HHS COMMITTEE #1
June 24, 2009

MEMORANDUM

June 22, 2009

TO: Health and Human Services Committee

FROM: Linda McMillan, Senior Legislative Analyst

SUBJECT: **Briefing and Discussion: Blue Ribbon Task Force on Mental Health (2002)**

Those expected for this session:

Uma Ahluwalia, Director, Department of Health and Human Services
Scott Greene, DHHS Behavioral Health and Crisis Services
Kevin Dwyer, Chair, Blue Ribbon Task Force on Mental Health (2002)

At this worksession, the Committee will receive a briefing from the Department of Health and Human Services on the recommendations included in the 2002 Blue Ribbon Task Force Report, "Developing a System of Care, Findings and Recommendations on the Public Mental Health System" and progress that has been made since the report was issued. Mr. Kevin Dwyer, who served as Chair of the Task Force, will be present to provide comments to the Committee. The Committee requested this briefing as a part of its budget worksessions on Behavioral Health and Crisis Services.

A copy of the 2002 Report is attached. As it is the only attachment it does not have "circle numbers" and this cover memo refer to the report pages.

The County Council appointed the Blue Ribbon Task Force in July 2001. This was about four years after the State of Maryland moved from a system that provided grants to localities to a fee-for-service system funded directly by the State. By 2000 and 2001, many mental health providers found that fee-for-service system was in adequate to fund the cost of providing services, particularly in areas of the State with higher costs of living, and many people were

unable to find providers willing to see patients funded through the public system. The County Council appropriated some local funding in response a crisis situation in the system serving Montgomery County and appointed this Task Force to provide recommendations on how to improve the system. Resolution 14-954 stated that the **Task Force would have two charges** (see page A-1 and A-2):

- The first charge is to make recommendations for improvement to the State's public mental health system.

- The second charge is to advise the Council on the local funding and delivery of public mental health services. The Task Force was to provide advice on (1) how and under what circumstances Montgomery County should provide services, (2) to whom these services should be provided; (3) in what priority ranking services should be provided; and (4) at what cost.

The Task Force issued its report on February 12, 2002. A summary of the findings is included at page 13 and recommendations at page 23. A crosswalk of the findings and recommendations is included at page 32. **The following are highlights of the Task Force's findings:**

- The Public Mental Health System is in both financial collapse and fragmented, structurally unable to provide services to many individuals with mental illness or to ensure service continuity for its clients.

The Task Force noted that even well-run outpatient clinics would lose money under the State's rate structure. The Task Force also highlighted the problems for people on Medicare or who make enough money to fall into the "gray-zone" where they are expected to provide a co-pay but in reality they cannot afford it. The Task Force also posed questions about the County Government and Montgomery County Public Schools' efforts to seek reimbursements for services they provide.

- The large number of outpatient providers registered to provide services in the Public Mental Health System is a "phantom network"; in reality, only a small fraction of these providers is able and willing to accept new public clients.

The Task Force shared that many providers who signed up with the State did not in reality take public patients because of financial disincentives and administrative burdens. Child Welfare experienced problems finding mental health providers for the families they serve. There was not sufficient capacity in the outpatient system to provide services for persons who are confined to a hospital but might be able to return to the community.

- The consequence of the inability to serve individuals in the mental health system is that their care is shifted to other systems, such as jails, homeless shelters, and emergency rooms, some of which are not designed to target mental health needs. The ultimate consequence is premature death by suicide or other unnatural causes.

The Task Force highlighted the data on the number of police calls to handle cases with people with mental illness, the high percentage of inmates with mental illness, the prevalence of mental illness among the homeless, and the limitation on hospital beds that then require people to wait in emergency room settings.

- Official information made available to the public regarding the state of the Public Mental Health System is misleading.

The Task Force cited the lack of a comprehensive data base or tracking system and questionable data on the number of persons served by the system. The Task Force also assessed that consumer satisfaction surveys are flawed.

- The Core Service Agency (Department of Health and Human Services) is not meeting its responsibility under State law to plan and provide accountability for the Montgomery County Public Mental Health System.

The Task Force concluded that the Core Service Agency did not measure outcomes that indicate whether clients receive successful treatment, but rather provides output information that counts numbers of people served. The Task Force felt that having the Core Service Agency as a part of County Government did not provide independence and because it was located specifically in adult mental health, it was inhibited in providing coordination for children's mental health services. The report also notes that consumers and family members stated they felt uninformed about services.

- At present (2002), there is no single agency or agent responsible to determine and coordinate services for children's mental health across systems that care for them.

