

ST. MARY'S COUNTY GOVERNMENT  
DEPARTMENT OF  
HUMAN SERVICES  
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# Annual Report FY 2008

St. Mary's County CSA

**Prepared By:**

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## *I. Executive Summary*

The FY08-09 Mental Health Plan for St. Mary's County, was submitted as mandated by the Annotated Code of Maryland, Health General, Title 10, Section 10-1202(d)(1), and in accordance with Mental Hygiene Administration Guidelines. The Plan, developed by the Mental Health Authority of St. Mary's, Inc., (MHASM) as the Core Service Agency for the county, continued existing efforts to assure the provision of mental health services that were of the highest quality; that were efficient in maximizing limited resources; and were responsive to the service needs of its consumers. This report seeks to detail the efforts made to achieve the goals detailed in the FY08-09 plan.

St. Mary's County undertook an initiative to assess and better meet the needs of its residents. At the request of our County Commissioners, and with the assistance of the St. Mary's County Local Management Board, a Health and Human Services plan was developed. The process took nearly two years to gather data and bring together stakeholders. During the process of data analysis, community and provider input; issues, priorities and strategies emerged. Service categories such as homelessness, substance abuse, mental health, the aging and employment were paramount. Via the assessment process it was found that our system had evolved into a service system of "silos." In which individuals with multiple service needs had to go to each individual system to access needed care. It was found that the limited resources of our county were not being maximized nor prioritized. Recommendations were developed for our leaders to transition our system into one that is accessible, coordinated and flexible.

In March of 2008 the St. Mary's County Board of County Commissioners voted to establish a Department of Human Services in St. Mary's County Government. This office assumed responsibility for services provided to citizens with mental health needs, substance abuse related issues, services for children, youth and other potentially in need people. This department facilitates an integrated network of services to improve conditions for people in need with a major focus on increasing the local authority to plan, implement and monitor human services. This department brings together local agencies, providers, consumers of services, other public and private entities and community representatives to empower local stake holders in addressing the needs and setting priorities for St. Mary's County. The St. Mary's Core Service Agency (CSA) is one component of the new Department of Human Services. As such the CSA is the entity at the local level that has the authority and the responsibility, in conjunction with the Mental Hygiene Administration, to develop, manage and purchase services in the Public Mental Health System. We are at this time taking the first steps to create structure, improve capacity and care to St. Mary's County residents.

The Department of Human Services has ushered in the development of a new way of doing business in St. Mary's. The Human Services Council of St. Mary's was established to provide direction for the new department as well as to enhance the quality of life for all St. Mary's

County residents through a coordinated and integrated system of care. The Council has begun work on the development of a one year strategic plan which is to focus on four key strategies: transportation, housing, behavioral health and employment. The work of the Council is also the work of the Department of Human Services, which includes the development of consistent evaluation, reporting and monitoring criteria for all grants to ensure accountability, critical evaluation of new and existing programs to ensure coordination, the promotion and support of system evaluation and development in order to enhance effectiveness and reduce the costs of providing human services. The Council includes approximately twenty members representing a broad cross section of community agency leaders, consumers, non-profit agencies, the business community and law enforcement. It is planned that the Council will develop recommendations to submit to our Board of County Commissioners to positively impact all human services in our community.

## *II. Introduction*

The Mental Health Authority of St. Mary's Inc. (MHASM) was established in 1995 as a private, non-profit Core Service Agency (CSA) and in conjunction with the Maryland Mental Hygiene Administration managed the Public Mental Health System (PMHS) in St. Mary's County. Accordingly, the agency's mission is to provide leadership to the local behavioral health system through public-private partnerships and collaborative relationships. Approximately \$7 million in federal, state, and local funds support the PMHS system in St. Mary's County, with the majority of services being provided through a fee-for-service network and other selected programs funded through contracts. The following services are available: *Inpatient Services, Outpatient Services, Crisis Services, Residential Rehabilitation Programs, Psychiatric Rehabilitation Programs, Supported Employment, Case Management Services, Transitional Age Youth Programs, the Bridge Subsidy, a HUD Shelter Plus Program, Homeless Outreach and other support to the Homeless, Detention Center Mental Health Services, including telemedicine, a consumer operated recovery and wellness center, mental health services for families served by the Department of Juvenile Services, and Intensive home-based services for children and adults.*

On June 30, 2008, MHASM closed its doors. The closure made way for a new Department to be housed in St. Mary's County Government. The St. Mary's County Department of Human Services was created on July 1, 2008; it represents a consolidation of existing County functions and the integration of programs and funding that had previously been handled by an array of public and private entities. The department creates a system that integrates the Core Service Agency, substance abuse coordination, Community Services, the Local Management Board and the Marcey House, an inpatient substance abuse facility. A bulk of the Department's work is accomplished through state and county funded contracts with community service providers, which includes the provision of all grant funded mental health services not included in the fee-for-service system, services for children and families, an array of substance abuse services, and prevention services. This unified system will address the health, mental health, housing, training, employment and transportation needs across all segments of the population: children and adults, disabled individuals, senior citizens and their families. It is the goal of the Department to make a measurable impact on the health, safety, and self sufficiency of our children, their families, adults, persons with disability and our older adults through collaboration and integration of dollars and services available through or public, private and business partners.

In keeping with its mandate as the Core Service Agency (CSA), the Department of Human Services will respond to the needs of the system by monitoring mental health programs and resources, and by providing technical assistance to the agencies who deliver services. As the local arm of the State system, programs such as Residential Rehabilitation, Supported Employment, and other services for the uninsured are managed almost in their entirety through the CSA, with community providers. On a daily basis, the Department strives to provide a local safety net that ensures no consumer goes without necessary services in St. Mary's County. The

Department shall be the first point of contact for St. Mary's citizens entering into the system; it provides a seamless entry point and guide through the system.

This FY 08 Annual Report will discuss the efforts undertaken by MHASM to address the myriad of challenges of rural mental health service delivery. At will also discuss the transition of responsibilities to the St. Mary's County Department of Human Services.

### *III. System Mission, Vision, Values*

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

The St. Mary's County Department of Human Services continues to support the mission of the Mental Hygiene Administration with a focus on enhancing the quality of life for all St. Mary's County residents through a coordinated and integrated system of care.

Vision: The vision of the Department of Human Services is to make a measurably positive impact on the health, safety, and self sufficiency of our children, their families, adults and our older adults through collaborative integration of dollars and services available through our public, private and business partners.

Values: The values underpinning the Public Mental Health System are:

- Basic Personal Rights
- Responsive System
- Empowerment
- Family and Community Support
- Least Restrictive Setting
- Collaborative Working Relationships
- Effective Management and Accountability
- Staff Resources
- Community Education

## *IV. Demographics of St. Mary's County*

St. Mary's County is located in Southern Maryland on a peninsula formed by the confluence of the Potomac and Patuxent Rivers and the Chesapeake Bay, 60 miles SE of Washington, D.C., and 90 miles south of Baltimore. It is 361 square miles in size and shares borders with Charles and Calvert Counties. St. Mary's may be considered a rural county, however it is a county in transition. The Census Bureau reported that St. Mary's County had 673 farms in 1992, occupying about 35 percent of the total land area; by 1997 there were 622 farms, and since then housing developments have burgeoned to meet the needs of one of the fastest growing counties in Maryland. Statewide, Maryland has about 542 persons per square mile; St. Mary's County has approximately 238. St. Mary's County citizens face the challenges that distances impose on social networks and service systems, such as isolation and transportation problems.

When St. Mary's County was named Maryland's second Technology Corridor several years ago, its identity as a rural county in transition was complete. The Patuxent Naval Air Station, a high-tech research and development military installation, is a major economic engine that contributes to steady population and job growth. A strong defense industry has replaced agriculture. The Naval Air Station attracts highly skilled and paid personnel, who have absorbed most of the housing stock and driven up rental costs.

The 2007 U.S. Census Bureau Quick Facts estimates 100,378 persons are living in St. Mary's County. 80.9% are White, 13% are African American, and 2.4% are Hispanic. The per capita income is estimated at \$31,194. The median family income estimated at \$78,838. It is reported that 7.4% of the County's population live below poverty level and it is estimated that 12.2% of the population is disabled. Both of which are just below the United States averages at 13.3% and 15.1% respectively. St. Mary's maintains a higher percentage of people living in poverty and the lowest per capita income in comparison to its bordering counties Calvert and Charles counties.

With a population of approximately 11,021, the town of Lexington Park was designated a Micropolitan Statistical Area in the 2000 census. It is much more heavily populated than other areas and towns, including the County seat of Leonardtown, which has a population of less than 2,000. Lexington Park is the most urbanized area of St. Mary's County and it is where most of the low-income housing and low wage jobs are located. Lexington Park was at one time designated a special Hot Spot area for increased law enforcement and human service integration due to its crime rate and other social problems. This continues to be where many PMHS consumers live.



