health and substance abuse services are the expansion of evidence based practice services and the increased coordination of our criminal justice services.

A critical review of our budget and services subsequent to our merger led the CSA to re-direct funds from existing programs to develop a pool of funds to be available for the start up of two new Evidence Based Practice (EBP) services; Assertive Community Treatment (ACT) and Brief Strategic Family Treatment (BSFT). Requests for Proposals were offered for both of these new programs in FY 2011. Start up activities for both programs were launched in the fourth quarter of FY 2011 with client enrollment starting in FY 2012. Prior to our merger, both bureaus provided services in the Baltimore County Detention Center including mental health, substance abuse, and trauma services for inmates. However, there had not been a great deal of coordination among these programs. Subsequent to our merger, all of these services have been placed under the direction of a single program manager resulting in increased coordination among bureau and detention center personnel, and the contracted vendors. One of the results of this collaboration has been the successful application for additional funding from the Maryland Health Care Resources Commission to expand case management services at the detention center. The Community Re-Entry Initiative (CRI) was launched in FY 2011.

3. **Blending of Program philosophies and values**
The Recovery Movement has been a primary value in the mental health system for many years. Recovery focuses on empowering individuals to be active participants in their

treatment, to develop goals for the future, and to encourage the treating professionals working with the individual to be respectful and responsive to consumers.

The Maryland Alcohol and Drug Abuse Administration (ADAA) and Baltimore County have adopted the Recovery Oriented System of Care (ROSC) model, which is very similar to the mental health Recovery Movement. ROSC is highly consumer oriented and involves recovering people in all aspects of planning and implementing the transformation of the system.

Several of our staff are certified as ROSC trainers and all BBH staff have received education and training in the model. We have compared the Recovery Movement and ROSC, drawn from each other's experience and expertise, and support the development of both of these initiatives.

In FY 2011, we launched our ROSC Initiative in the Dundalk community of Baltimore County. The ROSC group has met monthly in Dundalk and has grown to include community leaders and representatives, as well as staff from related County public and private agencies. The group has started an education campaign, conducted focus groups, and is expanding the On Our Own Wellness and Recovery Center in the community to include individuals with substance and co-occurring disorders. The goal is to help the local community identify and address substance abuse and co-occurring disorders.

Other benefits achieved from bureau merger:

We have:

- A broader range of staff expertise to draw on for the implementation of new practices….budgetary, data analysis, clinical, and educational

- A broader understanding of each other's disciplines in both mental health and substance abuse

- Advanced the activities of our Co-Occurring Workgroup and extended our outreach to representatives from the developmental disabilities community.

- Refined our internal administrative policies and quality assurance activities and have assigned additional staff to these functions.

- Broadened our pool of staff to draw from and have started to look at how to divide up functions. For example, quality assurance staff now conducts the annual inspections of our Residential Rehabilitation Programs.

- Positioned the Bureau to take advantage of future funding opportunities or respond to future budget reductions.

Baltimore County Demographics

According to 2010 census data, Baltimore County has a population of 805,029. 22% of the population is under age 18, 15 % is over the age of 65. Culturally, the County is 65 % white persons, 26% black persons, 5% Asian persons, and 4 % persons of Hispanic or Latino origin. Median household income is approximately $64,000, 8% of the population was below the poverty level, 2006-2010. In FY 2010 there were approximately 122,000 individuals eligible for Medical Assistance and 17,396 clients served in the Public Mental Health System.

A. Service Descriptions

Maximizing Non-MHA resources

One of the functions of the CSA is to develop funding for local mental health services beyond the support provided by the Mental Hygiene Administration (MHA). Additional funding sources included the Governor's Office of Crime Control and Prevention (GOCCP), the Local Management Board (LMB), the Mediation and Conflict Resolution Office of Maryland (MACRO), the State Department of Juvenile Services (DJS), and Baltimore County Local Government Funds. These funds supported various activities that included homeless outreach services, peer support programs, trauma services, home-based support for seniors, family mental health education programs, client support funds for medications and eviction prevention, and multiple services for at-risk youth including Multisystemic Therapy, mediation services, and other specialized services.

Public Forums

The CSA continued its tradition of providing public forums for mental health consumers and their families. These forums provide information on available mental health resources, updates on public mental health policy issues, and provide details about specific services available from our public and private agency partners. In FY 2011, the CSA held its 13th Annual Mental Health Fair and Town Hall Meeting and 4th Annual Children's Mental Health Fair. These events attracted over 500 attendees and included extensive vendor displays, open public forums/panel discussions with representatives from mental health and related public service agencies, classroom presentations on topics of special interest, and opportunities for individual consultation with experts on various elements of the Public Mental Health System. Participant satisfaction with these forums has been very high.

Target Services

The Baltimore County CSA provides targeted services for several special population groups. Some of these services have been described in greater detail elsewhere in this report. These services include:

1. Co-occurring disorders: The CSA facilitates the Co-Occurring Disorders Steering Committee which includes providers from both the substance abuse and mental health networks
2. Pregnant woman: As part of the Department of Health, the CSA collaborates and provides consultation and case management to high risk pregnant women identified in the Department's pre-natal support program.
3. The Bureau of Behavioral Health manages the tobacco cessation program and provides education and support to at risk populations.

4. The Bureau's Curb Underage Drinking (CUD) program provides assistance to at risk youth.
5. The CSA funds service to Transition Aged youth through a contract with PEP Inc.
6. The CSA funds several programs directed to older adults through the Geriatric Service Team program and the PEERS program.
7. The CSA is an active participant in the County's veteran's initiative "HomeFront" and the Returning Veteran's Workgroup. The Crisis hotline tracks calls by volume and type from veterans and their families.

For FY 2013, the CSA will be identifying the needs and opportunities to assist the GLBT community and issues related to suicide prevention.

Consumer Quality Teams (CQT)

In FY 2011, the Consumer Quality Team (CQT) program managed by the Mental Health Association of Maryland, conducted site visits to Baltimore County Psychiatric Rehabilitation Programs (PRP) including Prologue, Mosaic, Alliance, Key Point, and Community Behavioral Services. .The reviews have been generally favorable and CSA staff has worked with CQT and PRP personnel to implement recommendations offered by consumers. In addition, the Director of the Consumer Quality Team program is a member of the Baltimore County Mental Health Advisory Council. The Quality Assurance staff of the CSA has maintained a consistently strong working relationship with the CQT program.