The Task Force noted an absence of data to monitor children's needs and services; that parents, doctors, social workers, and advocates reported the system is fragmented, and that while services are provided across many systems there is no planning agency with clear responsibility for decision making. The report also says that the school system is not fully meeting is mental health responsibilities in serving children with Serious Emotional Disturbance (SED).

- The fee-for-service system as currently structured (2002) does not comport with best practices.

The report says that contrary to best practices, the State does not integrate the delivery of services to people with co-occurring disorders and places an administrative burden on providers that diverts their clinical efforts. Also, because reimbursement is on a per unit basis, there is no ability to monitor agencies or foresee or mitigate disruptions in service.

- The lack of parity in reimbursement rates for Medicare recipients places additional financial pressure on County level resources as the last resort to serve vulnerable adults.

The report noted that Medicare provided reimbursement for 80% of the cost of somatic health care but only 50% for treatment of mental illness.

- The lack of affordable housing is a major obstacle for people with mental illness.

The Task Force notes that research has shown that people who have stable housing maintain their treatment at a higher rate and that there is an "acute and dangerous" shortage of supervised residential placements.

- Many mental health and substance abuse problems can be prevented, and effective early intervention and supports can reduce the impact of stress on all age groups. Such prevention efforts do not currently exist.

The Task Force highlights programs that build on protective factors and notes the impacts of stressors, such as poverty and housing problems, place people at risk of mental illness.

Based on these findings, the Task Force presented eleven recommendations for action:

1. Urge the State to adequately fund the mental health system.

2. Request changes in the structure of the State's fee-for-service approach to managed care.

3. Request a waiver from the State's fee-for-service system.

4. Plan and implement an integrated system for the delivery of public mental health services.

5. Implement a system of effective management and accountability.

6. Build up the service delivery system for children.

7. Address the range of housing needs for people with mental illness.

8. Explore all potential sources of revenue.

9. Ensure that the Core Service Agency makes full public disclosures on a regular basis.

10. Advocate strongly with Federal legislators to eliminate disparity in Medicare coverage and private insurance.

11. Incorporate prevention efforts in all aspects of community planning and mental health services.

DEVELOPING A SYSTEM OF CARE

FINDINGS AND RECOMMENDATIONS ON
THE PUBLIC MENTAL HEALTH SYSTEM

BLUE RIBBON TASK FORCE ON MENTAL HEALTH
Appointed by the Montgomery County Council
February 12, 2002

Membership
Blue Ribbon Task Force on Mental Health

Chair:	Kevin P. Dwyer, M.A., NCSP, Senior Research Associate, American Institutes for Research
Co-Chair:	Wayne S. Fenton, M.D., National Institute of Mental Health
Members:	Sandy L. Berman, Chair, Montgomery County Mental Health Advisory Committee
	Kimberly Y. Campbell, Ph.D., Child Psychologist
	Raymond L. Crowel, Psy.D., Director, Child and Adolescent Services Division, Baltimore Mental Health Systems
	Richard L. Gross, M.D., Child and Adolescent Psychiatrist, American Psychiatric Association, Clinical Professor, George Washington University Medical School
	William B. Lawson, M.D., Ph.D., Professor and Chairman, Howard University College of Medicine, Department of Psychiatry
	Philip J. Leaf, Ph.D., Director, Johns Hopkins University Center for the Prevention of Youth Violence
	Garrett E. Moran, Ph.D., Associate Area Director, Westat
	David Osher, Ph.D., Managing Research Scientist, American Institutes for Research
	Milton F. Shore, Ph.D., Clinical Psychologist
	Diane S. Sterenbuch, President, Board of Directors, National Alliance for the Mentally Ill of Montgomery County
Consumer Consultants:	Randall D. Bosin
	Carolyn J. Figard
Liaisons:	Alice Hegner, State Department of Health and Mental Hygiene
	Matthew J. Kamins, M.Ed., A.G.S., Montgomery County Public Schools
	Roger Peele, M.D., Department of Health and Human Services

The dedicated efforts of the members of the Blue Ribbon Task Force in reviewing thousands of pages of material, listening patiently to all testimony, and debating every issue and recommendation cannot be overstated. All decisions of the Task Force were made by consensus after a full and open discussion. The Chair and Co-Chair particularly thank the consumer advocate members for their willingness to serve.

All Task Force members wish to acknowledge the skill and care of Council staff including Joan Planell, Essie McGuire, Victoria Rose, and intern Zoe Worrell in providing remarkable support and technical assistance throughout the work of the Task Force. The County is lucky to have such dedicated professionals with the brains, hearts, and energy to successfully help serve the mentally ill of Montgomery County.