## V. FY 2008

### Financial Plan

|  |           |                    |
|--|-----------|--------------------|
| Mental Health Authority of St. Mary's, Inc<br>2008 Financial Budget Plan-Funding |           |                    |
| <b>State Community Mental Health Grant</b>                                       |           |                    |
| <b>CSA Administration</b>  |           | \$259,790          |
| <b>Case Management</b>   |           |                    |
| CSA Case Management  | \$323,000 |                    |
| Emergency Response Grant   | \$208,947 |                    |
| <b>Total Case Management &amp; ERC</b>   |           | \$531,947          |
| <b>Community Grants</b>  |           |                    |
| Jail Mental Health Services  | \$38,221  |                    |
| St. Mary's Hospital-Emer. Pysch. Serv.   | \$68,592  |                    |
| Client Support-Purchase of Service   | \$10,679  |                    |
| On Our Own St. Mary's-Drop In Center   | \$82,744  |                    |
| DJS Family Intervention Specialist-Children                                      | \$68,965  |                    |
| Homeless Shelter Program   | \$3,180   |                    |
| <b>Total Community Grants</b>  |           | \$272,381          |
| <b>Total State Community Grants</b>  |           | \$1,064,118        |
| <b>Federal Grants</b>  |           |                    |
| PATH   | \$45,950  |                    |
| HUD Shelter Plus   | \$136,762 |                    |
| <b>Total Federal Grants</b>  |           | \$182,712          |
| <b>Other Grants</b>  |           |                    |
| Five County Project-Forensics Program  | \$66,000  |                    |
| St. Mary's County Sheriff's Office   | \$20,000  |                    |
| Five County Project-Administration   | \$15,222  |                    |
| St. Mary's County Grant  | \$54,945  |                    |
| <b>Total Other Grants</b>  |           | \$156,167          |
| <b>Total FY 2008 Funding</b>   |           | <b>\$1,402,997</b> |

## Accomplishments

- MHASM was an active participant in the Five County Community Services Project. The project included the planning and implementation of service opportunities created by the closing of Crownsville State hospital in July 2004. Efforts were focused on the implementation of community-based services that allowed the diversion of uninsured individuals from potential long-term acute inpatient and state hospitalizations. Persons that could be managed safely in the community were referred to the In-Home Intervention Programs (IHIP) and crisis beds. MHASM authorized 242 crisis bed days for PMHS participants. The IHIP program for children remained at capacity (9) for the entire year; they also maintained a significant waitlist. The IHIP program for adults maintained an average of 12 individuals for the year, with no waitlist for St. Mary's County residents. The Five County initiative was also used in conjunction with alternate funding sources to support a comprehensive mental health service program in our jail which included a full-time mental health professional, 24/7 availability of psychiatry, incorporated the use of telemedicine, and linkage to community-based targeted case management and HUD Shelter Plus.
- In FY08, MHASM along with community partners, continued to make strides in the area of Co-Occurring Disorders (COD). Work continued in the development of a co-occurring capable system. The St. Mary's County Workgroup on Co-Occurring Disorders, led by MHASM with representatives from local mental health and addictions providers and other community agencies, went through a consensus process and created a strategic plan around system design. Efforts focused on an assessment of COD capabilities across St. Mary's County agencies, including law enforcement, DSS, adult probation, and faith-based organizations; a look at a standard screening tool, and training. MHASM sponsored a series of six work sessions to train community stakeholders around the stages of change, quadrants, system of care, welcoming, facilitation and assessment screening tools. With the guidance of Tom Godwin from the University of Maryland, St. Mary's stakeholders undertook the COMPASS, an audit tool for dual diagnosis capability. At this time efforts continue to identify best practices to improve treatment and service to the co-occurring population in St. Mary's.
- In FY 08, MHASM was notified that a rural tele-mental health grant was awarded. In a joint effort, St. Mary's was one of seven rural counties to apply for videoconferencing technology to provide access to appropriate, high quality psychiatric services for the minority, uninsured, un-served and underserved populations. To date St. Mary's has been identified as the COD site, equipment has been purchased and an outpatient site to house the equipment has been identified. A physician from the University of Maryland will provide specialized treatment to those with co-occurring mental illness and substance abuse via video conferencing. This is one step toward improved access to care, availability to

quality mental health care professionals, and timely access to qualified psychiatrists.

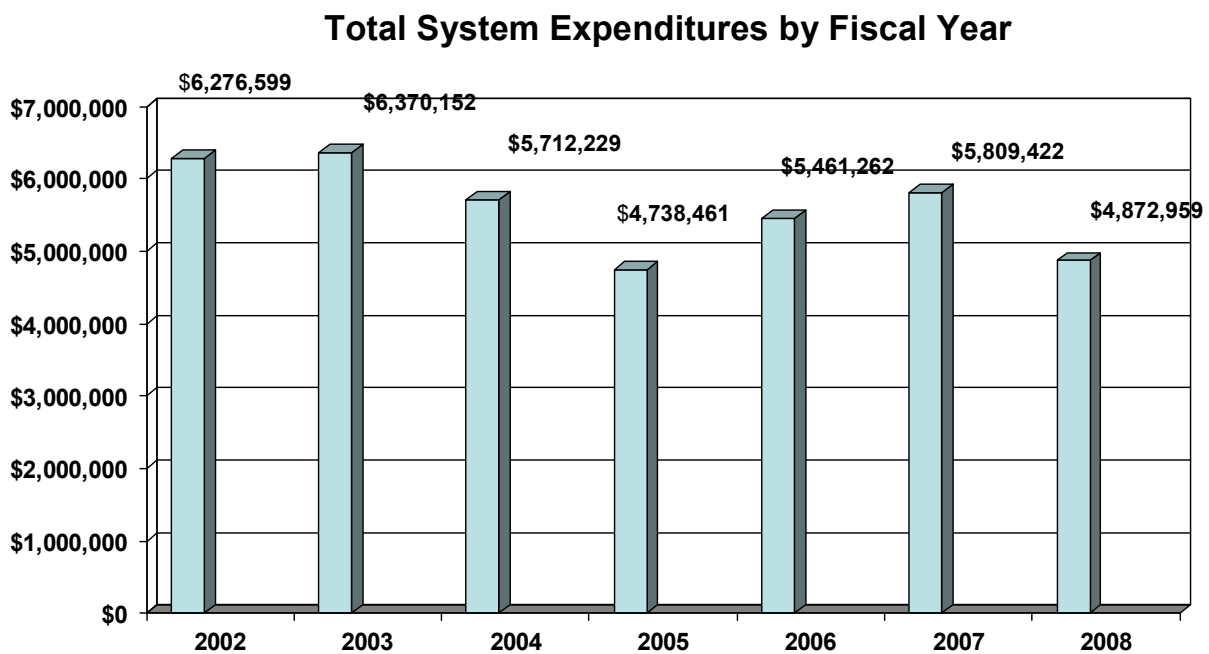
- MHASM provided assistance in locating services or in navigating the system to over 114 calls or walk-in requests in FY08 from individuals seeking help from both the public and the private sector.
- MHASM continued its partnership with the Southern Maryland Local Management Boards, Department of Juvenile Services, Department of Social Services and the Calvert and Charles Core Service Agencies in the establishment of a regional Residential Crisis Bed Program for Youth, which has added a valuable component to the array of options for families. Our commitment to ensuring the availability of community-based services for children and adolescents and their families prevented restrictive, out-of-home placements for 11 St. Mary's County youth (five of which were referred by the CSA), and kept youth in the community near their families.
- MHASM continued to work with the Local Management Board of St. Mary's County in the roll-out of a planned Managed Care Entity. MHASM sat on the Local Coordinating Council, participating monthly in an effort to provide technical assistance for the Council and families navigating the public mental health system. MHASM referred seven children through the Local Coordinating Council to access the Care Management Entity. By the end of FY08, all seven children had successfully accessed mental health services and community supports while remaining in their homes. With the availability of the resources provided by the Care Management Entity, the CSA was successful in avoiding all Residential Treatment Center placements for its youth in FY08. The Department of Human Services will continue to partner to ensure the integrity of mental health services as we develop a more comprehensive System of Care.
- Homelessness continued to absorb resources as MHASM helped mental health consumers access decent, affordable housing. Through the HUD Shelter Plus Care Program managed by the Mental Health Authority of St. Mary's, nine individuals maintained housing, and five individuals accessed housing and supports through the Bridge Subsidy, an FY06 initiative between MHASM and the St. Mary's County Housing Authority. MHASM continued its leadership role among agencies and providers involved in procuring resources and delivering services to people who are homeless. In FY08, MHASM assumed the chair of the local Homeless Prevention Board whose mission is to: *Educate the community regarding services available in the community, focus on prevention of homelessness in our youth, work toward the development of a system of care to meet the needs of our county, work toward the development and enhancement of partnerships in the community, provide leadership to prevent and reduce homelessness when possible, and identify and address the core issues and needs resulting in homelessness.* MHASM also participated in the Homeless Point-In-Time Survey for 2008 which reported 1884 individuals are homeless on a given day in St. Mary's.

