**Baltimore Mental Health Systems, Inc.**

**Annual Report**

**Table of Contents**

**Executive Summary** ................................................................. 1

**Annual Report, Fiscal Year 2010**

| Highlights of Accomplishments | ................................................................. 5 |
| Report of Activities | ........................................................................ 13 |
| **Goal I:** Americans Understand that Mental Health is Essential to Overall Health | ........................................................................ 13 |
| **Goal II:** Mental Health Care is Consumer- and Family-Driven | ................................................................. 16 |
| **Goal III:** Disparities in Mental Health are Eliminated | ........................................................................ 23 |
| **Goal IV:** Early Mental Health Screening, Assessment, and Referral to Services are Common Practice | ........................................................................ 42 |
| **Goal V:** Excellent Mental Health Care is Delivered and Research is Accelerated While Maintaining Efficient Service System Accountability | ........................................................................ 51 |
| **Goal VI:** Technology is Used to Access Mental Health Care Information | ................................................................. 71 |

**Data on Service Utilization** ................................................................. 73

**Appendices**

| **Appendix A:** Glossary and Acronym Description | ................................................................. 115 |
| **Appendix B:** Residential Rehabilitation Program Consumer Satisfaction Survey | ................................................................. 120 |
| **Appendix C:** Mental Health Services for Adults in Baltimore City | ................................................................. 123 |
| **Appendix D:** Baltimore City Community Health Survey | ................................................................. 148 |
EXECUTIVE SUMMARY

Baltimore Mental Health Systems, Inc. (BMHS) is a non-profit agency established by Baltimore City to perform the governmental function of managing the City’s public mental health system (PMHS). As such, BMHS serves as the local mental health authority, or core service agency (CSA), for Baltimore City. BMHS’ primary activities focus on: improving access to care; expanding and improving the range of services available to Baltimore City residents with mental illness; and ensuring accountability and active collaborations with City and State agencies.

BMHS oversees a network of predominately private non-profit providers that delivers services to over 39,000 Baltimore City residents who are Medicaid and/or Medicare recipients or uninsured. The majority of public mental health system services are reimbursed through a statewide fee-for-service system. In addition to overseeing the provision of these services, BMHS directly awards public and private funds to support the development of innovative programs and the ongoing operations of mental health services not reimbursable by the fee-for-service system.

BMHS has two non-profit affiliates. Community Housing Associates, Inc. (CHA) is dedicated to developing and managing affordable housing for low-income individuals and families in Baltimore City who are affected by mental illness. CHA owns or manages 226 housing units. The Behavioral Health Leadership Institute (BHLI) (formerly Mental Health Policy Institute for Leadership and Training, or MHPILT), the second affiliate, was established to address issues related to workforce development in community behavioral health across disciplines, and the gap between research findings, policy and practice.

BMHS and the State’s 18 other core service agencies are required to submit an annual report to Maryland’s Mental Hygiene Administration (MHA) in which progress on goals delineated in the agency’s Mental Health Plan is described. This document is Baltimore City’s annual report for Fiscal Year 2010 (July 1, 2009 through June 30, 2010). It reports on the activities and accomplishments of BMHS and public mental health system utilization during FY 10. BMHS will publish a three-year Mental Health Plan for FY 13 – 15 next year with its annual report for FY 11.

The Highlights of Accomplishments section of this document presents significant accomplishments organized under the following headings: Expanding Prevention and Early Intervention, Increasing Access to Mental Health and Related Services, Improving the Quality of Mental Health Service Delivery, Managing Public Funds, and Preparing for Federal Health Care Reform. Some of the accomplishments noted in this section fall outside of the purview of the plan created for this time period due to unforeseen opportunities and challenges. For example, the passage earlier this year of federal health care reform presents opportunities and challenges that merit BMHS’ attention and consideration. Therefore, the work BMHS did in regard to federal health care reform is described in this section.

1 Henceforth throughout this document, fiscal years; e.g., 2010, will be abbreviated FY 10.
BMHS exercises significant authority over public funds through its coordination and oversight of the fee-for-service Public Mental Health System and its management of grants portfolio. In FY 10, BMHS awarded $23 million in grants, with 147 contracts issued to 53 provider agencies. The Report of Activities section provides a detailed description of programmatic activities related to these grant funds and the administrative activities of the agency. It identifies BMHS’ goals and associated strategies and objectives, and describes the extent to which the strategies were accomplished. BMHS’ overarching goals are those put forth in *New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America*:

- **GOAL I:** Americans Understand that Mental Health is Essential to Overall Health
- **GOAL II:** Mental Health Care is Consumer and Family Driven
- **GOAL III:** Disparities in Mental Health are Eliminated
- **GOAL IV:** Early Mental Health Screening, Assessment, and Referral to Services are Common Practice
- **GOAL V:** Excellent Mental Health Care is Delivered and Research is Accelerated While Maintaining Efficient Service System Accountability
- **GOAL VI:** Technology is Used to Access Mental Health Care Information

The Data on Service Utilization section presents summary service utilization data, describing activity in Baltimore City’s fee-for-service Public Mental Health System based on claims paid data. It includes a comparison of FY 10 and previous years’ data, and notes trends in individuals served, services rendered and expenditures. Please note that not all data reported in last year’s report were available for FY 10. However, because these data describe important trends, the FY 09 data are presented, and will be updated if FY 10 data become available.

In FY 10, 39,772 individuals were served by the fee-for-service Public Mental Health System, and expenditures totaled $216,272,715. Significant trends noted in the FY 10 data include:

- The Public Mental Health System in Baltimore City continues to expand, both in terms of the number of individuals served (21% over the past three years) and the total amount of expenditures (19% over the past three years);
- In the last four years, there has been a 46% increase in consumers receiving Medicaid;
- The greatest driver of the increase in expenditures in FY 10 is inpatient care, which accounted for more than half of the $16 million increase from FY 09 to FY 10; and
- There has been a notable decline in service provision to uninsured individuals, as measured by a 43% decrease in expenditures for uninsured consumers

There are four appendices:

- **Appendix A:** Glossary and Acronym Description

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Appendix B: Residential Rehabilitation Program Consumer Satisfaction Survey
Appendix C: Mental Health Services for Adults in Baltimore City: A Guide to Services Available in the Public Mental Health System
Appendix D: Baltimore City Community Health Survey: Summary Results Report
ANNUAL REPORT, FISCAL YEAR 2010
HIGHLIGHTS OF ACCOMPLISHMENTS

EXPANDING PREVENTION AND EARLY INTERVENTION

Prevention and early intervention services aim to minimize the progression of mental disorders and the associated personal and societal costs.

Providing Mental Health Prevention and Treatment Services to Baltimore City Schoolchildren

- 47,979 children in over half (102) of Baltimore City’s public schools had access to prevention activities and mental health treatment through the Expanded School Mental Health program. Mental health clinicians provided individual and group counseling sessions to 7,942 students.

Expanding Substance Abuse and Dropout Prevention Among Sixth Graders

- Approximately 500 sixth graders participated in school dropout prevention activities, which are designed to teach problem solving, conflict resolution, and life skills, thereby increasing the likelihood that youth will complete school and not abuse drugs or alcohol. These services are available in 37 of the 102 schools that have Expanded School Mental Health services. BMHS partnered with Baltimore Substance Abuse Systems (bSAS) to implement the Sixth Grade Expanded School Behavioral Health Initiative.

Educating Low-Income Families About Mental Health Issues to Promote Wellness and Job Retention

- Over 3,000 Temporary Assistance for Needy Families (TANF) recipients participated in a Wellness Education Program, which provided information and support to assist individuals in maintaining mental wellness in order to secure and retain employment. This program also provided mental health screening and short-term treatment and/or referral for mental health services to 918 individuals. BMHS partnered with the Department of Social Services to develop and implement the Wellness Education Program.

Training Police Officers to Respond to Individuals Experiencing a Mental Health Crisis

- Eighty-six patrol officers received Behavioral Emergency Services Team (BEST) Crisis Intervention training this year. When responding to a crisis call, BEST-trained officers are able to de-escalate mental health crises, minimize arrests, and decrease officer injury. The BEST project reached a milestone in moving from a grant-funded initiative to being incorporated into the operations of the Baltimore City Police Department. Moving forward, all new recruits (approximately 160 per year) will receive BEST training.
Increasing access to community-based alternatives to expensive, restrictive and often-traumatizing mental health services improves outcomes for consumers and is cost-effective for the Public Mental Health System.

Reducing Unnecessary Psychiatric Hospitalization

- Seventy-six consumers identified as frequent users of psychiatric inpatient services were connected to ongoing community-based services in order to decrease use of unnecessary inpatient psychiatric care. The High Inpatient Utilizer Project, which has saved the Public Mental Health System almost $1 million since FY 07, is a collaboration between BMHS, the Mental Hygiene Administration and ValueOptions.

- Three hundred and twenty-nine individuals who presented in any of four City hospital emergency rooms received mobile crisis services through the Hospital Diversion Project. A mobile crisis team operated by Baltimore Crisis Response diverted 70% of individuals from high-cost psychiatric inpatient care to community-based alternatives. BMHS collaborated with the Mental Hygiene Administration and ValueOptions on this project.

- Eighty-eight consumers who have had long stays in State psychiatric and forensic hospitals were transitioned to community-based services, including Residential Rehabilitation Programs, the Forensic Assertive Community Treatment Team, and the Capitation Programs. BMHS helped identify consumers for whom community-based care is appropriate, oversaw and facilitated the transition, and provided follow-up monitoring to ensure consumers are doing well in the community.

Improving Integrated, Community-Based Care for Children and Families

- Starting in FY 10, 82 children with serious emotional disability (SED) received mental health services and a range of other supportive services through the newly designated care management entity for Baltimore City, Wraparound Maryland. The majority of these children receive services through MD-CARES (the System of Care grant), the State’s 1915c Medicaid Waiver or group home diversion program. BMHS serves as the coordinating agency for MD-CARES, working with the Department of Social Services to ensure that children with mental health needs are connected to the care management entity.

- During the last quarter of FY 10, 65 children at risk for intensive out-of-home and likely out-of-state placement were assessed to receive the same level of care at home and in their community, which allowed parents and caregivers to participate in treatment. So far, 10 children have begun to receive services in the community in lieu of institutions. BMHS facilitates this linkage as a component of MD-CARES.

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3 The FY 10 claims paid data were estimated based on the expenditure trends between FY 07 and FY 09 and includes individuals that BMHS worked with from FY 08 to FY 10 (n=39 individuals).
4 A care management entity is a nationally recognized model for developing and implementing comprehensive individualized plans of care across multiple providers and systems.
Expediting Access to Social Security Entitlements for Homeless Individuals

- Thirty-one homeless individuals applied for Social Security entitlements through the SSI/SSDI Outreach, Access and Recovery (SOAR) Initiative, which reduces the application process timeframe from an average of six months to an average of two months, with some SOAR-assisted applications being approved in less than one week. These expedited entitlements enable consumers to access basic needs such as housing and mental health care faster than they would have been able to otherwise. MHA already funded one SOAR coordinator at Health Care for the Homeless, and was able to add a second one in FY 10, using PATH funding.

Linking Individuals who are Street-Homeless to Housing and Related Services

- Three hundred and forty-one homeless individuals have received outreach services, and 138 have received Section 8 housing vouchers through coordinated homeless outreach. As a result of the collaborative leadership of BMHS and Baltimore HealthCare Access, Hands In Partnership (HIP), Baltimore City’s homeless outreach coalition, has made significant progress over the past year in growing its membership, adding an evaluation component, and prioritizing client needs based on coordinated decision-making.

Improving the Quality of Mental Health Service Delivery

High quality care is associated with beneficial outcomes and a better life for individuals with mental illness. Evidence-based practices (EBPs) are service protocols or program models whose beneficial impacts on consumers have been validated through research. Maryland certifies programs that demonstrate fidelity to EBP models. BMHS promoted the dissemination of five EBPs in Baltimore City this past year, as described below.

Increasing the Number of Consumers Receiving Evidence-Based Practices

- **Supported Employment Program (SEP):** One hundred and ninety-three consumers\(^5\) were enrolled in one of the three programs in Baltimore City that maintained certification as an evidence-based practice for Supported Employment. These programs strive to help consumers find and keep competitive jobs in their communities. Of consumers enrolled, approximately 50% were employed at any point during the year, and of those employed, 80% maintained a job for more than 3 months, 53% for more than 1 year, and 29% for more than 2 years. There are three additional City programs working toward certification as an SEP, which would significantly increase the number of consumers who could receive employment assistance through this evidence-based model.

- **Assertive Community Treatment (ACT):** Five hundred and twenty consumers\(^6\) received ACT services through one of the five ACT teams in Baltimore City. Assertive

\(^5\) Based on outcomes data submitted by SEP providers.

\(^6\) Based on outcomes data submitted by ACT providers.
Community Treatment provides individualized treatment available 24 hours a day with the goal of helping people with mental illness build skills for living in the community and avoiding unnecessary psychiatric inpatient care. In addition, BMHS provided technical assistance to one Mobile Treatment team to become an evidence-based ACT provider.

- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT):** Children and adolescents receiving care in four Baltimore City clinics now have access to Trauma-Focused Cognitive Behavioral Therapy. Twenty-eight clinicians from these clinics were trained in this evidence-based practice through a partnership with the University of Maryland’s Innovations Institute. Trauma-Focused Cognitive Behavioral Therapy is a type of psychotherapy for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events.

- **Functional Family Therapy (FFT):** Seventy-five children and their families will receive Functional Family Therapy during the next fiscal year following the procurement of these services by BMHS in FY 10. Functional Family Therapy is a family-based prevention and intervention program designed to improve long-term outcomes for youth either already involved or at risk of being involved in the Juvenile Justice System.

- **Integrated Dual Disorders Treatment (IDDT):** Individuals who are court-ordered for substance abuse treatment (8-507 Order) and have a mental illness often do not have access to integrated mental health and substance abuse treatment. BMHS and Baltimore Substance Abuse Services (bSAS) have partnered to develop an Integrated Dual Disorders Treatment team, an evidence-based practice model that fully supports consumers in the recovery process. This project is supported by funding from the substance abuse system and a grant from the Maryland Community Health Resources Commission. It is expected that services will be procured and implemented in FY 11.

**Improving Outcomes for Criminal Justice System-Involved Individuals with Mental Illness**

- Consumers with serious mental illness frequently appear before judges whose knowledge of available public mental health system services is limited. This lack of knowledge prevents judges from recommending the most appropriate treatment and level of care (e.g. community-based care versus incarceration). In an effort to improve outcomes for defendants with mental illness, BMHS is offering in-service education to the City’s Mental Health Court judges to increase their knowledge about the public mental health system. In addition, BMHS developed and disseminated a resource guide, Mental Health Services for Adults in Baltimore City, for judges and others outside the public mental health system. This document is available in Appendix C.

**MANAGING PUBLIC FUNDS**

BMHS exercises significant authority over public funds through its coordination and oversight of the fee-for-service Public Mental Health System in the City, which served more than 39,000 consumers at a cost of approximately $216 million in FY 10, and its management of a grants portfolio of approximately $23 million. This year, BMHS continued its focus on strengthening its organizational capacity to manage public funds through a range of administrative infrastructure and operational improvements.
Fee-For-Service Public Mental Health System Funds

Transitioning the Administrative Services Organization from APS to ValueOptions

- BMHS was an active participant in the transition to ValueOptions (VO) as the new administrative services organization (ASO) for Maryland’s Public Mental Health System. This included participation in the orientation of VO, serving as a core service agency representative on the VO Provider Council, being a conduit for information and linkage to the ASO for City mental health providers for problem resolution, and participating in systems management development meetings with MHA and VO.

Ensuring Efficient Service Delivery

- BMHS continued to manage the resources of the Public Mental Health System in order to provide uninsured individuals access to mental health services and to authorize services for consumers with public insurance. As the City’s core service agency, BMHS managed: the waitlist for the City’s 354 residential rehabilitation program beds; entry into the City’s 354 Capitation program slots, and over 100 referrals of state hospital patients to the City’s Assertive Community Treatment teams.

Improving Oversight and Risk Management of Capitation Project Funds

- BMHS negotiated significant revisions in the two Capitation program contracts to incorporate more rigorous fiscal and programmatic oversight, and better manage the financial risk to BMHS associated with this project. These changes have promoted closer collaboration between BMHS and the Capitation providers to better serve City consumers with intense service needs.

Grant Funds

Provider Contracting

The contracting process for BMHS’ $23 million portfolio of 147 mental health service contracts has been reviewed, many aspects redesigned, and numerous changes implemented. The table below, which lists just a portion of BMHS’ grant-funded contract portfolio, indicates the range of services funded.
### Contract-Funded Services

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Services Provided</th>
<th># Served/ # Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer-Run: Wellness and Recovery Centers</td>
<td>Peer support</td>
<td>795 individuals</td>
</tr>
<tr>
<td>Family-Driven: High Fidelity Wraparound</td>
<td>Mental health treatment and supportive services</td>
<td>63 families</td>
</tr>
<tr>
<td>Forensic (adults): Forensic Alternative Services Team (FAST), Forensic Assertive Community Treatment Team (FACTT), Case Management, Chrysalis House</td>
<td>Mental health treatment and diversion</td>
<td>1,021 individuals; 88 discharged from State Hospital</td>
</tr>
<tr>
<td>Forensic (youth): Court Medical Evaluation Team</td>
<td>Mental health assessments</td>
<td>445 individuals</td>
</tr>
<tr>
<td>Homeless: Hands In Partnership</td>
<td>Outreach and Coordination of care</td>
<td>341 individuals</td>
</tr>
<tr>
<td>Homeless: Transitional Housing</td>
<td>Housing services</td>
<td>256 individuals</td>
</tr>
<tr>
<td>Homeless: HUD-funded projects</td>
<td>Housing services</td>
<td>1,168 individuals</td>
</tr>
<tr>
<td>Trauma: Child Development Community Policing</td>
<td>Trauma-focused interventions</td>
<td>400 calls</td>
</tr>
<tr>
<td>Early Childhood</td>
<td>Prevention and treatment services</td>
<td>1,026 children &amp; families</td>
</tr>
<tr>
<td>School-Based</td>
<td>Prevention and treatment services</td>
<td>7,942 students in 102 schools</td>
</tr>
<tr>
<td>Crisis (adults): Baltimore Crisis Response Inc. (BCRI)</td>
<td>Crisis intervention and follow-through</td>
<td>29,719 calls</td>
</tr>
<tr>
<td>Crisis (youth): Baltimore Child and Adolescent Response Systems (B-CARS)</td>
<td>Crisis intervention and follow-through</td>
<td>1,544 calls</td>
</tr>
<tr>
<td>Hospital Diversion Project</td>
<td>Hospital diversion</td>
<td>329 individuals (70% diversion rate)</td>
</tr>
<tr>
<td>At-Risk Youth: YO! Centers</td>
<td>Prevention and treatment services</td>
<td>135 youth</td>
</tr>
<tr>
<td>Veterans: Pro Bono Counseling Project</td>
<td>Mental health counseling</td>
<td>80 veterans</td>
</tr>
</tbody>
</table>

- In FY 10, Maryland’s Mental Hygiene Administration reduced funding to services by $879,376. While every effort was made to minimize the impact of budget reductions, they did result in a decrease in access to certain types of care. The following grant-funded public mental health services experienced reductions: the High Fidelity Wraparound Initiative, Youth Opportunity (YO!) Centers, Expanded School Mental Health, the Early Childhood Mental Health Training Series, and BMHS’ Forensic Conference.

**Funding Critical Client Needs**

- BMHS responded to 434 requests for financial assistance with medications, lab costs, eviction prevention, utility turn-off, security deposits and furnishing apartments when
moving into independent living. In total, BMHS granted approximately $101,230 in need-based funds on a case-by-case basis.

**Repurposing Funds to Keep Needed Resources in Baltimore City**

- Improved compliance in fiscal reporting enabled BMHS to identify unspent grant funds and repurpose them to 11 providers in good standing as one-time supplemental grant awards. Awards totaling $64,334 met a range of needs: computers, telephone system upgrades, medication for undocumented consumers, community education materials, peer-to-peer education, and Wellness and Recovery Action Plan (WRAP) facilitator training.

**Improved Monitoring and Oversight of Provider Contracting**

- BMHS’ management of public grant funds is being refocused on quality, i.e., maximizing positive outcomes for Baltimore City residents in need of public mental health services, through the development and implementation of a five-year quality management plan. FY 11 objectives include: i) developing two quality outcomes (*beneficial impact of services and consumer perception*) on which providers will report, and ii) implementing a protocol with corrective action requirements for programs not meeting contractual programmatic requirements.

- Efforts to strengthen relationships with contracted providers resulted in more timely submission of quarterly fiscal reports. Provider compliance improved from 50% at the beginning of FY 09 to an average of 60% throughout FY 10 and nearly 70% by the end of the fiscal year.

**PREPARING FOR FEDERAL HEALTH CARE REFORM**

The Affordable Care Act (ACA) became law in March, 2010. The passage of federal health reform legislation presents both opportunities and challenges, among them, to increase access to mental health services through expanded Medicaid eligibility; to better integrate mental health services with substance abuse and somatic health services; and to expand prevention and improve quality. BMHS is eager to take advantage of health care reform to benefit Baltimore City residents at risk of mental illness or with mental health treatment needs. In FY 10, BMHS began to prepare for the changes ahead. This will continue to be an important area of focus for BMHS over the next several years. The steps taken toward health care reform and the integration of care include:

- Through affiliations with the National Association of County Behavioral Health & Developmental Disability Directors, Maryland Association of Core Service Agencies, and Mental Health Association, BMHS has sought to understand this complex legislation and its implications for mental health, and monitored the federal and state planning activities related to its implementation.
• BMHS established ongoing meetings with Baltimore Substance Abuse Systems (bSAS), the local substance abuse authority, to discuss what integrated mental health and substance abuse services should look like in Baltimore City.
GOAL I: Americans Understand that Mental Health is Essential to Overall Health.

Objective 1.1: Baltimore Mental Health Systems (BMHS) will increase public awareness of mental health disorders, prevention mechanisms, treatment services, and supports.

Status: All strategies were accomplished.

Strategy 1: Provide direction, funding and ongoing consultation to organizations that implement public education and training activities.

Action Step: Support organizations that provide public educational workshops, distribute educational literature, and offer information and referrals:

- Mental Health Association of Maryland (MHAMD);
- National Alliance on Mental Illness (NAMI);
- Maryland Coalition of Families for Children’s Mental Health;
- On Our Own of Maryland.

BMHS continued to support the agencies listed above, which provide outreach and education to a wide variety of audiences on a range of topics. In FY 10, over 31,000 individuals received training, participated in educational programs, or attended workshops sponsored by these agencies.

Indicator: Report on progress to date.

MHAMD held 272 performances of the “Kids on the Block” and distributed 29,148 publications, including a Spanish Teacher Resource Kit, various fact sheets, a Trauma Kit, and a “Healthy in Body and in Mind” brochure. MHAMD also participated in 37 health fairs, and conducted 13 trainings on mental health issues among older adults.

NAMI served 175 family members through six 12-week Family-to-Family courses, and conducted 65 workshops about mental health topics, with 1,284 individuals attending. Thirty-one consumers were trained as mentors to teach the peer-to-peer education course, which 106 consumers completed. Eighteen family members completed the train-the-trainer course. NAMI also held their annual NAMI Walk, a public education event that promotes awareness of mental illness. Over 1,000 individuals participated, including a BMHS team.

Maryland Coalition of Families for Children’s Mental Health held 10 webinars with 145 participants and 3 family leadership trainings with a total of 200 participants. They also
responded to 262 calls for information, referral or support. In addition, they participated in a statewide campaign for Children’s Mental Health Awareness Day.

On Our Own of Maryland held 3 workshops/trainings addressing topics such as cultural and linguistic competence and trauma. In addition, they completed 61 presentations dealing with the stigma of mental illness with 1,174 participants, and worked with 11 local consumer-run organizations through their participation in various educational events.

**STRATEGY 2: Participate in community events that promote awareness of mental health.**

**Action Step:** Coordinate participation of mental health providers in community events.

In coordination with the Baltimore City Health Department (BCHD), BMHS participated in community health fairs and distributed information on mental illness and community resources, such as Network of Care. BMHS staff participated in 23 health fairs across the City, which were held at various locations, including churches, recreation facilities and other community-based facilities. BMHS staff organized three targeted community events in which Youth Motivating Others through Voices of Experience (Youth MOVE) was introduced to each community and provided information on youth-guided care and self-advocacy. (Youth MOVE is a youth-led organization devoted to improving services and systems that support positive growth and development.)

**Action Step:** Provide education and outreach regarding depression and available mental health services through the Behavioral Health Leadership Institute’s (BHLI’s) Poverty and Depression Project Connections.

The education of paraprofessionals, clients and community stakeholders is an ongoing effort of the Poverty and Depression Project Connections (hereafter “Project Connections”). During the past year, Project Connections continued to provide training to paraprofessionals on mental health issues at five community sites, and provided informal educational groups to clients about symptoms of depression, parenting skills and issues, and other relevant topics. The educational activities were directed at reducing stigma about mental health treatment among both outreach workers and clients. As an outcome of the training, more clients have been referred and given appointments.

**Indicators:** Number of community events.

<table>
<thead>
<tr>
<th>Community Event</th>
<th>Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>23 Health Fairs</td>
<td>1,900*</td>
</tr>
<tr>
<td>Project Connections Staff Training Series</td>
<td>25</td>
</tr>
<tr>
<td>Client Education Groups at 5 Project Connections Sites</td>
<td>25</td>
</tr>
<tr>
<td>Training for YO! Center Staff</td>
<td>20</td>
</tr>
</tbody>
</table>

*Estimated
STRATEGY 3: Collaborate with the Baltimore City Health Department (BCHD) to identify opportunities to provide educational information about mental health issues to the somatic care sector.

**Action Step:** Reach out to staff at BCHD, with priority to those working with populations at high risk for mental health disorders.

BMHS participates on the B’more for Healthy Babies steering committee, and staff collaborated with BCHD to promote the “ABC’s of Safe Sleep,” a component of the B’more for Healthy Babies initiative to improve birth outcomes in Baltimore City. Presentations were given at service provider meetings throughout the year.

**Indicator:** Report on progress to date.

See above for progress to date.

<table>
<thead>
<tr>
<th>Objective 1.2: BMHS will educate public safety personnel regarding current information about mental illness, managing mental health emergencies and available services.</th>
</tr>
</thead>
</table>

**Status:** Strategy 1 was accomplished. Strategy 2 was partially accomplished.

STRATEGY 1: Improve the capacity of the City’s police officers, Downtown Partnership Safety Guides and other public safety personnel like parole and probation officers, 911 operators and correctional officers, to respond to psychiatric emergencies.

**Action Step:** In collaboration with the Baltimore Police Department, provide leadership to the Behavioral Emergency Services Team (BEST) to train police officers.

Significant progress was made with the BEST project this past year. The BEST project trains police officers in crisis intervention to de-escalate mental health crises, minimize arrests, and decrease officer injury. The decision made in FY 09 to train all new recruits was the focus for all activities for the project in FY 10. Three classes were held, and 86 new patrol officers were trained. This is a 34% increase from FY 09 and the largest number of officers trained in a one-year period since the project’s inception in January 2004. The Police Department predicts that if the project maintains the same pace of training, almost all patrol officers will have received the training after approximately three years. To facilitate ongoing training of all new recruits, steps are being taken to fully embed this training into the activities of the Police Department’s Education and Training Division.
**Action Step:** Collaborate with public safety organizations to identify opportunities to provide educational information about mental health issues.

The focus of training this year for the BEST project was on new police recruits. The addition of the Sheriff’s Deputies and Downtown Partnership Safety guides will be explored next year.

**Indicators:** Number of personnel trained; report on progress to date.

86 Baltimore City police officers were trained in FY 10. See above for progress to date.

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**GOAL II: Mental Health Care is Consumer- and Family-Driven.**

**Objective 2.1:** Promote efforts that facilitate recovery and build resiliency.

**Status:** All strategies were accomplished.

**STRATEGY 1:** Promote and support consumer-operated programs.

**Action Step:** Provide direction, funding, and consultation to the City’s three Wellness & Recovery Centers: Helping Other People through Empowerment (HOPE), On Our Own, and Hearts and Ears.

Wellness and Recovery (formerly Drop-In) Centers continue to be a vital component of the City’s public mental health system. On Our Own added a new site this fiscal year and converted an existing site to specialize in serving transitional age youth, a priority population for the public mental health system. Both of these developments will enhance access for City residents to Wellness and Recovery Centers. Between FY 09 and FY 10, there was a 9% decrease in the number of consumers served by the Wellness and Recovery Centers, with notable decreases at Helping Other People through Empowerment (HOPE) and Hearts and Ears. This is most likely related to the relocation of both of these programs, and to significant staff and board turnover at Hearts and Ears. Although fewer individuals were served by the City’s Wellness and Recovery Centers this year, it should be noted that the added site will likely increase access to Wellness and Recovery Center services, and the site for transitional age youth has the potential to increase access for this underserved population.

Baltimore’s three Wellness and Recovery Centers continue to provide consumer-centered peer support services, and have been serving a vital role in promoting the use of Wellness Recovery Action Plan (WRAP) among the City’s consumers. The Centers have worked to sustain On Our Own’s WRAP project by recruiting and training consumers as peer WRAP facilitators.
The chart below details the peer support and educational services provided by the Centers. The distribution of services by type has shifted, with an overall decrease (34%) in the number of peer support sessions and overall increases in the number of outreach sessions (55%) and educational forums (139%). This shift may be due to a revision in the definition of peer support sessions to promote consistency in reporting among all of the State’s centers.

<table>
<thead>
<tr>
<th>Wellness and Recovery Center</th>
<th>Outreach Sessions</th>
<th>Peer Support Sessions</th>
<th>Educational Forums</th>
</tr>
</thead>
<tbody>
<tr>
<td>On Our Own</td>
<td>17</td>
<td>59</td>
<td>7</td>
</tr>
<tr>
<td>Helping Other People Through Empowerment</td>
<td>16</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>Hearts and Ears</td>
<td>26</td>
<td>60</td>
<td>16</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>59</strong></td>
<td><strong>159</strong></td>
<td><strong>43</strong></td>
</tr>
</tbody>
</table>

**Indicator:** Number of consumers served.

<table>
<thead>
<tr>
<th>Number of Consumers Served by Wellness and Recovery Centers</th>
<th>Consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td>On Our Own</td>
<td>380</td>
</tr>
<tr>
<td>Helping Other People Through Empowerment</td>
<td>260</td>
</tr>
<tr>
<td>Hearts and Ears</td>
<td>155</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>795</strong></td>
</tr>
</tbody>
</table>

**STRATEGY 2: Increase implementation of consumer-centered practices such as Wellness and Recovery Action Planning (WRAP), use of peer staff and consumer-directed recovery planning.**

**Action Step:** Provide direction, funding and ongoing consultation to the Human Services Training program at Goodwill, Inc. that trains consumers for employment in the human services field.

The Human Services Training program at Goodwill enrolled 65 consumers in the training program for careers in public mental health, a 5% increase from FY 09. Of those enrolled, 34 (52%) graduated from the training compared to 34 (55%) in FY 09. As of June 30, 2010, 15 (44%) of the graduated consumers were employed and the remaining 56% were seeking employment.

**Action Step:** Facilitate collaboration between On Our Own, Inc. WRAP trainers and providers to promote the use of WRAP in clinical settings.

WRAP trainings offered by On Our Own, Inc. were promoted at BMHS provider meetings with particular emphasis on those programs that are required to provide peer support services, such as ACT teams. As a result of the support received from BMHS, the Capitation providers had several clients participate in the training and one ACT team had their peer support specialist participate. In addition, On Our Own, Inc. received enhanced funding,
secured through the repurposing of BMHS state block funds, to conduct an advanced WRAP training for individuals that have already received the basic training.

**Action Step:** Provide education and technical assistance to providers in implementing practices targeted at assisting consumers to move to their defined next level of recovery.

Methods to better facilitate recovery for consumers were discussed with the two Capitation providers, Creative Alternatives and Chesapeake Connections. Policies were reviewed and practices were changed to reflect a more consumer-driven approach to treatment planning. Creative Alternatives initiated a consumer needs assessment to obtain direction from program participants on how the recovery work of the program could be strengthened. Chesapeake Connections continued efforts to strengthen the program’s capacity to assist participants in obtaining employment, a priority identified by consumers.