Residential Rehabilitation Programs (RRP)

The CSA is responsible for the oversight of the County's Residential Rehabilitation Program beds. The residential specialist utilized a computerized RRP waitlist to track incoming referrals. Of the 233 applications received and logged onto waiting list, 113 referrals were sent to providers for placement consideration and of these: Twenty-three consumers were accepted and placed in RRP slots; 19 consumers were denied, and **71** consumers were not interested in services once contacted. As of June 30, 2011 there were 155 applicants on the waitlist.

The waitlist is divided into three levels of priority. First priority is given to referrals from state psychiatric hospitals; second priority is given to all community referrals; and third priority is given to non-residents of Baltimore County. Outcomes for RRP applicants referred by the CSA to Baltimore County providers are summarized below:

Table 6: FY 2011 Residential Rehabilitation Program (RRP) referrals by Level of Service and Status of Placement

LEVEL OF SERVICE	ACCEPTED*	DENIED	OTHER**
Intensive	19	12	41
General	4	7	30
Totals:	23	19	71

* "Accepted" refers to the number of individuals who were placed in an opening, and not the total number of actual vacancies. For example, it is quite common for an individual to decide to leave a program against staff advice within a few days or weeks of placement, resulting in availability of the original vacancy.
** "Other" refers to applicants who were not ready or interested for vacancies at the time the

vacancy was available

The CSA continues to review and update its policies and procedures related to residential rehabilitation referrals in FY 2011. The waitlist was updated and outreach efforts implemented in an attempt to secure updated clinical information and consent to release information forms for those consumers with expired applications on file. CSA will now issue a letter to the consumer or referral source at the 10th month prior to the expiration of the active status, requesting updated information in order to prevent applications from expiring and consumers being removed from the waitlist. Our residential program generally operates with a less than a 5% vacancy rate. Therefore, the volume of referrals always exceeds the number of slots available. The goal is to create a fair and equitable placement process within the priorities for placement established by MHA.

Table 7: FY 2011 LCT Statistics

Project:	**RESIDENTIAL TREATMENT CENTERS (RTC) & RTC WAIVER 1915 C RTC DIVERSION REVIEW, COORDINATION, AND MONITORING**
Staff:	Baltimore County CSA C & A Team
Providers:	State licensed RTC's (public and private) MD Choices Case Management for RTC Waiver 1915 C

CSA C & A Team responsibilities:	**Outcomes:**
# RTC cases with CSA as lead or co-lead:	**43** total, including: 25 new admissions 18 carryovers 21 discharges
# DHMH committed or co-committed cases:	**0**
# CON reviews with Value Options, for RTC admission – all lead:	**77**
# CON reviews with Value Options for RTC Waiver cases:	**13**

Services Related To Clients From All Lead Agencies:

1. Attend LCT reviews, with an average of four cases scheduled per week
2. Review and approve updated Certificate of Need (CON) as partner with Value Options RTC Care Managers for RTC admissions (for placement by all lead agencies)
3. Discuss policy and procedures at monthly LCT business meetings
4. Attend trainings provided by Governor's Office of Children and the State Coordinating Council

Case Management Services Related To Clients With CSA Lead:

1. Send referral packets to appropriate RTC and maintain contact with directors of admissions to review client's status
2. Consult clients' therapists and parents about the RTC – LCT process; for private insurance, potential CSA-lead RTC cases
3. Schedule, prepare forms, and document packets for LCT reviews
4. Monitor client and family progress in RTC via treatment team reviews, contacts with therapists for updates, and review monthly progress summaries
5. Consult on discharge arrangements from RTC
6. Collaborate with involved parties when referring clients to DSS funded hospital-based respite placements (while awaiting RTC) or step-down placements for RTC discharge

Highlights

The CSA enjoys a long-term, ongoing positive relationship with all the LCT member agencies both in formal meetings and numerous interagency meetings and communications. These other agencies, as well as Value Options, RTC Admissions Offices, and MD Choices viewed the CSA C & A staff as helpful consultants in the RTC and CSI processes.

Challenges

Private insurance cases present an on-going challenge. It is difficult to provide sufficient home and community-based services, such as PRP or TBS, to prevent RTC or to prevent hospitalization while the child is on the wait list for RTC. Thirteen Baltimore County youth, regardless of insurance status, were able to enter the 1915c Medicaid RTC Waiver during FY 2011, which could help address this service gap for wraparound services.

A challenge presented to RTC consumers, by ongoing State policy, is the requirement to enter into a Voluntary Placement Agreement with DSS when a child who needs an adolescent RTC placement lacks a non-public IEP. This policy effectively mandates DSS foster care

involvement for parents and children, while these consumers would likely prefer no DSS involvement. The VPA process is cumbersome, both at initiation and during the foster care contacts.

Collaboration Activities

CSA staff attends and participates on a variety of local and state committees. Participation may be required through the Mental Hygiene Administration (MHA) Memorandum of Understanding (MOU). At times, a committee may request participation to assure interdisciplinary representation of the committee and to obtain technical assistance from the CSA as the local public mental health authority. The following is a list of the collaborative activities for the CSA staff last fiscal year:

- Baltimore County Detention Center Advisory Group
- Baltimore County Police/CSA/Crisis Provider
- Baltimore County Homeless Roundtable
- Baltimore County Supported Employment
- Baltimore County Department of Aging Consortium
- Baltimore County Interagency Professional Practice Group
- Baltimore County Emergency Services Directors
- Baltimore County Substance Abuse Advisory Council
- Baltimore County Residential Rehabilitation Services Provider/Placement Meeting
- Baltimore County Psychiatric Rehabilitation Services
- Baltimore County Crisis Bed Provider Meeting
- Baltimore County Critical Incident Stress Management Team
- Baltimore County Vulnerable Adult Assistance Network
- Maryland Coalition on Mental Health and Aging Coalition
- MHA Residential Rehabilitation Services/Supportive Employment
- MHA Residential Crisis Meeting
- MHA Supported Employment Liaison Committee
- MHA Shelter Plus Care Meeting
- MHA PATH Meeting
- MHA All Hazard Advisory Board
- Spring Grove Hospital Center Liaison Meeting
- Special Needs Planning Group
- Baltimore County School Health Council
- Baltimore County School Health Council Bullying & Harassment Work Group
- Baltimore County School Mental Health Advisory Council
- Baltimore County Juvenile Drug Court Steering Committee
- Baltimore County Delinquency Reduction Committee
- Baltimore County Dept. of Social Services Family Team Decision Meetings
- Child & Adolescent Mental Health Fair Committee
- Disproportionate Minority Contact Committee
- Interagency Family Preservation Advisory Board
- Local Coordinating Team
- Local Management Board
- MHA Child and Adolescent Blue Print Mental Health Committee and Respite Care Sub-committee, Evidence Based Practice Sub-Committee
- MHA Child and Adolescent Coordinators' Meeting