Kevin P. Dwyer, Chair
Wayne S. Fenton, Co-Chair

Table of Contents

Executive Summary

The Blue Ribbon Task Force on Mental Health was established by the Montgomery County Council in July 2001. The Task Force examined the delivery of publicly funded mental health services to low-income adults with serious and persistent mental illness and children with Serious Emotional Disturbance (SED). The State implemented the current Public Mental Health System (PMHS) with the goals of increasing the availability and accessibility of providers, and increasing consumer choice in types of services and of providers available while containing costs. However, the system has not achieved its goals or performed as required under State law. The problems in the Public Mental Health System have now reached crisis proportions.

In Montgomery County, the system is in collapse, crippled by severe State underfunding, and lacking any coherent structure or plan to maintain accountability and insure a humane safety net for the County's most vulnerable children and adults.

In 1997 the State decided to transition the PMHS from a grant-funded system to a managed care, fee-for-service system. The former system provided grants to local jurisdictions that then had the flexibility to provide whatever mental health services were necessary for its community. Under the current fee-for-service system, the State directly pays the provider a discrete fee for each unit of individual service provided—for example a doctor visit to evaluate medications, an individual counseling session, or a three-hour block of psychiatric rehabilitation services.

Within a managed care environment, there are several options to consider in structuring service delivery. The Task Force concluded that the fee-for-service system as currently structured does not support an effective service delivery system. A better alternative can be found in Baltimore City, which for one catchment area employs an acuity-based case rate system and not a fee-for-service system for the most seriously ill adults. This system achieves good clinical outcomes for clients and is very cost effective.

The Task Force concluded that the fee-for-service system, if retained, should be restructured to promote service integration, provide greater flexibility, and monitor client outcomes. While the current system does record the number and type of services provided to the client, it does little to encourage quality and does not incorporate outcome measures. The current fee-for-service system is limited in its flexibility to accommodate unique client requirements and does not encourage the kind of linkage or coordination necessary to have a fully effective mental health system for adults or children.

While there are many dedicated and committed professionals providing mental health services, the Task Force found that the system in which they work is dysfunctional. Tax dollars are funding a system that cannot report back whether anyone who is being served is getting better and if everyone who needs services is being reached. Although there are more than 400 providers listed as part of the PMHS in Montgomery County, in reality, only a small fraction of these providers accept PMHS clients. Because they are referred to members of this "phantom network", many individuals and families seeking services become discouraged and give up in their efforts to find help. Available evidence indicates that because of limited access to the

necessary treatment, an increasing number of County residents with mental illness "fall between the cracks", only to re-emerge in jails, juvenile detention facilities, homeless shelters, or wandering the streets.

The present system requires low-income people who have Medicare or are underinsured to pay copayments that they cannot afford, resulting in a financial loss for providers trying to serve them. Even well managed outpatient clinics cannot recover their treatment costs from the State system, resulting in bankruptcies and interruptions in care.

As the Surgeon General has made clear, there are effective treatments for mental illnesses. There is a body of research that documents evidence based practices that can guide efforts to achieve successful outcomes. A model mental health system must integrate all the treatment components necessary to support clients' multiple needs into one comprehensive approach. Extensive and strong actions will be required to address the major obstacles that interfere with service delivery. These recommendations will require action on local, State, and Federal levels and unprecedented commitment to eliminate barriers to effective treatment.

- *Adequately fund the PMHS.* The State needs to increase funding to this system that has been under-resourced since its inception in 1997. Overall, the State estimates that it will end FY 02 with a $10 million to $20 million deficit in the PMHS. In addition, in FY 01 the Governor repaid $36 million to cover previous years' PMHS deficits.

- *Change the State's fee-for-service approach to managed care.* The Mental Hygiene Administration should seriously evaluate the feasibility of moving to an acuity-adjusted case rate model or capitation model. If the State chooses to retain a fee-for-service approach, it should restructure that system to improve coordination, accountability, and integrate evidence based clinical practices.

- *Request a waiver from the fee- for-service system.* The County should implement a system of care independent of the State's fee-for-service system. Any system change should be phased in. This new model should initially target the most seriously impaired.

- *Implement a system of effective management that has clear roles of responsibility and authority and strong leadership.* This would require the Core Service Agency, the entity charged with administering the PMHS in each locality, to address the needs of children, adults, and seniors and to evaluate whether good clinical outcomes are achieved in a cost effective manner. One mechanism to ensure accountability for service delivery is to use performance based contracts with providers.