At the request of On Our Own, Inc., BMHS staff participated in a review of the curriculum for the State’s certification of peer support specialists. This training is being piloted on the Eastern Shore with much success, and BMHS is collaborating with On Our Own, Inc. to develop a plan to market the certification training in Baltimore City.

**Indicators:** Number of consumers served; report on progress to date.

See above for numbers served and progress to date.

**STRATEGY 3: Increase consumer input in evaluation of mental health services.**

**Action Step: Participate in Consumer Quality Team (CQT) Project.**

The Consumer Quality Team (CQT) Project consists of consumers and/or family members conducting on-site interviews with consumers enrolled in public mental health services to evaluate consumer satisfaction with these programs and identify issues needing attention. BMHS participated in the workgroup, which evaluates the interviews for the Project and issues findings. The workgroup includes representatives from advocacy groups, MHA, Community Behavioral Health (CBH) and other core service agencies. The workgroup reviewed the findings of the consumer interviews and followed up with providers regarding consumers’ concerns. Many consumers voiced concerns about benefits, and the impact of employment and retaining ongoing benefits.

BMHS also participated in a feedback group, which reviewed the findings and discussed issues such as improving and expanding CQT to the entire state.

**Indicators:** Number of mental health programs participating in CQT.

In Baltimore City, 105 consumers were interviewed during 27 visits to 8 psychiatric rehabilitation programs (PRPs). Statewide, CQT teams made 180 site visits to PRPs in 11 jurisdictions and interviewed 1,018 consumers.
**Action Step:** Interview at least one-third of residents in residential rehabilitation program (RRP) housing to assess their level of satisfaction with housing and services.

BMHS exceeded the Department of Health and Mental Hygiene’s (DHMH’s) expectation that one-third of residents be interviewed each year. Baltimore City RRP's had the capacity to provide housing for 383 residents at the time of the annual inspection, and 339 beds were filled, with 44 vacant beds. The number of residents fluctuates throughout the year as residents leave housing for various reasons. Interviews focusing on resident satisfaction with housing conditions, mental health services and other topics were conducted individually in as private an area as possible, and participation was voluntary. On average, over 90% of residents reported being satisfied with their homes and the services. BMHS staff met with the RRP providers during the annual inspection to share any concerns that were noted during the interviews, and a written report was sent to each program following the site visit. Providers worked with consumers and BMHS staff to resolve identified concerns.

**Indicators:** Percentage of RRP residents interviewed.

BMHS staff interviewed 195 of the 339 residents, representing 58% of the residents living in RRP's at the time of the annual inspection.

97% of residents reported that the services they receive are helpful, and 93% would recommend the program to people with similar needs. Additionally, 19% were currently employed, 53% were not employed but would like to be, and 29% did not want employment at the time of the survey. (Survey results can be found in Appendix B).

**Objective 2.2:** Help families be active advocates for their children on the system, program and individual level.

**Status:** All strategies were accomplished.

**Strategy 1:** Increase family input in planning and evaluation of mental health services.

**Action Step:** Elicit feedback from family support and advocacy organizations concerning unmet child and family mental health service needs.

Within the framework of the MD-CARES System of Care Cooperative Agreement, BMHS worked closely with the Maryland Coalition of Families for Children’s Mental Health (hereafter “the Coalition”) to increase parental involvement in the governance structure that oversees MD-CARES. Additionally, BMHS staff worked with the Coalition to identify both youth and parent leaders to develop family-friendly policies that delineate standards for the System of Care. BMHS and the Coalition plan to continue developing the partnership, with the goal of identifying solutions to address previously identified unmet service needs.
**Action Step:** Provide funding, oversight, and evaluation of Planned Respite services, an expressed service priority for families.

In FY 10, Villa Maria served a total of 45 youth in the Planned Respite program, 15 of whom were served in facility-based respite care and 30 of whom were served in home-based care. The total number of youth served represents a 10% decrease over the number of youth served in FY 09 and an 18% increase over the number of youth served in FY 08. Although these are typical fluctuations seen in this type of program, the number of children receiving respite services in the fee-for-service system increased, offsetting the minor decrease served in this grant-funded program.

**Indicators:** Number of youth receiving planned respite services; composite summary of family satisfaction with planned respite.

The Mental Health Association of Maryland (MHAMD) conducted 30 interviews with 15 parents and 15 children who received Planned Respite services. Overwhelmingly, families reported that regular access to respite services helped avert future crises and reduced parent and family stress levels. 100% of those surveyed stated that they would recommend respite services to other families.

Overall, families reported being satisfied with respite services, with 93% of parents rating the services as “very good,” and 86% of children rating services as “excellent” or “good”. The satisfaction rates for both families and children increased in FY 10 from FY 09.

![Parent Satisfaction with Respite Services](chart1.png)
![Child Satisfaction with Respite Services](chart2.png)

**STRAtegy 2:** Promote leadership development and advocacy skills among families.

**Action Step:** Provide funding and support to the Maryland Coalition of Families for Children’s Mental Health (the Coalition) for their sponsorship of family leadership trainings.

The Coalition provided family leadership trainings to support families. Evaluations for the family leadership trainings showed a 100% satisfaction rate among participants that
submitted evaluations. In addition, the Coalition provided peer-to-peer training and family-to-family support, and conducted workshops on infrastructure development for family-serving organizations. The Coalition also responded to over 262 information requests (a service BMHS does not fund them to provide).

**Indicator:** Number of family members who attended leadership training.

A total of 55 family members attended 3 family leadership trainings.

<table>
<thead>
<tr>
<th>Objective 2.3: Promote family-driven and family-centered initiatives.</th>
</tr>
</thead>
</table>

**Status:** All strategies were accomplished.

**Strategy 1:** Provide support and consultation to family-centered initiatives implemented in Baltimore City.

**Action Step:** Participate in statewide and local planning for the implementation of home- and community-based wraparound services for youth involved in the child welfare system that would otherwise require group home placement.

BMHS staff participated in state and local planning in an effort to reduce the number of DSS-involved youth entering group homes. Staff worked closely with the Care Management Entity, Wraparound Maryland, and other stakeholders to remove barriers for youth in need of community-based services via the wraparound process. Ten youth were enrolled in Wraparound Maryland, where they received care coordination, mental health and supportive services in their home or community in lieu of being placed in a group home. Wraparound Maryland has provided Place Matters (DSS’ group home diversion program) with a total of 25 slots for DSS-involved youth. With ten youth enrolled this year, there are slots for an additional 15 youth to enroll to receive community-based wraparound services, preventing the need for group home placement.

**Indicator:** Report on progress to date on implementation.

There was a 61% decrease in the total number of youth served in the High Fidelity Wraparound Initiative due to the elimination of two funding streams, Rehab Options and the Community Support Initiative.

<table>
<thead>
<tr>
<th>High Fidelity Wraparound Initiative</th>
<th>Population/Funding Stream</th>
<th># Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTC Waiver</td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>MD-CARES</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>Group Home Diversion - DJS</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Group Home Diversion - DSS-Place Matters</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>63</td>
</tr>
</tbody>
</table>
Objective 2.4: Protect and enhance the rights of individuals in need of mental health services.

**Status:** All strategies were accomplished.

**STRATEGY 1: Oversee the complaint process for consumers and families.**

**Action Step:** Investigate and attempt to resolve all consumer and family complaints.

**Complaints**

BMHS received 41 complaints from consumers, advocates and family members this year, a 30% increase compared to FY 09. Complaints were primarily related to quality of care issues and HIPAA\(^7\) concerns. BMHS staff worked with consumers, family members, advocates and service providers to resolve complaints. Twenty-nine (71%) of the 41 complaints were resolved through BMHS intervention, with support from MHA, as needed. Twelve complaints were placed in an unresolved status, following BMHS’ investigation. Nine of the 12 unresolved complaints involved Therapeutic Behavioral Services (TBS). Because many providers lack adequate understanding of TBS regulations, MHA and ValueOptions (the administrative services organization (ASO) for the Public Mental Health System) provided trainings to TBS providers. The 12 unresolved complaints were forwarded to MHA for further action.

**Level III Appeals/Grievances**

Code of Maryland Regulations (COMAR) 10.09.70.08 provides mental health consumers with the right to file a grievance to request re-evaluation or review of a previous medical necessity decision that resulted in non-authorization of services. Consumers or providers may file an appeal on behalf of the consumer; however, only a physician can deny services. There are three levels in the appeal process:

- Level I appeals are reviewed by a physician advisor at the ASO;
- Level II appeals are reviewed by the medical director at the ASO; and
- Level III appeals are sent directly to BMHS as the core service agency. BMHS contracts with a psychiatrist to perform these appeal reviews.

BMHS staff complete the initial review of documents submitted by the provider and forward it to the psychiatrist. BMHS staff processed 31 Level III grievances in FY 10, compared to 50 grievances processed in FY 09. The decrease could be attributed to two events: 1) MHA determined in FY 09 that all Level III grievances have to be filed nine months within the date

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\(^7\) The Health Insurance Portability and Accountability Act (HIPAA) protects the privacy of individually identifiable health information and sets national standards for the security of electronic protected health information.
of service (prior to that determination, CSAs were receiving Level III grievances for services provided years earlier), and 2) a change in the ASO from MAPS-MD to ValueOptions in August 2010. BMHS upheld 71% of grievances in FY 10, compared to 36% in FY 09. This is likely due to a more consistent application of medical necessity criteria by VO compared to the previous ASO.

All of the consumers on whose behalf the grievances were filed received services, as grievances were filed retroactively to collect payments by providers. Seventy-one percent of the ASO denials were upheld by the BMHS psychiatrist based on lack of sufficient clinical documentation to support medical necessity for services provided. All grievances were processed and responses sent to providers, the ASO, and MHA within the specified timeframes.

**Indicator:** Number of complaints received/resolved; number of grievances processed.

BMHS received 41 complaints; 29 were resolved by BMHS, and 12 were forwarded to MHA for further action. BMHS staff processed 31 grievances as shown below.

<table>
<thead>
<tr>
<th>Total Grievances</th>
<th>Adults</th>
<th>Child &amp; Adolescent</th>
<th>Inpatient</th>
<th>RTC</th>
<th>Outpatient/ER/PHP</th>
<th>PRP</th>
<th>Denials Overturned</th>
<th>Denials Partially Overturned</th>
<th>Denials Upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>26</td>
<td>5</td>
<td>24</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>5 (16%)</td>
<td>4 (13%)</td>
<td>*22 (71%)</td>
</tr>
</tbody>
</table>

*All consumers received services. Appeals filed were for payment after service delivery. Denials were upheld due to insufficient documentation to support medical necessity for services provided.

**GOAL III: Disparities in Mental Health are Eliminated.**

**Objective 3.1:** Improve access to culturally and linguistically competent public mental health services for racial and ethnic minority individuals.

**Status:** All strategies were accomplished.

**Strategy 1:** Recruit and retain racial and ethnic minorities and multi-lingual professionals in the mental health services workforce.

**Action Step:** Provide direction, funding and ongoing consultation to the Maxie Collier scholarship program at Coppin State University, which encourages minority students to pursue careers in mental health.

The Maxie Collier scholarship program had eight students enrolled in classes in FY 10. Five scholars graduated and three scholars completed internships. Internship sites included Project
Plase, Inc., Bon Secours Hospital’s targeted case management program, and Jumoke, Inc., a psychiatric rehabilitation program.

In collaboration with the Maxie Collier scholarship program, Coppin State offers a course entitled “Emerging Issues in Mental Health,” which is open to all students and intended to increase the number of students who are exposed to the mental health field. Representatives from the provider community, the Mental Hygiene Administration, core services agencies, and the mental health advocacy community regularly present as part of the curriculum. Fifty students completed this class in FY 10.

**Indicators:** Number of students enrolled by discipline.

<table>
<thead>
<tr>
<th>Maxie Collier Scholars (n=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discipline</td>
</tr>
<tr>
<td>Social Work</td>
</tr>
<tr>
<td>Nursing</td>
</tr>
<tr>
<td>Psychology</td>
</tr>
<tr>
<td>Interdisciplinary Studies</td>
</tr>
<tr>
<td>Natural Sciences</td>
</tr>
</tbody>
</table>

**Strategy 2:** Develop collaborations with community-based organizations working to increase understanding of mental health issues and to improve access for services among racial, ethnic and linguistic minorities.

**Action Step:** Provide direction, funding and ongoing consultation to the Black Mental Health Alliance for Education and Consultation in promoting awareness of the needs of African Americans with mental illness and offering information, support and referrals to individuals and families.

The Black Mental Health Alliance (BMHA) continued to advocate for mental health issues, providing consultation to 85 community-based providers regarding issues of culture and mental illness. Through collaborations with other advocacy organizations, BMHA organized National Minority Mental Health Month awareness activities and sponsored an annual conference.

**Indicator:** Report on progress to date.

Through support groups, information, referrals, educational programs and individual support services, BMHA served 286 families and provided consultation to 85 providers.

**Strategy 3:** Increase understanding of unmet need and associated barriers to mental health care for Baltimore City’s growing Latino population.
**Action Step:** Conduct a needs assessment of mental health treatment access/barriers and generate actionable recommendations.

In FY 09, BMHS conducted a needs assessment focusing on the mental health service needs of the City’s Latino residents. It was based on published literature, key informant interviews, and focus groups with Baltimore City mental health clinicians, community center providers, Latino mental health consumers, and Latino and mental health advocacy organizations. The focus groups identified specific challenges and barriers to serving the City’s Latino population. As a result, four recommendations to improve access to mental health care for City Latinos were put forth. This report, entitled Mental Health Service Needs of Latinos in Baltimore City, was released in FY 10 as part of BMHS’ FY 09 Annual Report.

The four recommendations identified in the report include:

1. Integration of mental health care with existing community-based programs serving Latinos
2. Targeted development of a Latino/bi-lingual mental health workforce
3. Creation of a web-based Latino/bi-lingual resource within the City’s Network of Care website
4. Initiation of a Baltimore City Latino Mental Health Provider Coalition

The recommendation to create a web-based Latino/bi-lingual resource within the City’s Behavioral Health Network of Care website was selected for implementation in FY 10. It was subsequently learned that Network of Care has a Spanish translation for some sections of the website. A proposal is being developed to translate the remaining two sections, while at the same time BMHS is investigating whether the State will be able to identify continued funding for Network of Care.

**Indicator:** Report on progress to date.

See above for progress to date.

**STRATEGY 4: Collaborate with faith-based organizations to reduce barriers resulting from religious beliefs about mental illness and treatment.**

**Action Step:** Provide direction, funding and ongoing consultation to the Institute for Mental Health Ministry in sponsoring educational programs that target racial and ethnic minorities.

The Center for the Integration of Spirituality and Mental Health (CISMH), formerly known as the Institute for Mental Health Ministry, conducted outreach to local churches to provide information on mental illness and reduce stigma. Specifically, CISMH coordinated and implemented Mental Health Promotion Sunday, a day when participating churches conduct a mental health ministry. Sermons were focused on mental health topics and depression. 
screensings were conducted with the goal of identifying mental health needs in the congregations.

**Indicator:** Report on progress to date.

CISMH conducted Mental Health Promotion Sunday in 3 churches and provided 403 depression screenings in FY 10.

**Objective 3.2:** Improve access to mental health services for special populations that are underserved by the public mental health system.

**Status:** Strategies 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, and 13 were accomplished. Strategies 9 and 14 were partially accomplished.

**STRATEGY 1:** Provide direction, funding and ongoing consultation to agencies that serve transitional age youth.

**Action Step:** Contract with a vendor(s) to provide residential rehabilitation and case management services for youth who have complex mental health and social needs.

BMHS funded two vendors to provide residential rehabilitation and case management services for transitional age youth (TAY), those 18-24 years old. People Encouraging People (PEP) and the University of Maryland Medical Center (UMMC) were funded to provide enhanced support, which includes increased supervision, rehabilitation, and case management services to better address the complex presenting needs of transitional age youth.

**Action Step:** Provide technical assistance to child and adolescent mental health providers and other child serving systems regarding accessing the adult system and strategies to assist youth in developing skills needed for success in the adult system.

The Local Coordinating Council (LCC) is charged with reviewing cases of youth placed into in-state and out-of-state residential facilities to ensure that these placements are the least restrictive possible in order to promote greater youth autonomy. All referred TAY individuals who meet Medicaid eligibility criteria are encouraged to complete and submit applications to the appropriate CSA in order to ensure a smooth and timely transition to adult services.

**Action Step:** Provide funding to offer on-site mental health services to transitional age youth enrolled in Baltimore City Youth Opportunity (YO!) Centers.

BMHS funded two Youth Opportunity (YO!) centers in Baltimore: YO! Center in East Baltimore located within the Historic East Baltimore Community Action Center and YO! Center Westside in West Baltimore. The YO! Centers serve youth who are at risk for dropping out of school. The YO! Centers also have the capacity to provide mental health assessment and some treatment.
**Indicators:** Number of youth who receive services; report on technical assistance provided

In FY 10, approximately 10% of the youth referred to LCC were TAY consumers; 8 of the Certificates of Need (CON) reviewed by BMHS were for TAY consumers; and 44 of the placements reviewed by the LCC were for TAY consumers. BMHS staff provided technical assistance on all cases, which resulted in 100% of TAY being referred on to adult services within the PMHS.

<table>
<thead>
<tr>
<th>TAY Contracts</th>
<th># Individuals Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEP Case Management</td>
<td>15</td>
</tr>
<tr>
<td>PEP Enhanced RRP</td>
<td>9</td>
</tr>
<tr>
<td>UMMC Enhanced RRP</td>
<td>6</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>

A total of 17 gang prevention groups were held at each YO! Center. In addition, 142 individuals received mental health screenings, and 135 youth received ongoing treatment services. This is a 62% decrease in the number of individuals served between FY 09 and FY 10, which correlates with the 66% reduction in funding for this project in FY 10 by the Department of Labor.

**Strategy 2: Facilitate access to treatment for war returnees, especially those from Iraq and Afghanistan.**

**Action Step:** Make available free mental health treatment by contracting with a vendor to recruit and provide specialized training for volunteer mental health professionals.

The Pro Bono Counseling Project continued to provide free mental health treatment services to veterans and war returnees by utilizing a network of volunteer clinicians. In FY 10, 80 individuals received information and referral, and 48 of those individuals were linked with a clinician for free mental health care. A total of 373 hours of clinical services were provided statewide.

While two fewer individuals were served this year compared to FY 09, the total number of clinical hours increased by 41%, indicating that individuals received counseling for longer periods of time. Of all services provided, 33% were provided to Baltimore City residents, which is an increase from 15% in FY 09. In addition, the Pro Bono Counseling Project recruited 50 new clinicians to the program, and sponsored a one-day training for therapists who will be working with veterans and other war returnees throughout the State. Sixty-three therapists participated in the training.
**Action Step:** Support implementation of Maryland’s Commitment to Veterans, a 3-year national pilot project established by Senate Bill 210, and funded by the State of Maryland in an effort to assist combat veterans and their families in accessing mental health services.

For the first year of this project, the Veterans Resource Coordinator was housed at BMHS. This co-location aided in the collaboration between Baltimore City service providers and the Veteran’s network. The Veteran’s Resource Coordinator attended BMHS staff meetings,
provider meetings and homeless outreach advocate meetings. In addition, BMHS staff provided day-to-day support for the Veteran’s Resource Coordinator in understanding the public mental health system. The Veteran’s Resource Coordinator was relocated to a more central location in Maryland, but BMHS remains a resource for the Maryland’s Commitment to Veterans program.

**Indicator:** Number of individuals served.

80 individuals received information and referral from the Pro Bono Counseling Project, and 48 of those individuals were linked with a clinician for free mental health care.

**STRATEGY 3: Provide direction, funding and/or ongoing consultation to agencies that interact with individuals involved with the criminal justice system.**

**Action Step:** Divert individuals from incarceration by providing support and technical assistance to the Baltimore City Mental Health Court, Forensic Assertive Community Treatment Team (FACTT) and Forensic Alternative Services Team (FAST).

BMHS provided support to the Baltimore City Mental Health Court, FACTT, and FAST throughout the year. BMHS staff regularly attended meetings with Mental Health Court personnel. Access to services within the Public Mental Health System and the role of the service providers in serving court-involved clients were recurring topics. BMHS released *Mental Health Services for Adults in Baltimore City*, a document that was created to be a training guide to educate court personnel on the different service levels available in the Public Mental Health System (available in Appendix C). The goal of the document is to create more of an alignment between the Court’s requests for services and those services available in the community. To further align the Court’s expectations of available community services, an outreach campaign was undertaken by BMHS with assistance from FAST to four mental health providers selected by the Mental Health Court. The outreach effort focused on educating providers on the Court’s role, the provider’s role in serving a client with court involvement, and how to optimize communication to best serve the client.

FAST continued to provide jail diversion activities and actively participate in Mental Health Court. FAST screened 882 individuals and conducted 563 face-to-face assessments to determine eligibility for services and possible return to the community. FAST relies on the judicial system for the majority of its referrals, which determines the number of individuals who receive screening and assessments. In addition, FAST monitored 46 individuals in the community as a part of court-ordered release plans.
FACTT, a specialized ACT team, continued to provide intensive services to individuals with court involvement or forensic histories. Outcomes data reported to BMHS show that in FY 10, 57% of those receiving services in FACTT were referred from State hospital facilities and 10% from jails.

**Action Step:** Collaborate with the Baltimore City Jail and the Department of Corrections to develop community transition plans for defendants prior to release from incarceration.

Collaboration with the Department of Corrections (DOC) continued in order to implement a statewide process by which community transition plans for sentenced defendants are developed prior to release from incarceration. In FY 10, BMHS received 101 DOC referrals. Of the 101 individuals referred, 81 appointments for PMHS services were made for 76 individuals. Of the 81 appointments, only 24 (30%) were kept. Because the no-show rate (70%) was so high, the project is being re-examined by BMHS, the Department of Corrections and other stakeholders to determine the most effective method to coordinate community services for defendants before release from incarceration.

**Action Step:** Provide technical assistance to the Chrysalis House Healthy Start Program, which serves pregnant and post-partum women and their babies as an alternative to incarceration, to promote healthy, positive attachments between the mothers and their babies enrolled in the program.

Chrysalis House activities for FY 10 focused on enhancing the service array and building collaborations with referral sources to increase the number of individuals utilizing services. The program was successful in expanding the referral base and enrolled 12 new women for a total of 19 women served in FY 10, an increase of 2 from FY 09. For those women who moved into independent housing, financial assistance to purchase start-up furniture was provided by BMHS. In collaboration with the Mental Hygiene Administration, a researcher
was recruited to provide ongoing evaluation of the program and technical assistance on an as-needed basis.

**Action Step:** Assist State Hospital facilities to assess and refer those individuals with forensic histories to the appropriate level of care in the community.

BMHS employs a Referrals Coordinator to manage the referral process for residential rehabilitation programs, the Forensic Assertive Community Treatment Team and the Capitation Project. Communication occurred almost daily with State hospital facilities to ensure that individuals with forensic histories being discharged from these facilities were given priority for vacancies in the above programs. For a more detailed report, see report of progress for adults on page 59.

**Indicators:** Number of individuals served.

<table>
<thead>
<tr>
<th>Program</th>
<th># of Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAST</td>
<td>882</td>
</tr>
<tr>
<td>FACTT</td>
<td>120</td>
</tr>
<tr>
<td>Chrysalis House Healthy Start</td>
<td>19</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,021</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program</th>
<th># of Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>RRP</td>
<td>33</td>
</tr>
<tr>
<td>Capitation Project</td>
<td>14</td>
</tr>
<tr>
<td>FACTT</td>
<td>10</td>
</tr>
<tr>
<td>Geriatric Community Placements*</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>59</strong></td>
</tr>
</tbody>
</table>

*Coordinated by the Psychogeriatric Nurse Coordinator

**Strategy 4:** Fund mental health services targeted to individuals who are deaf and hard of hearing.

**Action Step:** Contract with a vendor to provide residential rehabilitation, psychiatric rehabilitation, and outpatient mental health treatment services to this population.

BMHS continued to fund People Encouraging People, Inc. to provide signing services for individuals that are deaf and hard of hearing. The services provided were residential rehabilitation, psychiatric rehabilitation, outpatient mental health treatment and supported employment.
**Indicators:** Number of individuals served and level of care received.

A total of 17 unduplicated individuals who are deaf or hard of hearing received signing services in the following levels of care:

<table>
<thead>
<tr>
<th>Level of Service</th>
<th># Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Rehabilitation</td>
<td>17</td>
</tr>
<tr>
<td>Outpatient Mental Health Treatment</td>
<td>15</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>8</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>5</td>
</tr>
</tbody>
</table>

**Strategy 5:** Fund mental health services targeted to individuals with traumatic brain injury (TBI).

**Action Step:** Contract with a vendor to provide individualized therapeutic activities in a residential setting, including life skill services and family supports.

BMHS funded Mary T. Maryland to provide residential services for up to four individuals with traumatic brain injury. Services are individualized and based upon a thorough assessment of the individual’s needs. Because the four individuals enrolled in the program were ineligible for the Medicaid waiver, which would otherwise cover their cost of care, there was no turnover in the program in FY 10.

**Action Step:** Monitor placements and plans of care for consumers identified by MHA who have a TBI.

BMHS staff continues to collaborate with MHA and Mary T. Maryland to identify clients who are appropriate for placement and to monitor clients’ progress in residential treatment. As mentioned previously, there was no turnover in the program this past year.

**Indicator:** Number of individuals served.

4 individuals with TBI received residential support services.

**Strategy 6:** Provide funding and/or consultation to programs that offer outreach or mental health services to individuals and families who are homeless.

**Action Step:** Provide leadership to the multi-agency coalition of homeless outreach advocates and providers known as the Hands in Partnership (HIP) initiative to identify, engage and coordinate outreach services to individuals experiencing homelessness.

In collaboration with the Mayor’s Office of Human Services (formerly Baltimore Homeless Services) and Baltimore HealthCare Access, BMHS continued to co-facilitate HIP. The goal of HIP is to provide coordinated, goal-directed outreach to homeless individuals on the street.
or in the City’s emergency shelter. Using HUD and PATH dollars, BMHS funds five outreach teams to participate in HIP. In FY 10, outreach service providers met weekly to coordinate services to homeless individuals. Data are tracked and analyzed to ensure accountability and to document the movement of clients from the street to permanent housing. Training of outreach workers and resource sharing is a regular aspect of HIP, with presentations from outside entities occurring at least monthly.

In FY 10, 341 documented individuals received outreach services through HIP, a 63% increase from FY 09 due to an increased availability of housing choice vouchers and the improved efforts and coordination of HIP. Of the 341 individuals, 132 (39%) were confirmed as having a mental illness and an additional 131 (38%) self-reported a mental illness that was not confirmed. One hundred and thirty-eight (40%) of the individuals receiving outreach services were housed using housing choice vouchers reserved by the Housing Authority for homeless individuals. Below is a breakdown of those individuals housed in FY 10:

<table>
<thead>
<tr>
<th>Location</th>
<th># Outreached</th>
<th># Housed</th>
<th># Confirmed Mental Illness</th>
<th># Self-Reported Mental Illness</th>
<th>Total Presumed Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encampment</td>
<td>105</td>
<td>41 (39%)</td>
<td>32 (30%)</td>
<td>39 (37%)</td>
<td>71 (68%)</td>
</tr>
<tr>
<td>Shelter</td>
<td>165</td>
<td>71 (43%)</td>
<td>52 (32%)</td>
<td>80 (48%)</td>
<td>132 (80%)</td>
</tr>
<tr>
<td>Street</td>
<td>71</td>
<td>26 (37%)</td>
<td>48 (68%)</td>
<td>12 (17%)</td>
<td>60 (85%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>341</strong></td>
<td><strong>138 (40%)</strong></td>
<td><strong>132 (39%)</strong></td>
<td><strong>131 (38%)</strong></td>
<td><strong>263 (77%)</strong></td>
</tr>
</tbody>
</table>

In January 2008, the City’s housing authority began reserving housing choice vouchers for homeless individuals identified by the Mayor’s Office of Human Services (formerly Homeless Services). This significantly increased the availability of housing vouchers for homeless individuals. Since then, 337 individuals have been housed with the assistance of HIP. In FY 10, HIP recruited a student to analyze the success of housing placements for individuals who moved into housing on or before August 1, 2009. A significant finding was that an average of 90% of the individuals placed in housing remained housed after 6, 12 or 18 months.

<table>
<thead>
<tr>
<th>Percentage of Housing Choice Voucher Clients Maintaining Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Elapsed Since Move-In</td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td>6 months</td>
</tr>
<tr>
<td>12 months</td>
</tr>
<tr>
<td>18 months</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
</tr>
</tbody>
</table>

In addition to the above HIP activities, a program at Health Care for the Homeless was active in coordinating Social Security benefits for homeless individuals. In FY 10, this program,
SSI/SSDI Outreach Assistance and Recovery (SOAR), experienced tremendous growth in both the numbers of providers trained in SOAR methodology and the number of SSI/SSDI claims submitted. Fifty-six individuals from provider agencies, including some HIP participants, received the SOAR training.

Thirty of the 31 claims submitted on behalf of homeless consumers with mental illness to the Social Security Administration by SOAR-trained providers this fiscal year were approved, with several claims being approved in less than 30 days. Individuals served by the SOAR initiative receive the benefit of expedited access to income, health insurance and treatment services, and decreased anxiety throughout the SSI/SSDI application process. Providers report that SOAR has been a successful tool in engaging individuals in services, and has assisted in the therapeutic process by helping to identify diagnoses and treatment needs during the application process.

**Action Step:** Provide direction, funding and ongoing consultation to HUD-funded projects: three mental health outreach teams; one SSI Presumptive Eligibility Outreach program; and one Wellness and Recovery Center for homeless individuals.

BMHS was again awarded $1,991,410 from HUD to fund projects as described above. Funding from HUD has remained level since the inception of each project. As a result, programs have been forced to increase their match beyond the 20% required by HUD and have struggled to balance budgets. Both safe havens have had particular difficulty meeting increased operational costs this year.

Representatives from every HUD-funded project are active in HIP. It is through regular meetings of HIP that BMHS provides guidance and support to the HUD-funded projects, which served 1,168 individuals, a 38% increase from FY 09 due to more coordinated outreach and the availability of additional housing choice vouchers.

**Action Step:** Secure funding and contract with a vendor to provide mental health services in the City’s low-demand single adult and family shelters.

Prior to FY 10, funding was sought annually to provide mental health treatment in the City’s low-demand single adult and family shelters. In FY 10, separate funding for treatment was not sought. This was due to more consumer demand for case management services than mental health treatment while in the shelter, and to shelter staff encouraging homeless individuals to seek treatment in a community-based outpatient mental health center, which promotes treatment continuity once individuals are housed. As the provider of shelter-based case-management services, HIP outreach workers outreached to 165 individuals at the low-demand shelter and facilitated the housing of 71 individuals.

**Action Step:** Provide funding and consultation to programs serving homeless children and families.

BMHS continued to fund a therapeutic nursery program, PACT, which offers specialized childcare, including mental health and educational services for children under the age of
three. Services are provided with their families, whom either currently live in homeless shelters or have recently experienced homelessness. The primary focus of services is to provide mental health interventions that promote parent-child attachment and improve stability in the family. Services are community-based and include those delivered in a family shelter, providing ease of access for families in Baltimore City.

In FY 10, BMHS was able to provide enhanced funding to PACT secured through the repurposing of unspent funds to purchase new computers meant to facilitate better programming for children and their families.

**Indicators:** Report on progress to date; number of individuals served.

See above for progress to date.