- MHA Early Childhood Mental Health Steering Committee
- Multi-disciplinary Reviews of Baltimore County DSS (four reviews/month)
- Multisystem Therapy (MST) Collaborative
- Project ACT of Abilities Network Early Childhood/Daycare Consultation Advisory Board
- RFP Review Committees for Contractor selection
- Residential Treatment Center Clinical Team Meetings
- Respite Grant Committee (Tri-county)
- Respite Grant Committee (MHA Statewide)
- Statewide Evidence Based Practices Advisory Board
- State Advisory Board for Dept. of Juvenile Services, Clinical Sub Committee

Director

- Baltimore County Co-occurring Disorder Steering Committee
- Baltimore County Criminal Justice Coordinating Council
- Baltimore County Crisis Response Steering Committee
- Baltimore County Emergency Operation Center designee
- Baltimore County Emergency Preparedness Council for People with Disabilities
- Baltimore County Mental Health Advisory Council
- Baltimore County Department of Health Executive Leadership Team Meeting
- Baltimore County Detention Center/Mental Health workgroup
- Maryland Association of Core Service Agencies (MACSA), President
- Maryland Mental Health Coalition
- MHA Variance Committee
- Sheppard Pratt Advisory Council – ex-officio member
- The CSA/Provider Workgroup
- Returning Veteran's Workgroup

B. Quality Management Activities

Priorities for Quality Assurance for FY 2011 were as follows:

- Respond to and track grievances/complaints and appeals
- Monitor deemed status programs
- Monitor contract providers through site visits
- Analyze and use data from the ASO in oversight of the local Public Mental Health System (PMHS)
- Receive and review satisfaction survey data
- Review and make recommendations for Performance Improvement Plans (PIPs)
- Review and make recommendations for new provider applications
- Participate in and contribute to CSA education and trainings activities
- Participate in annual Adult and Child & Adolescent Town Hall meetings or other needs assessment tasks

- Collaborate with the Consumer Quality Team (CQT) to monitor consumer satisfaction and concerns

Grievances and Complaints

The Quality Assurance Program Supervisor, Program Managers and the Chief of Mental Health Services are responsible for the resolution of grievances and complaints. Forty-five grievances and complaints were investigated in FY 2011, an increase from the thirty-three reviewed in FY 2010. There continues to be a large number of Adult Team HELP calls (1348), and it can sometimes be difficult to categorize what is a help call and what is a complaint. The Quality Assurance supervisor documents all grievances and complaints received. The team responding to HELP calls maintains records of calls received. At times, there are duplicates, and other times, grievance and complaints calls received do not make it to the grievance/compliant number count. Refinement of the tracking method is being explored to ensure a more accurate count.

Appeals

The Quality Assurance Manager, Child and Adolescent Team members, and a psychiatrist review third level appeals received by the CSA. All the appeals are logged, and any necessary follow up occurs. Until recently, the result of the review was sent to MHA for final authorization. Currently, the final decision is left to the CSA staff, along with the recommendation of the psychiatrist reviewer. During FY 2011, there were three appeals received and reviewed by the CSA.

Deemed Status Programs

The Quality Assurance Manager communicates regularly with the Mental Hygiene Administration regarding deemed status programs. Providers serving Baltimore County residents accredited by Commission on Accreditation of Rehabilitation Facilities (CARF) or Joint Commission on Accreditation of Hospital Organizations (JCAHO) are listed below:

Mosaic, Inc. received CARF accreditation and the three-year accreditation will run through June 30, 2013.

Catholic Charities Child and Family Services is currently accredited by JCAHO and will run through December 24, 2013.

Alliance, Inc. is CARF accredited through November 30, 2013.

Franklin Square Hospital Center has JCAHO accreditation beginning February 23, 2007 for three years (February 2010). They have not applied for deemed status but have been advised to do so. They still receive site visits from the Office of Health Care Quality. The program did not apply for deemed status in FY 2010.

Community Solutions, Inc., our Multisystemic Therapy (MST) provider, has been CARF accredited. While this provider is new to the County and state, they have been providing services in a number of other states for some time.

The CSA will continue to provide assistance to these programs to assure that they complete renewal packages and will submit verification to MHA to indicate compliance with the

conditions of deemed status. The CSA confers with the Chief, Division of Quality Management, Community Programs for the Mental Hygiene Administration regarding deemed status and the review of these programs as required by the CSA.

Schedule and Plan for Monitoring Contract Programs

The CSA has a policy that gives the option of site visiting programs every other year. The Contract Liaison and the Quality Assurance Program Supervisor review the need for an annual visit. The criteria used to determine these site visits was previously based on performance of the program as well as an examination of additional entities completing site visits with the provider during the year, i.e., Value Options and OHCQ. With the assignment of a designated CSA Contract Liaison, there is regular contact with each program and the annual site visits are less of a necessity. Five site visits were completed in FY 2011. The clinical, administrative and financial components of each program are reviewed in depth. Technical support and suggestions for further education are available from the site visit team. Programs are asked for input regarding the kind of training the Bureau could offer to be helpful to them. A list is compiled of their needs to aid the CSA in planning for future countywide trainings.

Satisfaction Surveys

Each program receiving funds through the CSA is required in their contract with the County to perform and review satisfaction surveys each year. In addition at each site visit, the satisfaction survey is discussed, and the processes for obtaining the surveys as well as the results are monitored.

Performance Improvement Plans (PIPS*)*

The CSA Quality Assurance Team and the Contract Liaisons review the Program Improvement Plans received from site visits. If needed, recommendations and support are provided to the program. The OHCQ and the Administrative Service Organization (ASO) have done a thorough and complete job of following up on site visits and PIPS, and the CSA serves as a backup to provide assistance as necessary.