- *Establish effective school-based community mental health services.* This will require Montgomery County Public Schools, the Collaboration Council for Children, Youth, and Families, and the Core Service Agency to jointly plan, fund, and manage a comprehensive mental health *system of care* for children.

- *Increase access to stable housing for people with mental illness.* Both the State and County need to address this issue. It includes both an increase in overall affordable housing and an end to the State moratorium on new crisis and residential rehabilitation placements. Without stable housing, it is difficult for people to make progress in their mental health treatment.

- *Work to eliminate the disparities in Medicare coverage and private insurance.* It is imperative that there be sustained and coordinated efforts to work with Federal legislators to abolish the disparity in reimbursement rates for mental health treatment.

Even though it is clear that much needs to be done, the Blue Ribbon Task Force is confident that the goal of quality mental health care for all individuals in need is achievable. As we submit this report, we hope that all leaders—the County Council, the County Executive, the Governor, and State legislators—will work together to improve the lives of all who are affected by mental illness.

The Story of John: In a school without integrated mental health services

John, age 9, entered school late after deciding not to skip school. The security personnel scolded him and told him to go to the principal's office. In response, John threw his backpack at the security guard – which resulted in John's automatic 10-day suspension, review for expulsion, and a law enforcement referral. Suspended and home alone, John attempted suicide, taking his mother's 30-day supply of Zoloft. John's emergency hospitalization resulted in him being diagnosed with depression and referred for medication and psychotherapy. Due to confidentiality rules, no contact with the school was made. John's mother, who suffers from anxiety and depression, is a single parent supporting three children. She had to travel 23 miles each week to the therapist assigned to John. John actively participated in therapy and showed less anger at home but remained academically behind his peers and friendless at school. His mother was unsure she could continue the costs of child-care and traveling for his treatment and shared her concern with the school, asking for help. The school said John is not "far enough behind" to qualify for special education and its related in-school counseling. Despite John's positive motivation in therapy and desire to learn, within six months John was no longer receiving private psychotherapy and remained even further behind academically.

The Story of John: In a school with integrated mental health services.

John, age 9, entered school late and was greeted by a trained volunteer who assisted John in getting ready to enter his class. The volunteer also informed John's teacher and the school counselor that John seemed stressed. Before the end of the day, John's teacher, recognizing a pattern of negative behaviors culminating in this tardiness, talked with John's mother who was also worried and they agreed to seek the help of the school's student support team (SST). The SST, including the school's principal, school psychologist, counselor, and reading teacher, met with John's teacher and parent. Information was shared; observations were planned as well as supportive consultations with both teacher and parent. The school psychologist reported to the SST that John showed several signs of serious depression with suicidal ideation as well as needs for remedial instruction in reading and study skills. With parent permission, John was referred to the school-linked clinical service.

Treatment plans were made by the clinicians and parent. The plan included medication and cognitive psychotherapy to reduce suicidal ideation. To ensure continuity of services, the clinician served John at the school and became part of John's SST that monitors behavioral and academic progress. A clinical service manager was assigned and found the family additional supportive services. Clinical services were continued at school. The school psychologist carried out periodic observations and assisted the teacher in learning to reinforce the therapist's cognitive therapeutic supports. John was given remedial reading and study skill supports. John's teacher noticed his artistic talent and John joined the extended day art program. The school nurse also monitored effects of medications on John's learning and behavior. Family supports and respite care were components of the treatment plan developed by the service manager in partnership with the parent and school. In six months John's suicidal thoughts were gone, his depression was managed, and he was behaviorally appropriate and academically near grade level. Mother reported John making more positive statements about school and peers.

> **John's problems are not unique. However, effective, coordinated caring responses to the behavioral manifestations of mental illness – described above in *Schools with integrated mental health services* -are unique and seriously needed.**

The Story of Mary: Adult Mental Health Services without a Community Support Model

Mary, 35 is an accountant. She received a voice-mail message that she had been terminated from her most recent temporary employment, having been unable to meet contract deadlines due to her confused state. For two months she lived in a relative's basement after being evicted from her apartment. Her relatives worried about Mary's depressive and manic swings and were frustrated by her sleepless nights and seemingly constant irritability. Mary was insured by Medicare and received treatment for serious and pervasive bipolar disorder and suicidal tendencies. However, with no income, Mary stopped seeing her psychiatrist, stopped regular therapy and stopped taking her medication due to the copayments and costs. The private clinic continually contacted Mary and she promised to keep her appointment. Knowing they will ask for the copayments "up-front" she did not keep the scheduled appointment. Mary, seeing herself as a burden, entered a homeless shelter. The shelter gave Mary names and places to seek additional help but because of Mary's decompensated state she was suspicious of the shelter staff. She wandered the streets, was arrested for trespassing and placed in the County detention center.