<table>
<thead>
<tr>
<th>Services Provided in Homeless Shelters in Baltimore City</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Bon Secours Outreach</td>
</tr>
<tr>
<td>HOPE Drop-In Center</td>
</tr>
<tr>
<td>HOPE Safe Haven</td>
</tr>
<tr>
<td>Johns Hopkins Hospital Outreach</td>
</tr>
<tr>
<td>People Encouraging People Outreach</td>
</tr>
<tr>
<td>UMMS Safe Haven</td>
</tr>
<tr>
<td>UMMS SSI Project</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services Provided to Homeless Individuals In Baltimore City</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>PACT Therapeutic Nursery</td>
</tr>
<tr>
<td>Baltimore City Homeless Family Shelter</td>
</tr>
</tbody>
</table>

**STRATEGY 7: Fund transitional housing opportunities.**

**Action Step:** Contract with a vendor(s) to provide transitional housing services.

BMHS funded five agencies to provide transitional housing for homeless individuals. Funding was received from MHA and HUD. All programs experienced an increased demand for transitional housing services this past year. The turnover rate for transitional beds was 184% in FY 10. This relatively high turnover rate is a positive development that is likely related to the City’s implementation of the Bailey Consent Decree. This legal settlement, which requires the Housing Authority to make housing vouchers available and give priority to non-elderly adults with disabilities, including mental illness, has been implemented over
the past two years, a period when there has been increased movement within the City’s Section 8 waiting list.

**Indicators:** Number of beds funded; number of individuals served.

<table>
<thead>
<tr>
<th>Transitional Housing Opportunities</th>
<th># of Beds</th>
<th># of Individual Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Jacob’s Well</td>
<td>42</td>
<td>72</td>
</tr>
<tr>
<td>Safe Haven I</td>
<td>20</td>
<td>62</td>
</tr>
<tr>
<td>Safe Haven II</td>
<td>19</td>
<td>59</td>
</tr>
<tr>
<td>My Sister’s Place Lodge</td>
<td>6</td>
<td>50</td>
</tr>
<tr>
<td>Project PLASE</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>90</strong></td>
<td><strong>256</strong></td>
</tr>
</tbody>
</table>

**STRATEGY 8:** Identify opportunities to increase attention to and action regarding Baltimore City’s homeless youth population.

**Action Step:** Collaborate with organizations serving homeless youth to identify opportunities to develop outreach to youth ages 12 to 17 years.

The Behavioral Health Leadership Institute (BHLI), an affiliate of BMHS, collaborated with the Rose Street Temporary Homeless Youth Shelter and the Baltimore City Mayor’s Office to provide mental health services at the Rose Street Shelter. BHLI participated in the evaluation of the shelter to determine what the structure of future services should be, and assisted in transitioning those services to better meet the mental health needs of consumers at the shelter.

**Action Step:** Participate in the Baltimore Homeless Youth Initiative and other forums addressing this problem.

BHLI participated in planning several meetings of the Baltimore Homeless Youth Initiative to advocate for the ability of homeless youth to consent to treatment.

**Indicator:** Report on progress to date.

Through May 2010, through its Project Connections program, BHLI provided clinical services at the Rose Street Youth Shelter. Services were provided on an ongoing basis for a total of 30 youth who lived at the shelter for approximately three weeks.

**STRATEGY 9:** Identify opportunities to increase attention to and action regarding individuals impacted by trauma.
**Action Step:** Facilitate professional development opportunities for the mental health provider community to increase knowledge of the child welfare system and trauma-informed treatments.

BHLI continued its educational activities regarding children and adolescents who exhibit inappropriate sexual behavior. BHLI presented its treatment model at the National System of Care conference in workshops attended by over 150 individuals. BHLI also participated with the University of Maryland’s Innovations Institute to develop a community provider-learning track focusing on this population at their annual training conference.

**Action Step:** Partner with other child-serving agencies and the foundation community to inform the development of a trauma-informed system of care.

BMHS staff collaborated with the University of Maryland’s Innovations Institute to train 28 clinicians in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based practice (EBP) model for treating trauma-related mental health issues. These clinicians work with children who suffered from abuse and/or neglect and were involved in Baltimore City’s Department of Social Services. The clinical goal for each of these children was to minimize the impact of trauma by providing an EBP, proven to be effective in addressing trauma-generated illnesses.

**Action Step:** Through a collaboration with BHLI and the Johns Hopkins School of Public Health’s Center for the Prevention of Youth Violence, establish a network of relevant programs to identify youth impacted by trauma, begin outreach to programs and provide them with training and education about mental health and trauma.

BHLI made no progress on this action step.

**Indicators:** Report on progress to date; number of trainings conducted; number of individuals trained.

BHLI conducted 3 workshops presenting a treatment model to work with children exhibiting inappropriate sexual behavior, with a total of 150 participants.

**STRATEGY 10:** Provide mental health screening, intervention, and referral for children exposed to violence.

**Action Step:** Provide funding and oversight to the Child Development Community Policing (CDCP) program, which provides mental health outreach, assessment, and referral for children who are witnesses or victims of a violent crime, and trains volunteers about the needs of this population.

CDCP works collaboratively with families, police officers, mental health clinicians and community members to break the cycle of violence by providing early intervention, mental health services, training and community outreach. The intervention occurs shortly after a child has witnessed or been impacted by violence and/or a traumatic event. The CDCP team
consists of community coordinators (i.e. a retired police officer) and a mental health clinician. In FY 10, the team responded to 51 incidents of violent crimes and traumatic events.

**Indicators:** Number of calls to CDCP; number of children and adolescents served; number of individuals trained.

<table>
<thead>
<tr>
<th>CDCP Calls Received</th>
<th>Fiscal Year</th>
<th># Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FY 06</td>
<td>129</td>
</tr>
<tr>
<td></td>
<td>FY 07</td>
<td>323</td>
</tr>
<tr>
<td></td>
<td>FY 08</td>
<td>384</td>
</tr>
<tr>
<td></td>
<td>FY 09</td>
<td>496</td>
</tr>
<tr>
<td></td>
<td>FY 10</td>
<td>400</td>
</tr>
</tbody>
</table>

Of the 400 calls:

- 385 (96%) were in response to children experiencing exposure to violence in the community.
- 51 (13%) resulted in face-to-face responses from the team.

<table>
<thead>
<tr>
<th>CDCP Calls Received by Age of Child</th>
<th>Fiscal Year</th>
<th># Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-5 years</td>
<td>7 (2%)</td>
</tr>
<tr>
<td></td>
<td>7-12 years</td>
<td>41 (10%)</td>
</tr>
<tr>
<td></td>
<td>13 years &amp; up</td>
<td>352 (88%)</td>
</tr>
</tbody>
</table>

As part of the training and community outreach, 93 individuals, including police officers, youth and other community members were trained:

- 3 police officers were trained in the Yale Model, a trauma response model;
- 38 individuals participated in two Community Youth Forums;
- 12 individuals, including 4 police officers, participated in Fellows Training; and
- 43 individuals, including 16 police officers participated in in-service training.

**STRATEGY 11:** Provide mental health services to individuals suffering from depression and trauma and living in highly vulnerable communities.

**Action Step:** Through BHLI’s Project Connections, in partnership with Johns Hopkins Bayview Medical Center, provide mental health services on-site in non-traditional community-based settings.

Project Connections entered its fifth year of activity in August of 2010. The goals for the year were to stabilize and strengthen activities at the sites served by the Project, continue to improve engagement and access to treatment, and begin Phase 2 of an evaluation of this
program model. Between August, 2009 and June, 2010, Project Connections added a new site and began a new program. The new site is at Jericho, a correctional release program for adult males. The new program is a buprenorphine project, which seeks to increase access to buprenorphine, an alternative medication to methadone. This project is provided at Dee’s Place, a substance abuse recovery program. During the year, BHLI phased-out the services provided at the Homeless Youth Shelter and assisted them in transitioning to in-house staff. These services include evaluation, psychiatric assessments, individual therapy, medication monitoring, formal group therapy, and informal educational groups.

**Indicators:** Number of sites; number of individuals served; number of services provided.

165 adult clients received mental health services at 5 sites.

In a typical month, there were approximately 30-45 initial evaluations across the sites and approximately 4 individual therapy sessions per client with a continuing caseload of about 70-80 adult clients per month. A total of 180 individual evaluations were completed in FY 10. The show-rate for follow-up appointments was approximately 60% across the sites. Approximately 40 clients were seen by the psychiatrist for evaluation and/or follow-up visit each month.

**STRATEGY 12: Fund mobile psychiatric assessment and treatment for elderly individuals.**

**Action Step:** Contract with vendor(s) to identify, assess, treat, and link elderly clients to services.

BMHS contracted with two vendors to provide mobile assessment and treatment for elderly individuals: Johns Hopkins Hospital for the Psycho-Geriatric Assessment and Treatment in City Housing (PATCH) program and the University of Maryland for the Senior Outreach Services (SOS) program. Over the last 13 years, the funding for these programs has not kept pace with increasing operating costs, and both providers have had difficulty maintaining balanced operational budgets. To address the funding challenges, PATCH downsized from two teams to one at the end of FY 10. It is expected that there will be a subsequent decrease in the number of individuals served in FY 11 because of the reduction in the number of teams.

**Indicator:** Number of individuals served.

<table>
<thead>
<tr>
<th>Program</th>
<th># Individuals Referred</th>
<th># Individuals in Active Treatment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Outreach Services (SOS)</td>
<td>70</td>
<td>54</td>
</tr>
<tr>
<td>PATCH</td>
<td>31</td>
<td>15</td>
</tr>
<tr>
<td>TOTAL</td>
<td>101</td>
<td>69</td>
</tr>
</tbody>
</table>

*At end of fiscal year*
**STRATEGY 13:** Provide technical assistance and consultation to coordinate access and community-based services for elderly individuals.

**Action Step:** Assist State hospital facilities to transition elderly residents to community placements.

BMHS continued to employ a Psychogeriatric Nurse Specialist to collaborate with State hospital facilities to assist with discharge planning and track clients’ progress when discharged to the community. As a part of this effort, the Nurse Specialist meets with State hospital facilities to review clinical information and progress toward discharge for all elderly or medically fragile residents in the facility. In addition, the Psychogeriatric Nurse Specialist works with assisted living facilities and nursing homes in the community to provide education, technical assistance and case consultation with the goal of assisting the client to remain in his/her community placement after discharge from a State hospital facility.

Of the 17 clients discharged from State hospital facilities, none were re-hospitalized within the first year of placement, and 35% were placed in community assisted living facilities instead of nursing homes. In FY 10, the Psychogeriatric Nurse Specialist served 101 individuals statewide, 51% of whom were Baltimore City residents. Of the new referrals, 71% were Baltimore City residents, reflecting an increase in City residents being served. A positive trend of movement from nursing homes to community assisted living facilities was noted in FY 10, with six clients moving from nursing homes to assisted living facilities. For the first time since the project started in 1987, community facilities receiving technical assistance were greater in number than nursing home facilities (24 community facilities versus 22 nursing homes). This is significant because it means that community facilities are serving an increased number of elderly individuals with mental health needs and are receptive to technical assistance being offered.

In addition to the work of the Psychogeriatric Nurse Specialist, BMHS provides funding to Glenmore Manor, a residential rehabilitation program that provides enhanced staffing for elderly and medically complicated individuals who have been discharged from State hospital facilities. BMHS staff has worked closely with State hospital facilities and Glenmore Manor to identify and transition individuals to this community setting.

**Action Step:** Provide support to the Psycho-Geriatric Assessment and Treatment in Baltimore City Housing (PATCH) program to conduct mental health educational workshops.

In FY 10, PATCH conducted two trainings on recognition of mental health issues in elderly individuals. PATCH had difficulty providing training in public housing sites due to a limited number of Housing Authority staff being available to advertise the training, and as a result, several scheduled trainings were canceled due to lack of participants.

**Indicators:** Number of individuals served; report on progress to date.

See above for number of individuals served and progress to date.
STRATEGY 14: Increase understanding of barriers to access to care for specific populations.

**Action Step:** Use Baltimore City Health Department’s Community Health Survey to query City residents on their knowledge and experience relating to accessing mental health services.

BMHS collaborated with the Health Department to select questions about mental health and access to care for the Baltimore City Community Health Survey. The Community Health Survey was released in March 2010. A random sampling of 1,100 Baltimore City residents were surveyed by phone in order to assess health needs, the use and perceptions of health services, and attitudes related to program and policy issues in Baltimore City. In some instances, the survey also addressed issues of barriers to health services.

One section of the survey asked residents about mental health care and social isolation. Fourteen percent of respondents reported needing mental health care in the previous year, and of those who reported needing mental health care, 23% reported having unmet mental health care needs. Black respondents were four times more likely to report having unmet mental health care needs than White respondents, 34% compared to 9%.

<table>
<thead>
<tr>
<th>Race Distribution for Mental Health Care Needs</th>
<th>Black</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needed Mental Health Care in the Past 12 Months</td>
<td>13%</td>
<td>15%</td>
</tr>
<tr>
<td>Unable to Get Needed Mental Health Care in Past 12 Months</td>
<td>34%</td>
<td>9%</td>
</tr>
</tbody>
</table>

BMHS will use these results to inform efforts to improve access to health care in Baltimore City.

**Indicators:** Identified obstacles for particular populations.

The most frequently identified barrier to receiving mental health services was cost. See below for additional barriers identified.

<table>
<thead>
<tr>
<th>Barriers Identified by Individuals with Unmet Mental Health Needs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost (Despite Having Health Insurance)</td>
<td>41%</td>
</tr>
<tr>
<td>Lack of Health Insurance</td>
<td>11%</td>
</tr>
<tr>
<td>Not Knowing Whom to Contact</td>
<td>5%</td>
</tr>
</tbody>
</table>

Complete results from this survey can be found in Appendix D.
Objective 4.1: Promote healthy social and emotional development by making mental health services available within settings where children grow and learn.

**Status:** All strategies were accomplished.

**Strategy 1:** Promote the provision of mental health promotion, prevention, and intervention services in early childhood settings.

**Action Step:** Partner with Baltimore City Head Start (BCHS) to make mental health services available on site.

The Early Childhood Initiative, a collaborative effort between BMHS and BCHS, resulted in the majority of Head Start sites being able to offer on-site mental health services. Four organizations (Hope Health Systems, Inc., University of Maryland, John’s Hopkins Bayview Medical Center, and Catholic Charities/Villa Maria) provide 13 licensed mental health professionals who work on a multidisciplinary team to plan and implement mental health services within 11 Head Start sites throughout the City. The Early Childhood Initiative is supported by funding from DHMH and Baltimore City’s Department of Housing and Community Development.

**Indicators:** Number of Head Start sites offering mental health services on-site; Number of mental health consultations provided.

In FY 10, 11 out of the City’s 17 Head Start and Early Head Start Centers offered mental health services on-site. Considerable collaboration, meetings with key stakeholders, negotiation with the provider network and budget planning was completed to prepare for a Head Start expansion for FY 11. This proposed expansion will add 3 new Head Start Centers to this initiative.

The Head Start Centers provided mental health consultations on behalf of 1,026 children to staff and families, and conducted 629 classroom observations.
STRATEGY 2: Promote the provision of mental health prevention, screening, assessment and treatment services in public schools.

**Action Step:** Partner with Baltimore City Public Schools (BCPS), the Family League of Baltimore City (FLBC), and the Baltimore City Health Department (BCHD) to fund school-based mental health services through the Expanded School Mental Health (ESMH) project.

BMHS continued to work with FLBC and BCHD to provide expanded school mental health (ESMH) services in 102 Baltimore City Public Schools in FY 10. The Sixth Grade - Expanded School Behavioral Health Initiative continued in 37 Baltimore City schools during the 2009-2010 academic year. This initiative is an innovative approach to targeting sixth graders exhibiting the following risk factors: attendance issues; behavioral issues; and low math and English proficiency. This initiative aims to support students during a critical transitional period and decreases the likelihood of school disengagement and drop out. Funding for this initiative is provided by Baltimore Substance Abuse Systems, Inc. and represents a collaborative effort to promote resiliency and prevent substance use and other negative outcomes for these at-risk students.

**Action Step:** Track outcomes to demonstrate impact of school-based mental health services.

The collection and analysis of data to determine whether ESMH services have a positive effect on measures of academic and school functioning continued during the 2009-2010 school year. The type (individual, group and universal) and quantity of ESMH services received by students was recorded by mental health clinicians and submitted to BMHS on a quarterly basis. The service use data were then merged with measures of academic and educational performance provided by the Division of Research, Evaluation, Assessment, and Accountability (DREAA) of BCPS. The results are reported below.

**Action Step:** Work with partners to explore possibilities for the expansion of ESMH services.

Efforts in FY 10 focused on minimizing the impact of budget reductions and sustaining ESMH services in as many schools as possible. A review of outcomes provided guidance in identifying the most effective prevention and treatment program components to preserve in order to minimize the negative impact of the funding reduction. Additionally, in light of the fiscal reduction, a preliminary financial analysis conducted in FY 10 supports current decision-making regarding appropriate funding levels. That is to say, two-thirds grant funding and one-third fee-for-service funding covers the cost of an ESMH clinician. In the future, BMHS staff will take advantage of opportunities to enhance data collection and reporting to support the development of a sustainability plan by engaging partners like the Family League of Baltimore City, Inc. and Baltimore City Public Schools in a targeted discussion about maintaining ESMH services.
**Action Step:** Provide oversight and support to specialized school based mental health initiatives that serve targeted populations.

BMHS engaged a diverse group of stakeholders to begin creating infrastructure support for bridging mental health services for children and families from early childhood in Head Start Centers to expanded school mental health programs in City Schools. The University of Maryland’s Innovations Institute joined the collaborative effort to facilitate an evaluation plan.

**Indicators:** Number of children and adolescents served; report on selected outcomes.

<table>
<thead>
<tr>
<th>Expanded School Mental Health Services</th>
<th>FY 08</th>
<th>FY 09</th>
<th>FY 10</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Schools Participating</td>
<td>96</td>
<td>106</td>
<td>102</td>
</tr>
<tr>
<td># of Providers</td>
<td>13</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Unduplicated Students Receiving Services</td>
<td>8,820</td>
<td>6,543</td>
<td>7,942</td>
</tr>
<tr>
<td>Total Funding Amount</td>
<td>$3,009,950</td>
<td>$3,118,950</td>
<td>$2,964,500</td>
</tr>
</tbody>
</table>

Despite a decrease in the number of schools offering ESMH services, there was a 21% increase in the number of children served between FY 09 and FY 10. This trend is due in part to higher concentrations of students within the schools still being served. Part of the decrease in the number of schools served was a result of school closure, and many of the students moved to schools that offered ESMH services.

Additionally, 47,979 students in the 102 schools with ESMH services have access to school-wide prevention activities, such as school assemblies and education campaigns.

**ESMH Outcomes:**

The charts below display a comparison of the average school-wide attendance and suspension rates for ESMH schools and all public schools, as presented by the Division of Research, Evaluation, Assessment, and Accountability (DREAA) of Baltimore City Public Schools. These charts show the highest and lowest attendance and suspension rates among the ESMH providers as reported by DREAA. “ESMH Highest Average” represents the ESMH provider that reported the highest attendance or suspension rate. “ESMH Lowest Average” represents the ESMH provider that reported the lowest attendance or suspension rates. The grade level attendance rates are depicted separately due to different measures for determining attendance for elementary/middle and high school.

It is noteworthy that the highest attendance rate exceeds the elementary/middle school average and the lowest attendance rate exceeds the high school average all three quarters indicating that on average, students receiving ESMH services have higher attendance rates than students not receiving ESMH services. The data on average suspension rates do not show a clear trend, with ESMH rates lower in the first and third quarters and higher in the second quarter.
The chart below shows an improvement between the first and third quarters in English Language Arts and Mathematics benchmarks for ESMH students. A greater percentage of ESMH students fell into the proficient category for both benchmarks in the third quarter in comparison to the first quarter. Student aptitude standards are broken down by the school system into “basic” and “proficient”, with the proficient standard defined as the advanced level for students. The percentage of students who scored at the advanced level in English Language Arts increased from 40% to 54% and from 14% to 44% for Mathematics between the first and third quarters, as shown below.
Objective 4.2: Identify and seek to address the mental health needs of children and adolescents in other child-serving systems.

Status: All strategies were accomplished.

STRATEGY 1: Work cooperatively with the Juvenile Justice System to identify and address the mental health needs of involved youth.

Action Step: Provide consultation and technical assistance regarding mental health services and resources on-site at Juvenile Court.

BMHS staff provided ongoing technical assistance and advocacy support services to assure that mental health services were delivered in a comprehensive family-friendly, culturally competent manner. Meetings were held regularly with the service provider, Hope Health Systems, Inc., in a continued effort to maximize service delivery within the Juvenile Justice Center.

Action Step: Provide funding and oversight for the delivery of court-ordered mental health assessments for post-adjudicated youth.

Despite statewide budget reductions that affected this program, 445 youth received mental health assessments during FY 10. A meeting was convened on February 3, 2010 by DJS to develop a strategy to maintain services in the context of continuing DJS budget reductions. The plan is to gradually transition from a high volume of in-house grant-funded psychological reviews to Medicaid-funded fee-for-service outpatient mental health clinic services (when appropriate) as a resource for youth to obtain assessment and/or treatment services.
**Action Step:** In collaboration with Department of Juvenile Services (DJS), provide funding and oversight for mental health and substance abuse screening and treatment services for youth supervised by DJS at the Baltimore City Juvenile Justice Center and in the community.

BMHS staff is on site once a week at the Juvenile Justice Center to provide technical assistance and advocacy support services to assure that mental health services are being delivered in a comprehensive family-friendly, culturally-competent manner.

**Indicator:** *Number of DJS-involved or court-involved youth served.*

The data sets below outline the numbers of youth receiving services at Baltimore City’s Juvenile Justice Center (BCJJC). Seventeen percent of the 70 cases reviewed by the Local Coordinating Council were cases concerning DJS-involved youth being placed in in-state residential or out-of-state placements.

<table>
<thead>
<tr>
<th>Court Medical Evaluation Team (CMET) Mental Health Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fiscal Year</strong></td>
</tr>
<tr>
<td>FY 06</td>
</tr>
<tr>
<td>FY 07</td>
</tr>
<tr>
<td>FY 08</td>
</tr>
<tr>
<td>FY 09</td>
</tr>
<tr>
<td>FY 10</td>
</tr>
</tbody>
</table>

The 24% decrease in mental health assessments noted above is due to DJS no longer requiring IQ scores for youth entering facilities operated by their agency, which decreases the need to conduct the component of the mental health assessments that provides an IQ score.

<table>
<thead>
<tr>
<th>Youth and Family Served by LINKS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fiscal Year</strong></td>
</tr>
<tr>
<td>FY 07</td>
</tr>
<tr>
<td>FY 08</td>
</tr>
<tr>
<td>FY 09</td>
</tr>
<tr>
<td>FY 10</td>
</tr>
</tbody>
</table>

**Strategy 2:** Participate in statewide and local efforts to more adequately meet the mental health needs of children and adolescents in foster care.
**Action Step:** Provide funding and oversight, in conjunction with MHA and Department of Human Resources (DHR), of mental health screening, assessment and case management services for children and families entering the foster care system.

BMHS staff has been involved in planning meetings to integrate mental health assessments into the Making All the Children Healthy (MATCH), the integrated care unit of Baltimore City’s Department of Social Services. This will ensure that all children entering the City’s foster care system receive thorough health assessments, including a mental health assessment. Those children who have identified treatment needs will be linked to care. As a next step, BMHS procured, through a competitive request for proposal (RFP) process, a qualified mental health agency to conduct mental health assessments on all children entering foster care. It is anticipated that mental health assessments will commence mid-FY 11.

**Action Step:** Provide funding and oversight, in conjunction with MHA and DHR, of mental health mobile crisis and stabilization services for children and families in the foster care system.

In FY 10, BMHS continued to foster collaborative efforts with Baltimore City Department of Social Services (BCDSS) and Catholic Charities in implementing the BCDSS/B-CARS Mobile Crisis Stabilization Program. Steering committee meetings were held monthly to provide updates on the work-plan, review quarterly reports and otherwise act to strengthen collaboration around stabilizing children and families in the foster care system. An example of an effective strategy that was implemented was the co-location of a B-CARS clinician at the DSS Biddle Street office to better facilitate referrals from DSS.

**Indicators:** Number of youth assessed; number of children connected to mental health treatment; number of children able to maintain foster care placement; number of mobile crisis responses.

<table>
<thead>
<tr>
<th>B-CARS/DSS Crisis Stabilization</th>
</tr>
</thead>
<tbody>
<tr>
<td># of referrals</td>
</tr>
<tr>
<td>177</td>
</tr>
<tr>
<td># of ineligible youth</td>
</tr>
<tr>
<td>47</td>
</tr>
<tr>
<td># of youth received services</td>
</tr>
<tr>
<td>130</td>
</tr>
</tbody>
</table>

67 children and families received crisis services, 3 (4%) of whom required immediate/urgent response. These 3 families received face-to-face services in less than 2 hours. 90% of children assessed remained in their current placements at the conclusion of B-CARS stabilization services being rendered, and 100% of families were linked to additional services for ongoing treatment. The average length of treatment associated with B-CARS/DSS stabilization services was 7.4 days.
Objective 4.3: Promote screening for mental health disorders, including co-occurring disorders, and linkage to appropriate treatment and supports across the lifespan.

**Status:** All strategies were accomplished.

**STRATEGY 1: Expand screening, assessment and coordinated treatment for individuals with co-occurring mental health and substance use disorders.**

**Action Step:** Continue planning activities initiated in FY 09 with Baltimore Substance Abuse Services (bSAS), Baltimore City stakeholders (providers, universities, consumers, the judiciary and other interested parties), MHA, ADAA and the office of the Deputy Secretary for Behavioral Health.

BMHS continued to participate in the planning process being facilitated by the Deputy Secretary for Behavioral Health toward establishing a co-occurring crisis program with the City’s current mental health crisis provider, Baltimore Crisis Response, Inc., which also provides residential detoxification services. The planning for this project was initiated by the State’s new Behavioral Health Deputy Secretary at a meeting in early FY 10, with the following participating partners: ADAA, MHA, BCRI (the provider), bSAS and BMHS.

Intensive collaboration continued throughout the year between bSAS and BMHS regarding the plan to jointly implement an Integrated Dual Disorders Treatment (IDDT) Initiative serving co-occurring individuals with 8-507 designations (for court-ordered substance abuse treatment). IDDT is an evidence-based practice model that fully supports consumers in the recovery process.

BMHS also continued to collaborate with bSAS to implement the Sixth Grade Initiative within schools with the Expanded School Mental Health program, as described on page 43. This initiative provides prevention and early intervention services for youth who are at risk of dropping out of school, which in turn is a risk factor for substance use.

**Action Step:** Continue efforts to increase knowledge among BMHS and bSAS staff of treatment issues relating to individuals with co-occurring disorders and promote closer collaboration between the two staffs.

BMHS and bSAS have continued an ongoing dialogue to generate ideas and opportunities to improve coordination of care for individuals with co-occurring disorders. Mid-year, the two agencies began holding regular management-to-management meetings to: increase shared knowledge of both service systems; strengthen relationships between the agencies, their staff and board; and identify opportunities to pursue further system-level collaboration.
**Indicator:** Number of relevant activities.

BMHS participated in ongoing meetings with bSAS and various key partners to improve integrated services for individuals with co-occurring disorders. See above for relevant activities.

**STRATEGY 2: Promote depression screening.**

**Action Step:** Support organizations interested in providing depression screens and help publicize events.

BMHS funded the Center for the Integration of Spirituality and Mental Health (CISMH) to conduct depression screenings. CISMH offered these screenings for participants during Mental Health Promotion Sunday described on page 25. Although BMHS only funds CISMH to conduct depression screenings, additional organizations in Baltimore City provide this service.

**Indicator:** Report on progress to date.

403 individuals were screened.

**STRATEGY 3: Make buprenorphine treatment available to individuals with mental illness and opioid addiction.**

**Action Step:** Work closely with Baltimore HealthCare Access and bSAS to develop models to support wider access to buprenorphine within the public mental health system.

Behavioral Health Leadership Institute (BHLI) met throughout the year with BHCA and bSAS to explore issues related to buprenorphine and to develop an initiative to increase access to services. BMHS continues to collaborate as needed with Baltimore HealthCare Access to ensure that mental health resources are available to the buprenorphine project.

**Action Step:** Through BHLI Project Connections, begin offering buprenorphine treatment in coordination with mental health treatment at one site.

BHLI developed a model for a pilot program to deliver services at Dee’s Place, a 24-hour substance abuse program, in coordination with the mental health treatment already provided there. BHLI coordinated activities with the University of Maryland and Johns Hopkins University School of Nursing and Bayview to develop a team to provide services. Additionally, BHLI worked closely with the community and the site to ensure that the program will meet their needs and operate in a manner that is sensitive to the culture and needs of the community.
Indicators: Report on progress to date and number served.

Buprenorphine treatments started at the end of FY 10, initially enrolling 3 individuals.

GOAL V: Excellent mental health care is delivered and research is accelerated while maintaining efficient service system accountability.

Objective 5.1: Promote workforce development and training through educational activities and technical assistance to mental health service providers and other service sectors.

Status: Strategy 2 was accomplished. Strategy 1 was partially accomplished.


Action Step: Sponsor an Early Childhood Mental Health training series.

Due to budget reductions in FY 10, BMHS did not host the Early Childhood Mental Health Training Series; however, clinicians received training and information sessions from community organizations such as the Center For Urban Families. Furthermore, the groundwork and preparation for the launching of the Center for Social Emotional Foundations of Early Learning (CSEFEL) train-the-trainer program was completed, which will provide additional training opportunities on evidence-based practices for early childhood mental health issues.

Action Step: Sponsor professional development sessions for school-based mental health clinicians.

In collaboration with Baltimore City Public Schools and Baltimore Substance Abuse Systems, Inc., BMHS organized three professional development sessions for Expanded School Mental Health clinicians during the 2009-2010 school year. Session topics focused on the value of evaluation and outcomes, evidence-based approaches to serving youth and wellness practices for the helping professional. Ninety-five percent of ESMH clinicians attended at least one of these sessions.

Action Step: Sponsor an annual forensic conference.

Funding for BMHS to sponsor an annual forensic conference was eliminated due to budget reductions in FY 10. This budget reduction did not have a significant impact because MHA sponsored its annual forensic conference, which Baltimore City providers participated in.
**Indicators:** Number of training activities; number of participants.

There were 3 professional development sessions for school-based mental health clinicians, with 270 clinicians attending.

**STRATEGY 2: Provide support and technical assistance to community service providers in how the public mental health system works.**

**Action Step:** Provide presentations to community service organizations about the resources available for clients in need of mental health services.

BMHS staff received multiple requests to educate community service providers on how the Public Mental Health System works. Presentations were made to homeless service providers, Baltimore HealthCare Access, the City’s 211 operators, the judiciary and other Mental Health Court personnel, State Hospital staff, caregivers, and geriatric service providers. BMHS staff also reached out to students training to become health care professionals by presenting at Coppin State University’s Emerging Issues in Mental Health class and at the University of Maryland School of Social Work.

BMHS’ Geriatric Nurse Specialist conducted 28 trainings to nursing home and assisted living staff on a variety of topics related to aging and mental health resources.

BMHS staff developed and distributed a document, *Mental Health Services for Adults in Baltimore City,* to guide presentations on community services available to adults in the fee-for-service Public Mental Health System. This document was presented to judges, service providers, and hospital staff in FY 10.

**Indicators:** Types of community service organizations that received presentations; number of presentations.

BMHS provided a total of 55 presentations to community service organizations. See above for types of organizations.

**Objective 5.2: Provide access to services in the least restrictive setting.**

**Status:** All strategies were accomplished.

**STRATEGY 1: Strengthen crisis response services.**

**Action Step:** Provide funding and oversight to Baltimore Crisis Response, Inc. (BCRI) and to Baltimore Child and Adolescent Response Services (B-CARS).

**Baltimore Crisis Response, Inc.**

BMHS continued to fund BCRI for mobile crisis services and a 24-hours-per-day, 7-days-per-week crisis hotline. In addition, BCRI is licensed as a residential crisis facility and
receives reimbursement through the State’s fee-for-service Public Mental Health System for this service. BCRI’s services continue to be vital to the City’s mental health services continuum. BCRI experienced financial challenges this year because of statewide funding reductions of diversion programs. BMHS worked with MHA and BCRI to assist BCRI in replacing grant funding for the diversion project with fee-for-service revenue. To accomplish this, BCRI applied for licensure as a targeted case management program and an outpatient mental health clinic. BCRI continues to collaborate with BMHS and MHA to address the programmatic challenges of fee-for-service delivery. It is expected that BCRI will begin collecting fee-for-service revenue in FY 11.