New Providers

Applications for new programs in Baltimore County are reviewed for compliance with the COMAR regulations. After review at the CSA, applications are sent with recommendations and assurance of collaboration with the CSA to OHCQ. In FY 2011 there were ten new program applications received. In 2010 there were four new programs. In general, Baltimore County has a rich network of service providers and the number of new provider applications has remained relatively low. MHA has established new procedures for interested applicants which require the prospective program to first attend a quarterly orientation session. As a result, only the most serious applicants pursue the full process. Several of the new program applications that have been submitted in this last year have required significant assistance from CSA staff to help them understand the requirements. There is good communication and collaboration with the ASO and OHCQ regarding this process.

NEEDS ASSESSMENT AND FINDINGS/ PLAN DEVELOPMENT PROCESS

The plan development process has included several measures to include consumer and stakeholder input into the content of the document. A workgroup comprised of representatives of the CSA, Bureau of Behavioral Health, and Mental Health Advisory Council was established to develop the Annual Report and Plan. The Advisory Council selected the Chairperson and Vice Chairperson to represent them on the workgroup. The workgroup established a weekly meeting schedule and began by reviewing the current goals, objectives, and strategies. The group also spent significant time reviewing the utilization data for Baltimore County provided by MHA. At the December meeting of the Advisory Council, the proposed goals for FY 2013 and Baltimore County data trends were discussed in detail. The feedback from the Council was incorporated into the document.

The needs assessment process for the FY 2013 plan utilized several sources of information to identify the most urgent mental health needs of the community.

The Bureau of Behavioral Health/CSA derives its data/needs assessment indicators from the following sources:

- Public Mental Health System (PMHS) data from MHA
- Analysis of Help Calls to the CSA
- Feed back from consumers at annual Public Forums.

PMHS DATA from MHA

A review of the PMHS utilization data for Baltimore County suggests several needs assessment related questions. A more detailed discussion of this analysis will be covered in the Data section of this document. However, several of the issues can be presented here:

Baltimore County data in general very closely resemble the statewide data in most trends. There are a few categories where this is not the case.

1. The cost per client served in Baltimore County is higher than the Statewide average. While adult expenditures are consistent with the Statewide average, the County spends significantly more per child on mental health services.
2. OMS data indicates fewer individuals reporting homelessness being served in Baltimore County OMHCs than the Statewide average. This bears further review as it may indicate access issues for County homeless individuals.
3. The County OMS data indicates a higher number of unemployed individuals receiving services in OMHCs than the Statewide average. This may indicate a need to increase a focus on Supported Employment and other vocational opportunities.

HELP Call Analysis

A major responsibility of the Clinical team is to respond daily to calls for assistance received from mental health consumers, family members, other agencies and the general public. In FY 2011, the CSA responded to **1,114 adult related calls** from consumers and families seeking assistance which was a decrease from 1,440 calls received in FY2010. The adult team rotates coverage of HELP calls and responds quickly to people's needs. Effort has been made to

improve the internal tracking system to ensure it is clear and accurate. HELP calls often require many contacts and follow-up calls to resolve the issue or need.

The team received **286 child and adolescent calls** in FY 2011, compared to 224 calls in FY 2010. These Help calls originate from three main sources: parents, therapists, and school personnel. The nature of the help calls range from callers having no knowledge of the public mental health system to service providers needing assistance with accessing higher levels of care. The majority of help calls are between 15-30 minutes long; however, some can last as long as an hour or more. A trend this year has been an increased number of calls from parents who have private health insurance and whose children's mental health needs exceed what their insurance carrier provides.

Overall, most of the calls received related to both child and adults are requests for resource information, service coordination and access to care (755 calls). A significant number of adult related calls are for housing support or assistance ((145 calls). The largest number of adult calls relate to depression or bi-polar disorder (410 calls). The largest diagnostic category for child related calls is for aggressive or agitated behavior ((125 calls).

Feed Back from Public Forums

The 14th Annual Baltimore County Behavioral Health Fair and Town Meeting was held in October 2011. Over 200 consumers, family members and providers attended the event. In the public forum portion of the program, attendees are able to ask a panel of experts questions related to any issue of concern related to public mental health services. As in years past, many of the questions and concerns relate to housing, entitlements, and access to services. Some of the questions form this year's event included:

Housing questions:
1. Once you leave a residential program, how can you access Section 8 housing?
2. How do people know if they are still active on the Section 8 wait list?
3. Is there a way to get a list of available subsidized housing?
4. How can I learn more about Project Home/Adult Foster Care?
5. If you have to leave Project Home, can you get back into the program?

Entitlement questions:
1. Is assistance available for dental care?
2. How do you get Food Stamps?
3. Is EID going to extend beyond age 65?
4. Is Social Security going to be cut?
5. Does SSI end when you turn 65?
6. Can a couple get married and still get SSI benefits?

Access to Care questions
1. If my 22 year old son needs to go to the emergency room, will the police take him?
2. How is Health Care Reform going to affect me?

Data Analysis: Baltimore County FY 2011

Identify major trends: Summary

There are several data trends that can be summarized for this Plan Update:

1. The data trends in Baltimore County are very consistent with the data trends that reflect the entire state. This has been true for at least the past three years. The distribution of services and expenditures among the age groups is very similar to the statewide trend.
2. More people received public mental health services in Baltimore County during FY 2011 than in FY 2010. The overall total increased by 13%,
3. Overall, expenditures on Public Mental Health Services increased in Baltimore County by less than 1%.
4. Baltimore County spends about 26% more (about $2000) per person on services to the early childhood through adolescent populations and about 12% less (about $1000) per person on adult services compared to the statewide average.

Introduction:

Each CSA has been provided the following standardized data templates by the Mental Hygiene Administration (MHA) for the review of key service indicators for its jurisdiction. MHA has requested that the CSA provide a review of this data for identification of local trends. These templates include:

1. **Tables 1a, 1b, and 1c.** A review of a three-year comparison of number of individuals served and expenditures by age, service type, and coverage type.

2. **Tables 2a and 2b.** A review of a three-year comparison of the number of individuals served and expenditures by service type, broken down separately for the child and adolescent, and adult populations

3. **Table 3a and 3b.** A State and local county comparison for of the number of persons served and expenditures by age, service type, and coverage type.

4. **Table 4.** Outcome Measurement System Data, and County comparison.