- Through an FY07 memorandum of understanding with St. Mary's County Schools, MHASM placed a Targeted Case Management component into a St. Mary's County Public School. This partnership provided the linkage between the parent, student, school and treatment that is essential to meet a child's mental health needs. The program generated a number of referrals, has been well received by personnel at the schools and has the potential to expand into other school-based initiatives.
- With regards to recovery-based initiatives, collaboration continued between MHASM and the National Alliance on Mental Illness regionalized affiliate, NAMI Southern Maryland, which serves St. Mary's, Calvert and Charles counties. We continued the provision of limited administrative support and active partnering by MHASM, the availability of consumer and family advocacy and supports will increase in the coming years. In addition, MHASM used its role in the PMHS, as appropriate, to support NAMI Southern Maryland's goal of increasing mental health services for Veterans. Connie Walker, president of NAMI Southern Maryland provided testimony to the General Assembly regarding SB-210. Ms. Walker's testimony was instrumental in the passing of the bill, with \$2.8 million funding which is being used to fund regional coordinator's working to assist veterans in bridging the gap between community services and the Veteran's Administration. NAMI Southern Maryland has also provided five Family to Family education classes, and a session of Peer to Peer Recovery Education is currently underway.
- Community collaboration expanded in 2008, with MHASM joining the Juvenile Drug Court team. Staff participated weekly in chambers to address the needs of involved youth and advocacy in the arena of co-occurring youth and their families. At this time all children entering the program are being assessed both by the substance abuse community and the mental health coordinator. The Juvenile Drug Court represents co-occurring capabilities of our system at its best.
- Transformation activities were paramount in FY 2008. Our coordinator was able to participate in the inaugural class of Mental Health First Aide. This course has since become a model for the nation. Efforts continued throughout the year to build a recovery oriented system, including having individuals locally trained in WRAP and participation in a state sponsored training on Wellness and Recovery. The CSA worked to promote systems of care participating in trainings offered by the Innovations Institute, as well as collaborated around the development of the 1915© waiver in our jurisdiction. Our coordinator also participated as the adult partner for Youth Move in FY08. Work continues as we try to better define the initiative in our jurisdiction and recruit additional youths.

## IV. Reporting and Analyzing Data

MHASM examined data from a variety of sources, including the Mental Hygiene Administration; information from the Administrative Services Organization (MAPS-MD) reports, and performance management data monitored internally, specifically on contracts for services not in the fee-for-service system.

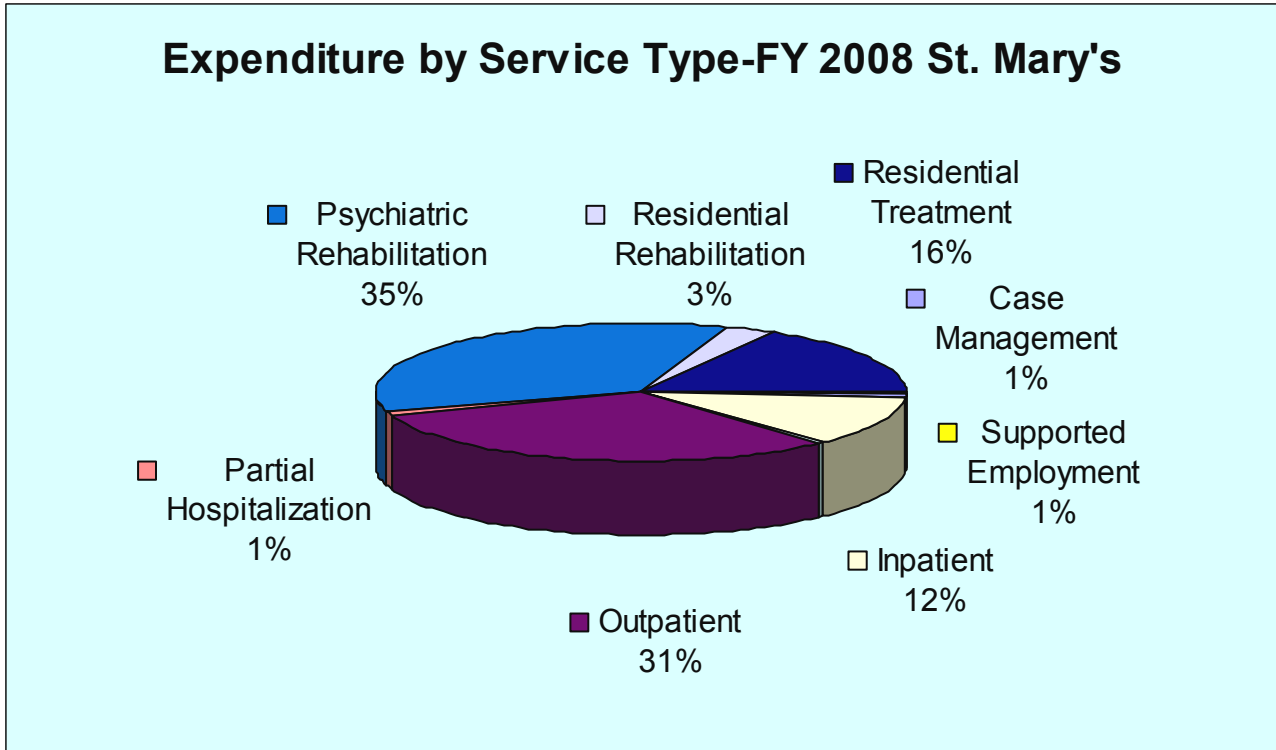
The data provided through MAPS-MD on total system expenditures in major categories (e.g., inpatient, outpatient, case management, crisis, psychiatric and residential rehabilitation, residential treatment center, and supported employment) was taken from Crystal Reports based on expenditures through June 30, 2008 (run date September 29, 2008, MARF0004).



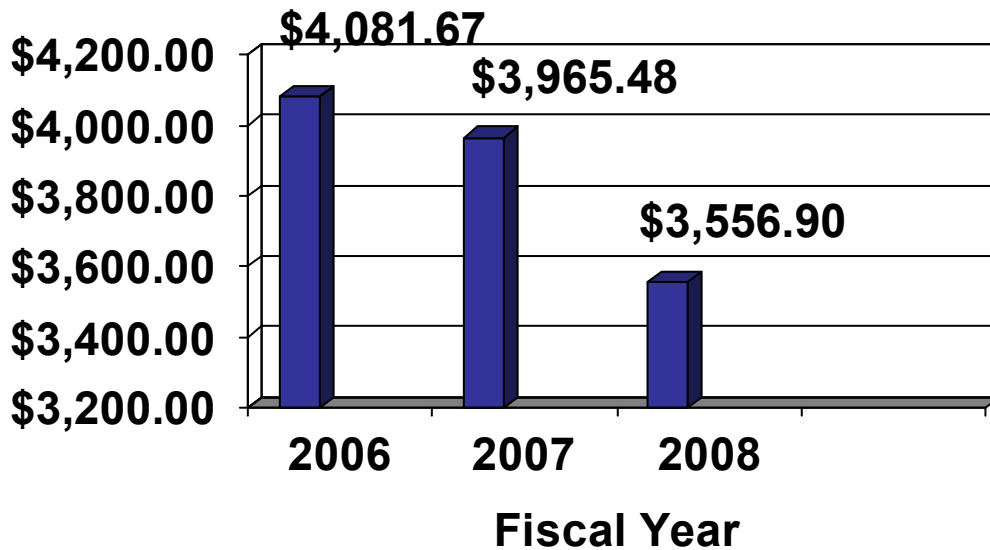
1.49% Increase from 2002 to 2003  
10.33% Decrease from 2003 to 2004  
17.05% Decrease from 2004 to 2005  
15.25% Increase from 2005 to 2006  
6.38% Increase from 2006 to 2007  
16.12% Decrease from 2007 to 2008\*