BCRI handled a call volume of 29,719 calls, only slightly less than its all-time peak of 30,314 last year.

![BCRI Hotline Calls, FY 06-FY 10](chart.png)
While the hotline call volume decreased slightly, BCRI experienced a slight increase in the number and percentage of face-to-face mobile crisis team referrals.

<table>
<thead>
<tr>
<th>BCRI Services</th>
<th>FY09</th>
<th>FY 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile Crisis Team Referrals</td>
<td>2,534</td>
<td>2,556</td>
</tr>
<tr>
<td>Mobile Crisis Team Visits</td>
<td>2,285</td>
<td>2,325</td>
</tr>
<tr>
<td>% of referrals resulting in Mobile Crisis Team face-face-visit</td>
<td>90%</td>
<td>91%</td>
</tr>
</tbody>
</table>

A concerted effort by BCRI to increase the occupancy rate in its residential crisis beds led to an increase in the number of clients served. At the same time, there was a slight decrease in the average length of stay, so the overall number of residential crisis bed days remained about the same.

<table>
<thead>
<tr>
<th>BCRI Services</th>
<th>FY 08</th>
<th>FY 09</th>
<th>% Change</th>
<th>FY 10</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals receiving Residential Crisis Services</td>
<td>593</td>
<td>789</td>
<td>33%</td>
<td>826</td>
<td>5%</td>
</tr>
<tr>
<td>Residential Crisis Bed Days</td>
<td>4,315</td>
<td>5,377</td>
<td>25%</td>
<td>5,351</td>
<td>0%</td>
</tr>
<tr>
<td>Residential Crisis Average Length of Stay</td>
<td>6.8</td>
<td>7.28</td>
<td>7%</td>
<td>6.5</td>
<td>-11%</td>
</tr>
</tbody>
</table>
Baltimore Child and Adolescent Response Services

The 1915c waiver expanded Medicaid services in seven categories, including crisis stabilization. B-CARS is the crisis stabilization provider for Baltimore City under the 1915c Medicaid waiver. There was a 10% increase in calls between FY 09 and FY 10. BMHS staff anticipates that B-CARS will continue to provide additional crisis stabilization services to youth who are experiencing crisis and are enrolled under the 1915c waiver. B-CARS found that 48% of the referred children were eligible for crisis stabilization services under the waiver. BMHS staff hopes to broaden eligibility requirements in the future, allowing more children to receive these services.

**Action Step:** Pursue opportunities for future improvement and expansion of crisis response services.

BCRI did not expand services in FY 10. Efforts instead focused on maximizing the use of existing resources and consolidating operations due to a need to both relocate in anticipation of the planned closure of Walter P. Carter Center, and adjust to budget reductions. BCRI moved into its new facility at the beginning of the fiscal year. In addition, BCRI realigned staffing to adapt to the elimination of diversion project’s grant funding and transition to fee-for-service revenue as described above.

As described on page 49, planning was initiated by the State’s Deputy Secretary for Behavioral Health to create a co-occurring crisis program at BCRI.

BMHS worked closely with B-CARS staff during FY 10 to identify opportunities to expand provision of crisis stabilization services. BMHS was able to contract with B-CARS to serve
children involved with the child welfare system. Children at risk for entering foster care or children currently placed in foster care at risk for placement disruption began receiving crisis stabilization services. Youth who fall into the aforementioned categories are eligible to receive up to 42 days of crisis intervention services.

**Indicator:** *Number of individuals served by each provider; report on progress to date.*

See above for progress to date.

<table>
<thead>
<tr>
<th>Baltimore City Crisis Services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BCRI Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis Calls</td>
<td>29,719</td>
<td></td>
</tr>
<tr>
<td>Mobile Crisis Team Visits</td>
<td>2,325</td>
<td></td>
</tr>
<tr>
<td>Individuals receiving Residential Crisis Services</td>
<td>826</td>
<td></td>
</tr>
<tr>
<td>Individuals Receiving In-Home Interventions</td>
<td>97</td>
<td></td>
</tr>
<tr>
<td><strong>B-CARS Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis Calls</td>
<td>1,544</td>
<td></td>
</tr>
<tr>
<td>Families Receiving Crisis Stabilization Services</td>
<td>633</td>
<td></td>
</tr>
</tbody>
</table>

**STRATEGY 2:** Facilitate coordination of care for individuals using emergency rooms as their point of access to psychiatric services.

**Action Step:** Facilitate access to community-based services and purchase of care beds for uninsured individuals through the Hospital Diversion Project.

The Hospital Diversion Project, a program that targets uninsured consumers visiting emergency rooms for psychiatric care, completed its third year of operation. The Baltimore City project, operated by BCRI, has the highest diversion rate among the four Maryland jurisdictions participating in this pilot project. The Hospital Diversion Project served 329 individuals, a 34% decrease from the number served in FY 09. There was also a corresponding decrease in the percentage of mobile crisis team referrals from emergency rooms: 46% in FY 10 compared to 53% in FY 09.

<table>
<thead>
<tr>
<th>Hospital Diversion Project</th>
<th>FY 09</th>
<th>FY10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # Served</td>
<td>340</td>
<td>329</td>
</tr>
<tr>
<td>% Referred from Emergency Rooms</td>
<td>53%</td>
<td>46%</td>
</tr>
</tbody>
</table>

This decrease is due to greater ease of inpatient admission for individuals presenting at local emergency rooms relating to recent changes in the way the Emergency Medical Treatment and Active Labor Act (EMTALA) is being implemented in Maryland. As a result, clients are more frequently admitted from City emergency rooms to acute psychiatric inpatient care units, and there are fewer requests for diversion. Of the individuals served, 231 (70%) were diverted to community-based alternatives. Below is a breakdown of the activity:
Dispositions of Individuals Diverted from Inpatient Care

<table>
<thead>
<tr>
<th>Where Diverted</th>
<th># Diverted</th>
<th>% of Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Crisis Services</td>
<td>129</td>
<td>56%</td>
</tr>
<tr>
<td>Refused</td>
<td>38</td>
<td>16%</td>
</tr>
<tr>
<td>Outpatient Addiction Treatment</td>
<td>25</td>
<td>11%</td>
</tr>
<tr>
<td>Residential Addiction Treatment</td>
<td>13</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>6%</td>
</tr>
<tr>
<td>Outpatient Mental Health Care</td>
<td>12</td>
<td>5%</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>231</strong></td>
<td></td>
</tr>
</tbody>
</table>

For those individuals who were assessed as needing an inpatient level of care, State funds were used to purchase inpatient beds in a community-based hospital. It is notable that since its inception, this project has succeeded in serving all referred clients in community-based settings and preventing placements in State hospital facilities.

**Action Step:** Facilitate access to community-based services for clients identified by MHA and the Administrative Services Organizations (ASO) as high inpatient utilizers.

BMHS continued to coordinate services for individuals identified as high utilizers of inpatient services - consumers who have either been hospitalized for more than 30 days or who have had five hospitalizations in the last six months. Of the individuals served, 38% had documented co-occurring substance abuse disorders, and 34% were homeless. Data on the number of individuals incarcerated were not available this year due to the disruption in the Datalink download from the Department of Corrections, as described on page 71. Individuals were referred to a variety of services: case management, mobile treatment, assertive community treatment, and Capitation.

BMHS submitted a request and received funding from the State’s Mental Health Transformation Project to enhance City Assertive Community Treatment (ACT) team services with two peer support specialists to better engage consumers identified as high-cost consumers. The goal of the project is to improve client outcomes and reduce avoidable use of hospital emergency and inpatient care, along with associated costs. Consumers identified as high utilizers of inpatient care will receive priority as referrals to this project. It is expected that the funding for these services will be procured in the first half of FY 11, and that services will begin shortly thereafter.

**Indicator:** Number of individuals served.

The Hospital Diversion project served 329 individuals, 230 of whom were diverted to community-based alternatives, a diversion rate of 70%. The High Inpatient Utilizers project served 76 individuals and made 63 referrals.
STRATEGY 3: Whenever possible, divert children and adolescents from admission to Residential Treatment Centers (RTCs) through offering alternative community-based interventions and supports.

**Action Step:** Participate in the approval process for home- and community-based wraparound services for children and adolescents.

In an effort to expand the continuum of community-based services available to youth, the State of Maryland received a federal System of Care grant in 2007 to be implemented in Baltimore City. In September 2008, MHA was awarded a six-year Children’s Mental Health Initiative (CMHI) cooperative agreement totaling $8,567,033 from the federal Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Mental Health Services (CMHS) to improve mental health outcomes for children, youth, and families served by, or at risk of entering, the State’s foster care system. This grant, titled Maryland Crisis and At Risk for Escalation diversion Services for children (MD-CARES), intends to strengthen cross-agency partnerships that blend family-driven, evidence-based practices within mental health and child welfare to better serve this high-risk population. Along with the 1915c waiver, this grant expanded the pool of children eligible to receive wraparound services, and thus, increased access to mental health services and related supports for families.

Due to a delay in the promulgation (or approval) of the regulations for wraparound, the care management entity did not begin enrolling youth into MD-CARES until the end of the year. Approximately seven youth were enrolled during FY10.

**Action Step:** Review Certificate of Need documents to assure that all appropriate community-based services have been exhausted prior to accessing RTC services.

BMHS staff reviewed 82 Certificates of Need (48 for the 1915c Waiver, and 34 for traditional RTCs) to ensure that children were referred to the least restrictive, most appropriate treatment environment. In addition, the Local Coordinating Council (LCC) reviewed the placements of 111 youth. There were over 30 fewer referrals to traditional RTCs in FY10 than compared to referrals in FY 09 as a direct result of the RTC waiver being fully implemented in FY 10.

**Indicators:** Number of children and adolescents diverted from RTC services.

85 children were diverted from RTC admission; 26 children were served under the 1915c Medicaid Waiver within the Care Management Entity (CME); and 59 children were served through other programs (i.e. Community Support Initiative) offered within the CME.

<table>
<thead>
<tr>
<th>Certificate of Need Packets Reviewed</th>
<th>FY 06</th>
<th>FY 07</th>
<th>FY 08</th>
<th>FY 09</th>
<th>FY 10</th>
</tr>
</thead>
<tbody>
<tr>
<td># of packets reviewed</td>
<td>107</td>
<td>99</td>
<td>104</td>
<td>106</td>
<td>82</td>
</tr>
<tr>
<td># Approved</td>
<td>106</td>
<td>95</td>
<td>103</td>
<td>93</td>
<td>77</td>
</tr>
<tr>
<td># Rejected</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>13</td>
<td>5</td>
</tr>
</tbody>
</table>
STRATEGY 4: Provide support to programs that work with children and adults transitioning out of inpatient/institutional facilities.

**Action Step:** Facilitate opportunities for communication between B-CARS and child and adolescent psychiatric inpatient programs in Baltimore City to increase utilization of B-CARS to assist youth in returning to the community following an inpatient admission.

B-CARS continued to provide brief and intensive community-based services for children in psychiatric crisis to divert or shorten inpatient hospitalization. B-CARS also linked clients to community providers for ongoing treatment once discharged from inpatient settings. BMHS and B-CARS staff communicated regularly to ensure that children and their families were able to access the continuum of services across the public mental health system, including services that facilitate a successful return to the community following inpatient admissions.

**Action Step:** Collaborate with State hospital and acute care facilities in identifying community resources to assist in discharge planning.

BMHS staff met quarterly with staff of Spring Grove Hospital, the State hospital facility with the largest number of Baltimore City residents, to share resources and collaborate on discharge planning. As part of this collaboration, a case review process was initiated whereby individual cases are presented and specific resources are recommended to assist in the discharge process. In addition, because of a large number of new staff at Springfield Hospital Center, BMHS staff met with representatives from the hospital’s social work department on several occasions to provide education about how to access resources in Baltimore City.

BMHS employs a Referrals Coordinator to manage the referral process for RRP, FACTT and Capitation. Communication occurred almost daily with State hospital facilities to ensure that individuals being discharged from these facilities were given priority for vacancies in the above programs. Of these programs, RRP experienced the most turnover with 43 individuals admitted from State hospital facilities. Of those individuals placed into RRP beds, the average length of stay in a State hospital facility prior to discharge was 1.6 years, with a range of 2 months to 20 years. For Capitation, the average length of stay in a State hospital facility prior to discharge was 3.9 years, with a range of 7 months to 30 years.

**Indicators:** Report on progress to date; number of individuals who transitioned from inpatient/institutional facilities.

In FY 10, B-CARS served a total of 633 youth in Baltimore City. (B-CARS counts step-down services in their numbers of total youth served. Step-down services are supportive services that assist in the transition from an inpatient to a community setting.)
<table>
<thead>
<tr>
<th>FY 10 Number of Individuals Discharged from State Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitation Project</td>
</tr>
<tr>
<td>FACTT</td>
</tr>
<tr>
<td>Geriatric Community Placements*</td>
</tr>
<tr>
<td>RRP</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

*Coordinated by the Psychogeriatric Nurse Coordinator

There was a decrease in the numbers discharged from State hospitals to public mental health services in FY 10 compared to FY 09, particularly for those individuals discharged to the Capitation Project and RRPs. These numbers are largely dependent on State hospitals identifying consumers in need of public mental health services. Additionally, the Capitation Project had an initiative in FY 09 that targeted Springfield Hospital to help identify individuals who would benefit from enrollment in the Capitation Project. This initiative is no longer in effect, which may account for some of the decrease to that program.

**Strategy 5: Provide access to affordable housing for individuals and families with mental illness.**

**Action Step:** BMHS’ housing affiliate, Community Housing Associates (CHA), will provide 256 units of safe and affordable housing throughout Baltimore City.

CHA provided housing to 226 households (161 individuals and 65 families). Ninety-five percent of tenants remained housed with CHA for more than a year. Due to delays in development, 40 planned units were not ready for tenants this fiscal year (10 more than the goal of 256).

**Indicators:** Number of individuals and families housed; retention in housing greater than 6 months.

See above for progress to date.

**Strategy 6: Increase the number of affordable housing units available to individuals and families with mental illness.**

**Action Step:** CHA will apply for funding to develop housing for adults and families with mental illness.

CHA applied for funding through the Department of Health and Mental Hygiene Capital Bond Program and received $3.5 and $2.9 million for FY 10 and FY 11, respectively. CHA has applied for $2.5 million in the FY 12 grant round. CHA is matching the awarded funds with funds committed from the Department of Housing and Community Development and the Housing Authority of Baltimore City to develop 100 new units of affordable housing for individuals with disabilities.
**Action Step:** CHA will secure funding to acquire and rehabilitate an additional ten (10) units of housing to serve adults and families with mental illness.

CHA has acquired 17 units of affordable housing. Ten units were acquired in December of 2009, and 7 additional units were acquired in June of 2010. Rehabilitative construction will begin in FY11 for these units.

**Action Step:** CHA will secure rental subsidies for all new units, ensuring tenants pay no more than 30% of income for rent.

All units will have Project Based Section 8 rental subsidies, and tenants will pay 30% of their income towards rent.

**Action Step:** CHA will secure funds to make support services available to residents of CHA housing.

Support for social services is incorporated in each of the budgets that fund the 17 units. The social service funds were approved and will support a Resource Coordinator to support the tenants.

**Indicators:** Number of applications submitted; number of individuals housed; number of units developed; number of units with rental subsidy.

CHA submitted 1 application to DHMH, 6 applications to the Department of Housing and Community Development and the Baltimore City Housing Authority, 2 renewal applications to Maryland’s Community Development Block Grant Program, and 2 renewal applications for the Shelter Plus Care Program. See above for progress to date for the remaining indicators.

**Objective 5.3:** Identify and promote the implementation of evidence-based, effective, promising and best practices for mental health services.

**Status:** Strategies 1 and 2 were accomplished. Strategies 3, 4, and 5 were partially accomplished.

**Strategy 1:** Explore opportunities to increase access to evidence-based practices (EBP) for children and adolescents.

**Action Step:** Provide oversight of and explore increased funding for the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) Positive Behavior and Supports (an evidence-based practice) in at least one Head Start Center.

In FY 10, Umoja Head Start was a State demonstration site for CSEFEL. Umoja staff received CSEFEL training and participated in the State Leadership Day that was hosted for demonstration sites around the State. To further support the Umoja Head Start site, BMHS
proposed to serve as the liaison and support for Umoja Head Start as a part of the State CSEFEL committee.

**Action Step:** Partner with the Maryland CESFEL Leadership Team to support the statewide implementation of CSEFEL.

BMHS staff participates in the statewide Steering Committee for Early Childhood and is an active member of the CSEFEL planning committee. As part of the process to move toward implementing CSEFEL, BMHS staff participated in the following activities: served as a CSEFEL trainer to increase the number of early childhood providers, served as a CSEFEL coach to support early childhood providers once they completed training, and served as the liaison between Umoja Head Start (a State-designated demonstration site) and the State.

**Action Step:** Collaborate with the Innovations Institute on the dissemination of Functional Family Therapy (FFT) in Baltimore City.

In FY 10, BMHS entered into an intergovernmental agreement (IGA) with the Maryland State Department of Juvenile Services (DJS) to provide oversight and to implement Functional Family Therapy (FFT) services in an effort to improve outcomes for at least 75 court-involved youth ages 10 to 18. The primary goal of this project is to reduce recidivism and out-of-home placements for DJS-involved youth. BMHS met monthly with DJS, Innovations Institute, and FFT, Inc. to assure that services were being designed in accordance to the evidence-based model.

BMHS issued a Request for Qualification (RFQ) to certified FFT providers with a demonstrated history of program success in providing evidence-based services to an urban juvenile justice population. At the recommendations of BMHS’ review committee, Vision Quest was selected as the sole provider of FFT services in Baltimore City. Services are scheduled to begin during the first quarter of FY 11.

**Indicators:** Number of youth served; progress report on implementation and associated outcomes.

See above for progress to date.

**STRATEGY 2:** Facilitate implementation of MHA’s evidence-based practice guidelines for supported employment and assertive community treatment (ACT).

**Action Step:** Provide information, support and encouragement to programs expressing interest in adopting evidence-based practices.

BMHS continued to promote the adoption of evidence-based practices in Baltimore City. Supported Employment Programs (SEPs) and Assertive Community Treatment (ACT) teams are the two evidence-based practice models most utilized for adults in the City. Family psycho-education, another evidence-based practice being promoted by the State, has not been widely embraced by providers due to an inadequate reimbursement rate.
BMHS continued to utilize mobile treatment provider meetings to discuss the benefit of adopting evidence-based practices. This has been particularly helpful, as programs already certified by the State as ACT teams have offered guidance and support to programs working to become certified. This year one existing mobile treatment program became certified as an ACT team. Currently, five of the eight mobile treatment programs in Baltimore City are certified as ACT teams. One additional mobile treatment team has received technical assistance from BMHS and will be submitting a plan for ACT certification in FY 11, and the remaining two mobile treatment programs have expressed interest in becoming certified ACT providers.

Two vocational providers received technical assistance from BMHS in the evidence-based practice of supported employment. In addition, a BMHS staff person participates on the leadership teams for two providers who are in the process of working to become certified SEP providers. Leadership teams are a recommended action for programs interested in adopting SEP.

Finally, BMHS has been collaborating with bSAS to begin an Integrated Dual Disorders Team (IDDT), an evidence-based program model similar to ACT for individuals with co-occurring mental health and substance abuse disorders. See page 49 for a fuller description.

**Indicators:** Number and type of programs maintaining fidelity to the models.

There were 3 Supported Employment Programs and 5 Assertive Community Treatment teams maintaining fidelity to the models in Baltimore City.

**STRATEGY 3: Explore opportunities to implement evidence-based practice guidelines for services to the elderly.**

**Action Step:** Provide leadership to identify evidence-based practices and providers willing to collaborate to better address the needs of the City’s elderly residents.

It was challenging to pursue evidence-based practices (EBP) for elderly individuals because, unlike other EBPs, the EBPs targeting this population of consumers are not covered by any funding stream such as Medicare or Medicaid.

**Indicator:** Report on progress to date.

See above for progress to date.

**STRATEGY 4: Solidify funding and expand and institutionalize Behavioral Emergency Services Team (BEST) within the City’s Police Department.**

**Action Step:** Develop a taskforce that consists of leadership from Baltimore Mental Health Systems, Inc. (BMHS), Baltimore City Police Department (BPD), Baltimore Crisis Response, Inc. (BCRI), Baltimore Child and Adolescence Response System (B-
CARS), National Alliance on Mental Illness (NAMI), and other community stakeholders. Convene task force meetings to maintain and strengthen the collaboration between the BPD and the local public mental health system.

For description of activities related to this action step, please see narrative on page 15.

**Action Step:** Adopt a uniform curriculum for the basic and advanced trainings.

Modifications were made to the BEST curriculum to best meet the educational needs of newly recruited police officers. As outlined in the BEST Plan of Action, a curriculum committee, coordinated by BMHS, will continue to review and update curriculum for the project as needed.

**Action Step:** Collaborate with the BPD to get the Behavioral Emergency Services Team (BEST) training incorporated into the BPD training curriculum.

The BEST training was incorporated into the BPD training curriculum for new recruits.

**Action Step:** Train 25% of all BPD patrol officers.

The goal of training 25% of patrol officers was replaced with the goal of providing training to all new recruits, with an ultimate goal of a fully trained patrol force. See page 15 for description of activities advancing the BEST project in FY 10.

**Action Step:** Explore opportunities to develop a comprehensive evaluation of the project.

No progress was made on this objective. For this fiscal year, all activities of the BEST project focused on facilitating training for all new recruits.

**Indicator:** Report on progress to date.

86 patrol officers trained were trained in FY 10, and 407 officers have been trained since the program’s inception in January 2004.

**STRATEGY 5:** Identify opportunities to improve coordination in the provision of mental health treatment and somatic care.

**Action Step:** Collaborate with MHA, Community Behavioral Health and other interested partners in implementing tobacco cessation and other practices that address somatic risk factors in mental health treatment settings.

BMHS staff participates on the MHA Smoking Cessation Committee and the MDQUIT Resource Center Advisory Board at the state level. Otherwise, no system-level planning occurred in FY 10 for tobacco cessation or other practices addressing somatic risk factors due to limited BMHS resources. (This is not a funded activity.)
**Objective 5.4 Improve public mental health programs’ compliance with quality standards established by MHA and State and Federal Regulations.**

**Status:** All strategies were accomplished.

**Strategy 1: Conduct quality assurance site visits to mental health programs.**

**Action Step:** Collaborate with MHA and ValueOptions to conduct audits of mental health programs to evaluate quality of services, billing practices and compliance with state and federal regulations.

BMHS staff collaborated with MHA and ValueOptions to conduct quality assurance site visits of mental health programs. Site visits were conducted with 20 providers during FY 10. Eighteen providers failed at least one quality standard and were required to submit Performance Improvement Plans (PIPs). BMHS acted as a technical advisor to providers in support of the provider PIP submissions, when requested.

**Action Step:** Using data from compliance audits, identify areas where system-wide improvements in services are needed.

BMHS staff collaborated with the Compliance Committee of MHA to identify areas where improvements were needed. The identified areas generally relate to programs not following COMAR regulations. One specific area of concern remains - that some outpatient mental health clinics did not have medical directors. System-wide improvement efforts may be needed to improve the tracking and reporting of medical director resignations, leave of absence and new medical director appointments. The new ASO, ValueOptions, which participates in the Quality Compliance Committee, oversees this process and is problem-solving around this issue.
**Action Step:** In collaboration with ValueOptions, develop targeted education and training to improve performance on quality standards where data show a pattern of performance below established thresholds.

ValueOptions (VO) conducted provider trainings in areas such as case management, psychiatric rehabilitation and residential treatment for minors. Trainings assisted case management providers in the transition from grant funding to fee-for-service reimbursement. BMHS acted as a liaison between providers and VO, and invited VO staff to be present at BMHS-sponsored provider meetings to answer questions related to the above. BMHS also provided technical assistance to providers on an as-needed basis throughout the fiscal year.

**Indicators:** Number of programs whose services meet quality standards; number of programs failing standards; number of programs with sanctions imposed due to non-compliance.

20 providers received quality assurance site visits; 18 failed at least one standard and were required to submit PIPs due to deficiencies; 2 met all quality standards, no programs received sanctions due to non-compliance.

**STRATEGY 2: Provide training and technical assistance to mental health programs.**

**Action Step:** Offer education and technical assistance to new programs that submit an application to deliver public mental health services.

Twenty-one programs submitted applications to provide mental health services in Baltimore City, and all received technical assistance. Some applicants were new providers to the PMHS and others were current providers interested in establishing new programs. Providers were asked to submit a business plan and a break-even cost analysis as part of their application submission. These documents are reviewed by BMHS staff to assure that system needs are being addressed during the application process. Providers were given feedback on application materials submitted and were given suggestions on how to attain compliance with COMAR. Once an application adequately addressed the regulations, BMHS provided a letter of support. Providers were then instructed to submit the revised application to the Office of Health Care Quality to initiate the approval process.

**Indicator:** Number of programs receiving technical assistance.

21 programs received technical assistance.

**Action Step:** Offer technical assistance to providers in developing performance improvement plans in response to quality assurance site visits.

BMHS staff provided technical assistance to eight providers who received PIPs resulting from OHCQ site visits. BMHS staff provided technical assistance to providers in developing their performance improvement plan, which is then submitted to OHCQ for approval.
**Indicator:** Number of programs receiving technical assistance.

8 programs received technical assistance with PIPs.

**Objective 5.5:** Ensure that residential rehabilitation programs (RRP) provide safe, affordable, and quality housing.

**Status:** All strategies were accomplished.

**Strategy 1: Inspect 100% of RRP housing to evaluate compliance with COMAR.**

**Action Step:** Conduct initial, annual housing inspections.

Every core service agency is required to conduct annual inspections of all residential rehabilitation program (RRP) housing. RRP housing is an umbrella category for three types of residential units: residential rehabilitation programs, consisting of one- to three-bedroom units; adult group homes that have four or more bedrooms; and crisis residential beds.

BMHS staff inspected 100% of the City’s housing units, which have the capacity to house a total of 383 residents. There are ten providers with 138 RRP units. Units are defined as individual dwellings with leases or ownership (i.e. apartment, house, group home, residential unit for crisis).

BMHS also conducted a housing inspection of BCRI’s 21 crisis residential beds as well as four initial inspections of new units as part of its annual housing inspection activity. (These four units were replacements for units providers closed.)

Overall, the housing was found to be in good repair, with all 138 inspections resulting in recertification after repairs were completed in a timely fashion.

**Action Step:** Conduct follow-up inspections to determine if deficiencies identified during inspections were corrected.

BMHS staff conducted 94 follow-up inspections of units that had deficiencies during their annual inspection. An RRP receives either general approval when no deficiencies are found or provisional approval for one or more deficiencies. Providers have 30 days to make repairs once they have received a provisional approval. Failure to make repairs can lead to a program’s license being revoked by MHA. The most common deficiencies cited in FY 10 were general maintenance that had not been performed. All deficiencies were corrected, resulting in recertification.

**Indicators:** Number of RRP units, number of RRP beds inspected, type of approvals

The number of RRP units, number of RRP beds inspected, and the types of approvals for FY 10 are as follows:
### FY10 Residential Housing Inspections Conducted by QM staff

<table>
<thead>
<tr>
<th>Provider</th>
<th>Type of Housing</th>
<th># Housing Units</th>
<th>Beds Inspected</th>
<th>Type of Approval</th>
<th>Year End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance Inc.</td>
<td>RRP</td>
<td>14</td>
<td>46</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Harford/ Belair</td>
<td>RRP</td>
<td>15</td>
<td>46</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Harbor City Unlimited</td>
<td>RRP</td>
<td>19</td>
<td>51</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>Key Point</td>
<td>RRP</td>
<td>21</td>
<td>49</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td>Bon Secours-New Phases</td>
<td>RRP</td>
<td>10</td>
<td>23</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>North Baltimore Center</td>
<td>RRP</td>
<td>34</td>
<td>80</td>
<td>34</td>
<td>0</td>
</tr>
<tr>
<td>People Encouraging People</td>
<td>RRP</td>
<td>6</td>
<td>28</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Volunteers of America</td>
<td>RRP</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Mosaic -RRP</td>
<td>Adult Group Home</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>BCRI</td>
<td>Residential Crisis</td>
<td>1</td>
<td>21</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>138</strong></td>
<td><strong>383</strong></td>
<td><strong>138</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

### Objective 5.6: Improve BMHS vendor contract management process.

**STRATEGY 1: Improve BMHS vendor contract management process.**

**Action Step:** Assess vendor performance through submission of quarterly reports and conduct site visits to providers identified as having inconsistencies in achieving deliverables.

There were 147 contracts issued in FY 10, totaling $23,341,998 in awards. One hundred and sixteen contracts were funded by DHMH and 31 were funded by various non-DHMH funding sources. The provider contract compliance rate is measured by the percentage of providers that receive payment on time. Payments are held when the submission of contractual documents, including quarterly program reports, invoices, quarterly fiscal reports, insurance, and fidelity bonds are not timely, complete or accurate.

The average provider contract compliance rate improved from 54% in FY 09 to 59% in FY 10. By the end of FY 10, 100% of providers had submitted program reports (reports on programmatic deliverables), up from 88% in FY 09. The charts below describe quarterly contract compliance ratings.
BMHS has made a concerted effort to improve contractual compliance rates this year. During the contract renewal meetings with providers, BMHS reviewed requirements as well as the consequences of non-compliance, including payments withheld, ineligibility for re-purposed funding, and delay in renewing or nonrenewal of contracts. BMHS also increased communication with providers throughout the year in an effort to help providers become compliant.

Challenges continue to exist with timely submission of some of the non-DHMH contract documents, particularly with the larger provider institutions where information must flow through various departments prior to release to BMHS. BMHS staff is working with these larger organizations to improve their compliance rates.

The tables below compare timeliness of contract execution over the past five years. Efforts to improve the contract renewal process began in FY 10 and resulted in a slight decrease in timeliness of contract execution. However, BMHS used lessons learned from this contract renewal process, and strengthened the renewal process for FY 11. These data will be reported in next year’s report.

<table>
<thead>
<tr>
<th>Timeliness of Contract Execution</th>
<th>FY 06</th>
<th>FY 07</th>
<th>FY 08</th>
<th>FY 09</th>
<th>FY 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executed by contract renewal date</td>
<td>93 (82%)</td>
<td>97 (81%)</td>
<td>88 (81%)</td>
<td>100 (85%)</td>
<td>93 (80%)</td>
</tr>
</tbody>
</table>

This number was previously reported as 87 (71%). However, this number has been updated to accurately reflect BMHS’ records.
Timeliness of Contract Execution
FY 06 – FY 10 Non-DHMH Contracts

<table>
<thead>
<tr>
<th>Indicator</th>
<th>FY 06 (15%)</th>
<th>FY 07 (12%)</th>
<th>FY 08 (32%)</th>
<th>FY 09 (37%)</th>
<th>FY 10 (6%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executed by July 1</td>
<td>7</td>
<td>6</td>
<td>18</td>
<td>19</td>
<td>2</td>
</tr>
<tr>
<td>Executed by start-date</td>
<td>13</td>
<td>5</td>
<td>13</td>
<td>7</td>
<td>2</td>
</tr>
</tbody>
</table>

**Action Step:** Track vendor performance and compliance with conditions in their contract and address issues of non-compliance in a consistent and timely manner.

Contract performance per programmatic deliverables on the progress report is rated as “met,” “partially met,” or “not met.” This rating system indicates whether a provider has completed the specific programmatic requirements outlined in their contract (e.g., the number of clients served, the number of services provided). One hundred and six contracts (86%) were rated as “met” at year-end, 15 contracts (12%) were rated as “partially met” and two contracts (2%) were rated as “not met.”

<table>
<thead>
<tr>
<th>Contract Types</th>
<th>Rating of “MET” at Year-End</th>
<th>Rating of “PARTIALLY MET” at Year-End</th>
<th>Rating of “NOT MET” at Year-End</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHMH</td>
<td>86</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>NON-DHMH</td>
<td>20</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>106</td>
<td>15</td>
<td>2</td>
</tr>
</tbody>
</table>

**Action Step:** Conduct site visits at scheduled intervals to evaluate actual contract services delivered and compare to documents submitted to BMHS.