The Story of Mary: Adult Mental Health Services with a Community Support Model

Mary is an accountant with persistent mental illness. At one time she received effective treatment, was employed and was involved in her church. Over the past year she had a significant relapse resulting in long-term unemployment and homelessness. The Assertive Community Treatment Team, receiving a call from the police, found Mary in a decompensated state living on the street. After a crisis intervention, she was placed in a residential rehabilitation facility. Back on medication and receiving psychosocial and cognitive therapies she was initially stabilized and began moving toward recovery. After six weeks her assigned case manager, working with Mary, and her *system of care* team assisted Mary in moving from the residential mental health rehabilitation facility to assisted housing. Using the Individualized Placement Support model that integrates on site job counseling, transportation and other services, Mary started a three-day workweek as a contract employee. The employer knew about Mary's illness but also knew her significant skills in accounting and was willing to provide accommodations to support her recovery. Mary was also provided psychosocial skill counseling to address potential job site conflicts. In six months, Mary was working four days a week and received independent housing. She frequently used On Our Own, a consumer run support group for social support. Her relatives have participated in psycho-education and problem solving sessions that have enabled Mary to re-connect with her family. During this period Mary was not hospitalized and reported her once persistent suicidal thoughts were gone. Most of Mary's services were funded through multiple sources including State grant funds, County funds, and braided agency funds. All services were continually evaluated using clinical symptom measures, self-satisfaction reports, adherence to medication and treatment and importantly objective functional measures of employment and social functioning reported by family and others selected by Mary. The Core Service Agency used lessons learned from this intervention to plan ways to intervene earlier to prevent serious consequences.

> **Mary's problems are not unique. Adults with serious and persistent mental illness often have multiple needs and do not consistently maintain compliance with treatment. Coordinated services with easy information about access and referral are crucial to protect mentally ill adults; however, they are not often available.**

"Mental health is the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity from early childhood until late in life. Mental health is the springboard of thinking and communication skills, emotional growth, resilience and self esteem." (Surgeon General David Satcher, 1999)

I. INTRODUCTION

A. Authority and Scope

On July 17, 2001, the County Council adopted Resolution No. 14-954 that established a Blue Ribbon Task Force to develop a model mental health system. The resolutions to establish the Task Force and to appoint the members are attached in Appendix A. The Blue Ribbon Task Forces has two charges:

1) To recommend improvement to the State's public mental health system;

2) To advise the Council on how to proceed if the State fails to make changes to its system. Specifically, how and under what circumstances Montgomery County should provide services; to whom should these services be provided; in what priority ranking; and at what cost.

B. Methodology

The Blue Ribbon Task Force on Mental Health analyzed information from diverse sources. Using a corroborative findings based model, it looked for consistency across these sources. The Task Force spoke with staff from public and private agencies, other professionals in the community, individual providers, family members, and consumers, assuring anonymity when necessary. Task Force members reviewed documents, reports, other written information, and research on evidence based practice. (See Appendix E.) This report reflects the information that was sent to the Task Force. Some requested information, especially State and County outcome data, was not available.

The Blue Ribbon Task Force on Mental Health held its first meeting on September 4, 2001, and met regularly until the end of January 2002. At its first meeting, then Council President Blair Ewing; Tim Santoni, Deputy Director, Mental Hygiene Administration, Department of Health and Mental Hygiene; and Charles Short, Director, Montgomery County Department of Health and Human Services (DHHS) addressed the Task Force providing a context for the state of the current Public Mental Health System.

Over the past five months, the Task Force held a variety of meetings and discussions including roundtable discussions, public hearings, informal discussions, and meetings with experts as follows:

- *Roundtable Discussions.* At three forums, participants were asked to address the strengths and weaknesses of the Public Mental Health System from their viewpoints and to make recommendations for change. A list of local government officials, providers, and consumers who participated in these discussions is attached in Appendix D.

- *Public Hearings.* At two public forums, a total of thirty-two speakers addressed issues from their experiences as consumers, family members, providers, or advocates. In addition to oral testimony, the Task Force received written comments from seven individuals and the Commission on Children and Youth. See Appendix C.