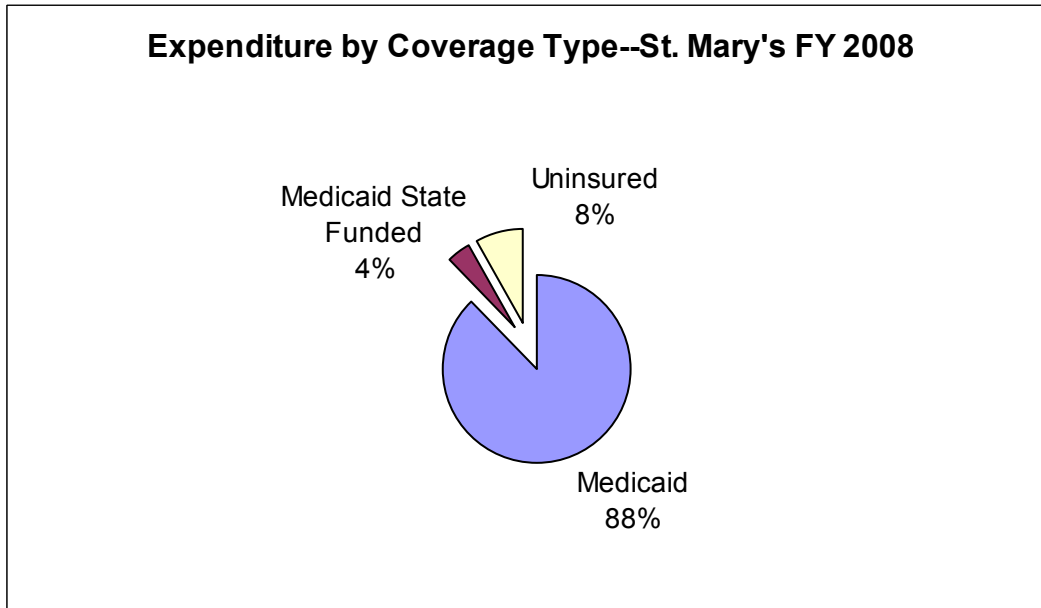
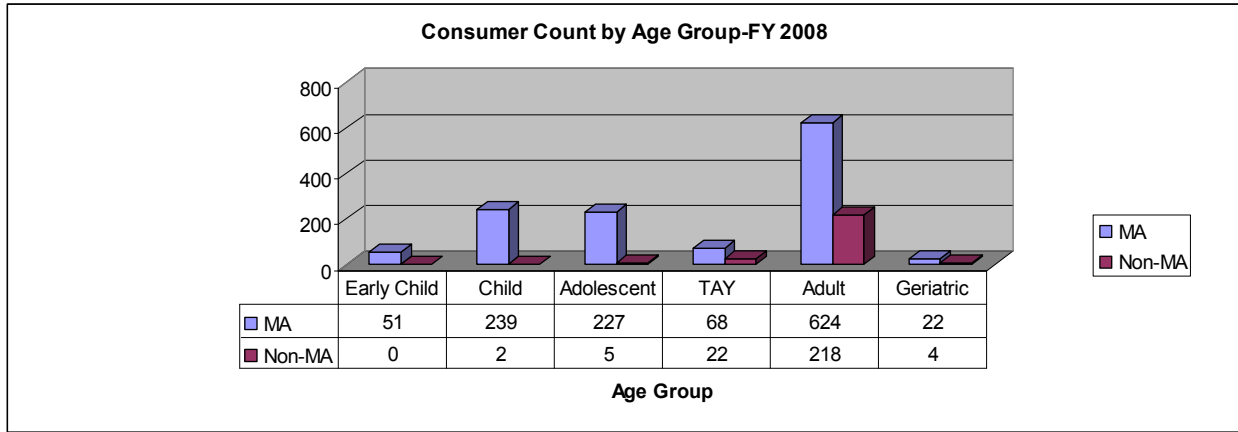
\* FY 2008 data is incomplete as claims may be submitted up to nine months from date of service.

(Green=represents an increase; Red=represents a decrease.)



### Average Annual Cost Per Consumer--St. Mary's





| <b>Expenditures—St. Mary’s</b>        |                                  |                       |                 |                                |                       |                     |
|---------------------------------------|----------------------------------|-----------------------|-----------------|--------------------------------|-----------------------|---------------------|
|                                       | <b>0 - 17<br/>Child / Adoles</b> |                       |                 | <b>18 &amp; Over<br/>Adult</b> |                       |                     |
|                                       | <b>FY2007</b>                    | <b>FY2008</b>         | <b>% Change</b> | <b>FY2007</b>                  | <b>FY2008</b>         | <b>%<br/>Change</b> |
| <b><u>SERVICE<br/>TYPE</u></b>        |                                  |                       |                 |                                |                       |                     |
| <b>Case Management</b>                | \$249,623.00                     | \$11,761.00           | 95.29%          | \$363,378.00                   | \$24,065.00           | 93.38%              |
| <b>Crisis</b>                         | \$5,126.00                       | \$0.00                | 100.00%         | \$14,305.00                    | \$8,297.00            | 42.00%              |
| <b>Inpatient</b>                      | \$228,672.00                     | \$151,384.00          | 33.80%          | \$582,318.00                   | \$373,103.00          | 35.93%              |
| <b>Mobile Treatment</b>               | \$0.00                           | \$0.00                | 0.00%           | \$0.00                         | \$4,680.00            | -<br>4680.00%       |
| <b>Outpatient</b>                     | \$746,136.00                     | \$741,732.00          | 0.59%           | \$801,579.00                   | \$762,556.00          | 4.87%               |
| <b>Partial<br/>Hospitalization</b>    | \$13,589.00                      | \$16,332.00           | 20.19%          | \$65,833.00                    | \$43,487.00           | 33.94%              |
| <b>Psychiatric<br/>Rehabilitation</b> | \$100,614.00                     | \$93,759.00           | 6.81%           | \$1,849,204.00                 | \$1,659,094.00        | 10.28%              |
| <b>Residential<br/>Rehabilitation</b> | \$0.00                           | \$944.00              | 944.00%         | \$154,104.00                   | \$142,072.00          | 7.81%               |
| <b>Residential<br/>Treatment</b>      | \$454,862.00                     | \$723,097.00          | 58.97%          | \$71,273.00                    | \$0.00                | 100.00%             |
| <b>Respite Care</b>                   | \$0.00                           | \$0.00                | 0.00%           | \$0.00                         | \$0.00                | 0.00%               |
| <b>Supported<br/>Employment</b>       | \$0.00                           | \$759.00              | 759.00%         | \$80,435.00                    | \$96,489.00           | 19.96%              |
| <b>Emergency Petition</b>             | \$259.00                         | \$0.00                | 100.00%         | \$5,330.00                     | \$6,493.00            | 21.82%              |
| <b>Purchase of Care</b>               | \$0.00                           | \$0.00                | 0.00%           | \$22,785.00                    | \$12,823.00           | 43.72%              |
| <b>TOTAL</b>                          | <b>\$1,798,881.00</b>            | <b>\$1,739,768.00</b> | <b>3.29%</b>    | <b>\$4,010,544.00</b>          | <b>\$3,133,159.00</b> | <b>21.88%</b>       |

| <b>Persons Served—St. Mary's</b> |                                  |            |               |                                |             |               |
|----------------------------------|----------------------------------|------------|---------------|--------------------------------|-------------|---------------|
|                                  | <b>0 - 17<br/>Child / Adoles</b> |            |               | <b>18 &amp; Over<br/>Adult</b> |             |               |
|                                  | FY2007                           | FY2008     | % Change      | FY2007                         | FY2008      | % Change      |
| <b><u>SERVICE TYPE</u></b>       |                                  |            |               |                                |             |               |
| Case Management                  | 91                               | 27         | 70.33%        | 166                            | 67          | 59.64%        |
| Crisis                           | 1                                | 0          | 100.00%       | 4                              | 3           | 25.00%        |
| Inpatient                        | 18                               | 14         | 22.22%        | 55                             | 38          | 30.91%        |
| Mobile Treatment                 | 0                                | 0          | 0.00%         | 0                              | 1           | 100.00%       |
| Outpatient                       | 525                              | 507        | 3.43%         | 806                            | 758         | 5.96%         |
| Partial Hospitalization          | 6                                | 9          | 50.00%        | 21                             | 12          | 42.86%        |
| Psychiatric Rehabilitation       | 41                               | 41         | 0.00%         | 152                            | 153         | 0.66%         |
| Residential Rehabilitation       | 0                                | 1          | 100.00%       | 44                             | 43          | 2.27%         |
| Residential Treatment            | 11                               | 10         | 9.09%         | 1                              | 0           | 100.00%       |
| Respite Care                     | 0                                | 0          | 0.00%         | 0                              | 0           | 0.00%         |
| Supported Employment             | 0                                | 1          | 100.00%       | 47                             | 76          | 61.70%        |
| Emergency Petition               | 1                                | 0          | 100.00%       | 10                             | 14          | 40.00%        |
| Purchase of Care                 | 0                                | 0          | 0.00%         | 3                              | 2           | 33.33%        |
| <b>TOTAL</b>                     | <b>694</b>                       | <b>610</b> | <b>12.10%</b> | <b>1309</b>                    | <b>1167</b> | <b>10.85%</b> |