BMHS conducts site visits to verify actual services delivered and the quality of those services purchased by the contract. Contracts funded for more than $200,000 require an annual site visit. Contracts funded for less than $200,000 are visited bi-annually. Providers who have a deemed status through third party accreditation are visited every three years. During the site visit, BMHS interviews vendor program staff, consumers, and family members, and then issues a written report to the vendor and Office of Health Care Quality (OHCQ). In FY 10, 67 site visits were conducted compared to 94 in FY 09. These 67 visits constituted all required site visits. The number of required site visits fluctuates from year to year based on the number of sites that require a regularly scheduled visit and the number of sites that require a visit initiated by a complaint or previous finding. All site visits were conducted according to these schedules.

Additionally, at the request of MHA, BMHS began conducting site visits in FY 10 for certification of the fee-for-service case management programs. BMHS created a new audit tool for the purpose of certifying the case management programs. Nine case management programs were reviewed and certified for an annual period. These programs will be reviewed for re-certification annually hereafter.


**Indicators:** Number of contracts in compliance; timeliness of contract execution; performance ratings; reduction in the number of non-compliant programs.

The average provider contract compliance rate improved overall from 54% in FY 09 to 59% in FY 10. In FY 10, the highest percentage of providers that were contractually compliant for a given month was 74%. Please see above for more detailed compliance rates.

**GOAL VI: Technology is used to access mental health care information.**

**Objective 6.1:** Explore the application of technology to improve service delivery including promoting the use of web-based technology as a tool to improve information sharing, data collection, and evaluation.

**Strategy 1:** Use Datalink to access services for individuals in the City’s jails who have mental health service needs.

**Action Step:** Develop a plan in collaboration with the Department of Corrections and the Mayor’s Office of Criminal Justice and Planning to utilize the data available through Datalink to improve release plans for incarcerated individuals with mental illness.

Due to the State’s selection of a new ASO, there was an interruption in the data-feed for the Datalink project, and data have not been received since the PMHS transitioned to the new ASO in September, 2009. A new memorandum of understanding (MOU) was required and was signed in early FY 11. It is expected that the data-feed will be restored sometime in FY 11 or FY 12. Although the data are not being received, several meetings were held with MHA, the Department of Corrections, ValueOptions (the State’s new ASO), and core service agencies to discuss how to streamline the import of the data so that the project could expand to other jurisdictions in the State. At this time, a workflow process has not yet been delineated for the Datalink project.

**Indicator:** Report on progress to date.

See above for report on progress.

**Strategy 2:** Consolidate BMHS data systems to facilitate coordination of care.

**Action Step:** Contract with a vendor to provide project oversight, database development and programming for a web-based system.

BMHS’ integrated database was successfully launched in FY 10. This database links client-, program-, and contract-level data in support of key core service agency operations. Tutorials have been created and used to train BMHS staff on the use of the database.
**Indicator:** Report on progress to date.

The integrated database was officially launched on September 14, 2009.

**STRATEGY 3:** Develop, maintain and publicize Baltimore City’s site for Network of Care, a web-based application that includes a service directory and other mental health-related resources.

**Action Step:** Collaborate with other City providers to update and add new resources as identified.

The BMHS data coordinator has been trained by Trilogy Integrated Resources, Inc. on how to navigate the Network of Care site to update and add new resources. As BMHS receives information on new resources and receives updated contact information for providers, the data coordinator makes the requested edits to the site.

BMHS continues to encourage Baltimore City mental health providers to participate in Network of Care through announcements at provider meetings. In addition, BMHS provided four trainings on Network of Care to community stakeholders, including Baltimore City’s 211 operators, Baltimore HealthCare Access, Coppin State University and Hope Health Systems.

**Action Step:** Launch the Baltimore City Network of Care site through a press release and other planned communications targeted at potential users.

BMHS has taken a soft approach to launching the Baltimore City Network of Care site. It has promoted the site during various community meetings, including the all-provider meetings held by BMHS, and used site launch announcements, promotional give-a-ways and the BMHS website to advertise the site.

**Indicator:** Report on progress to date.

The Network of Care site received 1,197,124 hits, or views, in FY 10 compared to 1,012,147 in FY 09, a 15% increase.
DATA ON SERVICE UTILIZATION SUMMARY

Baltimore City Population

- 637,418 individuals, < 0.1% increase
- 11% of the State’s population, no change
- 62% Non-Hispanic Black (2% decrease), 32% Non-Hispanic White (1% increase), 3% Hispanic (any race) (<1% increase), 2% Asian (no change), and 1% other races (<1% increase)
- Non-Hispanic Whites are the fastest growing racial/ethnic group

Prevalence of Mental Illness and Substance Use Disorders in Adults (18 years and older)

- 26% of individuals (128,561) have a mental disorder
- 11% of individuals (54,391) have a substance use disorder, compared to 8% of the State
- 12,149 – 25,515 individuals need both mental health and substance abuse treatment

Utilization of the Public Mental Health System (PMHS)

- 39,772 individuals served, a 12% increase
- 93% of individuals Medicaid, 10% uninsured and 9% Medicaid State-funded
- 37,020 individuals served in the PMHS covered by Medicaid, a 46% increase over the last 4 years
- 24,753 adults 18 years and older served, a 17% increase
- # of adults with inpatient hospitalizations increased by 8%
- # of adults utilizing outpatient services increased by 17%
- 15,019 children and adolescents served, a 5% increase
- # of children and adolescents with inpatient hospitalizations increased by 5%
- # of children and adolescents utilizing outpatient services increased by 5%

Expenditures for Services

- City consumers represent 33% of those served in the State and 35% of the State’s PMHS expenditures
- Total PMHS expenditures in Baltimore City increased by 8%
- 33% (7,075) of adults served had co-occurring mental health and substance abuse disorders and accounted for 33% of the expenditures
- Average expenditure per adult consumer was $5,285, a 8% decrease from $5,715 in FY 09
  - $126,724 for adults identified as high-cost consumers
- Average expenditure per child/adolescent consumer was $5,690, a 3% increase from $5,504 in FY 09
  - $184,290 for the top 50 child and adolescent high-cost consumers

9 Unless otherwise noted, US Census Bureau Data from 2008 and 2009 are compared.
12 Based on estimates from the U.S. Department of Health and Human Services.
13 Unless otherwise noted, comparisons are to FY 09 data.
14 Many people use services in more than one service type and/ or coverage type. As a result, the sum of the percentage of people served across service types and across coverage types may exceed 100%.
15 Italics are used throughout this section to identify data that is from FY 09.
DATA ON SERVICE UTILIZATION

SOURCE OF DATA

Unless otherwise specified, the data presented in this section of the report are service utilization data collected by the Administrative Services Organization (ASO) for Maryland’s fee-for-service Public Mental Health System (PMHS), currently ValueOptions (VO). The data describe the use of services and associated expenditures for children and adults in FY 10, from July 1, 2009 through June 30, 2010. Data reports were run through September 30, 2010 (three months after the end of FY 10), with the exception of the co-occurring disorders data which was run through January 31, 2011.

As in previous years, the most recent data reported (FY 10) are incomplete, as claims may be submitted up to twelve months after the date of service delivery. Therefore, as in previous annual reports, the data for FY 10 do not reflect all of the claims for services rendered to Baltimore City individuals in FY 10, yet the data for previous years to which it is being compared represent 100% of claims for those years. This needs to be kept in mind when comparing FY 10 data to FY 09 and FY 08 data for trends. When comparisons with previous years show increases in FY 10, it is likely that the actual increase is somewhat greater. Conversely, decreases in FY 10 compared to previous years will be somewhat offset by the missing claims data. This artifact of the PMHS is more pronounced for expenditures and service data and less for numbers of consumers served, since the majority of consumers served have a severe mental illness or emotional disorder, and receive services for significant duration.

The tables and charts that follow are required by Maryland’s Mental Hygiene Administration (MHA) for inclusion in this report. They present summary data from the past three fiscal years for Baltimore City and the past fiscal year for Maryland. It should be noted that previously reported data for the three fiscal years prior to FY 10 were updated to include claims that were paid after September 30th following the respective fiscal year, and, therefore, may be different from data reported in previous BMHS annual reports.

There were three changes in FY 10 relating to reimbursement and eligibility for PMHS services that need to be considered when reviewing trends in data over the past three years: 1) medical necessity criteria, guidelines that determine the appropriate level of care, were tightened for therapeutic behavioral, intensive outpatient, partial hospitalization, and residential treatment center services; 2) case management reimbursement changed from grant funding to fee-for-service (FFS); and 3) additional eligibility requirements for uninsured individuals were implemented, which restricted access to intensive outpatient and partial hospitalization services.

Furthermore, it should be noted that the data presented here do not provide a complete picture of the utilization of publicly funded mental health services, since services funded by Medicare are not included, nor are services funded through grant-funded contracts. Throughout this report, “those served by the Public Mental Health System” refers only to individuals utilizing services funded through the fee-for-service PMHS.
Finally, as of the writing of this report, some of the data reported annually by BMHS were not available from ValueOptions for inclusion in this report. This includes data on co-occurring disorders, high-cost users, and serious mental illness. However, because these data describe important aspects of the PMHS and are unlikely to change significantly over a one-year period, FY 09 data are presented. Italics are used throughout this section to differentiate FY 09 data from FY 10 data. (This report will be updated once the FY 10 data become available.)

Overview of Utilization Data

Comments on the data that follow will be limited to overall trends. Many of the trends of interest are specific to particular age groups and program types, and will be discussed later in this section under headings entitled Service Utilization by Adults and Service Utilization by Children and Adolescents, beginning on page 91.

Overall, there are four striking observations from the FY 10 data on service utilization in the PMHS:

- The Public Mental Health System in Baltimore City continues to expand, both in terms of the number of individuals served (21% over the past three years to 39,772) and the total amount of expenditures (19% over the past three years to $216 million).
- There has been a significant increase in Medicaid consumers, 46% in the last four years.
- The greatest driver of the increased cost in FY 10 is inpatient care, which contributed more than half of the $16 million increase in expenditures from FY 09 to FY 10.
- There has been a notable decline in service provision to uninsured individuals.

Consumers Served

While Baltimore City represents 11% of the State’s population, it represents 33% of those who utilized the PMHS in FY 10. During the past three fiscal years, the number of City residents served has increased by 21% and the number of Maryland residents served has increased by 22%. The overall increase in the City is due to more service to all age groups, but can be largely attributable to an increase in service utilization by adults (22-64 years) of 3,047 or 16%, followed by: transitional age youth (18-21 years) of 478 or 25%; adolescents (13-17 years) of 255 or 5%; children (0-5 years) of 125 or 7%; and elderly consumers (65 years and older) of 34 of 10%.

Expenditures

Total expenditures of $216,272,715 for Baltimore City account for 35% of the State’s total expenditures on public mental health services in FY 10. During the past three years, City expenditures increased at a slightly higher rate than the State, 19% and 17% respectively, and in FY 10, City expenditures increased by 8% versus 7% statewide. Some of this increase was due to the previously mentioned transition of case management from grant-funded to fee-for-service reimbursement. Factoring out the case management expenditures, there was a 7% increase in expenditures between FY 09 and FY 10, all of which is attributable to greater utilization, since there were no PMHS rate increases in FY 10, unlike in the previous two years.
The increase of more than $16 million in PMHS expenditures in Baltimore City is largely due to increases associated with three service types: inpatient ($8.5 million), outpatient ($5 million) and psychiatric rehabilitation ($2.9 million), which were offset by a decrease in partial hospitalization ($1.3 million). For inpatient treatment, the number of consumers served increased by 7% and expenditures increased by 17%. The cost per consumer for inpatient treatment increased by 9%, due in part to a 6% increase in hospital reimbursement rates and to more inpatient days per consumer (i.e., some combination of longer lengths of stay and more episodes of care). The opposite was true for both outpatient treatment and psychiatric rehabilitation, where the cost per consumer decreased. The cost per consumer for outpatient treatment, the most frequent service utilized (by 94% of those receiving PMHS services), decreased by 5% (8% for adults and less than 1% for children/adolescents), and for psychiatric rehabilitation by 6%. This suggests the increase in expenditures for these two service types is due to more consumers served (12% for outpatient and 16% for psychiatric rehabilitation).

In FY 10, nearly one out of five consumers in the PMHS was treated for co-occurring mental health and substance use disorders, though the actual percentage of individuals with co-occurring disorders is most likely higher, since many consumers are reluctant to report substance use to providers. There are also inconsistencies in how providers define “individuals with co-occurring disorders”; i.e., some providers only identify those who have a current need to be treated for substance abuse, while others include those who have histories of substance abuse, but do not currently require treatment.

Baltimore City continues to have a greater proportion of individuals with co-occurring disorders and to spend more on treatment for co-occurring disorders than the State. In FY 09, individuals with co-occurring disorders accounted for 19% of those served in the City and 15% of those served in the State, accounting for 33% of City expenditures and 28% of State expenditures, respectively.

**Insurance Coverage**

The main source of health insurance coverage for public mental health services is Medicaid, including Medicaid State-funded. Most noteworthy is the continued expansion of service to individuals with Medicaid, which has increased by 46% over the last four years and 13% in the last year alone. The total number of uninsured consumers has remained steady in the past three fiscal years, with a slight decrease in FY 10. However, there was a 43% decrease in uninsured expenditures in FY 10, due to restrictions imposed on uninsured access to intensive outpatient care and partial hospitalization. Medicaid State-funded expenditures for public mental health services increased by 44%, and the number of individuals served in this category nearly doubled.

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16 Most of the City’s hospitals received an increase in their reimbursement rate, some more than 21%, for inpatient psychiatric hospitalization from the Health Services Cost Review Commission. The HSCRC is an independent State agency with seven Commissioners appointed by the Governor, which has broad responsibility regarding the public disclosure of hospital data and operating performance and authorization to establish hospital rates to promote cost containment, access to care, equity, financial stability and hospital accountability.

17 Medicaid State-funded expenditures are state-only funds (versus those with a federal match) for State programs such as Primary Adult Care (PAC) for individuals who are eligible based on certain income and assets criteria.
between FY 08 and FY 10. These increases can be attributed to: 1) the expansion of the Primary Adult Care (PAC) program, a State program that covers outpatient mental health services and prescription drugs for adults who meet income and assets eligibility and are not on Medicare; and, to a lesser degree, 2) case management services transferring to the fee-for-service system. Between FY 09 and FY 10, Medicaid expenditures increased by 10%, while the number of consumers in the public mental health system receiving Medicaid increased at a slightly higher rate of 13%.

The following tables present overall data for Baltimore City and the State of Maryland. It should be noted that statewide data include data from Baltimore City, which, as previously stated, comprises about a third of all consumers served in Maryland and more than a third of State expenditures.
### Baltimore City Public Mental Health System Utilization

#### Baltimore City Consumers Served by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>FY 08</th>
<th>FY 09</th>
<th>% Change 08-09</th>
<th>FY 10</th>
<th>% Change 09-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Child (0-5)</td>
<td>1,827</td>
<td>1,902</td>
<td>4.1%</td>
<td>2,027</td>
<td>6.6%</td>
</tr>
<tr>
<td>Child (6-12)</td>
<td>6,859</td>
<td>7,018</td>
<td>2.3%</td>
<td>7,341</td>
<td>4.6%</td>
</tr>
<tr>
<td>Adolescent (13-17)</td>
<td>5,424</td>
<td>5,396</td>
<td>-0.5%</td>
<td>5,651</td>
<td>4.7%</td>
</tr>
<tr>
<td>Transitional (18-21)</td>
<td>1,641</td>
<td>1,916</td>
<td>16.8%</td>
<td>2,394</td>
<td>24.9%</td>
</tr>
<tr>
<td>Adult (22 to 64)</td>
<td>16,870</td>
<td>18,926</td>
<td>12.2%</td>
<td>21,973</td>
<td>16.1%</td>
</tr>
<tr>
<td>Elderly (65 and over)</td>
<td>380</td>
<td>352</td>
<td>-7.4%</td>
<td>386</td>
<td>9.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>33,001</td>
<td>35,510</td>
<td>7.6%</td>
<td>39,772</td>
<td>12.0%</td>
</tr>
</tbody>
</table>

#### Baltimore City Consumers Served by Service Type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>FY 08</th>
<th>FY 09</th>
<th>% Change 08-09</th>
<th>FY 10</th>
<th>% Change 09-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>569</td>
<td>7</td>
<td>-98.8%</td>
<td>940</td>
<td>13,328.6%</td>
</tr>
<tr>
<td>Crisis</td>
<td>626</td>
<td>636</td>
<td>1.6%</td>
<td>702</td>
<td>10.4%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>2,787</td>
<td>2,960</td>
<td>6.2%</td>
<td>3,177</td>
<td>7.3%</td>
</tr>
<tr>
<td>Mobile Treatment</td>
<td>856</td>
<td>825</td>
<td>-3.6%</td>
<td>849</td>
<td>2.9%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>30,280</td>
<td>33,210</td>
<td>9.7%</td>
<td>37,203</td>
<td>12.0%</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>2,162</td>
<td>1,859</td>
<td>-14.0%</td>
<td>1,476</td>
<td>-20.6%</td>
</tr>
<tr>
<td>Psychiatric Rehabilitation</td>
<td>5,249</td>
<td>5,609</td>
<td>6.9%</td>
<td>6,526</td>
<td>16.3%</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>1,002</td>
<td>1,062</td>
<td>6.0%</td>
<td>1,102</td>
<td>3.8%</td>
</tr>
<tr>
<td>Residential Treatment</td>
<td>175</td>
<td>184</td>
<td>5.1%</td>
<td>192</td>
<td>4.3%</td>
</tr>
<tr>
<td>Respite Care</td>
<td>54</td>
<td>65</td>
<td>20.4%</td>
<td>84</td>
<td>29.2%</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>385</td>
<td>376</td>
<td>-2.3%</td>
<td>392</td>
<td>4.3%</td>
</tr>
<tr>
<td>BMHS Capitation</td>
<td>303</td>
<td>295</td>
<td>-2.6%</td>
<td>316</td>
<td>7.1%</td>
</tr>
<tr>
<td>Emergency Petition</td>
<td>27</td>
<td>3</td>
<td>-88.9%</td>
<td>14</td>
<td>366.7%</td>
</tr>
<tr>
<td>Purchase of Care</td>
<td>168</td>
<td>201</td>
<td>19.6%</td>
<td>160</td>
<td>-20.4%</td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facility Waiver</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>33,001</td>
<td>35,510</td>
<td>7.6%</td>
<td>39,772</td>
<td>12.0%</td>
</tr>
</tbody>
</table>

#### Baltimore City Consumers Served by Coverage Type

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>FY 08</th>
<th>FY 09</th>
<th>% Change 08-09</th>
<th>FY 10</th>
<th>% Change 09-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>30,198</td>
<td>32,699</td>
<td>8.3%</td>
<td>37,020</td>
<td>13.2%</td>
</tr>
<tr>
<td>Medicaid State Funded</td>
<td>1,890</td>
<td>2,039</td>
<td>7.9%</td>
<td>3,431</td>
<td>68.3%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>3,700</td>
<td>3,780</td>
<td>2.2%</td>
<td>3,760</td>
<td>-0.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>33,001</td>
<td>35,510</td>
<td>7.6%</td>
<td>39,772</td>
<td>12.0%</td>
</tr>
</tbody>
</table>

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18 Many people use services in more than one service type and are covered by more than one coverage type. The totals presented here represent an unduplicated count, so the numbers in each service or coverage type may add up to a number higher than the total listed.
### Baltimore City Consumers with Co-Occurring Disorders Served

<table>
<thead>
<tr>
<th></th>
<th>FY 08</th>
<th>FY 09</th>
<th>% Change 08-09</th>
<th>FY 10</th>
<th>% Change 09-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-Occurring</td>
<td>7,132</td>
<td>7,242</td>
<td>1.5%</td>
<td>7,604</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

### Baltimore City Expenditures By Age

<table>
<thead>
<tr>
<th>Age</th>
<th>FY 08</th>
<th>FY 09</th>
<th>% Change 08-09</th>
<th>FY 10</th>
<th>% Change 09-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Child (0-5)</td>
<td>$5,000,417</td>
<td>$5,831,452</td>
<td>16.6%</td>
<td>$6,140,606</td>
<td>5.3%</td>
</tr>
<tr>
<td>Child (6-12)</td>
<td>$35,791,905</td>
<td>$39,669,161</td>
<td>10.8%</td>
<td>$44,685,216</td>
<td>12.6%</td>
</tr>
<tr>
<td>Adolescent (13-17)</td>
<td>$31,745,892</td>
<td>$33,299,453</td>
<td>4.9%</td>
<td>$34,633,668</td>
<td>4.0%</td>
</tr>
<tr>
<td>Transitional (18-21)</td>
<td>$8,286,010</td>
<td>$8,412,842</td>
<td>1.5%</td>
<td>$10,564,487</td>
<td>25.6%</td>
</tr>
<tr>
<td>Adult (22 to 64)</td>
<td>$97,022,532</td>
<td>$109,168,334</td>
<td>12.5%</td>
<td>$117,117,161</td>
<td>7.3%</td>
</tr>
<tr>
<td>Elderly (65 and over)</td>
<td>$3,304,895</td>
<td>$3,552,366</td>
<td>7.5%</td>
<td>$3,131,578</td>
<td>-11.8%</td>
</tr>
<tr>
<td>Total</td>
<td>$181,151,651</td>
<td>$199,933,607</td>
<td>10.4%</td>
<td>$216,272,715</td>
<td>8.2%</td>
</tr>
</tbody>
</table>

### Baltimore City Expenditures By Service Type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>FY 08</th>
<th>FY 09</th>
<th>% Change 08-09</th>
<th>FY 10</th>
<th>% Change 09-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>$201,424</td>
<td>$1,995</td>
<td>99.0%</td>
<td>$1,541,539</td>
<td>77,170.1%</td>
</tr>
<tr>
<td>Crisis</td>
<td>$1,402,066</td>
<td>$1,430,176</td>
<td>2.0%</td>
<td>$1,521,652</td>
<td>6.4%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$38,163,305</td>
<td>$49,146,024</td>
<td>28.8%</td>
<td>$57,664,402</td>
<td>17.3%</td>
</tr>
<tr>
<td>Mobile Treatment</td>
<td>$6,140,107</td>
<td>$6,745,113</td>
<td>10.8%</td>
<td>$7,116,458</td>
<td>5.5%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$71,905,660</td>
<td>$79,996,507</td>
<td>11.3%</td>
<td>$84,981,636</td>
<td>6.2%</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>$10,065,511</td>
<td>$8,793,833</td>
<td>12.6%</td>
<td>$7,492,593</td>
<td>-14.8%</td>
</tr>
<tr>
<td>Psychiatric Rehabilitation</td>
<td>$28,069,918</td>
<td>$30,354,518</td>
<td>8.1%</td>
<td>$33,299,770</td>
<td>9.7%</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>$1,512,107</td>
<td>$1,538,850</td>
<td>1.8%</td>
<td>$1,570,739</td>
<td>2.1%</td>
</tr>
<tr>
<td>Residential Treatment</td>
<td>$13,229,969</td>
<td>$11,483,347</td>
<td>13.2%</td>
<td>$11,512,556</td>
<td>0.3%</td>
</tr>
<tr>
<td>Respite Care</td>
<td>$113,689</td>
<td>$107,301</td>
<td>5.6%</td>
<td>$162,099</td>
<td>51.1%</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>$838,837</td>
<td>$830,657</td>
<td>1.0%</td>
<td>$793,618</td>
<td>-4.5%</td>
</tr>
<tr>
<td>Baltimore Capitation</td>
<td>$7,745,740</td>
<td>$7,786,710</td>
<td>0.5%</td>
<td>$7,538,480</td>
<td>-3.2%</td>
</tr>
<tr>
<td>Emergency Petition</td>
<td>$21,995</td>
<td>$1,581</td>
<td>92.8%</td>
<td>$8,804</td>
<td>456.9%</td>
</tr>
<tr>
<td>Purchase of Care</td>
<td>$1,337,121</td>
<td>$1,716,994</td>
<td>28.4%</td>
<td>$1,070,320</td>
<td>-37.7%</td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facility Waiver</td>
<td>$0</td>
<td>$0</td>
<td>0%</td>
<td>$1,050</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>$181,151,651</td>
<td>$199,933,607</td>
<td>10.4%</td>
<td>$216,272,715</td>
<td>8.2%</td>
</tr>
</tbody>
</table>

### Baltimore City Expenditures By Coverage Type

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>FY 08</th>
<th>FY 09</th>
<th>% Change 08-09</th>
<th>FY 10</th>
<th>% Change 09-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>$163,077,065</td>
<td>$180,556,986</td>
<td>10.7%</td>
<td>$198,837,158</td>
<td>10.1%</td>
</tr>
<tr>
<td>Medicaid State-Funded</td>
<td>$7,625,777</td>
<td>$8,095,598</td>
<td>6.2%</td>
<td>$10,989,772</td>
<td>35.7%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>$10,448,810</td>
<td>$11,281,024</td>
<td>8.0%</td>
<td>$6,445,785</td>
<td>-42.9%</td>
</tr>
<tr>
<td>Total</td>
<td>$181,151,651</td>
<td>$199,933,607</td>
<td>10.4%</td>
<td>$216,272,715</td>
<td>8.2%</td>
</tr>
</tbody>
</table>
### Baltimore City Expenditures for Consumers with Co-Occurring Disorders

<table>
<thead>
<tr>
<th>Service Type</th>
<th>FY 08</th>
<th>FY 09</th>
<th>% Change 08-09</th>
<th>FY 10</th>
<th>% Change 09-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-Occurring</td>
<td>$62,244,587</td>
<td>$67,803,768</td>
<td>8.9%</td>
<td>$72,930,667</td>
<td>7.6%</td>
</tr>
</tbody>
</table>

### Baltimore City Persons Served: Child / Adolescent (Age 0 – 17 Years)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>FY 08</th>
<th>FY 09</th>
<th>% Change 08-09</th>
<th>FY 10</th>
<th>% Change 09-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>101</td>
<td>0</td>
<td>100.0%</td>
<td>140</td>
<td>-</td>
</tr>
<tr>
<td>Crisis</td>
<td>31</td>
<td>4</td>
<td>-87.1%</td>
<td>1</td>
<td>-75.0%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>720</td>
<td>779</td>
<td>8.2%</td>
<td>821</td>
<td>5.4%</td>
</tr>
<tr>
<td>Mobile Treatment</td>
<td>133</td>
<td>115</td>
<td>-13.5%</td>
<td>108</td>
<td>-6.1%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>13,817</td>
<td>14,058</td>
<td>1.7%</td>
<td>14,723</td>
<td>4.7%</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>411</td>
<td>449</td>
<td>9.2%</td>
<td>447</td>
<td>-0.4%</td>
</tr>
<tr>
<td>Psychiatric Rehabilitation</td>
<td>2,222</td>
<td>2,274</td>
<td>2.3%</td>
<td>2,760</td>
<td>21.4%</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>3</td>
<td>4</td>
<td>33.3%</td>
<td>4</td>
<td>0.0%</td>
</tr>
<tr>
<td>Residential Treatment</td>
<td>170</td>
<td>182</td>
<td>7.1%</td>
<td>183</td>
<td>0.5%</td>
</tr>
<tr>
<td>Respite Care</td>
<td>54</td>
<td>65</td>
<td>20.4%</td>
<td>81</td>
<td>24.6%</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Baltimore Capitation</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Emergency Petition</td>
<td>0</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>0.0%</td>
</tr>
<tr>
<td>Purchase of Care</td>
<td>13</td>
<td>14</td>
<td>7.7%</td>
<td>7</td>
<td>-50.0%</td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facility Waiver</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>14,110</td>
<td>14,316</td>
<td>1.5%</td>
<td>15,019</td>
<td>4.9%</td>
</tr>
</tbody>
</table>

### Baltimore City Expenditures: Child / Adolescent (Age 0 – 17 Years)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>FY 08</th>
<th>FY 09</th>
<th>% Change 08-09</th>
<th>FY 10</th>
<th>% Change 09-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>$39,806</td>
<td>-</td>
<td>-</td>
<td>$252,000</td>
<td>-</td>
</tr>
<tr>
<td>Crisis</td>
<td>$86,047</td>
<td>$9,155</td>
<td>-89.4%</td>
<td>$5,855</td>
<td>-36.0%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$11,615,542</td>
<td>$15,563,430</td>
<td>34.0%</td>
<td>$18,836,113</td>
<td>21.0%</td>
</tr>
<tr>
<td>Mobile Treatment</td>
<td>$746,087</td>
<td>$776,745</td>
<td>4.1%</td>
<td>$786,187</td>
<td>1.2%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$38,705,859</td>
<td>$41,994,376</td>
<td>8.5%</td>
<td>$43,740,454</td>
<td>4.2%</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>$2,759,475</td>
<td>$3,117,010</td>
<td>13.0%</td>
<td>$3,111,089</td>
<td>-0.2%</td>
</tr>
<tr>
<td>Psychiatric Rehabilitation</td>
<td>$5,411,676</td>
<td>$5,852,892</td>
<td>8.2%</td>
<td>$7,551,245</td>
<td>29.0%</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>$272</td>
<td>$457</td>
<td>68.0%</td>
<td>$4,429</td>
<td>869.1%</td>
</tr>
<tr>
<td>Residential Treatment</td>
<td>$12,985,544</td>
<td>$11,253,113</td>
<td>-13.3%</td>
<td>$10,973,878</td>
<td>-2.5%</td>
</tr>
<tr>
<td>Respite Care</td>
<td>$113,689</td>
<td>$107,301</td>
<td>-5.6%</td>
<td>$160,871</td>
<td>49.9%</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>$0</td>
<td>$0</td>
<td>0.0%</td>
<td>$624</td>
<td>-</td>
</tr>
<tr>
<td>Baltimore Capitation</td>
<td>$0</td>
<td>$0</td>
<td>0.0%</td>
<td>$0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Emergency Petition</td>
<td>$1,975</td>
<td>$1</td>
<td>-99.9%</td>
<td>$1,174</td>
<td>117,300.0%</td>
</tr>
<tr>
<td>Purchase of Care</td>
<td>$74,216</td>
<td>$125,586</td>
<td>69.2%</td>
<td>$34,520</td>
<td>-72.5%</td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facility Waiver</td>
<td>$0</td>
<td>$0</td>
<td>0%</td>
<td>$1,050</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$72,540,188</td>
<td>$78,800,066</td>
<td>8.6%</td>
<td>$85,459,490</td>
<td>8.5%</td>
</tr>
</tbody>
</table>
### Baltimore City Persons Served: Adult (Age 18+ Years)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>FY 08</th>
<th>FY 09</th>
<th>% Change 08-09</th>
<th>FY 10</th>
<th>% Change 09-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>468</td>
<td>7</td>
<td>-98.5%</td>
<td>800</td>
<td>11,328.6%</td>
</tr>
<tr>
<td>Crisis</td>
<td>595</td>
<td>632</td>
<td>6.2%</td>
<td>701</td>
<td>10.9%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>2,067</td>
<td>2,181</td>
<td>5.5%</td>
<td>2,356</td>
<td>8.0%</td>
</tr>
<tr>
<td>Mobile Treatment</td>
<td>723</td>
<td>710</td>
<td>-1.8%</td>
<td>741</td>
<td>4.4%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>16,463</td>
<td>19,152</td>
<td>16.3%</td>
<td>22,480</td>
<td>17.4%</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>1,751</td>
<td>1,410</td>
<td>-19.5%</td>
<td>1,029</td>
<td>-27.0%</td>
</tr>
<tr>
<td>Psychiatric Rehabilitation</td>
<td>3,027</td>
<td>3,335</td>
<td>10.2%</td>
<td>3,766</td>
<td>12.9%</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>999</td>
<td>1,058</td>
<td>5.9%</td>
<td>1,098</td>
<td>3.8%</td>
</tr>
<tr>
<td>Residential Treatment</td>
<td>5</td>
<td>2</td>
<td>-60.0%</td>
<td>9</td>
<td>350.0%</td>
</tr>
<tr>
<td>Respite Care</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>385</td>
<td>376</td>
<td>-2.3%</td>
<td>390</td>
<td>3.7%</td>
</tr>
<tr>
<td>Baltimore Capitation</td>
<td>303</td>
<td>295</td>
<td>-2.6%</td>
<td>316</td>
<td>7.1%</td>
</tr>
<tr>
<td>Emergency Petition</td>
<td>25</td>
<td>2</td>
<td>-92.0%</td>
<td>13</td>
<td>550.0%</td>
</tr>
<tr>
<td>Purchase of Care</td>
<td>155</td>
<td>187</td>
<td>20.6%</td>
<td>153</td>
<td>-18.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18,891</td>
<td>21,194</td>
<td>12.2%</td>
<td>24,753</td>
<td>16.8%</td>
</tr>
</tbody>
</table>