- *Informal Discussions.* Four smaller group discussions were held to solicit input from consumer members of On Our Own, front line clinicians, National Alliance for the Mentally Ill (NAMI), and the Federation of Families For Children's Mental Health.

- *Additional Meetings.* The Task Force invited other individuals and groups to provide information about publicly funded clinics locally and State-wide, housing issues, grant-funded programs, financing options, alternate delivery service systems, and the Montgomery County Core Service Agency. A list of participants is attached in Appendix D. In addition, Dr. Raymond Crowell, Task Force member, discussed Baltimore Mental Health Systems, the non-profit agency that serves as Baltimore's core service agency.

C. Organization of the Report

Part II – Overview Description of Public Mental Health System at State and County Levels provides background information about the Public Mental Health System, the County's response to managed care, and the issues related to outpatient mental health clinics.

Part III – Managed Care and the Maryland Public Mental Health System describes the goals and dimensions of managed care, and differentiates among different forms of managed care.

Part IV – Summary of Best Clinical Practices provides examples of evidence based practices. The detailed overview of evidence based practice for adults and children is found in Appendix B.

Part V – Findings presents ten findings that summarize the state of the Public Mental Health System.

Part VI – Recommendations presents 11 recommendations regarding how the State and the County can improve the Public Mental Health System. Following this section, there is a *crosswalk* between Findings and Recommendations - a matrix that links the two sections.

Part VII – Further Areas of Study identifies five issues that were brought to the attention of the Task Force that merit additional exploration.

D. Effective Resources in Existing Mental Health Services

Numerous dedicated professionals in both the private and public sectors are working diligently to serve children and adults with mental illness. The Task Force received testimony concerning dedicated and caring providers in public and private clinics, in the schools, housing, homeless shelters, law enforcement, and other systems. Many of these individuals have secured life-saving services, circumventing bureaucratic barriers to secure services. Parents mentioned school social workers' endless hours of effective case management for securing needed services. Adults talked about life-saving efforts of clinicians and rehabilitation staff.

In addition, many components of the system can provide a foundation from which to build overall system improvement. A number of effective programs provide prevention for children and families at-risk, reach out to very seriously compromised mentally ill adults, and provide endless hours of support of consumers by consumers. The County and State are beginning to address the need for data systems to measure the effects of services.

Effective existing components and the wealth of dedicated professionals and advocates must be incorporated into a system of care for some of the most vulnerable persons in Montgomery County and the State. Shepherding these human resources is fundamental to any success.

E. Acknowledgements

The Blue Ribbon Task Force on Mental Health received extensive information and assistance from consumers, family members, advocates, private and public mental health professionals, government officials, and consultants. The Task Force would like to express appreciation to the individuals who took their time to speak and write to the Task Force.

II. Overview Description of Public Mental Health System at State and County Levels

A. Overview of State System

The Maryland Department of Health and Mental Hygiene (DHMH) establishes general policy and standards to promote and guide the development of the State's physical and mental health services. The Mental Hygiene Administration, located in DHMH, oversees the public mental health system to determine the eligibility criteria for consumers and providers, and establish contracts with an Administrative Services Only (ASO) organization to administer the fee-for-service system under which eligible providers offer mental health services. The Mental Hygiene Administration is also responsible for determining criteria for utilization and management and to evaluate the appropriateness and effectiveness of services.

The current system originated in 1997, when the State changed the public mental health system from a grant system to a managed care fee-for-service system. The State's Mental Hygiene Administration contracted with a private limited liability company, Mental Health Partners (MHP), to serve as the ASO and to authorize treatment and payment of claims that are deemed "medically necessary". The delivery of mental health services was "carved out" (that is, delivered separately) from the delivery of physical, or "somatic", services and substance abuse treatment. For mental health services, the State established a fee-for-service system, which reimbursed providers at set rates for certain services. The State had three primary goals for the new system: 1) to improve access to mental health services; 2) to ensure mental health services helped consumers achieve their treatment goals; and 3) to ensure that the public mental health services were of high quality and cost effective.

MHP is authorized to: determine eligibility for public mental health services; refer to qualified providers; pre-authorize non-emergency care; manage care and cost of care according to State protocols; conduct utilization reviews of services to insure quality appropriateness and effectiveness; collect data and submit reports; process billing claims and remit payments; and evaluate the public mental health system.