## *What does the data tell us?*

- Changes in total system expenditures reflect state policy changes. It can be noted that in 2004 policy specifically targeted PRP programming resulted in a decrease in total system expenditures in 2005. Again, in 2007 state policy changed at the state level, removing Targeted Case Management from the fee-for-services system and placing it into grant funded service system. Fiscal year 2008 reflects this shift both in the numbers of individuals served and expenditure.
- It can be noted that a majority of expenditures in our system are made in the outpatient setting, as there are limited RRP beds and inpatient beds in St. Mary's. The limited resources were a driving force behind MHASM's goal of assisting individuals with mental illness to live successfully in their community.
- Over the last three years the average annual cost per consumer in St. Mary's has consistently decreased, by a total of 12.86%. This can be explained in several ways. First, St. Mary's has over the last several years been granted the opportunity and access to funds outside of the fee-for-services system. Our children that previously would have been sent to costly residential center placements are now being served in the home via the Care Management Entity—Md. Choices. This service includes crisis planning and the development of natural resources. The Five County Project has generated services in our community not available previously, both adults and children have benefited from the availability of in-home intervention. Individuals are now capable of receiving intensive individualized services in their homes. Inpatient stays are able to be reduced or avoided altogether. Secondly, the state itself has experienced both a policy shift and a paradigm shift. Case Management was removed from the fee-for-service system in FY08, and placed into the grant funded system. The state is moving forward promoting recovery initiatives and transformation activities in which individuals can get better. Lastly, St. Mary's has been consistently experiencing a shortage of mental health professionals of the last several years, consumers and community providers alike report long wait times to access psychiatric care. Which means that residents are having to wait or go without much needed care.
- The predominant consumer of services in St. Mary's PMHS are adults: age 22 to 64. There is a gross under representation of the geriatric population in St. Mary's; seniors are the most under served population in our jurisdiction. This is due in part to the lack of outreach to this segment of the population. This is also due to the stigma that the older generations continue to express regarding seeking treatment.
- We have seen a dramatic increase (62%) in the numbers served via Supported Employment. This is reflective of the changing policy of Mental Hygiene Administration toward Recovery and our provider's pursuit to achieve fidelity as an evidence based provider of service. Pathways, our sole Supported Employment provider in St. Mary's, has established a solid reputation while expanding their program.

- FY 2008 saw a dramatic increase in the amount expended on RTC (59%). However there was no significant change in the numbers of persons served. It should be noted that all St. Mary's children placed into RTC were placed by other child serving agencies. All CSA youth were diverted to other levels of care in FY 2008.
- Overall, in St. Mary's there was a decrease in expenditures and total persons served in FY 2008.

## **Contracts for Services Not in the Fee for Service System**

In FY08, the agency monitored six contracts for services not covered in the fee-for-service system:

**Detention Center Mental Health Services**—These services, supported through state jail and federal PATH funds, were delivered to 906 and 36 individuals respectively, by staff contracted through Correctional Mental Health Services, LLC. FY 08 was another successful year with no suicides reported at the detention center. Correctional Mental Health Services reported completing 729 assessments, 2046 face-to face visits for inmates with the social worker, 499 face-to-face visits for inmates with the psychiatrists, and 135 individuals successfully linked to services upon release from jail. The services provided at the jail included an Anger Management Groups and Tele-Psychiatry to provide the detention center with 24/7 accessibility to psychiatric services.

**On Our Own Drop-In Center**—In FY 08, 324 individuals participated in activities sponsored by Own Our Own of St. Mary's, Inc. This is a dramatic increase from the previous year, more than doubling the number of consumers served. The center has an average of 156 hours of operation each month. Regularly scheduled activities at the center included movies, peer education, such as an Anti-Stigma Workshop, and support groups, such as AA, Double Trouble and Eating Disorder Groups. Social activities included Listening Forums, social outings to Washington, D.C., Earth Day, Multi-Cultural Day and local concerts. The Executive Director and an On Our Own Board member were also trained in "WRAP," Wellness Recovery Action Planning. This is a simple and concise program designed to help people who struggle with any kind of difficulty achieve Wellness and Recovery.

**St. Mary's Hospital Emergency Psychiatric Services**—In FY 08, 1079 individuals were evaluated by the Emergency Psychiatric Services at St. Mary's Hospital. Of those evaluations, 120 were children age 17 or younger. The average percentage of admission for patients evaluated by the service for FY 08 was 26%, those not admitted for inpatient psychiatric care were able to be referred more appropriate levels of care or redirected to services in the community such as outpatient mental health, inpatients substance abuse treatment and partial hospitalization.

**Three Oaks Center Case Aides**—21 individuals benefited from supportive services provided through our contract for Case Aide Services with the Three Oaks Center. The Three Oaks Center staff member providing services to these individuals is a licensed addictions counselor and provides substance abuse counseling and case management services. The Aide was able to use her expertise to help more individuals access services such as entitlements, substance abuse services, outpatient mental health, the Kennedy Institute and employment. For many this service has given them an opportunity to access services that they may not have been able to independently, and assist them with the transition from homelessness.

**Three Oaks Center Outreach**—A total of 413 people were outreached in FY 08. Of those 72 individuals benefited from intensive outreach services provided through PATH funding via the Three Oaks Center, which included screening and diagnostic treatment, community mental

health, alcohol and drug treatment, case management and referrals to other community services. 61 of those individuals were identified as having a co-occurring substance abuse diagnosis.

**Family Intervention Specialist**—The Family Intervention Specialist hired to work with Department of Juvenile Services children served approximately 147 children and their families. During FY 08, the Family Intervention Specialist continued to utilize Functional Family Therapy (FFT) with families deemed appropriate. FFT is an alternative therapy and evidence based practice that has once again proved beneficial this fiscal year. The Family Intervention Specialist reported 552 hours of case management services, 74 of the FIS enrolled children attended school regularly and only 6 children re-offended in FY 08. The Family Intervention Specialist was able to offer therapy services in the home, prioritize access to outpatient mental health services, and provide family support and crisis intervention when needed. Only three of the children served by the FIS required out-of-home placement. This service continued to prove its worth as an opportunity to develop the collaborative relationship with the SMC Department of Juvenile Services.

**Purchase of Service**—Many consumers were served through MHASM's Purchase of Service funding. This funding was used primarily in emergency situations for prescriptions, housing and utility assistance. This fiscal year MHASM continued to monitor closely the use of these funds, assuring that they were used only as a "last resort" and that the greatest numbers of consumers were served.

**Southern Maryland Community Network Crisis Beds**—In FY 08, St. Mary's County adults accessed 249 bed days. The crisis bed placements allowed adults to be diverted and in some cases stepped down from inpatient psychiatric hospitalization, it also allowed for adults to have a stable short term placement while other services in the system were applied for and obtained.

**Mental Health Case Management**—FY 08 saw dramatic changes in the delivery of Mental Health Case Management Services. In August 2008 Case Management was taken out of the fee-for-service system and grant funded by the state. The change in funding impacted the way services were delivered and the staffing requirements. The Mental Health Authority of St. Mary's, Inc. (MHASM) continued to offer Mental Health Case Management in St. Mary's. In FY 08, 409 individuals were served by MHASM. Of the 46 individuals surveyed 100% reported that the program linked to services that were helpful to them and/or their family. 85% of those served reported their personal situation was better than when they began receiving services. Case Management, at the close of the fiscal year, again experienced a change. The Mental Health Authority of St. Mary's, Inc. closed its doors on June 30<sup>th</sup>, 2008. The provision of Case Management was bid out to a new vendor.

## VIII. *Goals, Objectives and Strategies*

**GOAL 1:** *Increase the ability of individuals with mental illnesses to live successfully in the community.*

**GOAL 2:** *Promote recovery and increase the ability of adults with serious mental illnesses and the ability of children with serious emotional disturbances to live in the community.*

**GOAL 3:** *Increase the participation of consumers, family members, secondary consumers and caregivers in the PMHS, and encourage the provision of services and supports which incorporate the consumer's ethnic and cultural background.*

**GOAL 4:** *Advance public understanding of psychiatric disorders to promote community awareness, acceptance, and integration.*

**GOAL 5:** *Provide more efficient services while working continuously to improve the quality of services and maintain system accountability.*

**GOAL 6:** *Work to assure that there will be a knowledgeable, skilled, diverse, accessible workforce in the PMHS.*

## MENTAL HEALTH PLAN: FY 2008-2009 GOALS AND OBJECTIVES/STRATEGIES

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| <b><u>GOAL 1</u></b>   | Increase the abilities of individuals with mental illnesses to live successfully in the community.  |                  |  |  |
| <b><u>OBJECTIVE 1.1</u></b>  | Assist in the maintenance of the St. Mary’s County Mental Health Advisory Committee (MADAC) to support the planning and monitoring activities of MHASM. |                  |  |  |
| <b>STRATEGY</b>  | <b>RESPONSIBLE POSITION</b>   | <b>TIME LINE</b> | <b>OUTCOME</b>   | <b>PERFORMANCE MEASURE/MILESTONES</b>  |
| <b>1.1.1</b> Collaborate with the St. Mary’s County Commissioners and Health Officer to appoint a full compliment of committee members reflecting the cultural composition of County residents to include increasing consumer membership and transition age youth participation. | MHASM Director or Designee in conjunction with MADAC Chairperson  | Ongoing          | Community ideas, beliefs and opinions represented by a diverse membership reflective of the community at large.    | MADAC has full statutory representation at 85% of meetings. The group ceased to meet in late FY08 due to system transition. Work will continue in FY09 to develop further membership.  |
| <b>1.1.2</b> Increase knowledge of MADAC members through education programs and participation in the PMHS.   | MHASM Director or Designee  | Ongoing          | MADAC members actively participate in MHASM activities and provide input and feedback to MHASM Director and staff. | MADAC members attend one educational meeting per year; prepare reports; meeting minutes reflect increase in decision-making and advocacy efforts.  |
| <b>1.1.3</b> Increase MADAC involvement in planning and evaluation activities through development of subcommittees and provision of technical assistance.  | MHASM Director or Designee in conjunction with MADAC chairperson.   | Ongoing          | MADAC advises MHASM. Approves Annual Plan and Annual Update Plan. Completes self-evaluation.                       | Sub committee reports; attendance at meetings; meeting minutes; MADAC self-evaluation completed. System experienced dramatic changes in FY08. MADAC discontinued meeting for brief period as MHASM function transitioned into county |