5. **Table 5.** Penetration rate

Table 1a.Three Year Comparisons By Age

	Persons Served					Expenditures				
	FY2009	FY2010	% Change	FY2011	% Change	FY2009	FY2010	% Change	FY2011	% Change
Early Child (0-5)	667	749	12.3%	813	8.5%	$2,446,630	$2,404,398	-1.7%	$2,441,804	1.6%
Child (6-12)	2,947	3,210	8.9%	3,552	10.7%	$19,338,453	$20,338,995	5.2%	$21,785,597	7.1%
Adolescent (13-17)	2,207	2,302	4.3%	2,496	8.4%	$20,175,253	$22,387,181	11.0%	$18,616,594	-16.8%
Transitional (18-21)	823	998	21.3%	1,093	9.5%	$4,789,227	$5,588,569	16.7%	$6,104,219	9.2%
Adult (22 to 64)	6,639	7,921	19.3%	9,237	16.6%	$40,066,629	$45,177,798	12.8%	$47,458,591	5.0%
Elderly (65 and over)	168	180	7.1%	190	5.6%	$1,476,178	$1,424,787	-3.5%	$1,570,562	10.2%
TOTAL	13,451	15,360	14.2%	17,381	13.2%	$88,292,370	$97,321,728	10.2%	$97,977,367	0.7%

*Based on claims paid through September 30, 2010.

Table 1b. Three Year Comparisons By Service Type

	Persons Served					Expenditures				
	FY2009	FY2010	% Change	FY2011	% Change	FY2009	FY2010	% Change	FY2011	% Change
Case Management	0	400		479	19.8%	$0	$506,757		$743,814	46.8%
Crisis	206	202	-1.9%	187	-7.4%	$742,703	$658,077	-11.4%	$593,517	-9.8%
Inpatient	1,146	1,312	14.5%	1,415	7.9%	$16,168,901	$20,905,009	29.3%	$21,237,828	1.6%
Mobile Treatment	343	393	14.6%	375	-4.6%	$2,159,099	$2,360,234	9.3%	$2,288,626	-3.0%
Outpatient	12,594	14,416	14.5%	16,508	14.5%	$27,682,684	$30,392,552	9.8%	$33,849,688	11.4%
Partial Hospitalization	440	386	-12.3%	365	-5.4%	$1,803,300	$1,961,521	8.8%	$1,430,524	-27.1%
Psychiatric Rehabilitation	1,619	1,863	15.1%	2,001	7.4%	$15,637,721	$16,765,683	7.2%	$17,811,524	6.2%
Residential Rehabilitation	530	545	2.8%	529	-2.9%	$1,397,290	$1,402,347	0.4%	$1,423,977	1.5%
Residential Treatment	182	193	6.0%	178	-7.8%	$19,191,434	$19,372,335	0.9%	$15,431,523	-20.3%
Respite Care	55	61	10.9%	58	-4.9%	$105,657	$83,905	-20.6%	$109,578	30.6%
Supported Employment	197	203	3.0%	231	13.8%	$413,321	$378,860	-8.3%	$380,327	0.4%
BMHS Capitation	63	58	-7.9%	55	-5.2%	$1,674,950	$1,583,370	-5.5%	$1,537,580	-2.9%
Emergency Petition	7	37	428.6%	30	-18.9%	$4,023	$29,063	622.4%	$26,054	-10.4%
Purchase of Care	147	118	-19.7%	126	6.8%	$1,311,286	$921,313	-29.7%	$1,109,820	20.5%
PRTF Waiver	0	2		9	350.0%	$0	$700		$2,987	326.7%
**TOTAL	13,451	15,360	14.2%	17,381	13.2%	$88,292,369	$97,321,726	10.2%	$97,977,367	0.7%

*Based on claims paid through September 30, 2010.

Table 1c. Three Year Comparisons By Coverage Type

	Persons Served					Expenditures				
	FY2009	FY2010	% Change	FY2011	% Change	FY2009	FY2010	% Change	FY2011	% Change
Medicaid	12,274	14,231	15.9%	16,169	13.6%	$77,956,507	$86,799,416	11.3%	$88,782,504	2.3%
Medicaid State Funded	970	1,884	94.2%	2,429	28.9%	$5,681,678	$7,523,851	32.4%	$6,556,331	-12.9%
UnInsured	1,571	1,410	-10.2%	1,356	-3.8%	$4,654,185	$2,998,459	-35.6%	$2,638,531	-12.0%
**TOTAL	13,451	15,360	14.2%	17,381	13.2%	$88,292,370	$97,321,726	10.2%	$97,977,366	0.7%
DUALLY Dx										

*Based on claims paid through September 30, 2010.
**Does not include adjustments included in Table 1a..

Table 1 Three year comparisons by age, service type, and coverage type

Despite the expenditures in the adolescent range (13-17) decreasing by 16.8% ($3,770,587), our persons served in this range increased by 8.4%. This observation could represent shorter lengths of stay in various services, namely Residential Treatment.

The expenditures for Partial Hospitalization decreased by 27.1%, the number of persons served decreased by 5.4%. The expenditures for Residential Treatment decreased by 20.3%, the number of persons served decreased by 7.8%. One explanation for the decreases is the RTC waiver changes that were implemented. This resulted in decreased utilization of RTC centers.

The number of Uninsured persons served has decreased, but the number of Medicaid and Medicaid State Funded persons have increased. The total number of persons served has increased, which reflects an increase in insurance eligibility, and success in getting people in the

Mental Health community insured. Overall we have served 13.2% more people, while spending 0.7% more in expenditures.