Currently, the Maryland system primarily serves Medicaid recipients who meet medical necessity standards. In addition, Maryland has made an effort to serve individuals who are not eligible for Medicaid but do not have access to or cannot afford private insurance. Individuals in this situation are often referred to as "gray zone" clients. Maryland has been innovative and ahead of many other states in terms of trying to serve gray zone clients. However, the cost of these services and the number of people needing services has prompted the State to impose certain restrictions on gray zone services and eligibility in recent years.

In addition, senior citizens and people with disabilities may be covered by Medicare, the health insurance component to Social Security. This Federal program reimburses providers at a significantly lower rate for mental health treatment than for somatic illnesses and requires that the client pay the balance as a copay. Recent federal legislation to address this disparity failed to receive adequate support.

The State requires that each local jurisdiction establish a Core Service Agency (CSA) that is responsible to manage the State's public mental health system locally. The Core Service Agencies are responsible for planning, managing, monitoring, and evaluating the public mental health system at the local level. CSAs are charged with assuring access and consumer rights; assessing local needs and planing implementation of a delivery system that meets these needs; assuming financial and fiscal accountability; processing complaints, grievances and appeals; and reporting to the Mental Hygiene Administration. CSA's collaborate with private and public sources to secure grants to complement the fee-for-service system to pay for special services.

CSA's can be organized in three ways: within government; outside of government, as a non-profit organization; or as a quasi-governmental organization. In Montgomery County, the CSA is located in the County Government's Department of Health and Human Services, in the Adult Mental Health and Substance Abuse Service Area.

B. County's Response to Managed Care

In response to the State's transition from grants to fee-for-service, the County decided to discontinue its role as a direct provider of outpatient mental health services and to privatize its publicly operated clinics. The County determined that State reimbursement rates would be insufficient to meet the cost of operating the public clinics and planned to privatize the clinics over a three-year transition period.

Prior to 1997, the County operated five adult and three child and adolescent outpatient clinics. From 1997 to 1999, approximately 900 consumers of public mental health services in County clinics were transferred to private providers. The County decided to retain two County operated clinics to operate as safety net providers for special populations. The County still operates a clinic for children and adolescents and a multi-cultural clinic.

C. Overview of Current County System

Health and human services in the County are consolidated under one department, the Department of Health and Human Services. The Department is divided into service areas, one of which is Adult Mental Health and Substance Abuse Services. As noted earlier, the Core Service Agency is located within this service area. Not all mental health functions and services are within this service area however. Certain programs for children and seniors, along with crisis services are in other service areas.

The Core Service Agency has a total budget of $7.1 million. (This is 3.9% of the total DHHS budget.) Nearly $4 million of this is State grant funds and $2.6 million is County funded. The CSA also receives about $700,000 in Federal and other grant funds. The CSA budget supports staff to carry out the planning and evaluation functions of the CSA, as well as a range of specialized and targeted services. See Appendix F for a detailed breakdown of CSA funding.

Private providers in Montgomery County directly receive approximately $27 million each year in State funds as reimbursement under the State fee-for-service system. (These funds go directly to providers from the State.)

The County directly funds a variety of programs that provide or support mental health services, including a Crisis Center, an Assertive Community Treatment Team, and a school-based program called Linkages to Learning. These and other County mental health initiatives have been designed to respond to specific local needs or address gaps in the mental health system.

D. Primary Concern: Outpatient Mental Health Clinics

After three years' experience in the fee-for-service system, outpatient mental health clinics report that they are struggling to support their clinic operations with the State reimbursement rates.

- A recent study conducted under contract with the Department of Health and Human Services found that no private clinic in Montgomery County was breaking even.

- The County operated Child and Adolescent Clinic in Silver Spring collects approximately 17% of its costs from the State. The County operated Multi-cultural Clinic in Silver Spring does not bill for any of its services under the fee-for-service system. Local tax dollars finance the majority of the costs of both these clinics.

- In April 2001, CPC Health, Inc., the largest provider of private mental health services in the County, declared bankruptcy. Their clients were transferred to other providers. The County Council appropriated funds to assist with the transition and ensure continuity of care for consumers.

- For financial reasons, Montgomery General's Colesville Clinic closed its operations on January 31, 2002. Clients can receive outpatient services at the hospital-based clinic.

- The County continued to hear concerns from clinics about funding deficits. The nine private clinics located in the County reported a projected aggregate deficit of $1.3 million for FY 02 for their clinic operations. In October 2001, the County Council appropriated an additional $695,000 to provide administrative grant support for clinics. This appropriation was combined with $175,000 that had been appropriated for the same purpose in the regular FY 02 budget process, for a total of $870,000 to support outpatient mental health clinics. The Council was concerned that without this support, some clinics would not be able to continue to absorb losses.