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|  |  |  |  | government. Council resumed meeting on 10/9/08. |
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| <b><u>GOAL 1</u></b>   | <b><u>CONTINUED</u></b>  |                  |  |   |
| <b><u>OBJECTIVE 1.2</u></b>  | <b>Develop a data gathering process and complete Mental Health Plans which reflect stakeholder input and needs assessment and which drive resource development. Involve consumers, family members, service providers and others.</b> |                  |  |   |
| <b>STRATEGY</b>  | <b>RESPONSIBLE POSITION</b>  | <b>TIME LINE</b> | <b>OUTCOME</b>   | <b>PERFORMANCE MEASURE</b>  |
| 1.2.1 Plan and convene stakeholder strategic planning conference, using format such as Town Meeting. | MHASM Director and Staff   | FY 2008/09       | St. Mary’s County PMHS needs are assessed, gaps in service are identified and strategic progress is monitored. | Community needs assessment was compiled at the request of the Board of County Commissioners by the SMC Local Management Board. Assessment was conducted in 2007, however work group sessions continued well into FY 2008 of which MHASM was a participant. Report summarized emerging needs in St. Mary’s, including Mental Health and Substance Abuse. New office established in county government (3/08) to include an array of public and private agencies to better coordinate health and human services in county. MHASM dissolved on June 30, 2008. CSA function turned over to government on July 1, 2008. |

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| <b><u>GOAL 1</u></b>   | <b><u>CONTINUED</u></b>   |                   |   |  |
| <b><u>OBJECTIVE 1.3</u></b>  | <b>Promote and maintain formal communications between child/adolescent agencies to identify mental health needs and appropriate services.</b> |                   |   |  |
| <p><b>1.3.1</b> Collaborate through the LCC, and other Multi-Disciplinary Planning forums to identify needs and plan services for C&amp;A with mental health needs.</p>                | <p>CSA Mental Health Services Coordinator and other staff.</p>  | <p>Ongoing</p>    | <p>St. Mary’s County child and adolescent service needs are assessed, gaps in service are identified and unmet needs are monitored.</p> | <p>*CSA Mental Health Services Coordinator attends monthly LCC and C&amp;A Coordinator’s Meetings; participates in all key collaborative planning team meetings, serves as a resource providing technical assistance on implementation of programs.</p>  |
| <p><b>1.3.1</b> Collaborate with St, Mary’s County Public Schools on school based mental health opportunities in PBIS and expansion of the targeted case management pilot project.</p> | <p>MHASM Director and Staff</p>   | <p>FY 2008/09</p> | <p>To improve the ability and responsiveness of SMCPS and MHASM to meet the needs of children in the school setting.</p>                | <p>To increase referrals to the targeted case management program served in the school by 50%.<br/>                 *MHASM placed a case manager in a SMCPS through an MOU. Improved care coordination with school staff and case management; no notable increase in referrals on FY08.<br/>                 *The provision of Case Management was moved from MHASM and bid out to a private provider. Work began in 4/08. Contract was awarded to Psychotherapeutic Services of Southern Maryland (PSSM). They began providing targeting case management on 7/1/08. At this time there is no plan to continue the pilot in the schools due to the limitation of staff resources.</p> |

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| <b>OBJECTIVE 1.4</b>  |  | <b>Improve mental health services for SMC citizens age 65 and older.</b>                          |  |   |
| <b>1.4.1</b> Collaborate with the SMC Office on Aging, the State Dept of Disabilities to implement the single point of access diagnostic tool called the ADRC.    | CSA Mental Health Services Coordinator | FY 2008/09  | To improve assessment and linkage to services.   | Increased numbers of older citizens utilizing formal Mental Health services.<br>*Goal not achieved in FY08. Participated in submission of articles to Office on Aging monthly news letters to better inform/educate elderly citizens in St. Mary’s. Work has begun in FY09; Coordinator has presented overview of PMHS services to Senior Forum, scheduled to present to Resource Coordination. |
| <b>1.4.2</b> Collaborate with partners including the Office on Aging to design a specific public education campaign targeting mental health needs in the elderly. | MHASM Director                         | FY 2008/09  | To increase knowledge of MH services and reduce the stigma attached to accessing them. | Number of individuals served by the media campaign.<br>*Goal not achieved in FY08.  |
| <b>OBJECTIVE 1.5</b>  |  | <b>To improve the integration of primary health care with specialized mental health services.</b> |  |   |
| <b>1.5.1</b> Provide education opportunities for physicians around mental health assessment and referral.   | MHASM Staff                            | FY 2008-09  | Increase numbers of referrals to specialized mental health care by 5%.                 | One educational session with CME's provided to physicians per year.<br>*Goal not achieved in FY08.  |

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| <p><b>GOAL 2</b><br/><b>SERVICE CONTINUUM</b></p>  | <p>Promote recovery and increase the ability of adults with serious mental illnesses and the ability of children with serious emotional disturbances to live in the community.</p>   |                         |   |   |
| <p><u>OBJECTIVE 2.1</u></p>  | <p>Research and seek funding to establish and maintain a comprehensive and collaborative Countywide Mobile Crisis Response System designed to meet the urgent needs of individuals with mental illness in St. Mary’s County.</p> |                         |   |   |
| <p><b>STRATEGY</b></p>   | <p><b>RESPONSIBLE POSITION</b></p>   | <p><b>TIME LINE</b></p> | <p><b>OUTCOME</b></p>   | <p><b>PERFORMANCE MEASURE</b></p>   |
| <p><b>2.1</b> In collaboration with MHA and stakeholders, continue to explore resources that will support the establishment of a (regional) mobile crisis response system.</p> | <p>MHASM Director and Staff</p>  | <p>FY 2008 – 2009</p>   | <p>Information gathered and analyzed that (1) identified (regional) crisis service needs, cost of services and means to procure necessary funding to meet those needs; or (2) determination made that total funding not available but committed to work on a (regional) incremental plan of action.</p> | <p>Study completed including an analysis of the feasibility of establishing and maintaining a (regional) crisis response system to serve residents of St. Mary’s County and neighboring jurisdictions.<br/>*In FY 07 a Child and Adolescent Crisis Bed facility was opened in Southern Maryland. Facility was a collaborative effort between the LMB’s, DJS’s, DSS’s and the CSA’s in Southern Maryland. To date program is successful. Work is underway to expand crisis bed capacity for adolescents. Work is also underway to develop and identify funding to increase access to regional crisis intervention and mental health services via a mobile crisis team.</p> |

| OBJECTIVE 2.2  | Design and implement a Mental Health Disaster Plan for St. Mary’s County. |                            |  |  |
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| <p><b>2.2.1</b> In collaboration with the St. Mary’s County Health Department, manage the Disaster Mental Health Response capacity for the County.</p>                 | <p>MHASM Director and Health Officer</p>                                  | <p>FY 2008 and ongoing</p> | <p>Mental Health Disaster Plan prepared and supported by stakeholders.</p>   | <p>Document completed and approved by MHA and annually thereafter.<br/>*Currently in the process of updating the plan to incorporate new office and initiatives in the community.</p>  |
| <p><b>2.2.2</b> Promote disaster mental health training opportunities to assist in maintaining the Mental Health Disaster Response Team and State Volunteer Corps.</p> | <p>MHASM Director &amp; Staff</p>   | <p>Ongoing</p>             | <p>Trained mental health professionals available to assist in the event of a disaster in St. Mary’s County and other parts of the State.</p> | <p>List of trained volunteers maintained at MHASM; 90% are to report an increase in skill/knowledge base after training.<br/>*List maintained in FY08; have need to re-train individuals in FY09 as volunteers have changed. MHASM staff trained in NIMS and Psychological First Aide.</p> |

| <b><u>GOAL 2</u></b><br><b>SERVICE CONTINUUM</b>   | <b><u>CONTINUED</u></b>                    |                  |   |  |
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| <b>STRATEGY</b>  | <b>RESPONSIBLE PERSON</b>                  | <b>TIME LINE</b> | <b>OUTCOME</b>  | <b>PERFORMANCE MEASURE</b>   |
| <p><b>2.2.3</b> To collaborate with criminal justice and criminal health providers to explore opportunities to train law enforcement personnel responsible for responding to mentally ill persons in crisis.</p> | <p>MHASM Director and designated Staff</p> | <p>FY 2008</p>   | <p>Educational model identified and funding explored.</p> | <p>20% of law enforcement trained.<br/>*Sheriff’s Office has completed training for 4 officers in Crisis Intervention Training (CIT). MHASM assisted NAMI and Sheriff with a stake holder’s meeting to discuss the CIT Module and promote collaboration. Currently working to articulate future work, training and strategic plan. Sheriff has had 10% of staff trained on basic mental health. MHASM also sponsored Dr. Richard Ortega from the Office of Forensics. Both corrections and sheriff’s officers were trained on emergency petitions and responding to persons with mental illness.</p> |