### Baltimore City Expenditures: Adult (Age 18+ Years)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>FY 08</th>
<th>FY 09</th>
<th>% Change 08-09</th>
<th>FY 10</th>
<th>% Change 09-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>$161,619</td>
<td>$1,995</td>
<td>-98.8%</td>
<td>$1,289,539</td>
<td>64,538.5%</td>
</tr>
<tr>
<td>Crisis</td>
<td>$1,316,019</td>
<td>$1,421,020</td>
<td>8.0%</td>
<td>$1,515,798</td>
<td>6.7%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$26,547,763</td>
<td>$33,582,593</td>
<td>26.5%</td>
<td>$38,828,290</td>
<td>15.6%</td>
</tr>
<tr>
<td>Mobile Treatment</td>
<td>$5,798,222</td>
<td>$5,968,367</td>
<td>2.9%</td>
<td>$6,327,272</td>
<td>6.0%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$33,199,801</td>
<td>$38,002,131</td>
<td>14.5%</td>
<td>$41,241,181</td>
<td>8.5%</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>$7,306,036</td>
<td>$5,676,823</td>
<td>-22.3%</td>
<td>$4,381,504</td>
<td>-22.8%</td>
</tr>
<tr>
<td>Psychiatric Rehabilitation</td>
<td>$22,658,241</td>
<td>$24,501,627</td>
<td>8.1%</td>
<td>$25,748,526</td>
<td>5.1%</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>$1,511,836</td>
<td>$1,538,393</td>
<td>1.8%</td>
<td>$1,566,309</td>
<td>1.8%</td>
</tr>
<tr>
<td>Residential Treatment</td>
<td>$244,425</td>
<td>$230,234</td>
<td>-5.8%</td>
<td>$538,677</td>
<td>134.0%</td>
</tr>
<tr>
<td>Respite Care</td>
<td>$0</td>
<td>$0</td>
<td>0.0%</td>
<td>$1,228</td>
<td>-</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>$838,837</td>
<td>$830,657</td>
<td>-1.0%</td>
<td>$792,993</td>
<td>-4.5%</td>
</tr>
<tr>
<td>Baltimore Capitation</td>
<td>$7,745,740</td>
<td>$7,786,710</td>
<td>0.5%</td>
<td>$7,538,480</td>
<td>-3.2%</td>
</tr>
<tr>
<td>Emergency Petition</td>
<td>$20,019</td>
<td>$1,580</td>
<td>-92.1%</td>
<td>$7,631</td>
<td>383.0%</td>
</tr>
<tr>
<td>Purchase of Care</td>
<td>$1,264,880</td>
<td>$1,591,410</td>
<td>25.8%</td>
<td>$1,035,799</td>
<td>-34.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$108,613,438</td>
<td>$121,133,542</td>
<td>11.5%</td>
<td>$130,813,226</td>
<td>8.0%</td>
</tr>
</tbody>
</table>

Source: ValueOptions
Based on claims paid through September 30, 2010 and January 31, 2011 (co-occurring disorders data)
Run Date: October 18, 2010 and February 14, 2011 (co-occurring disorders data)
<table>
<thead>
<tr>
<th>Age</th>
<th>Persons Served</th>
<th>Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State</td>
<td>Baltimore City</td>
</tr>
<tr>
<td>Early Child (0-5)</td>
<td>5,743 (4.7%)</td>
<td>2,027 (5.1%)</td>
</tr>
<tr>
<td>Child (6-12)</td>
<td>24,094 (19.8%)</td>
<td>7,341 (18.5%)</td>
</tr>
<tr>
<td>Adolescent (13-17)</td>
<td>18,614 (15.3%)</td>
<td>5,651 (14.2%)</td>
</tr>
<tr>
<td>Transitional (18-21)</td>
<td>7,948 (6.5%)</td>
<td>2,394 (6.0%)</td>
</tr>
<tr>
<td>Adult (22 to 64)</td>
<td>63,987 (52.6%)</td>
<td>21,973 (55.2%)</td>
</tr>
<tr>
<td>Elderly (65 and over)</td>
<td>1,172 (1.0%)</td>
<td>386 (1.0%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>121,558</td>
<td>39,772</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Persons Served</th>
<th>Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State</td>
<td>Baltimore City</td>
</tr>
<tr>
<td>Case Management</td>
<td>2,918 (2.4%)</td>
<td>940 (2.4%)</td>
</tr>
<tr>
<td>Crisis</td>
<td>1,589 (1.3%)</td>
<td>702 (1.8%)</td>
</tr>
<tr>
<td>Inpatient</td>
<td>9,395 (7.7%)</td>
<td>3,177 (8.0%)</td>
</tr>
<tr>
<td>Mobile Treatment</td>
<td>2,364 (1.9%)</td>
<td>849 (2.1%)</td>
</tr>
<tr>
<td>Outpatient</td>
<td>113,772 (93.6%)</td>
<td>37,203 (93.5%)</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>2,927 (2.4%)</td>
<td>1,476 (3.7%)</td>
</tr>
<tr>
<td>Psychiatric Rehabilitation</td>
<td>17,308 (14.2%)</td>
<td>6,526 (16.4%)</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>4,218 (3.5%)</td>
<td>1,102 (2.8%)</td>
</tr>
<tr>
<td>Residential Treatment</td>
<td>729 (0.6%)</td>
<td>192 (0.5%)</td>
</tr>
<tr>
<td>Respite Care</td>
<td>438 (0.4%)</td>
<td>84 (0.2%)</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>2,657 (2.2%)</td>
<td>392 (1.0%)</td>
</tr>
<tr>
<td>BMHS Capitation</td>
<td>376 (0.3%)</td>
<td>316 (0.8%)</td>
</tr>
<tr>
<td>Emergency Petition</td>
<td>904 (0.7%)</td>
<td>14 (0.0%)</td>
</tr>
<tr>
<td>Purchase of Care</td>
<td>870 (0.7%)</td>
<td>160 (0.4%)</td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facility Waiver</td>
<td>0 (0%)</td>
<td>3 (0%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>121,558</td>
<td>39,772</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Persons Served</th>
<th>Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State</td>
<td>Baltimore City</td>
</tr>
<tr>
<td>Medicaid</td>
<td>110,539 (90.9%)</td>
<td>37,020 (93.1%)</td>
</tr>
<tr>
<td>Medicaid State Funded</td>
<td>14,168 (11.7%)</td>
<td>3,431 (8.6%)</td>
</tr>
<tr>
<td>Uninsured</td>
<td>14,226 (11.7%)</td>
<td>3,760 (9.5%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>121,558</td>
<td>39,772</td>
</tr>
</tbody>
</table>

---

19 Many people use services in more than one service type and are covered by more than coverage type. The totals presented here represent an unduplicated count, so the numbers in each service or coverage type may add up to a number higher than the total listed. Additionally, the sum of the percentages for service types and coverage types may exceed 100%.
### State of Maryland and Baltimore City Cost per Person Served

<table>
<thead>
<tr>
<th>Age</th>
<th>State</th>
<th>Baltimore City</th>
<th>Difference</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Child (0-5)</td>
<td>$2,375</td>
<td>$3,029</td>
<td>$654</td>
<td>21.6%</td>
</tr>
<tr>
<td>Child (6-12)</td>
<td>$4,530</td>
<td>$6,087</td>
<td>$1,557</td>
<td>25.6%</td>
</tr>
<tr>
<td>Adolescent (13-17)</td>
<td>$6,110</td>
<td>$6,129</td>
<td>$19</td>
<td>0.3%</td>
</tr>
<tr>
<td>Transitional (18-21)</td>
<td>$4,230</td>
<td>$4,413</td>
<td>$183</td>
<td>4.2%</td>
</tr>
<tr>
<td>Adult (22 to 64)</td>
<td>$5,149</td>
<td>$5,330</td>
<td>$181</td>
<td>3.4%</td>
</tr>
<tr>
<td>Elderly (65 and over)</td>
<td>$8,704</td>
<td>$8,113</td>
<td>$-591</td>
<td>-7.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$5,017</td>
<td>$5,438</td>
<td>$421</td>
<td>7.7%</td>
</tr>
</tbody>
</table>

### Service Type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>State</th>
<th>Baltimore City</th>
<th>Difference</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>$1,443</td>
<td>$1,640</td>
<td>$197</td>
<td>12.0%</td>
</tr>
<tr>
<td>Crisis</td>
<td>$2,857</td>
<td>$2,168</td>
<td>$-689</td>
<td>-31.8%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$14,584</td>
<td>$18,151</td>
<td>$3,567</td>
<td>19.7%</td>
</tr>
<tr>
<td>Mobile Treatment</td>
<td>$7,674</td>
<td>$8,382</td>
<td>$708</td>
<td>8.4%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$1,845</td>
<td>$2,284</td>
<td>$439</td>
<td>19.2%</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>$4,407</td>
<td>$5,076</td>
<td>$669</td>
<td>13.2%</td>
</tr>
<tr>
<td>Psychiatric Rehabilitation</td>
<td>$7,768</td>
<td>$5,103</td>
<td>$-2,666</td>
<td>-34.3%</td>
</tr>
<tr>
<td>Residential Rehabilitation</td>
<td>$2,439</td>
<td>$1,425</td>
<td>$-1,014</td>
<td>-71.1%</td>
</tr>
<tr>
<td>Residential Treatment</td>
<td>$75,689</td>
<td>$59,961</td>
<td>$-15,728</td>
<td>-26.2%</td>
</tr>
<tr>
<td>Respite Care</td>
<td>$2,605</td>
<td>$1,930</td>
<td>$-675</td>
<td>-35.0%</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>$2,213</td>
<td>$2,025</td>
<td>$-189</td>
<td>-9.3%</td>
</tr>
<tr>
<td>BMHS Capitation</td>
<td>$24,959</td>
<td>$23,856</td>
<td>$-1,103</td>
<td>-4.6%</td>
</tr>
<tr>
<td>Emergency Petition</td>
<td>$421</td>
<td>$629</td>
<td>$208</td>
<td>33.0%</td>
</tr>
<tr>
<td>Purchase of Care</td>
<td>$7,327</td>
<td>$6,690</td>
<td>$-637</td>
<td>-9.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$5,017</td>
<td>$5,438</td>
<td>$421</td>
<td>7.7%</td>
</tr>
</tbody>
</table>

### Coverage Type

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>State</th>
<th>Baltimore City</th>
<th>Difference</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>$4,883</td>
<td>$5,371</td>
<td>$488</td>
<td>9.1%</td>
</tr>
<tr>
<td>Medicaid State Funded</td>
<td>$3,138</td>
<td>$3,203</td>
<td>$65</td>
<td>2.0%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>$1,796</td>
<td>$1,714</td>
<td>$-82</td>
<td>-4.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$5,017</td>
<td>$5,438</td>
<td>$421</td>
<td>7.7%</td>
</tr>
</tbody>
</table>

Source: ValueOptions
Based on claims paid through September 30, 2010
Run Date: October 18, 2010
Between FY 08 and FY 10, Baltimore City consistently had a higher overall cost per consumer than the State. In FY 10, the cost per consumer was 8% higher in Baltimore City than in Maryland. This cost difference appears to be the result of greater utilization of higher cost services in the City. For example, a higher percentage of consumers in Baltimore City received inpatient care, and the cost per consumer of inpatient care was 24% higher for City consumers.
For the first time since FY 05, the overall cost per consumer for both Baltimore City and the State decreased.

The chart below indicates that the cost per consumer is comparable between Baltimore City and the State for adolescents (13-17 years), transitional age youth (18-21 years) and adults (22-34 years). However, the cost per consumer in Baltimore City is substantially higher for the early child (0-5) and child (6-12) age groups, 22% and 26% respectively.
Consumers with co-occurring disorders disproportionately utilize high-cost services, such as inpatient, crisis, and partial hospitalization services. In FY 10, individuals with co-occurring disorders accounted for 19% of the consumer population and 33% of all service dollars spent in Baltimore.  

Adults represent 78% of the total population in Baltimore City and 76% statewide. In the PMHS, adults represent 62% of consumers served and 60% of the expenditures in Baltimore City, and 60% of consumers served and 61% of the expenditures statewide. In FY 10, the proportion of adults served increased and the proportion of expenditures for adults remained the same for the City, while both percentages increased for the State. The percentage of adults in Baltimore City and statewide increased by 6% and 2%, respectively. The trend in Baltimore City shows a slowly widening gap in the distribution of PMHS services between children and adults between FY 05 and FY 10, with adults increasing from 51% to 62% and child and adolescent consumers decreasing from 49% to 38%.

Source: ValueOptions  
Run Date: February 14, 2011

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20 All co-occurring claims paid data was run through January 31, 2011 on February 14, 2011. In addition, the total expenditures and individuals served report was re-run for the same dates.
The charts below show that the distribution of expenditures and cost per consumer by service type in Baltimore City differs in several respects from that of the State. There are proportionately more expenditures in Baltimore City for five service types: outpatient, inpatient, partial hospitalization, Capitation, and mobile treatment. There are fewer expenditures for three service types: psychiatric rehabilitation, residential rehabilitation and residential treatment.

The difference in expenditures and per-consumer costs reflect characteristics specific to Baltimore City’s population and its Public Mental Health System. The Baltimore City population is among the poorest in the State, as measured by median income, and likely experiences a higher rate of serious mental illness/severe emotional disturbance, requiring more intensive services. The City’s mental health service system is the largest and most diversified in the State. There are more hospitals and, therefore, proportionately more hospital-based services (i.e., inpatient and partial hospitalization) available. Additionally, Baltimore City has services that many other jurisdictions do not currently have. For example, Baltimore City is the sole jurisdiction with the Capitation Project, which serves frequent users of inpatient and emergency services; is one of four jurisdictions in which the children’s High Fidelity Wraparound Initiative has been implemented; and is a leader in the State in the development of Assertive Community Treatment (ACT) teams (which are included in the “mobile treatment” category).

Changes in expenditures and the number of consumers served by different program categories over the past three years are highlighted and discussed in the separate adult and child and adolescent sections beginning on page 91.
The below graphs show the distribution of expenditures across service types. Of note, despite being a Baltimore City program, the Capitation Project serves residents of other jurisdictions, and the payment claims are submitted in the county of residence. Therefore, Capitation expenditures are broken out by State and Baltimore City in order to capture all expenditures.

Source: ValueOptions
Based on claims paid through September 30, 2010
Run Date: October 18, 2010
INSURANCE COVERAGE

Most (93%) of the individuals being served by the public mental health system are covered by Medicaid, while 10% or 3,760 individuals are uninsured. Compared to the State’s 12% uninsured rate, Baltimore City has proportionately fewer uninsured individuals. The proportion of expenditures for uninsured individuals is slightly higher for the State, 4% versus 3%.

The total number of uninsured consumers has remained steady in the past three fiscal years, with a slight decrease in FY 10. Although there was a 4% decrease in the number of uninsured adults in FY 10, there was a 23% increase in uninsured children and adolescents (see page 107 for fuller explanation). Medicaid has the highest cost per consumer of the three coverage types in the PMHS. This is likely due to previously mentioned restrictions in access to care for uninsured individuals.

<table>
<thead>
<tr>
<th>Cost Per Consumer by Coverage Type</th>
<th>Medicaid</th>
<th>Medicaid State-Funded</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 09</td>
<td>$5,522</td>
<td>$3,970</td>
<td>$2,984</td>
</tr>
<tr>
<td>FY 10</td>
<td>$5,371</td>
<td>$3,203</td>
<td>$1,714</td>
</tr>
<tr>
<td>% Change</td>
<td>-3%</td>
<td>19%</td>
<td>-43%</td>
</tr>
</tbody>
</table>

Between FY 08 and FY 10, the Medicaid State-funded population increased by 82% as a result of the expansion of the Primary Adult Care (PAC) program, which began in 2006. The largest increase of 68% in the Medicaid State-funded population occurred in FY 10 compared to FY 09. Over the last 4 years, the number of Medicaid consumers receiving services in the PMHS has continued to increase in the City and State at the same rate, a 46% increase. Between FY 07 and

21 Many people use services in more than one category. As a result, the sum of the percentage of people served across service categories and across insurance statuses will exceed 100%.
FY 10, the City’s Medicaid penetration rate, or the percentage of Medicaid enrollees accessing the PMHS, increased from 14% to 18%, the highest rate in the State.

Source: DHMH Membership Data
SERVICE UTILIZATION BY ADULTS

This section presents PMHS utilization data and trends specific to adults, 18 years and older.

Populations Served

In FY 10, 24,753 adults were served by the PMHS, an increase of 17% from FY 09. Expenditures increased by 8% for a total of $130,813,226 for all adult consumers, representing 60% of all City expenditures.

There was a decrease in the percentage of Baltimore City adults enrolled in Medicaid who were served by the PMHS between FY 07 and FY 09. This rate, the Medicaid penetration rate, also decreased in Baltimore and Montgomery Counties, but slightly increased in Prince George’s County.  

![Adult Medicaid PMHS Penetration Rate](image)

Source: DHMH Membership Data

In FY 10, there was a 5% decrease in the number of uninsured adult consumers utilizing the PMHS. This corresponds with a 4% decrease in the overall number of uninsured adults in Baltimore City, and is likely attributable to the migration of uninsured individuals to PAC. Uninsured expenditures decreased significantly, with a 44% decrease between FY 09 and FY 10, likely due to restrictions implemented in the beginning of FY 10 for services for uninsured individuals. Specifically, uninsured individuals were no longer eligible to receive partial hospital and intensive outpatient services, a subcategory of outpatient services. Conversely, there has been a 47% increase in the number of adults in the PMHS with Medicaid State-funded coverage, likely a reflection of the expansion of PAC.

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22 Information throughout this section in italics is reflective of FY 09 data as updated FY 10 data was unavailable at the time of publication.

In FY 09, a disproportionate number of individuals with co-occurring disorders continued to utilize high-cost services. These individuals represent 32% of all adults served and 51% of the total expenditures for adult services.
With the exception of FY 09, there has been a notable increase in the number of adult consumers with a diagnosis of a serious mental illness\textsuperscript{24} that have been served by the PMHS since FY 04. In FY 09, 14,167 out of 21,160 (67\%) adult consumers were diagnosed with a serious mental illness. The slight decrease seen in FY 09 is likely due to the delay in claims noted earlier.

\begin{figure}
\centering
\includegraphics[width=\textwidth]{percent_of_adults_served_in_PMHS_with_serious_mental_illness.png}
\caption{Percent of Adults Served in PMHS with Serious Mental Illness}
\end{figure}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{number_of_adult_consumers_with_serious_mental_illness_and_co_occuring_substance_abuse_disorders.png}
\caption{Number of Adult Consumers with Serious Mental Illness and Co-Ocurring Substance Abuse Disorders}
\end{figure}

The vast majority (89\%) of the adult population served by the PMHS is between the ages of 22 and 64. Transitional age youth (TAY) are between the ages of 18 and 21 and represent 10\% of

\begin{itemize}
  \item An individual qualifies as having a serious mental illness in the PMHS if he/she is 18 or older and is diagnosed with one of the following: Schizophrenia, Schizoaffective disorder, Bipolar disorder, Major Depressive disorder, other psychotic disorders, Schizotypal Personality disorder, or Borderline Personality disorder.
\end{itemize}

\textsuperscript{24} Source: MAPS-MD
Based on claims paid through August 31, 2009
Run Date: August 31, 2009
adults served. Elderly consumers 65 and over represent 2% of adults served. (Due to rounding, these percentages do not add up to one hundred.) As displayed in the charts below, the elderly population is underrepresented in the PMHS as compared to the total Baltimore City adult population. This is most likely due to Medicare covering a significant portion of the elderly’s health care costs. Transitional age youth are slightly overrepresented, yet significant unmet need for mental health services likely persists in this age group, since many individuals experience onset of serious mental illness as young adults.

The number of TAY consumers served has nearly doubled since FY 05.

The largest growth in service types utilized by TAY consumers in FY 10 were outpatient, partial hospitalization, PRP and crisis services. Expenditures on TAY consumers have increased proportionately.
As previously mentioned, it is difficult to assess trends in the utilization of the fee-for-service PMHS by elderly consumers because these data do not include Medicare-funded mental health services, and Medicare is the primary payer for inpatient and outpatient mental health treatment services for this population. The data in this report describe utilization by elderly consumers of only those service types not funded by Medicare or those services in which the fee-for-service PMHS is the secondary payer.

Between FY 09 and FY 10, there was a 10% increase in the number of elderly consumers receiving services, representing only 2% of the adult population served by the PMHS. Services for the elderly continue to be disproportionately expensive. Despite a 12% decrease in expenditures for the elderly and a 20% decrease in the cost per elderly consumer, elderly consumers continue to have the highest average cost per consumer of any age group, $8,113 versus $5,240 for adults younger than 65 in Baltimore City. This is likely because elderly consumers are utilizing more expensive services such as mobile treatment, which is not covered by Medicare. Additionally, Medicare is likely covering the lower cost services such as outpatient treatment for which it is the primary payer. This is suggested by the fact that only 53% of elderly consumers in the PMHS utilize outpatient services compared to 94% of consumers overall.

<table>
<thead>
<tr>
<th>TAY Consumer Percent Increase in Service Utilization, FY 10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Type</strong></td>
</tr>
<tr>
<td>Outpatient</td>
</tr>
<tr>
<td>Partial</td>
</tr>
<tr>
<td>PRP</td>
</tr>
<tr>
<td>Crisis</td>
</tr>
<tr>
<td>Mobile</td>
</tr>
<tr>
<td>Inpatient</td>
</tr>
</tbody>
</table>

Source: ValueOptions
Based on claims paid through September 30, 2010
Run Date: October 18, 2010

As previously mentioned, it is difficult to assess trends in the utilization of the fee-for-service PMHS by elderly consumers because these data do not include Medicare-funded mental health services, and Medicare is the primary payer for inpatient and outpatient mental health treatment services for this population. The data in this report describe utilization by elderly consumers of only those service types not funded by Medicare or those services in which the fee-for-service PMHS is the secondary payer.

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Utilization by Service Type

The following data describe trends in utilization of specific types of services.

Psychiatric inpatient utilization is of great interest because it is the most intensive and most expensive service type. It is also of interest because utilization of community-based treatment and other mental health services can minimize the use of inpatient care. Use of inpatient services increased by 8% in FY 10, the second consecutive year of increased service utilization after an 18% decrease between FY 03 and FY 04 and a leveling off between FY 04 and FY 08.
Between FY 05 and FY 10, the cost per adult consumer utilizing inpatient services increased by 66% from $9,940 to $16,481. This increase may be related to the increase in reimbursement rates to City hospitals with a 10% rate increase between FY 08 and FY 10.25

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25 HSCRC New Approved Rates for FY 08, 09 and 10.
Outpatient mental health services continue to be the most widely accessed type of service, utilized by 91% of adult PMHS consumers. There has been a steady increase in the number of adults receiving outpatient mental health care, with a 17% increase in FY 10. However, the proportion of adults receiving this service type remained the same. At the same time, the cost per consumer utilizing outpatient mental health services decreased by 5% in FY 10.
Inpatient care is such a high cost service that it continues to account for a disproportionate share of total public mental health expenditures relative to the number of consumers served. In FY 10, the 10% of adult PMHS consumers who utilized inpatient services accounted for 30% of the total PMHS expenditures, increasing from 28% of total expenditures in FY 09. The 91% of adult PMHS consumers who utilized outpatient services accounted for 32% of total PMHS expenditures, increasing from 31% of total expenditures in FY 09.

**Inpatient vs. Outpatient Spending for Adults, FY 10**

<table>
<thead>
<tr>
<th></th>
<th>Expenditures</th>
<th>Persons Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>30%</td>
<td>10%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>32%</td>
<td>91%</td>
</tr>
</tbody>
</table>

Source: ValueOptions
Based on claims paid through September 30, 2010
Run Date: October 18, 2010

In FY 10, there were increases in the utilization of almost all service types, most notably residential crisis, PRP and RRP services. The number of adult consumers who received residential crisis services increased 18%, PRP 24%, and RRP 10% since FY 08. These increases are explained by more consumers being served overall by the PMHS, as the proportions of adults receiving these services remained the same. During FY 10, the RRP programs experienced greater turnover, which may account for this increase, since there was no increase in the capacity or number of beds associated with these programs.
BMHS has been particularly focused on adult consumers who utilize a disproportionate number of high-end mental health services and generate disproportionately high expenditures, usually without experiencing positive service outcomes. The Capitation Project, in its 17th year, provides a community-based alternative to consumers with histories of long or recurring inpatient admissions. The Capitation Project has 354 slots, and the average cost per year per consumer is $23,856, a 10% decrease from FY 09. By comparison, the average cost per year in FY 10 for Baltimore City residents treated at Spring Grove Hospital was $77,757.

In FY 09, the City’s 50 “high-cost” consumers, those whose public mental health service costs were highest among all consumers served in Baltimore City, accounted for 5% of total adult expenditures. The costs for these individuals include inpatient treatment and other service types within the PMHS. The median expenditure per high-cost consumer has increased 25% since FY 08, while expenditures for all adult consumers have decreased by 2% during the same period.

Source: ValueOptions
Based on claims paid through September 30, 2010
Run Date: October 18, 2010

26 Mental Hygiene Administration, December 2, 2010.
High-cost consumers continue to represent a disproportionate amount of expense for inpatient care. In FY 09, high-cost consumers (0.24% of all adult consumers) accounted for 15% of total inpatient expenditures.

BMHS continues to focus on diverting consumers from inpatient treatment when appropriate, and strengthening community-based treatment and rehabilitation service alternatives. A collaborative project with the administrative services organization to target consumers who are high users of inpatient psychiatric services began in FY 07. A consumer is flagged as a high inpatient user when s/he has been hospitalized for more than 30 days or has had five hospitalizations within the last 6 months.

In FY 09, BMHS actively coordinated services for 63 high-inpatient users, 19% of whom are also among the top 50 high-cost consumers. A majority of these high-inpatient users have multiple challenges, including homelessness and a co-occurring substance abuse disorder. In addition, 20% of the 63 clients have had recent arrests, as identified by the Datalink database, with four individuals having multiple arrests in the last year.
Forty-three individuals received service coordination from BMHS in FY 07. Subsequent expenditures for this group have declined significantly over the past two years.

Utilization of Evidence-Based Practices

The implementation of Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based practices (EBPs) is a priority for Maryland’s PMHS. BMHS has been actively promoting two EBP models for adults: Assertive Community Treatment (ACT) and Supported Employment Programs (SEPs). ACT is an evidence-based model used by five of the City’s eight mobile treatment teams, including one existing provider that became certified as an ACT team in FY 10. Outcomes data collected from mobile treatment/ACT providers document that 520 individuals (69%) were served by ACT teams in FY 10.

There has been a steady increase in the number of individuals served in mobile treatment and ACT since FY 05. Anecdotal information from mobile treatment providers suggests that the length of stay is decreasing due to a notable number of clients who are discharged in less than six months. A shorter length of stay would account for the increase in the number of clients served, since there has been no increase in program capacity. Outcome data collected from mobile treatment providers further support this by a documented increase in discharges over the last several years. BMHS will continue to monitor this trend and address these higher rates of discharge with the City’s mobile treatment providers.
There has been a 35% increase in the number of consumers receiving supported employment services through EBP-certified and non-certified programs since FY 06. This increase may be due to the State’s promotion of EBPs as well as promotion of the federal government’s Employment for Individuals with a Disability (EID) Program, which provides a financial incentive for Supplemental Security Income (SSI) recipients to work. Three out of nine supported employment programs continue to be certified as evidence-based practice programs and two additional providers have received technical assistance from BMHS to become certified.

According to outcomes data submitted by SEP providers, 193 individuals participating in SEP programs (32%) were served by evidence-based SEP providers. While 392 individuals were served according to the claims paid data, providers also report data directly to BMHS. According to these data, the number of individuals served totaled 610. This is most likely due to the lag in time between service provision and claims payment. SEP is one of the least expensive service types, with a cost per consumer of $2,025, an 8% decrease from FY 09.
Forensic Services

The number of individuals referred for pretrial evaluations (evaluations of a defendant’s competency\textsuperscript{27} and/or criminal responsibility\textsuperscript{28} completed while the individual is incarcerated) decreased steadily between FY 06 and FY 10, with a 37% overall decrease. In FY 10, 138 (55\%) of the pretrial evaluations were at the District Court level and 113 (45\%) were at the Circuit Court level.

\textsuperscript{27} Competency refers to an individual’s ability to understand the court process, the offense being charged, the possible penalty, and the possible dispositions.

\textsuperscript{28} Criminal responsibility refers to an individual’s ability to conform his/her behavior to the law and appreciate the criminality of the offense at the time of the alleged offense.
The number of Baltimore City defendants with suspected mental illness that were sent to DHMH State hospital facilities for further evaluation of competency and/or criminal responsibility decreased slightly between November 2009 and September 2010. Specifically, this decrease was noted in individuals committed as Not Criminally Responsible.

<table>
<thead>
<tr>
<th>Status</th>
<th># Defendants as of 11/1/09</th>
<th># Defendants as of 9/15/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committed as Not Criminally Responsible (NCR)</td>
<td>124</td>
<td>106</td>
</tr>
<tr>
<td>Committed as Incompetent to Stand Trial (IST)</td>
<td>79</td>
<td>84</td>
</tr>
<tr>
<td>Signed Conditional Release Plan</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>208</strong></td>
<td><strong>195</strong></td>
</tr>
</tbody>
</table>
SERVICE UTILIZATION BY CHILDREN AND ADOLESCENTS

This section presents PMHS utilization data and trends specific to children and adolescents, from birth to 17 years of age.

Population Served

In FY 10, the number of children and adolescents served by the fee-for-service PMHS increased for the second consecutive year. However, the child and adolescent utilization rate did not increase as quickly as the adult utilization rate, so the portion of the total population utilizing the PMHS attributable to children and adolescents declined from 42% in FY 08 and 40% in FY 09 to 38% in FY 10 as shown on page 87. As a result of the State receiving an RTC 1915c Medicaid waiver, which added additional services to the PMHS in FY 10, the number of youth receiving public mental health services will likely continue to increase.

Source: ValueOptions
Based on claims paid through September 30, 2010
Run Date: October 18, 2010

In FY 09, Baltimore City had the highest Medicaid penetration rate (approximately 12%) for children and adolescents in the PMHS among the four largest jurisdictions in the State. This trend has remained constant since FY 05 and is likely to continue with the addition of seven mental health services added to Medicaid as a result of the RTC 1915c Medicaid waiver.

29 The RTC 1915c Medicaid waiver is a Medicaid Psychiatric Residential Treatment Facility demonstration waiver that provides families with the option of receiving comprehensive community-based services through a Wraparound process that provides a variety of services for youth with serious mental health needs.
The percentage of children and adolescents served by the PMHS who meet the criteria for severe emotional disturbance (SED) has increased from 72% to 76% over the last six fiscal years. One hundred and fifty-one additional youth served by the PMHS met the criteria for SED in FY 09 than in FY 08.

There was a 44% increase in the number of uninsured children and adolescents served by the PMHS from FY 09 through FY 10, due in part to Medicaid applications not being submitted and/or renewed in a timely manner. Other contributing factors are unknown. Conversely, based on claims paid through August 31, 2009, Map-MD has advised that this number (which along with others in this report will be adjusted based on additional payment claims and further review of the data) will likely decrease as consumers became enrolled in Medicaid after initially receiving services as uninsured.

30 MHA has advised that this number (which along with others in this report will be adjusted based on additional payment claims and further review of the data) will likely decrease as consumers became enrolled in Medicaid after initially receiving services as uninsured.
on Census data there was a 6% decrease in the overall number of uninsured children in Baltimore City between 2008 and 2009.\textsuperscript{31}

![Baltimore City Uninsured Child and Adolescent Consumers](chart.png)

Source: ValueOptions  
Based on claims paid through September 30, 2010  
Run Date: October 18, 2010

There was a 16% increase in service utilization among the early childhood population (ages 0-5) in Baltimore City, from 1,902 children served in FY 09 to 2,207 in FY 10. While this continues an upward trend since FY 07, Baltimore City’s 16% increase is lower than the State’s 27%.