Table 2a. Child / Adolescent - 0 - 17										
	Persons Served					Expenditures				
	FY2009	FY2010	% Change	FY2011	% Change	FY2009	FY2010	% Change	FY2011	% Change
Case Management	0	150		187	24.7%	0	$237,071		$252,309	6.4%
Crisis	1	2	100.0%	2	0.0%	1,708	$7,318	328.5%	$6,830	-6.7%
Inpatient	409	435	6.4%	514	18.2%	5,299,733	$7,146,244	34.8%	$7,565,903	5.9%
Mobile Treatment	45	50	11.1%	39	-22.0%	271,688	$287,274	5.7%	$223,976	-22.0%
Outpatient	5704	6,144	7.7%	6,753	9.9%	16,162,467	$16,517,139	2.2%	$17,926,605	8.5%
Partial Hospitalization	188	193	2.7%	226	17.1%	968,381	$1,108,907	14.5%	$860,368	-22.4%
Psychiatric Rehabilitation	429	585	36.4%	662	13.2%	1,248,209	$1,758,670	40.9%	$1,976,074	12.4%
Residential Rehabilitation	2	2	0.0%	2	0.0%	85	$548	544.7%	$365	-33.4%
Residential Treatment	167	180	7.8%	161	-10.6%	17,816,823	$17,898,240	0.5%	$13,745,599	-23.2%
Respite Care	55	60	9.1%	58	-3.3%	105,658	$83,831	-20.7%	$109,579	30.7%
Supported Employment	3	0	-100.0%	1		832	$0	-100.0%	$0	
BMHS Capitation	0	0		0		0	$0		$0	
Emergency Petition	6	2	-66.7%	3	50.0%	3,633	$48	-98.7%	$916	1808.3%
Purchase of Care	13	5	-61.5%	13	160.0%	111,117	$84,584	-23.9%	$172,984	104.5%
****TOTAL**	5,821	6,261	7.6%	6,861	9.6%	$41,990,334	$45,129,874	7.5%	$42,841,508	-5.1%

*Based on claims paid through September 30, 2010.

Table 2b. Adults - Ages 18 and Over										
	Persons Served					Expenditures				
	FY2009	FY2010	% Change	FY2011	% Change	FY2009	FY2010	% Change	FY2011	% Change
Case Management	0	250		292	16.8%	0	$269,686		$491,505	82.3%
Crisis	205	200	-2.4%	185	-7.5%	740,995	$650,759	-12.2%	$586,687	-9.8%
Inpatient	737	877	19.0%	901	2.7%	10,869,167	$13,758,766	26.6%	$13,671,925	-0.6%
Mobile Treatment	298	343	15.1%	336	-2.0%	1,887,412	$2,072,960	9.8%	$2,064,650	-0.4%
Outpatient	6890	8,272	20.1%	9,755	17.9%	11,520,218	$13,875,413	20.4%	$15,923,082	14.8%
Partial Hospitalization	252	193	-23.4%	139	-28.0%	864,919	$852,614	-1.4%	$570,156	-33.1%
Psychiatric Rehabilitation	1190	1,278	7.4%	1,339	4.8%	14,389,512	$15,007,014	4.3%	$15,835,450	5.5%
Residential Rehabilitation	528	543	2.8%	527	-2.9%	1,397,204	$1,401,799	0.3%	$1,423,612	1.6%
Residential Treatment	15	13	-13.3%	17	30.8%	1,374,611	$1,474,095	7.2%	$1,685,925	14.4%
Respite Care	0	1		0	-100.0%	0	$73		$0	-100.0%
Supported Employment	194	203	4.6%	230	13.3%	412,488	$378,860	-8.2%	$380,327	0.4%
BMHS Capitation	63	58	-7.9%	55	-5.2%	1,674,950	$1,583,370	-5.5%	$1,537,580	-2.9%
Emergency Petition	1	35	3400.0%	27	-22.9%	389	$29,016	7359.1%	$25,138	-13.4%
Purchase of Care	134	113	-15.7%	113	0.0%	1,200,168	$836,730	-30.3%	$936,836	12.0%
****TOTAL**	7,630	9,099	19.3%	10,520	15.6%	$46,332,033	$52,191,155	12.6%	$55,132,873	5.6%

*Based on claims paid through September 30, 2010.
**Does not include adjustments included in Table 1a..

Table 2 Three year comparisons of adolescents and adults, by service type

The number of Adolescents utilizing Inpatient treatment increased by 18.2%, while expenditures increased by 5.9%. The increase here is likely correlated with our Residential Treatment decreases. Also, these data points speak to a shorter length of stay for our Inpatient clients.

Adolescent Partial Hospitalization expenditures dropped 22.4%, while the persons served increased by 17.1%

Adult Case Management expenditures have increased 82.3%, while the persons served increased by 16.8%. (The expenditures only make up 0.89% of our total expenditures.) While they only make up a small portion of the total expenditures (~1%), this large increase is worth mentioning. The change to fee for service from grant funding occurred in September of Fiscal Year 2011. These few months of data seem to be the cause of the increase.

Table 3a. Fiscal Year 2011 State & County Comparisons

	Persons Served				Expenditures			
	STATE*		COUNTY		STATE*		COUNTY	
AGE	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Early Child	6,388	4.8%	813	4.7%	$14,719,600	2.3%	$2,441,804	2.5%
Child	26,185	19.5%	3,552	20.4%	$121,022,174	18.8%	$21,785,597	22.2%
Adolescent	19,584	14.6%	2,496	14.4%	$110,048,502	17.1%	$18,616,594	19.0%
Transitional	8,996	6.7%	1,093	6.3%	$35,549,747	5.5%	$6,104,219	6.2%
Adult	71,637	53.5%	9,237	53.1%	$350,755,367	54.6%	$47,458,591	48.4%
Elderly	1,166	0.9%	190	1.1%	$10,790,147	1.7%	$1,570,562	1.6%
TOTAL	133,956		17,381	1	$642,885,537		$97,977,367	
SERVICE TYPE								
Case Management	3,762	2.8%	479	2.8%	$5,726,318	0.9%	$743,814	0.8%
Crisis	1,638	1.2%	187	1.1%	$4,847,920	0.8%	$593,517	0.6%
Inpatient	9,914	7.4%	1,415	8.1%	$146,516,812	22.8%	$21,237,828	21.7%
Mobile Treatment	2,662	2.0%	375	2.2%	$20,150,335	3.1%	$2,288,626	2.3%
Outpatient	126,190	94.2%	16,508	95.0%	$227,650,549	35.4%	$33,849,688	34.5%
Partial Hospitalization	2,183	1.6%	365	2.1%	$9,682,474	1.5%	$1,430,524	1.5%
Psychiatric Rehabilitation	18,494	13.8%	2,001	11.5%	$141,400,497	22.0%	$17,811,524	18.2%
Residential Rehabilitation	4,230	3.2%	529	3.0%	$10,337,097	1.6%	$1,423,977	1.5%
Residential Treatment	730	0.5%	178	1.0%	$52,527,476	8.2%	$15,431,523	15.8%
Respite Care	413	0.3%	58	0.3%	$1,242,256	0.2%	$109,578	0.1%
Supported Employment	2,964	2.2%	231	1.3%	$6,401,704	1.0%	$380,327	0.4%
BMHS Capitation	368	0.3%	55	0.3%	$9,558,060	1.5%	$1,537,580	1.6%
Emergency Petition	785	0.6%	30	0.2%	$392,756	0.1%	$26,054	0.0%
Purchase of Care	778	0.6%	126	0.7%	$6,245,469	1.0%	$1,109,820	1.1%
PRTF Waiver	117		9	0.1%	$205,814	0.0%	$2,987	0.0%
TOTAL	133,956		17,381	1	$642,679,724	$1	$97,977,367	
COVERAGE TYPE								
Medicaid	123,551	92.2%	16,169	93.0%	$579,208,707	90.1%	$88,782,504	90.6%
Medicaid State Funded	18,009	13.4%	2,429	14.0%	$43,458,244	6.8%	$6,556,331	6.7%
UnInsured	11,776	8.8%	1,356	7.8%	$20,218,586	3.1%	$2,638,531	2.7%
TOTAL	133,956		17,381		$642,885,537		$97,977,366	