| <u>OBJECTIVE 2.3</u>  | <b>Coordinate efforts to divert children and adolescents who are at risk for more restrictive placements to ensure that least restrictive service options are available for consumers and their families.</b> |                  |  |  |
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| <b>STRATEGY</b>   | <b>RESPONSIBLE PERSON</b>   | <b>TIME LINE</b> | <b>OUTCOME</b>   | <b>PERFORMANCE MEASURE</b>   |
| <p><b>2.3.1</b> In collaboration with LCC, track referrals to hospitalizations and discharges to identify children and adolescents who are at risk for out-of-home/community placement.</p> | <p>CSA Mental Health Services Coordinator</p>   | <p>Ongoing</p>   | <p>CSA Mental Health Services Coordinator receives timely notification to plan post-hospital services for youth.</p>   | <p>Data indicating that CSA Mental Health Services Coordinator is notified by hospitals/ agencies within 48 hours of a child/adolescent admission.<br/>*Coordinator participates monthly with LCC. Seven of CSA youths have been referred and accepted to the Care Management Entity-MD Choices.</p>   |
| <p><b>2.3.2</b> Plan and participate with LCC, LMB to identify and apply for funds for in-home/community services.</p>  | <p>MHASM Director and CSA Mental Health Services Coordinator</p>  | <p>FY 2008</p>   | <p>Funds are available to St. Mary’s County, aside from Medicaid dollars, for funding diversion services for SED children and adolescents at risk for out of home/community placement.</p> | <p>New and/or ongoing funding sources are available for diversion services for children and adolescents.<br/>*CME pilot awarded in St. Mary’s.<br/>*MHASM bid out the IHIP children’s program to a local PRP provider to make the provision of service consistent across the IHIP programs funded by the Five County Project. Program currently being studied by the University of Maryland.</p> |

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| <p><b>2.3.3</b> Collaborate with other stake holders in the community to ensure community based service options for children.</p>                 | <p>CSA Mental Health Services Coordinator</p> | <p>FY 2008/09</p> | <p>Positive outcomes for Children and Adolescents in functioning; reduced hospitalizations and institutional placements; children and adolescents remain in the community.</p> | <p>RTC usage is decreased by 10% through collaborative community based options. *Goal met in FY08; 100% of CSA youths were referred/accepted to the Care Management Entity. CSA placed no children in RTC level of care in FY08.</p>  |
| <p><b>2.3.4</b> Collaborate with DJS to manage the Family Intervention Specialist Program for aftercare services for youth in DJS placements.</p> | <p>CSA Mental Health Services Coordinator</p> | <p>Ongoing</p>    | <p>Reduction in youth recidivism through coordinated MH and SA services provision.</p>   | <p>Quarterly reports from CSA to MHA’s DJS behavioral health programs documenting services delivered, referrals, fiscal expenditures. Reports to demonstrate an 85% successful discharge/ completion rate from program. *FIS maintained an average active monthly caseload of 14.7 in FY08. Data available reports a 2:1 rate of unsuccessful to successful discharges. However this number includes children referred to service but were not served by the program ie) children placed and refusal of services.</p> |

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| <p><b>OBJECTIVE 2.4</b></p>  | <p><b>MHASM will continue to provide technical assistance and monitoring in order to increase usage of the Supported Employment Programs.</b></p> |                     |   |  |
| <p><b>2.4.1</b> Work with MHA to support the full implementation and increase numbers served through the EBP Supported Employment Program.</p> | <p>MHASM Director</p>   | <p>FY 2008-2009</p> | <p>Individuals with mental illness will fully participate in the community workforce in “competitive employment.”</p> | <p>Monitoring reports show continuation of SEP; a 15% increase in number of persons assessed for services; and placed into job placements.<br/>*Data reports 61% increase in numbers of persons accessing SEP. To date our provider has not obtained fidelity as an EBP, however the program utilizes the principles/practices of EBP.</p> |

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| <b><u>GOAL 2</u></b>   | <b><u>CONTINUED</u></b>   |                     |   |   |
| <b>SERVICE CONTINUUM</b>   |   |                     |   |   |
| <b>STRATEGY</b>  | <b>RESPONSIBLE PERSON</b>   | <b>TIME LINE</b>    | <b>OUTCOME</b>  | <b>PERFORMANCE MEASURE</b>  |
| <b><u>OBJECTIVE 2.5</u></b>  | <b>MHASM will assist and provide leadership to increase system capacity in the area of co-occurring mental illness and substance abuse disorders.</b> |                     |   |   |
| <p><b>2.5.1</b> Provide staff resources and direction to develop capacity within the St. Mary’s County Co-Occurring Workgroup.</p> | <p>MHASM Director and Staff</p>   | <p>FY 2008-2009</p> | <p>Individuals with co-occurring disorders in mental illness and substance abuse are identified and receive appropriate assessment and referral to treatment.</p> | <p>Monitoring reports demonstrate the behavioral health workforce received the COMPASS assessment; identified a universal assessment tool; training group identified and an action plan developed.<br/>                     *Consensus document signed, work plan established.<br/>                     *Six work sessions completed on COD principles in FY08. Staff trained, COMPASS assessment administered. COD initiative lost momentum due to our systems transition. Work to continue in FY09.</p> |

| OBJECTIVE 2.6   | Improve coordination between behavioral health and criminal justice. |                     |  |   |
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| <p><b>2.6.1</b> Create a behavioral health/criminal justice steering committee to identify best practices and implement policy and program implementations.</p>                 | <p>MHASM Director and Staff</p>                                      | <p>FY 2008-2009</p> | <p>Increase collaboration between behavioral health and criminal justice systems.</p>  | <p>Identify and implement policies and best practices in program implementations.<br/>*Goal not achieved in FY08.</p>         |
| <p><b>2.6.2</b> Work collaboratively with the St. Mary’s County Addictions Coordinator to design and implement a program for COD at the St. Mary’s County Detention Center.</p> | <p>MHASM Director and Staff</p>                                      | <p>FY 2008</p>      | <p>Individuals with co-occurring disorders are treated efficiently and effectively while incarcerated and linked with appropriate case management and other community based services upon discharge.</p> | <p>RFP issued and awarded.<br/>*Addictions Coordinator position vacant, has been merged into the Dept. of Human Services.</p> |

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| <b>GOAL 3</b>  | To increase the participation of consumers, family members, secondary consumers and caregivers in the PMHS, and encourage the provision of services and supports which incorporate the consumer’s ethnic and cultural background. |                  |  |   |
| <b>OBJECTIVE 3.1</b>   | <b>The MHASM will develop mechanisms to foster an increase in the number of consumers, parents, care givers, and advocates involved in the policy and decision making process.</b>  |                  |  |   |
| <b>STRATEGY</b>  | <b>RESPONSIBLE POSITION</b>   | <b>TIME LINE</b> | <b>OUTCOME</b>   | <b>PERFORMANCE MEASURE</b>  |
| 3.1.1 Convene formal and informal meetings with consumers, family members and advocacy groups. | MHASM Director and Staff  | FY 2008-2009     | Monthly meetings held with target groups, such as ON OUR OWN and NAMI. Positive working relationships and trust developed.   | Minutes of meetings reflect consumers, parents, caregivers and advocates actively involved in decision making.<br>*MHASM maintained positive relationships with target groups, MHASM combined bi-monthly provider meeting to include advocacy groups.                                 |
| 3.1.2 Provide technical assistance and support to On Our Own of St. Mary’s, Inc.               | MHASM Director and Staff  | FY 2008-2009     | Consumers actively participate in On Our Own of St. Mary’s, Inc., MHASM and PMHS activities; provide input and advocate for accessible, high quality services that protect and respect clients’ rights and meet their needs. | Wellness and Recovery Center open on an average of 25 hours per week, 130 unduplicated consumers served per year, consumer groups meet weekly, newsletter distributed monthly, twice a year advocacy training provided; and reports generated monthly. Staff trained in WRAP in FY08. |