Between FY 09 and FY 10, the number of children and adolescents served increased by 5% and the cost per child/adolescent increased by 3% due to the increase in the utilization of inpatient treatment, a very expensive service.
Utilization by Service Type

The chart below delineates the number of children and adolescents who received psychiatric rehabilitation (PRP) services, partial hospitalization, inpatient hospitalization, and residential treatment center (RTC) services. There was a significant (21%) increase in the utilization of PRP services.

The overall declining trend in youth being placed in RTCs was maintained in FY 10. This downward trend in children and adolescents utilizing RTCs is a direct result of an increased use of community-based services that emulate a similar level of intensity of services once solely delivered in RTCs. Moreover, Baltimore City saw the development of a Care Management Entity (CME) in FY 08. The CME serves as a specialized managed care organization for children with special needs and their families. The CME organizes the wraparound process in a manner that delivers comprehensive mental health and other needed community-based supportive services as an alternative to residential care.

The increase in inpatient utilization was proportional to the increase in the number of children and adolescents utilizing PMHS services.

As with the adult population, inpatient care accounts for a disproportionate share of total public mental health expenditures relative to the number of consumers served. Inpatient services received by 5% of the child and adolescent population accounted for 22% of total PMHS expenditures, and 98% of child and adolescents received outpatient services, which accounted for only 51% of total PMHS expenditures.
The number of children and adolescents receiving respite services has steadily increased over the last five years, with a 25% increase in FY 10. While expenditures for respite services have fluctuated over this period, there was a significant increase of 51% in FY 10. This is most likely a result of the efforts of the care management entity (CME) to provide wraparound services, with the aim of reducing residential treatment utilization.
The City’s network of Expanded School Mental Health (ESMH) services is an important source of access to mental health services and prevention activities for children and adolescents. Access to ESMH services for all children in the City’s public schools is a goal for Baltimore City. In FY 08, a standard model for ESMH service provision, which specified services and staffing levels, was implemented. In FY 09, the standard model was further modified, resulting in more clearly delineated definitions of what constituted a prevention or treatment activity.

In FY 10, 7,942 unduplicated students received mental health treatment or prevention services in ESMH programs. Approximately one-fifth of students attending schools with an ESMH clinician received mental health support. Over 1,000 additional youth received mental health treatment services in FY 10 compared to FY 09.

<table>
<thead>
<tr>
<th>Expanded School Mental Health</th>
<th>FY 08</th>
<th>FY 09</th>
<th>FY 10</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Schools Participating</td>
<td>96</td>
<td>106</td>
<td>102</td>
</tr>
<tr>
<td># of Mental Health Providers</td>
<td>13</td>
<td>12</td>
<td>12</td>
</tr>
</tbody>
</table>

High-cost users refer to consumers whose PMHS costs were highest among all children and adolescents served in Baltimore City. A comparison of FY 08 and FY 09 expenditures for child and adolescent high-cost users shows a decrease of 24%. More specifically, the data show:

- A 22% ($599,462) decrease in expenditures for RTC services largely resulting from the development of the CME, which provides community-based comprehensive mental health treatment as an alternative to RTC services.
- A 36% ($279,034) decrease in inpatient hospital expenditures, also largely resulting from the development of the CME, which provides community-based comprehensive mental health treatment. The CME was utilized as a step-down from inpatient hospitalization, resulting in decreased length of hospital stays, which in turn lowered the overall cost.

32 High-cost users refer to consumers whose public mental health service costs were highest among all child and adolescent consumers. Because data was not available for FY 09 data, due to the transition to the new ASO, only the 22 individuals who were also high-cost users in FY 08 are included in this comparison.
C&A High-Cost Users Expenditures, FY 08 and FY 09
(n=22 individuals)

Source: MAPS-MD
Based on claims paid through August 31, 2009
Run Date: August 31, 2009
APPENDICES

APPENDIX A:
Glossary and Acronym Description

APPENDIX B:
Residential Rehabilitation Program Consumer Satisfaction Survey

APPENDIX C:
Mental Health Services for Adults in Baltimore City: A Guide to Services Available in the Public Mental Health System

APPENDIX D:
Baltimore City Community Health Survey: Summary Results Report
APPENDIX A: GLOSSARY AND ACRONYM DESCRIPTION

A

ACT – Assertive Community Treatment – An evidence-based practice of mobile, community-based treatment provided by a multidisciplinary team to persons requiring higher level of care than traditional outpatient programs.

ASO – Administrative Service Organization – An organization that assists MHA in the operations of the PMHS. It switched from MAPS-MD to ValueOptions in August 2009.

B

B-CARS – Baltimore Child & Adolescent Crisis Response System – A program that provides mobile psychiatric crisis stabilization services to children and adolescents.

BCDSS – Baltimore City Department of Social Services

BCHD – Baltimore City Health Department

BCHS – Baltimore City Head Start

BCPS – Baltimore City Public Schools

BCRI – Baltimore Crisis Response, Inc. – A program that provides 24/7 crisis intervention services such as a crisis hotline, mobile crisis teams, and residential crisis beds.

BEST – Behavioral Emergency Services Team – A project that trains police officers and other public safety personnel about mental illness and how to respond to psychiatric emergencies.

BHLI – Baltimore Health Leadership Institute (formerly Mental Health Policy Institute for Leadership and Training or MHPILT) addresses the issues related to workforce development in community behavioral health across disciplines and the gap between research findings, policy, and practice.

BMHS – Baltimore Mental Health Systems, Inc.

BPD – Baltimore City Police Department

bSAS – Baltimore Substance Abuse Systems, Inc.

C

Capitation Project – Intensive community-based treatment service that removes categorical funding barriers to facilitate high quality comprehensive care to clients in the community with individualized, flexible and innovative treatment plans.
CBH – Community Behavioral Health

CDCP – Child Development Community Policing – Trauma response services provided to children/adolescents who have witnessed or been a victim of violence.

CHA – Community Housing Associates, Inc

CISMH – Center for Integration of Spirituality and Mental Health

CME – Care Management Entity

COMAR – Code of Maryland Regulations

CON – Certificate of Need – Evaluation documents (i.e., psychiatric, psychological, psycho-social assessment, and physical) required to validate a clinical recommendation for placing a youth in a residential treatment center.

CQT – Consumer Quality Team – A consumer team that visits mental health programs and interviews consumers with the goal of improving the quality of services within the PMHS.

Crisis Services – Short-term crisis interventions, including crisis beds, designed to address psychiatric emergencies and reduce unnecessary hospitalizations.

CSA – Core Service Agency – Local mental health authority

CSEFEL – Center on the Social and Emotional Foundations for Early Learning – A national resource center funded by the Office of Head Start and Child Care Bureau focused on promoting the social emotional development and school readiness of young children, birth to age 5, and responsible for disseminating research and evidence-based practices to early childhood programs across the country.

D

DHMH – Department of Health and Mental Hygiene

DJS – Department of Juvenile Services

E

EBP – Evidence-Based Practice – A service or service model that has been demonstrated through research to be effective.

ESMH – Expanded School Mental Health – Mental health prevention and treatment services provided in identified Baltimore City public schools.
FACTT – Forensic Assertive Community Treatment Team

FAST – Forensic Alternative Services Team

FLBC – Family League of Baltimore City – Local management board for Baltimore City designed to focus attention and resources on improving the well-being of children and families by engaging communities and encouraging public and private partnerships.

HEBCAC – Historic East Baltimore Community Action Center

High Fidelity Wraparound Services – A family-driven team process to develop, implement and monitor a plan of care that is culturally competent, strength-based, and individualized to achieve positive outcomes for the family of children with severe emotional disturbance.

HIP – Hands In Partnership – A coalition of outreach advocates jointly led by BMHS, Baltimore Homeless Services, and Baltimore Health Care Access.

Hospital Diversion – Coordination of services and linkage to the appropriate level of community-based care for uninsured individuals using emergency departments as their primary source of psychiatric care.

LCC – Local Coordinating Council – A collaborative body of child-serving agencies that meets regularly to address the needs of youth with special or intensive needs requiring residential or community-based placement due to behavioral, educational, developmental or mental health disabilities.
MD-CARES – Maryland Crisis and At-Risk for Escalation diversion Services for children - The State’s System of Care grant.

MHA – Maryland Mental Hygiene Administration

MHAMD – Mental Health Association of Maryland


N/A

O

OHCQ – Office of Health Care Quality – The agency within DHMH charged with monitoring the quality of care in Maryland’s 8,000 health care and community residential programs.

OMHC – Outpatient Mental Health Clinic – Multidisciplinary community-based services such as individual, group, and family therapies as well as medication management.

P

PAC – Primary Adult Care Program – A program in Maryland that provides health coverage for a limited set of health services for income-eligible adults.

PMHS – Public Mental Health System

PRP – Psychiatric Rehabilitation Program – A range of rehabilitation services designed to maximize the ability of the mental health consumer to function successfully in the community.

Q

N/A

R

RRP – Residential Rehabilitation Program – Community-based residential services for adults enrolled in psychiatric rehabilitation programs (may include adult group homes).

RTC – Residential Treatment Center – Intensive residential programs for children and adolescents with serious emotional disturbance whose needs cannot be met in the community.
SAMHSA – Substance Abuse and Mental Health Services Administration

SEP – Supported Employment Program – Employment training and support to prepare persons for employment and link to jobs.

T

TAY – Transitional Age Youth – Young people, between age 16 and 24, who are transitioning from the child to the adult mental health system.
The Department of Health and Mental Hygiene (DHMH) requires that one-third of consumers in residential rehabilitation programs be surveyed to assess their level of satisfaction with the program. BMHS uses a survey that asks residents to comment on their housing conditions, mental health services, family involvement, and employment. Staff conducted interviews privately, and participation was voluntary. Overall, residents reported being satisfied with their homes and services. BMHS staff met with providers to share any concerns following the interviews and providers generally work with consumers to resolve concerns.

<table>
<thead>
<tr>
<th>Demographics of Residents Participating in Consumer Satisfaction Survey (N=195)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Females</td>
</tr>
<tr>
<td><strong>Race</strong></td>
</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td><strong>Average Age</strong></td>
</tr>
<tr>
<td>47</td>
</tr>
<tr>
<td><strong>Average length of Stay</strong></td>
</tr>
<tr>
<td>5 Years</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
</tr>
<tr>
<td>Employed</td>
</tr>
<tr>
<td>Unemployed but want job</td>
</tr>
<tr>
<td>Unemployed and did not want job</td>
</tr>
<tr>
<td>Questions</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1  Satisfied with the comfort of my bed (size, cleanliness &amp; linen)</td>
</tr>
<tr>
<td>2  Satisfied with my closet/storage space for my clothes &amp; personal items</td>
</tr>
<tr>
<td>3  Satisfied with the privacy provided by my window covering</td>
</tr>
<tr>
<td>4  Satisfied with the working condition of my toilet</td>
</tr>
<tr>
<td>5  Satisfied with the hot and cold water for my shower, bath and sink</td>
</tr>
<tr>
<td>6  Satisfied with the supplies provided for me (toilet paper, towels, Soap)</td>
</tr>
<tr>
<td>7  Satisfied with the condition of my stove, refrigerator and sink</td>
</tr>
<tr>
<td>8  Satisfied with the amount of food and drink</td>
</tr>
<tr>
<td>9  Satisfied with my supplies (pots &amp; pans, dishes &amp; utensils)</td>
</tr>
<tr>
<td>10 Satisfied with the my heating unit, it keeps my house warm</td>
</tr>
<tr>
<td>11 Satisfied with the my air conditioner, it keeps my house cool</td>
</tr>
<tr>
<td>12 Satisfied with the condition of my household furniture</td>
</tr>
<tr>
<td>13 Satisfied with the amount of lighting in my home</td>
</tr>
<tr>
<td>14 Satisfied with the time it take to fix things and the quality of the repairs</td>
</tr>
<tr>
<td>15 Consider this my permanent home</td>
</tr>
<tr>
<td>16 I have family members in the area</td>
</tr>
<tr>
<td>17 I visit/spend enough time with my family</td>
</tr>
<tr>
<td>18 My family is supportive of me</td>
</tr>
<tr>
<td>19 The staff teach me to take right medicine on time</td>
</tr>
<tr>
<td>20 The staff teach me to watch out for and report side effects of medications</td>
</tr>
<tr>
<td>21 The staff listen when I want to talk about my feelings and concerns</td>
</tr>
<tr>
<td>22 I feel that staff treat me better than others in the program</td>
</tr>
<tr>
<td>23 I feel that staff treat me same as others in the program</td>
</tr>
<tr>
<td>24 I feel that staff treat me worse than others in the program</td>
</tr>
<tr>
<td>Questions</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>25 The services I receive are helpful to me</td>
</tr>
<tr>
<td>26 I recommend this program to people with the same needs as me</td>
</tr>
<tr>
<td>27 I have a job and earn a pay check</td>
</tr>
<tr>
<td>28 I do not work but I would like a paid job</td>
</tr>
<tr>
<td>29 I feel safe in this neighborhood</td>
</tr>
<tr>
<td>30 All safety items work (door locks, smoke detectors work)</td>
</tr>
<tr>
<td>31 I participate in fire drills at least every three months</td>
</tr>
<tr>
<td>32 My religious/spiritual beliefs help me cope with my problems</td>
</tr>
<tr>
<td>33 I know the number to dial in case of emergency (fire, need ambulance,</td>
</tr>
<tr>
<td>police)</td>
</tr>
<tr>
<td>34 There is something in my house that needs fixing but has not been</td>
</tr>
</tbody>
</table>

*Due to rounding, some rows may not add up to exactly 100%.*
Mental Health Services for Adults in Baltimore City:

A Guide to Services Available in the Public Mental Health System

Baltimore Mental Health Systems, Inc.
201 E. Baltimore Street, Suite 1340
Baltimore, MD 21202
410-837-2647 • http://bmhsi.org
Mental Health Services for Adults in Baltimore City

Table of Contents

Overview of the Public Mental Health System

Introduction ........................................................................................................................ 127
What is the Public Mental Health System? ............................................................... 127
What Services Are Available? ........................................................................................... 128
What Are the Guidelines for Accessing Care? ............................................................... 128
Where Can I Find Assistance for Individuals in Crisis? ....................................... 129

Overview of Specific Service Types

Acute Care .......................................................................................................................... 132
Inpatient Care ..................................................................................................................... 132
Residential Crisis ................................................................................................................. 133
Partial Hospital .................................................................................................................... 133

Ongoing Care .................................................................................................................... 134
Capitation Project ................................................................................................................ 135
Assertive Community Treatment and Mobile Treatment ............................................. 135
Residential Rehabilitation ................................................................................................. 136
Psychiatric Rehabilitation ................................................................................................. 136
Targeted Case Management .............................................................................................. 137
Outpatient Mental Health Clinics .................................................................................... 137
Supported Employment .................................................................................................... 137

Concurrent Service Use ................................................................................................... 139

Appendices

Appendix A: How to Refer to Mental Health Services ......................................................... 141
Appendix B: Eligibility by Diagnosis for Public Mental Health Services ................................ 144
Appendix C: Eligibility Criteria for Uninsured Individuals ................................................. 145
Appendix D: Glossary of Terms ........................................................................................... 146
Overview of the Public Mental Health System

- Introduction
- What is the Public Mental Health System?
- What Services Are Available?
- What Are the Guidelines for Accessing Care?
Introduction

Every year in Baltimore City, an estimated 38,000 individuals will experience a serious mental illness such as major depression, bipolar disorder, or schizophrenia. With mental health treatment and support services, many of these individuals can lead productive, meaningful lives.

This guide was written to assist individuals in accessing publicly funded mental health services in Baltimore City. The goal is to help the reader understand the types of services available and the characteristics of individuals who will benefit from each type of service. This guide is intended to be consistent with the Code of Maryland Regulations (COMAR) and the Public Mental Health System’s medical necessity criteria.

What is the Public Mental Health System?

Maryland’s Public Mental Health System (PMHS) was developed to ensure that individuals with mental illness have access to the mental health treatment and support services they need. The Department of Health and Mental Hygiene (DHMH), the state’s public health authority, oversees Maryland’s health care delivery system. Within DHMH, the Mental Hygiene Administration (MHA) is the agency responsible for managing state and federal funds for mental health services, developing state policies and procedures to guide service delivery, and operating state-run psychiatric hospitals. MHA funds the majority of the Public Mental Health System services in Maryland through a statewide fee-for-service Medicaid carve out.

MHA contracts with an administrative services organization (ASO) to serve as the managed care organization for the fee-for-service Public Mental Health System. The ASO is responsible for connecting consumers to the most appropriate services, authorizing services based on medical necessity criteria, processing reimbursement claims, remitting payments to service providers, and collecting and analyzing data in order to evaluate the Public Mental Health System. ValueOptions is the company currently serving as the ASO for Maryland’s Public Mental Health System.

Baltimore Mental Health Systems, Inc. (BMHS) is the local mental health authority, or core service agency (CSA), for Baltimore City. MHA delegates to the core service agencies many of the responsibilities associated with managing the Public Mental Health System at the local level. BMHS is a non-profit agency that was established by Baltimore City for this purpose. In this capacity, BMHS oversees a network of predominately private non-profit providers that delivers services, totaling nearly $200 million, to over 35,000 Baltimore City residents each year who are Medicaid and/or Medicare recipients or uninsured. In addition to managing the fee-for-service Public Mental Health System, BMHS also funds approximately 160 programs through grants, totaling approximately $22 million. BMHS does not provide direct services.

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35 In Maryland, there are seven managed care organizations that provide somatic care and substance abuse treatment to Medicaid recipients. Mental health has been carved out, and services are provided to Medicaid, Medicare and uninsured individuals by a separate network of mental health provider agencies (including some hospitals) that are paid on a fee-for-service basis.
This guide describes services and outlines the levels of care available to adult consumers in the fee-for-service PMHS. It does not include the City’s many grant-funded programs. For a more comprehensive description of BMHS and grant-funded programs, please see BMHS’ latest Annual Report, located at www.bmhsi.org.

What Services Are Available?

The Public Mental Health System offers an array of services for individuals with mental illness, ranging from outpatient mental health treatment to inpatient psychiatric hospitalization. The types of services individuals need depend on a number of factors such as their mental health status, the level of support they require, and their individual goals.

Acute Care

Acute care provides services to individuals who are experiencing a crisis or whose mental health becomes so unstable that their symptoms cannot be stabilized in their current level of care. Acute care provides short-term intensive services in a highly monitored environment such as a hospital. In general, the PMHS promotes utilizing the least restrictive setting appropriate. Whenever possible, community-based services are preferred to inpatient settings so that individuals can access family and other social support systems, and be more integrated into the community—which has been shown to support long-term recovery. However, there are times when time-limited, more intensive services are required in order to stabilize individuals experiencing severe mental health problems.

Ongoing Care

Ongoing care provides services to support individuals to live a meaningful life in the community. These services are not time-limited. Many individuals with serious and persistent mental illness will require some type of ongoing care, which might include mental health treatment, rehabilitation, and/or case management. Treatment services help individuals manage the symptoms of their mental illness such as mania, depression, psychosis, or disorganized thoughts. Treatment can include medication management and different types of therapy. Rehabilitative services help individuals build life skills and provide meaningful activity. Case management services ensure that individuals are connected to the services, supports, and community resources they need.

What Are the Guidelines for Accessing Care?

Who is Eligible?

Individuals must meet certain medical necessity and income criteria in order to be eligible for Public Mental Health System services. Individuals must have a mental illness; individuals with a serious mental illness are given priority. Individuals who have Medicaid are eligible for all Public Mental Health System services, while individuals who have Primary Adult Care (PAC) and Medicare are eligible for most, but not all, services. Individuals with no insurance are eligible for some services if certain criteria are met.

36 Medications are an important part of mental health treatment, and individuals with mental illness need varying levels of assistance with their medications. Medication management refers to a psychiatrist prescribing medication to treat psychiatric symptoms and monitoring its effectiveness. Medication administration refers to a medical professional giving the correct medications and dosages to the individual. Medication monitoring refers to a mental health professional monitoring the individual to ensure that they are taking medication as prescribed.
and funding is available. The eligibility criteria for uninsured individuals are outlined in Appendix C on page 145. Individuals with mental illness who have private insurance are not eligible for Public Mental Health System services. For more information on eligibility related to diagnosis, see Appendix B on page 144. For specific medical necessity criteria, please visit ValueOptions’ website at http://maryland.valueoptions.com/provider/prv_man.htm.

ValueOptions, Maryland’s Public Mental Health System administrative services organization, can help determine an individual’s eligibility for services, and can be reached at 1-800-888-1965.

**Which Services Can Clients Access Concurrently?**

The Public Mental Health System will not reimburse similar services for the same individual at the same time. Individuals receiving services that provide a comprehensive range of interventions such as Assertive Community Treatment (ACT) are not permitted to access additional services similar to those already included. The more comprehensive the service type, the fewer additional services individuals need. Because acute care services are time-limited, individuals are permitted to receive these services while also enrolled in ongoing care services. See the Concurrent Service Use section on page 139, which shows how services can overlap.

**How Quickly Can Services be Accessed?**

Availability of services is dependent upon program capacity and service demand. There may be times when a program is full, and individuals are unable to enroll in the program immediately. In particular, residential rehabilitation and the Capitation Project utilize waitlists, and individuals often have to wait until there are openings in the program before they can enroll.

**Where Can I Find Assistance For Individuals in Crisis?**

Baltimore Crisis Response, Inc (BCRI) operates a crisis hotline that anyone can call 24 hours per day, 7 days per week. The phone number is **410-433-5175**. Baltimore Crisis Response can provide information about community resources, face-to-face crisis assessment, brief crisis intervention in the community, and residential crisis placement (described on page 133).

**How Long Can Clients Receive Services?**

Individuals utilize acute care for short time periods such as a few hours, days, or weeks, whereas ongoing care may be utilized for several months to years. In all cases, the length of time individuals engage in any particular service is highly individualized and based on individuals’ needs and goals.

**How Are Clients Referred?**

The process by which individuals are referred to programs varies from service to service. Some programs can be contacted directly and others will only accept individuals through specific procedures. Referral processes for different programs and services are listed in Appendix A on page 141.

**Are Services Voluntary?**

All services in the public mental health system are voluntary. This means that individuals must sign a consent form indicating their willingness to participate in the services offered.
Where Can I Find Assistance for an Individual Who Refuses Voluntary Services?

A petition can be filed for an emergency evaluation at a local hospital emergency room if there is reason to believe that the individual

- has a mental disorder and
- presents a danger to the life or safety of himself/herself or others

This petition is called an Emergency Petition (EP). For assistance in filing an Emergency Petition, please refer to the brochure “What to do in a Psychiatric Crisis in Maryland” published by the Maryland Chapter of the National Alliance on Mental Illness (NAMI). This brochure can be found at http://www.namimd.org/help/crisishelp.htm.

Where Can I Find a Directory of Mental Health Service Providers?

A useful tool for identifying and accessing mental health and other health-related services in Baltimore City is Network of Care, a website that anyone can access online. Features include a service directory, a resource library, community message boards, legislative and advocacy information, and the capability for users to create their own personalized service pages. Network of Care can be accessed at: http://baltimorecity.md.networkofcare.org/mh/home/index.cfm.

Where Can I Find Assistance in Getting Health Insurance?

Baltimore Health Care Access is an agency that assists low-income Baltimore City residents with determining eligibility and applying for public health insurance and other community resources. Baltimore Health Care Access can be reached by calling 410-649-0500 or visiting http://www.bhca.org/.
Overview of Specific Service Types

- Acute Care
- Ongoing Care
- Concurrent Service Use
Individuals use acute care services to resolve mental health crises and stabilize psychiatric symptoms (e.g. mania, psychosis, severe depression, etc.). These services are short-term and more intensive and restrictive than ongoing care, so individuals who need a high level of support and/or 24-hour monitoring may benefit from acute care. Detailed service descriptions follow the table.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Goal of Service</th>
<th>24-Hour Staffing</th>
<th>Setting</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Services</td>
<td>• Stabilize and resolve acute psychiatric symptoms</td>
<td>Yes</td>
<td>Hospital</td>
<td>Medicaid, Medicare, PAC*, Uninsured*</td>
</tr>
<tr>
<td></td>
<td>• Connect to ongoing, community-based services upon discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential Crisis</td>
<td>• Stabilize and resolve acute psychiatric symptoms</td>
<td>Yes</td>
<td>Community</td>
<td>Medicaid, Medicare, PAC, Uninsured</td>
</tr>
<tr>
<td></td>
<td>• Address precipitating factors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Connect to ongoing, community-based services upon discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial Hospital Programs</td>
<td>• Stabilize and resolve acute psychiatric symptoms</td>
<td>No</td>
<td>Hospital</td>
<td>Medicaid, Medicare</td>
</tr>
<tr>
<td></td>
<td>• Address precipitating factors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Connect to ongoing, community-based services upon discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Although individuals with these insurance types can receive inpatient services, the cost of their care is not covered by the Public Mental Health System, and they may receive a bill.

Service Descriptions

Some services provide a similar level of care, and what may distinguish one service type from another is a particular feature of that service, such as the setting or average length of stay. The service descriptions below will delineate the level of care each provides and the unique features of each.

Inpatient Care

Individuals who are experiencing severe distress related to their mental illness and require 24-hour medically supervised intensive psychiatric treatment, may need inpatient care. The care is delivered by a multidisciplinary team and includes: psychiatric evaluation and treatment; clinical assessment; medical and nursing supervision and intervention; diagnostic testing; medical consultation as needed; care coordination with community providers; medication management and monitoring; individual, group and family counseling; and case management to coordinate discharge placement needs.

Frequency of Contact: Daily

Average Length of Stay: 5 days (range: 1 day – 10 days)
Residential Crisis

Individuals who are experiencing a mental health crisis, but do not require a high level of medical supervision may benefit from 24-hour residential crisis services, which provide short-term, intensive psychiatric treatment and support services in a community-based residential setting. These services provide a community-based alternative to psychiatric inpatient care, and can shorten the length of an inpatient stay when used as a step-down disposition. Services include: psychiatric evaluation and treatment; clinical assessment; medical and nursing supervision and intervention; care coordination with community providers; medication management and monitoring; individual, group and family counseling; and case management to coordinate discharge placement needs.

(It is important to note that this service cannot be used solely for housing purposes. While housing is often difficult to access in Baltimore City, there are resources for individuals who need housing, many of which are listed on Network of Care (described on page 130).)

Frequency of Contact: Daily

Average Length of Stay: 6 days (range: 2 days - 3 weeks)

Partial Hospitalization

Individuals who require intensive treatment services to stabilize psychiatric symptoms, but do not require 24-hour monitoring could benefit from partial hospital program (PHP) services, also known as psychiatric day treatment services. Individuals can utilize PHP services as an alternative to 24-hour psychiatric inpatient care or to shorten the length of an inpatient stay. Services are provided in a hospital setting and the individual is expected to return to their residence at the end of the day. Individuals in partial hospitalization will receive: psychiatric evaluation and treatment; clinical assessment; medical and nursing supervision and intervention; care coordination with community providers; medication management and monitoring; individual, group and family counseling; and case management to coordinate discharge placement needs.

Frequency of Contact: Daily

Average Length of Stay: 10 days (range: 4 days - 4 weeks)
Many individuals with serious mental illness require ongoing care services to live productive, meaningful lives. The services described below provide individualized levels of treatment, rehabilitation, and support at a lower level of intensity and restrictiveness than acute care. Detailed service descriptions follow the table. Individuals with Medicaid, Medicare, PAC, and uninsured individuals are eligible for all of these services; however, targeted case management and psychiatric rehabilitation programs have limited spaces for individuals who are uninsured or have Medicare.

<table>
<thead>
<tr>
<th>Service</th>
<th>Type of Service</th>
<th>Goal of Service</th>
<th>24-Hour On-Call</th>
<th>Referral Process</th>
</tr>
</thead>
</table>
| Capitation Project             | Treatment, Rehab., Case Mgmt.| • Increase community integration  
                                 |                  | Yes  
                                 |                  | Contact BMHS at 410-837-2647. |
| Assertive Community Treatment  | Treatment, Rehab., Case Mgmt.| • Increase community integration  
                                 |                  | Yes  
                                 |                  | Contact programs directly. See Appendix A on page 141. |
| Mobile Treatment               | Treatment, Rehab., Case Mgmt.| • Increase community integration  
                                 |                  | Yes  
                                 |                  | Contact programs directly. See Appendix A on page 141. |
| Residential Rehabilitation Programs | Rehab., Case Mgmt.         | • Develop skills to live in the community  
                                 |                  | Yes  
                                 |                  | Contact BMHS at 410-837-2647. |
| Psychiatric Rehabilitation Programs | Rehab., Case Mgmt.         | • Develop skills to live in the community  
                                 |                  | No   
                                 |                  | Contact programs directly. See Appendix A on page 141. |
| Targeted Case Management       | Case Mgmt.                  | • Connect to treatment and support services  
                                 |                  | Yes  
                                 |                  | Contact programs directly. See Appendix A on page 143. |
| Outpatient Mental Health Clinics | Treatment                  | • Promote increased awareness and coping in order to reduce and stabilize symptoms  
                                 |                  | No   
                                 |                  | Contact programs directly. See Appendix A on page 142. |
| Supported Employment Programs  | Rehab.                      | • Obtain and maintain competitive employment consistent with interests, preferences, and skills  
                                 |                  | No   
                                 |                  | Contact programs directly. See Appendix A on page 143. |
## Service Descriptions

Some service types provide a similar level of care, and what may distinguish one service type from another is a particular feature of that service, such as the frequency of contact. The service descriptions below will delineate the level of care each provides and the unique features of each. While regulations specify minimum or maximum frequency of contacts for most service types, actual duration, frequency and intensity of services provided is guided by individuals’ needs and goals.

### Capitation Project

The Capitation Project is a unique program in Baltimore City that provides a comprehensive range of coordinated services to individuals with a serious mental illness who are able to live in the community, but have difficulty managing their various treatment and service needs independently. Individuals enrolled in Capitation have access to staff 24 hours per day, 7 days per week. Individuals receive: psychiatric evaluation and treatment; clinical assessment; medication management, administration, and monitoring; individual, group, and family therapy; support with daily living skills; assistance with locating housing; entitlements coordination; supported employment services; and case management.

Treatment teams use assertive outreach, treatment, and support to assist individuals to live successfully in the community. Caseloads are small and average eight to ten individuals per clinician.

What distinguishes Capitation from other programs is that providers receive a predetermined amount of funding each month to manage and pay for all of an individual’s psychiatric care, including inpatient care. When consenting to Capitation services, individuals are agreeing to a limited benefit package within the PMHS. This means that individuals still have access to the full range of services, but the Capitation provider authorizes and pays for services instead of the administrative services organization.

**Frequency of Contact:** There is no minimum or maximum contact frequency requirement. The average number of contacts is 19 per month, with a range of 2 - 26.

### Assertive Community Treatment and Mobile Treatment

Individuals with serious mental illness who are able to live in the community, but have difficulty managing their mental health independently often benefit from Assertive Community Treatment (ACT) or mobile treatment, which provides an array of services coordinated by a treatment team, similar to Capitation. ACT/mobile treatment and Capitation serve clients with a similar level of need; the biggest difference between these programs is the frequency of contact, which is greater for Capitation.

Individuals in ACT/mobile treatment have access to staff 24 hours per day, 7 days per week. They receive: psychiatric evaluation and treatment; clinical assessment; medication management, administration, and monitoring; individual, group, and family therapy; support with daily living skills; assistance with locating housing; entitlements coordination; and case management.

ACT is an evidenced-based practice model that requires mobile treatment providers to receive specialized training and evaluation by the State of Maryland using the Dartmouth Assertive Community Treatment Scale (DACTS). All ACT providers are licensed as mobile treatment programs and provide mobile treatment services as described above. The duration, frequency and intensity of services provided by ACT are higher than mobile treatment. Some of the services ACT provides, but mobile treatment does not, are substance abuse treatment, supported employment, peer support, daily review of consumer progress toward goals, and the use of more assertive engagement techniques.
The Forensic Assertive Community Treatment Team (FACTT) is an ACT program that provides specialized services for individuals with current involvement with the criminal justice system.