*Based on claims paid through September 30, 2010.

Table 3b. FY 2011 Comparisons: Cost per Person Served				
	State	County	Difference	Per Cent
AGE				
Early Child	$2,304	$3,003	$699	23.3%
Child	$4,622	$6,133	$1,512	24.6%
Adolescent	$5,619	$7,459	$1,839	24.7%
Transitional	$3,952	$5,585	$1,633	29.2%
Adult	$4,896	$5,138	$242	4.7%
Elderly	$9,254	$8,266	-$988	-12.0%
TOTAL	$4,799	$5,637	$838	14.9%
SERVICE TYPE				
Case Management	$1,522	$1,553	$31	2.0%
Crisis	$2,960	$3,174	$214	6.7%
Inpatient	$14,779	$15,009	$230	1.5%
Mobile Treatment	$7,570	$6,103	-$1,467	-24.0%
Outpatient	$1,804	$2,051	$246	12.0%
Partial Hospitalization	$4,435	$3,919	-$516	-13.2%
Psychiatric Rehabilitation	$7,646	$8,901	$1,256	14.1%
Residential Rehabilitation	$2,444	$2,692	$248	9.2%
Residential Treatment	$71,955	$86,694	$14,739	17.0%
Respite Care	$3,008	$1,889	-$1,119	-59.2%
Supported Employment	$2,160	$1,646	-$513	-31.2%
BMHS Capitation	$25,973	$27,956	$1,983	7.1%
Emergency Petition	$500	$868	$368	42.4%
Purchase of Care	$8,028	$8,808	$781	8.9%
		$332		
TOTAL	$4,798	$5,637	$839	14.9%
COVERAGE TYPE				
Medicaid	$4,688	$5,491	$803	14.6%
Medicaid State Funded	$2,413	$2,699	$286	10.6%
UnInsured	$1,717	$1,946	$229	11.8%
TOTAL	$4,799	$5,637	$838	14.9%

*Based on claims paid through September 30, 2010.

Table 3 State and County comparisons

On par with the past 4 years, Baltimore County's data has mirrored the State's.

With a few exceptions, the persons served and expenditure distributions of the county closely match those of the State. Baltimore County's Psychiatric Rehabilitation made up a lesser portion of our persons served and expenditures than the State. This service type constituted 13.8% of the state's persons served, and 11.5% of the County's. Baltimore County is fortunate to offer a wide variety of services to the mental health population. It is possible that other counties are using Psychiatric Rehabilitation more frequently as a result of not having more options, such as the 4 Wellness and Recovery sites located in Baltimore County.

The County's residential treatment accounted for 15.8% of its expenditures, but only 8.2% of the State's.
Baltimore County historically spends more on RTC than other jurisdictions. Baltimore County has a RTC based in Baltimore County, and is likely receiving more clients as a result.

Overall, the County spends more per person served, with the exception of the elderly. More specifically, the County is spending more on adolescents. This likely stems from challenges with using RTC waivers.

Table 4. Fiscal Year 2011 State & County Comparisons					
Outcome Measurement System					
Point In Time Observations - FY 2011 *					
	Child and Adolescent			Adults	
	STATE Per Cent	COUNTY Per Cent		STATE Per Cent	COUNTY Per Cent
Homeless in last 6 months	2.6%	2.3%		15.5%	10.6%
Arrested in last 6 months	4.3%	3.9%		8.1%	6.1%
In jail or prison in last 6 months	n/a	n/a		7.7%	5.6%
Employed now or last 6 months	n/a	n/a		29.0%	21.0%
Cigarette smokers**	12.7%	6.2%		54.3%	52.6%
Attend school when in session	95.2%	95.5%		n/a	n/a
Suspended from school in last 6 months	20.3%	20.7%		n/a	n/a
Expelled from school in last 6 months	2.0%	2.8%		n/a	n/a
General Health Status					
Excellent	25.6%	26.2%		6.5%	5.5%
Very Good	32.4%	33.0%		15.8%	15.8%
Good	33.7%	32.0%		35.7%	35.8%
Fair	7.4%	7.9%		31.0%	31.0%
Poor	0.9%	0.9%		11.0%	11.9%
I am hopeful about my future					
Strongly Agree	32.8%	32.9%		n/a	n/a
Agree	49.7%	48.9%		n/a	n/a
Neutral	14.6%	14.9%		n/a	n/a
Disagee	2.4%	2.9%		n/a	n/a
Strongly Disagree	0.5%	0.4%		n/a	n/a
How satisfied are you with your recovery					
Very Satisfied	n/a	n/a		26.7%	24.6%
Satisfied	n/a	n/a		30.0%	30.9%
Neutral	n/a	n/a		26.1%	25.6%
Dissatisfied	n/a	n/a		8.6%	9.1%
Very Dissatisfied	n/a	n/a		8.5%	9.8%

* Most recent observation for each consumer in FY 2011; provision data which may change slightly as Datamart refinement cor
** For children and adolescents, only those ages 13 to 17

Data Source: http://maryland.valueoptions.com/services/OMS_Welcome.html
Most Recent Interview Only, FY 2011

Table 4 OMS

The County is serving less homeless (10.6) than the state (15.5%). Health Care for the Homeless is an organization in Baltimore County that offers many services to homeless persons, including Mental Health services. Despite this, Baltimore County does need to look into Outpatient clinics providing access to homeless clients.