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| <p><b>3.1.3</b> Ensure consumer, family and advocacy group representation on various boards and councils in the community.</p> | <p>MHASM Director and Staff</p> | <p>FY 2008-2009</p> | <p>Consumers and family members have input into program design, policies and procedures.</p> | <p>Board membership rosters reflect diversity of mental health consumer advocacy population.<br/>*Board of MHASM and Mental Health Advisory Council included at a minimum 2 primary consumers and 1 secondary consumer in FY08.</p> |
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| <b><u>GOAL 4</u></b>  |                             | <b>Advance public understanding of psychiatric disorders and mental health services to reduce the stigma associated with mental illnesses, and promote activities to advance community awareness, acceptance and integration.</b> |  |  |
| <b><u>OBJECTIVE 4.1</u></b>   |                             | <b>General public’s knowledge of mental health/mental illness is equal to their knowledge of somatic medicine; stigma is reduced.</b>   |  |  |
| <b>STRATEGY</b>   | <b>RESPONSIBLE POSITION</b> | <b>TIME LINE</b>  | <b>OUTCOME</b>   | <b>PERFORMANCE MEASURE</b>   |
| 4.1.2 Co-sponsor educational and consumer activities with On Our Own of St. Mary’s, Inc. and NAMI Southern Maryland.                  | MHASM Director              | Ongoing   | Consumers and family members gain increased knowledge about mental health and mental health system.  | Two educational sessions held in FY 08; participant evaluations report increased knowledge and 90% satisfaction with materials offered. Reports available. |
| 4.1.3 Update and disseminate resource directory for agencies, providers, consumers, and general public. Update MHASM web-site.        | MHASM Director and Staff    | Annually  | General public is made aware of community resources and access to the system is increased.   | Web site is updated monthly. Worked to develop Network of Care website in St. Mary’s, site is active to date.  |
| <b>STRATEGY</b>   | <b>RESPONSIBLE POSITION</b> | <b>TIME LINE</b>  | <b>OUTCOME</b>   | <b>PERFORMANCE MEASURE</b>   |
| 4.1.4 Continue to explore resources, in conjunction with other healthcare organizations, in order to maintain ongoing media campaign. | MHASM Director and Staff    | Ongoing   | General public gain increased knowledge and understanding about mental health, the mental health system, and the importance of early identification, prevention and intervention services. | Informational meetings held; participant evaluations report increased knowledge and understanding.   |

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| <p><b>4.1.5</b> Promote interagency awareness of mental health issues of through cross-training activities and presentations, including presentations by the Anti-Stigma Project.</p> | <p>MHASM Director</p> | <p>Ongoing</p> | <p>Agency staff will gain increased understanding of mental health issues, early screening and identification and treatment options.</p> | <p>Six training sessions/presentations held; participant evaluations report increased knowledge and 90% satisfaction with materials offered. Reports available.</p> |
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| <b>GOAL 5</b>  | <b>Provide more efficient services while working continuously to improve the quality of services and maintain system accountability.</b> |                  |   |  |
| <b>MANAGE/<br/>ACCOUNTABILITY</b>  |  |                  |   |  |
| <b>OBJECTIVE 5.1</b>   | <b>Enhance and maintain a fully functioning, accountable Core Service Agency [Administrative Budget].</b>                                |                  |   |  |
| <b>STRATEGY</b>  | <b>RESPONSIBLE POSITION</b>  | <b>TIME LINE</b> | <b>OUTCOME</b>  | <b>PERFORMANCE MEASURE</b>   |
| <b>5.1.1</b> MHASM monitors data from the Administrative Service Organization for discrepancies and variance.          | MHASM Director & Staff   | Ongoing          | Report discrepancies to ASO.  | Documentation of reports. Data analysis available in report.   |
| <b>5.1.2</b> MHASM conforms to HIPAA requirements and assists providers in conforming to HIPAA requirements            | MHASM Director   | Ongoing          | MHASM is HIPAA compliant.   | Identification and correction in 100% of activities found to be non-compliant of HIPAA.  |
| <b>5.1.3</b> Continue to build a fully functioning administrative support system that is both effective and efficient. | MHASM Director   | Ongoing          | MHASM staff is highly productive.   | MHASM staff fulfilled 100% of MOU deliverables in FY 2008. MHA site visit report.  |
| <b>5.1.4</b> Performance measures are incorporated into contracts to ensure accountability and efficiency.             | MHASM Contract Monitor   | Ongoing          | Measurable performance indicators utilized to assure program/service accountability. Consumer rights shall be promoted and protected. | 100% of MHASM grant funded programs are monitored using documented performance indicators. Moved to cost-reimbursement in 2 contracts. Monitoring reports available. |

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| <b>GOAL 5</b>  | <b><u>CONTINUED</u></b>  |                  |   |   |
| <b>MANAGE/<br/>ACCOUNTABILITY</b>  |  |                  |   |   |
| <b>STRATEGY</b>  | <b>RESPONSIBLE POSITION</b>  | <b>TIME LINE</b> | <b>OUTCOME</b>  | <b>PERFORMANCE MEASURE</b>  |
| <b>5.1.5</b> All grant contracts contain performance outcome measures and quality assurance indicators, and are negotiated and signed prior to the start of the contract period. | MHASM Contract Monitor   | Ongoing          | Providers informed of MHASM expectations; accountability measures instituted at grant commencement.   | Contracts contain outcome measures and are executed prior to grantee providing services.<br>*Goal achieved in FY 08, documented through quarterly monitoring by MHA.  |
| <b>5.1.6</b> Program staff analyzes data from State consumer satisfaction surveys and provider management reports.   | Program Staff  | Ongoing          | Analytical mechanisms are developed to demonstrate quality of programs/services and to determine whether changes are needed to assure consumer needs and preferences are met. | Analysis demonstrates 95% of programs/services are high quality and meet 85% of consumer needs and preferences. Reports available.  |
| <b>OBJECTIVE 5.2</b>   | <b>Monitor service provisions and provide on going individualized technical assistance and provider training to assure high quality of care.</b> |                  |   |   |
| <b>5.2.1</b> Contract monitor performs site visits to evaluate service provisions and provide technical assistance as needed.  | MHASM Contract Monitor   | Ongoing          | Monitoring schedule established and implemented. Technical assistance/training provided as necessary.   | 100% of MHASM contractors are monitored monthly through review of report submission. 100% of MHASM contractors were monitored through a site visit in FY08. All programs were found to be in compliance with expected deliverables. MHASM participated in the OHCQ exit interview of one PMHS provider in St. Mary’s. |

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| <p><b>GOAL 6</b></p> <p><b>WORKFORCE DEVELOPMENT</b></p>   | <p>Work to assure that there will be a knowledgeable, skilled, diverse, accessible workforce in the PMHS.</p>   |                   |   |   |
| <p><b>OBJECTIVE 6.1</b></p>  | <p><b>Provider’s knowledge of clinical mental health/mental illness is equal to their sensitivity to the diversity of the issues faced by the mentally ill population; stigma is reduced.</b></p> |                   |   |   |
| <p><b>6.1.1</b> Conduct collaborative meetings with community providers and stake holders around training on cultural competencies/diversities.</p>                                | <p>MHAM Director and Staff</p>  | <p>FY 2008/09</p> | <p>To educate providers and community stake holders with and end result of better service to the community.</p>                           | <p>Two training sessions/presentations held; participant evaluations report increased knowledge and 90% satisfaction with materials offered. Reports available.</p>   |
| <p><b>6.1.2</b> Promote interagency awareness of mental health issues through cross-training activities and presentations, including presentations by the Anti-Stigma Project.</p> | <p>MHASM Director</p>   | <p>Ongoing</p>    | <p>Agency staff will gain increased understanding of mental health issues, early screening and identification, and treatment options.</p> | <p>Three training sessions/presentations held; participant evaluations report increased knowledge and 90% satisfaction with materials offered. Reports available.</p> |

## **Appendix A ABBREVIATIONS:**

ASO: Administrative Service Organization  
COD: Co-Occurring Disorders  
CRT: Crisis Response Team  
CSA: Core Service Agency  
DDA: Developmental Disabilities Administration  
DHMH: Department of Health and Mental Hygiene  
DORS: Department of Rehabilitation Services  
DSS: Department of Social Services  
DJS: Department of Juvenile Services  
FFT: Functional Family Therapy  
FIS: Family Intervention Specialist  
GOC: Governor's Office for Children  
HD: Health Department  
HMIS: Homeless Management Information System  
LCC: Local Coordinating Council  
LMB: Local Management Board  
MA: Medical Assistance  
MADAC: Mental Health Advisory Committee  
MAIR: Medical Assistance Ineligible Recipient  
MAPS-MD: Administrative Services Organization for MHA  
MDOD: Maryland Department of Disabilities  
MHA: Mental Hygiene Administration  
MHASM: Mental Health Authority of St. Mary's, Inc.  
MI/DD: Mental Illness/Developmental Disabilities  
NAMI/SM: National Alliance on Mental Illness/Southern Maryland  
OHCQ: Office of Health Care Quality  
OMHC: Outpatient Mental Health Clinic  
PATH: Programs to Assist With the Transition From Homelessness  
PMHS: Public Mental Health System  
POS: Purchase of Services  
PRP: Psychiatric Rehabilitation Program

RRP: Residential Rehabilitation Program

RTC: Residential Treatment Center

SEP: Supported Employment

SMC: St. Mary's County

SMCPS: St. Mary's County Public Schools

SMI: Severe Mental Illness

TAY: Transitional Age Youth

TCM: Targeted Case Management