**Frequency of Contact:**

- **ACT:** A minimum of 4 contacts per month, with a home visit every 90 days. The average number of contacts is 7 per month, with a range of 4 - 20.
- **Mobile Treatment:** A minimum of 4 contacts per month, with a home visit every 90 days. The average number of contacts is 4 per month, with a range of 4 - 10.

**Residential Rehabilitation**

Residential rehabilitation programs (RRPs) provide rehabilitative services and housing for individuals with a serious mental illness who need extensive support and a structured living environment. Individuals receive rehabilitative and support services both in the residence (on-site) and in the community (off-site) to help them develop the skills they need to live as independently as possible. Specific services include: **psychosocial assessment; medication monitoring; support with daily living skills; and case management.** Individuals have access to on-call staff 24 hours per day, 7 days per week.

RRP residents are encouraged to participate in some type of meaningful daytime activity. The majority of RRP residents attend a psychiatric rehabilitation program (PRP); however, attendance at a PRP is not a requirement. Because RRPs only provide rehabilitative and case management services – not mental health treatment – RRP residents usually go elsewhere for outpatient mental health treatment. Four of the City’s eight RRPs serve specific populations: two serve young adults (ages 18 - 23); one serves geriatric individuals (ages 64+); and one serves individuals who are deaf and hard of hearing.

(It is important to note that this service cannot be used solely for housing purposes. While housing is often difficult to access in Baltimore City, there are resources for individuals who need housing, many of which are listed on Network of Care (described on page 146).)

**Frequency of Contact:** There are two levels of support services available to RRP residents:

1. **General Level:** A minimum of 3 contacts per week with an average of 17 per month.
2. **Intensive Level:** A minimum of 23 contacts per month, with staff available in the residence for a minimum of 40 hours per week.

**Psychiatric Rehabilitation**

Psychiatric rehabilitation programs (PRPs) provide rehabilitative and support services that assist individuals with a serious mental illness to develop independent community living skills, including how to manage their illness while living in the community. Services may be provided on-site at a PRP facility or off-site at an individual’s residence, job, or other location in the community. On-site PRP services provide a structured environment where rehabilitation activities and services are provided predominantly in a group setting. Individuals enrolled in a PRP also receive: **case management services, including assistance with securing and maintaining entitlements; transportation to appointments; coordination of services; and liaison with external services like somatic, substance abuse, and mental health practitioners.** Because PRPs only provide rehabilitative and case management services – not mental health treatment – PRP participants usually go elsewhere for outpatient mental health treatment.

**Frequency of Contact:** A minimum of 6 contacts per month. The average range of contacts is 6 – 20 per month.
Targeted Case Management

Targeted case management provides assessment of service needs and coordination of care. It is most beneficial to individuals with serious mental illness who are homeless or transitioning from one level of care to another, including being released from detention or psychiatric inpatient care. It is also helpful for individuals who are residing in independent housing, but need linkage to mental health treatment and other supportive services in order to continue living successfully in the community. Priority is given to individuals who are not linked to mental health services; lack basic supports for shelter, food and income; or are transitioning from one level of care to another. Services include: psychosocial assessment; linkage to resources, including housing; entitlements coordination; linkage to psychiatric, substance abuse, and somatic health treatment; and monitoring of engagement in services. Individuals have access to staff 24 hours per day, 7 days per week.

Frequency of Contact: There are two levels of support services available:

1. **General Level**: A maximum of 2 visits per month, with a home visit every 90 days.
2. **Intensive Level**: A maximum of 5 visits per month, with a home visit every 90 days.

Outpatient Mental Health Clinics

Many individuals with mental illness seek outpatient mental health treatment, which can provide: psychiatric evaluation and treatment; clinical assessment; medication management; and individual, group and family therapy. These services are available in outpatient mental health clinics (OMHCs); federally qualified health centers (FQHCs); hospital-based clinics; and private individual or group practices.

Frequency of Contact: A minimum of one (1) contact every 90 days. The average range of contacts is between one (1) time every 3 months and 2 times per week.

Supported Employment

Supported employment programs (SEPs) provide supportive services for individuals with a serious mental illness who are not employed competitively, and for whom employment is a goal. The service includes five components:

1. **Pre-placement**: Assessment, entitlements counseling, discussion of the risks and benefits of disability disclosure, and job development.
2. **Placement in competitive job**: Assisting the individual in negotiating with the employer a mutually acceptable job offer and advocating for the terms of employment.
3. **Intensive job coaching**: Systemic intervention to help the individual: learn to perform job tasks to the employer’s specifications; develop the interpersonal skills necessary to assume the employee role; and be acknowledged as an employee at the job site. This component may also include advocacy, mobility skills training and other support services to promote job stability and social integration within the work environment.
4. **Extended support services**: Proactive employment advocacy and support services at or away from the job site to assist the individual in maintaining continuous, uninterrupted competitive employment.

37 Competitive employment refers to employment that: (1) pays at least minimum wage; (2) takes place in an integrated community setting; (3) is held by the individual worker (not by the program in which he or she participates); and (4) is available to anyone qualified for the job (i.e. not set aside for people with disabilities).
employment, developing an employment-related support system, and managing changes with entitlements related to employment income, including accessing work incentives.

5. **Psychiatric rehabilitation program services**: Psychiatric rehabilitation service interventions needed to assist the individual with symptom management and to develop coping mechanisms to manage his/her illness while on the job.

6. **Treatment coordination**: Regular meetings and collaboration with the individual’s treatment team including case manager, psychiatric rehabilitation counselor, employment specialist, residential specialist, therapist, psychiatrist and any other individual(s) who may be involved in the treatment and rehabilitation of the individual in order to integrate supported employment efforts with mental health treatment.

*Frequency of Contact*: A minimum of 2 contacts per month. The average range of contacts is 2 – 4 per month.
**Concurrent Service Use**

In the table below, check marks indicate which services the Public Mental Health System will reimburse at the same time for a given individual. In general, the Public Mental Health System strives to limit duplicate service utilization and unnecessary expenditures by limiting concurrent use of similar services.

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<tr>
<th>Services</th>
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Appendices

- **Appendix A**: How to Refer to Mental Health Services
- **Appendix B**: Eligibility by Diagnosis for Public Mental Health Services
- **Appendix C**: Eligibility Criteria for Uninsured Individuals
- **Appendix E**: Glossary of Terms
Appendix A: How to Refer to Mental Health Services

Directory of Mental Health Services
Network of Care is a publicly available website that lists local behavioral health resources. Features include a services directory, a resource library, community message boards, legislative and advocacy information, and the capability for each user to create their own personalized services page. The site to find services available in Baltimore City can be accessed at the following address: http://baltimorecity.md.networkofcare.org/mh/home/index.cfm.

ACT and Mobile Treatment
How to Refer: Contact the program directly.*

ACT teams:
Bon Secours Baltimore Health System
Mobile Assertive Services Team
3101 Towanda Avenue
Baltimore, MD 21215
410-383-4921

Johns Hopkins Hospital
Assertive Community Treatment Team
405 N. Caroline Street
Baltimore, MD 21205
410-955-4550

People Encouraging People, Inc.
Assertive Community Treatment Team
4201 Primrose Avenue
Baltimore, MD 21215
410-358-9570
410-764-8560

People Encouraging People, Inc.
Forensic Assertive Community Treatment Team*
4201 Primrose Avenue
Baltimore, MD 21215
410-358-9570
410-764-8560

University of Maryland Medical System
Program for Assertive Community Treatment
701 W. Pratt Street
Baltimore, MD 21223
410-328-2564

* Individuals residing in state hospital facilities must refer to FACTT by contacting BMHS at 410-837-2647.

Mobile treatment programs:
Harford Belair Community Mental Health Center
4536 Harford Road
Baltimore, MD 21214
410-426-5650

Johns Hopkins Bayview Medical Center
1821 Portal Street
Baltimore, MD 21224
410-633-4295

North Baltimore Center
2225 N. Charles Street
Baltimore, MD 21218
410-366-4360

Capitation
How to Refer: Contact BMHS at 410-837-2647. A copy of the referral form is located on BMHS’ website at www.bmhsi.org. There are currently 354 slots for which there is generally a waiting list.

Chesapeake Connections
Mosaic Community Services
2225 N. Charles Street
Baltimore, MD 21218
410-366-4360

Creative Alternatives
Johns Hopkins Bayview Medical Center
1821 Portal Street
Baltimore, MD 21224
410-631-6021
Inpatient Care

How to Refer: Individuals must go to the emergency room to access inpatient mental health services.

The following seven Baltimore City hospitals have emergency rooms and inpatient psychiatric units:

- Bon Secours Hospital
  2000 W. Baltimore Street
  Baltimore, MD 21223
  410-362-3075
- Sinai Hospital
  2401 W. Belvedere Avenue
  Baltimore, MD 21215
  410-601-5000
- Johns Hopkins Bayview Medical Center
  4940 Eastern Avenue
  Baltimore, MD 21224
  410-550-0350
- Union Memorial Hospital
  201 E. University Parkway
  Baltimore, MD 21218
  410-554-2000
- Johns Hopkins Hospital
  600 N. Wolfe Street
  Baltimore, MD 21287
  410-955-5964
- University of Maryland Medical System
  22 S. Greene Street
  Baltimore, MD 21201
  410-328-6722
- Maryland General Hospital
  827 Linden Avenue
  Baltimore, MD 21201
  410-225-8100

The following four Baltimore City hospitals do not have inpatient psychiatric units. However, individuals can receive psychiatric evaluation in the emergency room of one of these facilities, and be transferred to a psychiatric inpatient unit if inpatient care is needed.

- Good Samaritan Hospital
  5601 Loch Raven Boulevard
  Baltimore, MD 21239
  410-532-4040
- Mercy Medical Center
  301 St. Paul Place
  Baltimore, MD 21202
  410-332-9477
- Harbor Hospital
  3001 S. Hanover Street
  Baltimore, MD 21225
  410-350-3575
- St. Agnes Hospital
  900 Caton Avenue
  Baltimore, MD 21229
  410-368-2000

Outpatient Mental Health Clinics

How to Refer: Contact programs directly.

A directory for outpatient mental health clinic providers is listed on the Network of Care website at http://baltimorecity.md.networkofcare.org/mh/resource/searchbycat.cfm?cat=21531.

Partial Hospital Programs

How to Refer: Contact programs directly.

A directory for partial hospital service providers is listed on the Network of Care website at http://baltimorecity.md.networkofcare.org/mh/resource/tax_list.cfm?sw=RM-3300.6500&cat=21524.
Psychiatric Rehabilitation Programs
*How to Refer:* Contact programs directly.


Residential Crisis
*How to Refer:* Contact the provider (currently Baltimore Crisis Response) at 410-752-2272 – the City’s 24/7 crisis hotline.

Residential Rehabilitation Programs
*How to Refer:* Contact Baltimore Mental Health Systems, Inc. at 410-837-2647. There are eight RRP providers with a total of 353 beds for which there is generally a waiting list.

Supported Employment Programs
*How to Refer:* Contact programs directly.


Targeted Case Management
*How to Refer:* Contact programs directly.

<table>
<thead>
<tr>
<th>Bon Secours Baltimore Health System</th>
<th>North Baltimore Center</th>
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<tr>
<td>3101 Towanda Avenue</td>
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<th>People Encouraging People, Inc.</th>
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<tr>
<td>4308 Harford Road</td>
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<td>Baltimore, MD 21214</td>
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<th>Johns Hopkins Bayview Medical Center</th>
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<td>Baltimore, MD 21205</td>
<td>410-955-1770</td>
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Appendix B: Eligibility by Diagnosis for Public Mental Health System Services

Individuals must meet certain diagnostic criteria in order to be eligible for Public Mental Health System services. Individuals with diagnoses designated as “serious mental illnesses” are eligible for all Public Mental Health System services, while individuals with other primary mental health diagnoses (e.g. anxiety and trauma-related disorders) may be eligible for some Public Mental Health System services. Further, individuals with certain primary diagnoses are not eligible for Public Mental Health System services.

Diagnoses Designated as Serious Mental Illnesses

- Bipolar I Disorder, Most Recent Episode, Manic, Severe Without Psychotic Features
- Bipolar I Disorder, Most Recent Episode, Manic, Severe With Psychotic Features
- Bipolar I Disorder, Most Recent Episode, Depressed, Severe Without Psychotic Features
- Bipolar I Disorder, Most Recent Episode, Depressed, Severe With Psychotic Features
- Bipolar I Disorder, Most Recent Episode, Mixed, Severe Without Psychotic Features
- Bipolar I Disorder, Most Recent Episode, Mixed, Severe With Psychotic Features
- Bipolar I Disorder, NOS
- Bipolar II Disorder
- Borderline Personality Disorder
- Delusional Disorder
- Major Depressive Disorder, Recurrent, Severe Without Psychotic Features
- Major Depressive Disorder, Recurrent, Severe With Psychotic Features
- Psychotic Disorder, NOS
- Schizoaffective Disorder
- Schizophrenia, Disorganized Type
- Schizophrenia, Catatonic Type
- Schizophrenia, Paranoid Type
- Schizophrenia, Residual Type
- Schizophrenia, Undifferentiated Type
- Schizotypal Personality Disorder

Diagnoses that Can Disqualify Individuals from Receiving Services (when Primary)

- Mental Retardation
- Learning Disorder
- Motor Skills Disorder
- Communication Disorder
- Pervasive Developmental Disorder
- Tic Disorder
- Sexual Dysfunctions except paraphilias and Gender Identity Disorder
- Antisocial Personality Disorder
- Relational Problems
- Delirium, Dementia, Amnestic other Cognitive Disorders
- Mental Disorders due to a General Medical Condition
- Substance-Related Disorder
- Substance-Induced Disorder
- Sleep Disorder
Appendix C: Eligibility Criteria for Uninsured Individuals

Uninsured individuals who request a service are eligible for Public Mental Health System services if the following criteria are met:

The individual must have:

- Income of no more than 200% of the federal poverty level.
- All four of the following:
  - Requires treatment for a mental health diagnosis covered by the PMHS;
  - Is financially needy;
  - Has a verifiable social security number; and
  - Has applied for MA, Supplemental Security Income (SSI), or Social Security Disability Insurance (SSDI) if they are expected to have a disability/illness for a period of 12 months or more.
- And one of the following:
  - Has received services in the PMHS in the last two years;
  - Is currently receiving SSDI for mental health reasons;
  - Is currently homeless within the state of Maryland;
  - Was released from prison, jail or a Department of Correction facility within the last three months;
  - Was discharged from a Maryland-based psychiatric hospital within the last three months;
  - Is currently receiving services as required by an order of Conditional Release.
Appendix D: Glossary of Terms

Acute Care - Individuals may need acute care services to resolve mental health crises and stabilize psychiatric symptoms (mania, psychosis, severe depression, etc.). These services are short-term and provided at a higher level of intensity and restrictiveness than ongoing care, so individuals who need high-level support and/or 24-hour monitoring may benefit from acute care. See detailed service descriptions starting on page 132.

ASO – Administrative services organizations serve as the managed care organization for a specific set of services. In Maryland, the Mental Hygiene Administration contracts with an ASO to manage the State’s fee-for-service Public Mental Health System. The ASO is responsible for connecting consumers to the most appropriate services, authorizing services based on medical necessity criteria, processing reimbursement claims, remitting payments to service providers, and collecting and analyzing data in order to evaluate the Public Mental Health System. ValueOptions is the company currently serving as the ASO for Maryland. See ValueOptions’ glossary listing below for more information.

BMHS – Baltimore Mental Health Systems, Inc. is the local mental health authority, or core service agency, that directly manages Public Mental Health System services not reimbursable through the fee-for-service Public Mental Health System and oversees the Public Mental Health System in collaboration with the Mental Hygiene Administration. For more information, see BMHS’ website at www.bmhsi.org. Also see the glossary listing for core service agency (CSA).

Case Management – Case management generally refers to services that assess need and help connect individuals to a full range of community mental health and support services and resources. Many service types outlined in this guide include some level of case management services.

CSA – Core service agencies are the local mental health authorities in Maryland. Each jurisdiction (county or region) has a core service agency that oversees the local Public Mental Health System in collaboration with the Mental Hygiene Administration.

COMAR – The Code of Maryland Regulations contains the rules that describe how health services must be provided.

DHMH – The Department of Health and Mental Hygiene is the state-level public health authority that oversees Maryland’s health care delivery system.

FFS – Fee-for-service refers to a billing system that pays for individual services delivered. In Maryland, Public Mental Health System service providers are reimbursed through this type of billing system.

Medical Necessity – Medical necessity refers to an individual’s need for specific services based on diagnostic criteria and level of functioning, which then determines the individual’s eligibility to receive Public Mental Health System services.

Medicaid – Medicaid is the state program that provides public health insurance to income-eligible individuals. In Maryland, it is called the Maryland Medical Assistance Program, or Medical Assistance (MA) for short. For more information about Medicaid, visit http://www.dhmh.state.md.us/mma/Eligibility/med_medical%20asst%20overview_Doc%202/medassto v.html.
**Medicare** – Medicare (MC) is a federal program that provides health insurance to individuals with disabilities, including mental illness, and to individuals over the age of 65. For more information about the Medicare program, please visit http://www.medicare.gov/.

**MHA** – The Mental Hygiene Administration is a division of Maryland’s Department of Health and Mental Hygiene, and is responsible for managing the State’s Public Mental Health System.

**Network of Care** – Network of Care is a website that provides health resources and service provider directories for areas across the country. Baltimore City’s Network of Care provides a wide range of mental and behavioral health resources, and can be accessed at the following address: http://baltimorecity.md.networkofcare.org/mh/home/index.cfm.

**Ongoing Care** – Many individuals with mental illness require ongoing care services to maintain or improve their mental wellness. These services provide varying levels of treatment, rehabilitation, and support, and are provided at a lower level of intensity and restrictiveness than acute care. These services are not time-limited. See detailed service descriptions starting on page 134.

**PMHS** – The Public Mental Health System refers to the network of publicly funded mental health services and providers that are reimbursed through the fee-for-service system.

**PAC** – Primary Adult Care is a program in Maryland that provides health coverage for a limited set of health services for income-eligible adults. To learn more about PAC, visit http://www.dhmh.state.md.us/mma/pac/index.htm.

**Rehabilitation** – Rehabilitation is a type of service that helps individuals build life and recovery skills. These services also tend to provide structure and meaningful activity.

**Serious Mental Illness** – Serious mental illnesses are diagnoses designated by the Public Mental Health System as most likely to cause functional impairment. These diagnoses are used to prioritize services for individuals most likely in need of service. For a list of these diagnoses, see Appendix B on page 144.

**Treatment** - Treatment services help individuals manage the symptoms of their mental illness through the provision of psychiatric evaluation and diagnosis; medication management; and a range of therapeutic interventions including individual, group and family counseling.

**ValueOptions** – ValueOptions is the company currently serving as the administrative services organization for Maryland’s Public Mental Health System. ValueOptions can help individuals find the most appropriate mental health services by visiting their website at http://maryland.valueoptions.com or by calling them at 1-800-888-1965.
Background and Introduction

During the spring of 2009, the Baltimore City Health Department’s Community Health Survey reached over 1,100 Baltimore City adult residents by landline and cellular telephone. The main goals of the survey were to: assess health needs of city residents, identify gaps in access to health services, assess the use and perceptions of city health services, and assess attitudes related to current programmatic and policy issues. The Health Department will use the results to guide planning and policy development.

National and state health organizations administer similar surveys among Baltimore City residents each year, including the Centers for Disease Control and Prevention’s Behavior Risk Factor Surveillance System (BRFSS). The Health Department’s Community Health Survey expands upon information available from other surveys and allows for a more customized and targeted assessment of health topics most relevant to the City. For example, the survey assessed areas such as exposure to violence and perceptions of neighborhood safety. The survey also assessed residents’ access to health promoting resources, such as healthy housing, food security, and health insurance. In addition, this Community Health Survey includes a larger sample size and allows us to obtain results and estimates with more precision than other surveys permit. Survey responses were weighted to be representative of Baltimore City’s population in terms of sex, age, and race/ethnicity. The 95% confidence intervals (as indicated by the red error bars on the charts) provide an estimate of the precision of each proportion and should be used when comparing data between subgroups, and when comparing data to the overall survey response (as indicated by the dark line on the charts).

The results presented in the following report highlight the variation in health status, health behaviors, and health care access, especially as determined by factors representing social determinants of health, such as education and household income.

In the coming months, the Health Department will provide more detailed information on topics highlighted in this report. The Health Department will conduct the Community Health Survey every two years in order to monitor trends in these important health indicators.
Survey Demographics

Key Highlights

- 63% of respondents were Black, while 33% were White. Asians, Native Hawaiians/Pacific Islanders, and American Indians/Alaskan Natives made up most of the remaining 4%.
- 54% of respondents were women.
- 29% of all respondents reported having a bachelor’s degree (BA) or higher, with White respondents 3 times more likely than Black respondents to having earned a BA.
- White respondents were 3 times more likely than Black respondents to be in the highest household income group.
- 13% of all respondents reported having a history of incarceration.
- 4% of all respondents reported being unemployed for a year or more at the time of the survey, with Blacks 3 times more likely than Whites to report so.

Social Determinants of Health

The Social determinants of health (SDoH) are the health promoting and enhancing resources and opportunities we need in order to live long and healthy lives. SDoH include things like access to education and employment opportunities, healthy food, healthy housing, safe parks and recreational space, healthcare, safe neighborhoods, and transportation. In essence, SDoH are the conditions in which we live, learn, work, and play. The World Health Organization and other leading public health authorities have unequivocally stated that the SDoH are mostly responsible for inequities in health, and emphasize the importance of recognizing that all social and economic policies are health policies, including housing, education, transportation, and zoning policies.

Education and income, two common measures of socioeconomic position (SEP), are major social determinants. Research has consistently shown that health improves incrementally as levels of income and education increase. This is what is commonly referred to as the social gradient of health—simply put, the higher your SEP, the healthier you are.

Having a higher socioeconomic position grants people greater access to and control over health promoting and enhancing resources and opportunities, thus enabling them to live longer and healthier lives.

As demonstrated in the above graphic, there are large differences in SEP in Baltimore. The results of this survey were analyzed to show the magnitude of the impact that SEP has on health. Income and education are thus used here to capture the impact of social determinants on health. Throughout this report, you will see SDoH on the presented data to indicate where social determinants are shaping health inequities in Baltimore.
- 20% of all respondents reported being in ‘fair’ or ‘poor’ health
- Those with less than a BA degree were 3 times more likely than those with a BA or higher to report being in ‘fair’ or ‘poor’ health
- Those of the lowest income group were 4 times more likely than those of the highest income group to report being in ‘fair’ or ‘poor’ health
- Those with a chronic health condition were 2 to 3 times more likely than those without a chronic health condition to report being in ‘fair’ or ‘poor’ health

General Health Status

Percent of respondents who felt their overall health was "fair" or "poor"
Healthy Homes and Communities

Key Highlights

- 10% of respondents reported feeling that their neighborhood is ‘very dangerous’
- Those of the lowest income group were 14 times more likely than those of the highest income group to report their neighborhood as ‘very dangerous’
- Black respondents were 3 times more likely than Whites to report their neighborhood as ‘very dangerous’
- 16% of respondents reported seeing signs of roaches in their homes, while 37% reported seeing signs of mice/rats
- Those of the lowest income group were 3.5 times more likely than those in the highest income group to report seeing signs of roaches
- Only 47% of respondents reported having a CO detector in their home
Food and Energy Security

Percent of respondents who reported concerns about having enough food within past 30 days

- 23% of respondents reported having concerns about having enough food
- Those of the lowest income group were almost 6 times more likely than those of the highest income group to report concerns about having enough food
- Black respondents were 2 times more likely than Whites to report concerns about having enough food
- 33% of respondents reported having had trouble paying their heating bill
- Those of the lowest income group were 3 times more likely than those in the highest income group to report having had trouble paying their heating bill
- Among those who reported having trouble paying their heating bill, 20% reported that they ‘don’t know’ who to contact for help

Percent of respondents who reported having trouble paying their heating bill within past 3 years

- Overall
- 95% CI
Health Behaviors: Food

Key Highlights

- 5% of respondents reported eating ‘very unhealthy’ in the last week
- Those with less than a BA degree were 3 times more likely than those with a BA or higher to report eating ‘very unhealthy’ in the last week
- 36% of respondents reported eating fast food at least once per week
- Men were 66% more likely than women to report eating fast food at least once per week
- Those with less than a BA degree were 75% more likely than those with a BA or higher to report eating fast food at least once per week
- Those ages 18-44 were more likely than older age groups to report eating fast food at least once per week
Health Behaviors: Food

73% of respondents reported reading nutritional labels ‘always’ (30%) or ‘sometimes’

42% all of respondents reported checking labels for salt, with women more likely to check than men

Only 55% of those with high blood pressure reported checking for salt

Just 36% of diabetics reported checking for sugar, and only 21% reported checking for carbohydrates

39% of all respondents reported checking for calories, while 43% reported checking for fat

Only 13% of all respondents reported checking for cholesterol

The most commonly reported barriers to eating more healthy were expense (18%), time (15%), and taste (14%)
Health Behaviors: Physical Activity

53% of respondents reported fully meeting physical activity (PA) recommendations, with men slightly more likely to report meeting recommendations than women.

Those who are obese or in fair/poor health were less likely than those not obese or in fair/poor health to report fully meeting PA recommendations.

The most commonly reported barriers to meeting PA recommendations were time (34%), motivation (24%), and having an injury or disability (17%).

Those of the highest income group were almost 10 times more likely than those of the lowest income group to report time as a barrier to PA.

Those of the lowest income group were over 3 times more likely than those of the highest income group to report having an injury or disability as a barrier to PA.

Key Highlights:

- 53% of respondents reported fully meeting physical activity (PA) recommendations, with men slightly more likely to report meeting recommendations than women.
- Those who are obese or in fair/poor health were less likely than those not obese or in fair/poor health to report fully meeting PA recommendations.
- The most commonly reported barriers to meeting PA recommendations were time (34%), motivation (24%), and having an injury or disability (17%).
- Those of the highest income group were almost 10 times more likely than those of the lowest income group to report time as a barrier to PA.
- Those of the lowest income group were over 3 times more likely than those of the highest income group to report having an injury or disability as a barrier to PA.
Health Behaviors: Smoking

28% of respondents reported being current smokers, with men 54% more likely to be current smokers than women. Those of the lowest income group were 2.4 times more likely than those of the highest income group to report being current smokers. 61% of those with a history of incarceration reported being current smokers, which is 2.5 times the rate for those without an incarceration history.

Key Highlights

- 28% of respondents reported being current smokers, with men 54% more likely to be current smokers than women.
- Those of the lowest income group were 2.4 times more likely than those of the highest income group to report being current smokers.
- 61% of those with a history of incarceration reported being current smokers, which is 2.5 times the rate for those without an incarceration history.
6% of all respondents reported that someone in their household had an alcohol problem. That number was 16% for households where the respondent had a history of incarceration.

7% of all respondents reported that someone in their household had a drug problem. That number was 26% for households where the respondent had a history of incarceration.

There were no differences in reported alcohol/drug abuse problems by respondent education, income, gender, or race.

27% of all respondents reported that they don’t know who they would contact for help with alcohol/drug problems.

Among respondents who reported someone in their household having a drug/alcohol problem, over 30% said they didn’t know who to contact for help.
Health Behaviors: Condom Use

15% of respondents reported that they had 2 or more sex partners in the last 12 months, with men almost 3 times more likely to report having multiple partners than women.

38% of respondents reported that they or their partner used a condom the last time they had sex.

Those with 2 or more sex partners in the last 12 months were 2.5 times more likely than those with 1 partner to report that they or their partner used a condom the last time they had sex.

80% of those with concurrent sex partners reported that they or their partner used a condom the last time they had sex.
Health Behaviors: Maternal and Child Health

Among households with children under 5, just 57% of respondents correctly identified that babies younger than 12 months should be put to sleep on their backs.

Among all households, respondents with less than a BA were less likely to identify safe sleep position than respondents with a BA or higher.

Among households with children under 5, 78% of respondents agreed that it is not safe for babies younger than 12 months to share beds with other children or adults.

Among households with children under 5, 67% of respondents said that it is ‘very important’ to breastfeed for the first 6 months of a baby’s life.

Among all households, respondents with less than a BA were less likely than respondents with a BA or higher to say that it is ‘very important’ to breastfeed for the first 6 months of a baby’s life.

12
Chronic Health Conditions: Obesity and Diabetes

34% of respondents reported being obese, with women 36% more likely than men to report so.
67% of respondents with diabetes reported being obese, along with 47% of those with hypertension, and 54% of those in fair/poor health.
Those of the lowest income group were 2.4 times more likely than those of the highest income group to report being obese.
14% of respondents reported having diabetes, with Blacks 85% more likely than Whites to report so.
31% of respondents with hypertension reported having diabetes, along with 25% of the obese, and 32% of those in fair/poor health.
Those of the lowest income group were 3.7 times more likely than those in the highest income group to report having diabetes.

Key Highlights
Chronic Health Conditions: Hypertension and Asthma

36% of respondents reported having hypertension, with Blacks 44% more likely than Whites to report so.

81% of respondents with diabetes reported having hypertension, along with 50% of the obese, and 64% of those in fair/poor health.

Those of the lowest income group were 2 times more likely than those of the highest income group to report having hypertension.

28% of respondents reported that someone in their household has asthma.

Those of the lowest income group were over 2 times more likely than those in the highest income group to report that someone in their household has asthma.

Among households that have someone with asthma living in them, 22% have roaches, 39% have mice/rats, and 33% have a current smoker.

Percent of respondents who reported being diagnosed with hypertension

Percent of respondents who reported someone with asthma living in their household

Among households reporting asthma, percent of respondents reporting presence of asthma triggers
Health Care

- 17% of respondents reported being uninsured, with men 74% more likely than women to report so. Blacks were 2 times more likely than Whites to report being uninsured.
- Those of the lowest income group were 3.8 times more likely than those of the highest income group to report being uninsured.
- 28% of respondents with a history of incarceration reported being uninsured, as did 8% of those with diabetes, and 14% of those with hypertension.
- 23% of all respondents reported having had unmet health care needs in the previous 12 months.
- Among respondents with insurance, those of the lowest income group were 25 times more likely than those of the highest income group to report having had unmet health care needs.
Mental Health Care and Social Isolation

Percent of respondents who reported needing mental health care in the previous 12 months. Among this 14%, 23% reported having had unmet mental health care needs.

- Black respondents were 4 times more likely than Whites to report having had unmet mental health care needs.
- Among those with unmet needs, the most commonly reported barriers to getting mental health care were costs (41%), not having insurance (11%), and not knowing who to contact (5%).
- Respondents with less than a BA were more likely than those with a BA or higher to report not knowing who to contact for help as a barrier. Also, 5% of Blacks reported not knowing who to contact for help as a barrier, compared to 0% of Whites.
- 7% of respondents reported feeling socially isolated, with those of the lowest income level were 12.5 times more likely than those of highest income level to report so.
Education (social determinants of health) – Respondents were categorized into those with less than a four-year college degree, “<BA”, and those with a four-year college degree or higher, “BA+”.

History of incarceration (social determinants of health) – Respondents were asked “Have you ever been incarcerated in a correctional facility, jail, prison, or detention center?” and were categorized into those who responded “Yes” and those who responded “No”.

Physical activity (health behaviors) – Respondents were asked “Thinking about the past month, how many weeks did you get as much physical activity as is recommended?” The recommended amount was described to respondents as follows:

“Federal guidelines recommend 30 minutes of physical activity per day at least 5 days per week. Physical activity can occur through work or school, through walking or biking to work or school, as well as through exercising on purpose.”

Three-item social isolation scale (mental health) – Respondents were asked the three following questions, and asked to reply with “hardly ever”, “some of the time”, or “often”:

- “First, how often do you feel that you lack companionship?”
- “How often do you feel left out?”
- “How often do you feel isolated from others?”

“Hardly ever” replies were scored as 1 point, “some of the time” as 2 points, and “often” as 3 points. If a respondent’s composite score for the three questions was 7 points or higher, that respondent was regarded as “feeling socially isolated”.

Glossary and Notes

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17

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