The County is serving more unemployed than the state. Access to vocational opportunities needs to improve. Promoting employment is a challenge, but will be addressed.

Average Medical Assistance Eligibility, PMHS MA Participation, and PMHS MA Penetration Rates
Fiscal Year 2010 - PMHS claims as of September 30, 2010

COUNTY	Avg 2010 MA Elig	PMHS MA Served	Penetration Rate
Allegany	16,728	3,140	18.8%
Anne Arundel	58,039	7,906	13.6%
Baltimore City	228,679	41,249	18.0%
Baltimore County	121,996	17,396	14.3%
Calvert	10,838	1,647	15.2%
Caroline	8,751	1,487	17.0%
Carroll	15,184	2,774	18.3%
Cecil	18,754	2,858	15.2%
Charles	18,836	2,135	11.3%
Dorchester	9,533	1,718	18.0%
Frederick	25,417	3,968	15.6%
Garrett	7,171	1,023	14.3%
Harford	28,336	4,836	17.1%
Howard	24,719	2,616	10.6%
Kent	3,754	646	17.2%
Montgomery	113,933	9,597	8.4%
Prince George's	142,154	10,233	7.2%
Queen Anne's	6,580	982	14.9%
St. Mary's	6,342	1,804	28.4%
Somerset	15,184	1,158	7.6%
Talbot	5,747	986	17.2%
Washington	28,925	5,116	17.7%
Wicomico	23,579	3,805	16.1%
Worcester	9,163	1,653	18.0%
Out of State/Unk	1,247	146	11.7%
Statewide	949,589	130,879	13.8%

		Avg 2010 MA Elig	PMHS MA Served	Penetration Rate
Mid Shore	Caroline	8,751	1,487	17.0%
	Dorchester	9,533	1,718	18.0%
	Kent	3,754	646	17.2%
	Queen Anne's	6,580	982	14.9%
	Talbot	5,747	986	17.2%
	Mid Shore Total	34,365	5,819	16.9%
Wicoimico-Somerset	Somerset	15,184	1,158	7.6%
	Wicomico	23,579	3,805	16.1%
	Lower Shore Total	38,763	4,963	12.8%

Table 5 Penetration Rates

Baltimore County has shown little change in penetration, as is again on par with the State.

Moving forward, there are several questions raised by this data for Baltimore County to consider.

1. *Why is spending on children's service, significantly higher than the statewide trend?*
3. *Is Baltimore County providing access to mental health services for homeless individuals?*
4. *Are there adequate employment opportunities for individuals with serious mental illnesses?*
5. *How can access to affordable housing be improved?*

Source: Crystal Reports MARF0004 based on claims paid through 9/30/2011

FY 2013-2015 Goals:

The primary goals established for Baltimore County for FY 2013-2015 are as follows:

Goal 1.

The Core Service Agency (CSA), in partnership with local stakeholders (e.g. consumers , family members) will develop strategies and programs to guide behavioral health consumers to an integrated array of clinically appropriate and cost effective services.

Goal 2.

The CSA will oversee implementation of fiscal, operational, and policy changes within the Public Mental Health System with consideration to local best interests.

Goal 3.

The CSA will develop and manage targeted services and initiatives to serve special needs populations.

Goal 4.

The CSA will monitor, evaluate, and analyze public behavioral health services in Baltimore County.

The objectives and strategies for goals 1-4 are updated and included in the Annual Report section of this document. Goal 5 is newly established for FY 2013 and is listed below along with the objectives and strategies

Goal 5.

The CSA will promote a system of integrated care where prevention of substance and mental illness is common practice across the lifespan.

OBJECTIVE #1:

Reduce tobacco use and exposure to second hand smoke among persons with mental health and substance use disorders.

STRATEGIES:

1. Assess the identification, accessibility, treatment protocols, clinical practices, program policies and resources that address the use of tobacco and exposure to second hand smoke among persons receiving county funded mental health services
2. Support mental health providers in addressing the use of tobacco products as a significant behavioral health issue that should be clinically addressed along with other treatment issues as a standard clinical practice for persons seeking mental health treatment services

3. Collaborate with community partners to provide a continuum of tobacco services ranging from: avoidance of smoke filled environments, education, screening, assessment, cessation, treatment, follow support and nicotine replacement therapies are available for persons and their families with a mental health diagnosis
4. Facilitate the use of best practices and tools in developing a continuum of tobacco services to support persons and their with a mental health diagnosis to quit and/or reduce the use of tobacco products and exposure to second hand smoke
5. Monitor and support compliance of state and county tobacco and second hand smoke laws and regulations in housing and treatment facilities of persons with a mental health diagnosis.
6. Provide opportunities for mental health service providers to receive the most current information on best practices, research findings, clinical skills and community resources on the prevention and treatment of tobacco use and consequences of second hand smoke exposure.

OBJECTIVE #2:

Partner with the Bureau of Behavioral Health's prevention oriented social marketing and public education campaigns to prevent or intervene early to reduce the death and illness associated with mental health and substance use disorders and promote the adoption of health and wellness behaviors and attitudes for persons and their families with a mental health diagnosis.

STRATEGIES:

1. Use social marketing and health promotion strategies to include research based information to educate the community about mental health and substance use disorders, recognition of signs and symptoms, render effective interventions, benefits of community responsiveness and involvement, identification of appropriate resources, and availability of recovery supports for persons and their families with a mental health diagnosis.
2. Increase capacity of communities to develop and sustain best practice prevention, intervention and recovery supports for persons and their families by increasing the opportunities for them to receive on line, in person and through other training venues programs such as: Mental Health First Aid training, Active Minds on Campus (a national organization specifically focused on college mental health issues and helping colleges create campaigns to counter stigma and discrimination), Finding Hope and Help (a college focused mental health campaign), National Alliance on Mental Illness, the National Mental Health Association, Substance Abuse and Mental Health Services Administration, etc.
3. Collaborate with mental health service providers to integrate prevention research on issues such as: resiliency; risk and protective factors; assets and strength based approaches, etc. in their clinical approach and treatment of persons and their families at risk or diagnosed with a mental health disorder.