  The Council's resolution to appropriate these funds also placed significant requirements on providers who would receive the funds to participate in a management audit and work to develop outcome measurement systems.

- Medicare copay requirements present a specific problem to clinic providers in serving the Medicare population. Medicare reimburses the provider at a relatively low rate, with a high client copay required. The copay for mental health is significantly higher than for somatic health care under Medicare. Clinics report that consumers cannot afford these copayments, and that clinics do not consistently receive copayments. Some clinics have reported that they

will no longer be able to serve Medicare clients, or that they will not be able to take on new Medicare clients.

- Clinics also report taking other measures to reduce costs, including administrative efficiencies, providing more group treatment rather than individual sessions, lowering staff salaries, limiting gray zone clients to maintain a balanced funding mix, increasing caseload ratios, and reducing training opportunities. To reduce costs, some clinics report that they are substituting experienced and highly credentialed staff with less costly, less experienced and credentialed staff.

- On January 29,2002, County Executive Duncan announced that County and State funds totaling $1 million dollars ($400,000 in FY 02 and $600,000 in FY 03) will be used to cover administrative and managerial costs for any provider serving the underserved and Medicare consumers, and to transition clients from failing clinics. Among other actions, the State will provide training for providers in the managed care system and the County will provide outcomes training for homeless service providers and outpatient mental health clinic providers.

III. Managed Care and the Maryland Public Mental Health System

When examining managed care systems it is essential to look at the **goals** of the system and how that system has been structured to provide **incentives** so that the goals can be realized. As we see far too often, many managed care systems seem to have cost control as their only goal and to have incentives only for holding down the use of services. However, it is possible to design managed care systems whose goals include high quality of care and appropriate allocation of resources. A well-designed and well-implemented managed care system can also provide incentives for quality care, including preventive care. The key to achieving the goals of the system is the way the system is structured, the way its performance is measured, and the kinds of incentives that are provided for goal achievement.

A central concept in managed care is that of **utilization management**. The two components of utilization management are **prior authorization** and **utilization review**. Prior authorization involves contacting a representative of the funding agency before the care or treatment is provided and getting their approval. Usually the provider is required to give the representative information about the person's condition and proposed treatment plan that will illustrate clearly why the care is medically necessary. Utilization review occurs after the fact, that is after the care has been provided, and assesses whether the care provided was in fact necessary and proper. For many years it has been common for hospitals to obtain prior authorization in the case of costly, non-emergency procedures; for many years hospitals have also been required to conduct post hoc utilization review.

There are many different forms of managed care. In fact, it has been said that no two implementations of managed care are alike. When many people speak of managed care they are often thinking about **capitation based systems**. Capitation simply means that a certain amount of funding is provided to the care manager for each plan participant (known as a member), whether they receive services in that month or not. This funding amount is sometimes referred to as the "per member per month," or PMPM amount. If the care manager receives a PMPM amount of $10 then he must provide all required services for this amount or less. This amount can often be relatively low since most people receive health care only occasionally. In this case the care manager is said to be "at risk" for the cost of the care. If they succeed in providing all medically necessary services within the capitation rate, then they may make a profit. On the other hand, if it costs more to deliver services than is received through the capitation rate, the care manager is at risk of losing money.

An alternative approach to managed care is the **case rate system**. In many respects a case rate works like a capitation rate, but there are also important differences. Where capitation rates are based on an estimated average cost of treating **all** the members of a plan, **case rates are tailored to the acuity or problem severity of defined subgroups of clients**. For example, there might be one case rate for a client subgroup such as adults with serious mental illness who have been hospitalized repeatedly and have a long history of medication non-compliance. The case rate for other adults whose mental illness is less serious or who present fewer problems might be substantially lower than that for the more serious group. So, in case rate systems there has to be a clear method of evaluating clients to see which subgroup they fit into. The amount of money available for their care is based on this assessment of problem severity.

A **fee-for-service managed care system** like the Public Mental Health System is very different from capitation based or case rate managed care systems. Maryland's fee-for-service managed care system uses the same means of paying providers that insurance companies have used for decades. For each individual service provided—for example a doctor visit to evaluate medication levels, an individual counseling session, or a three hour block of psychiatric rehabilitation services—the provider is paid a discrete fee. Thus the name "fee-for-service". All services above a minimum level, and any expensive services, must be authorized in advance by representatives of the Public Mental Health System. The representative the State has contracted with to perform the utilization management services is Mental Health Partners, a subsidiary of Magellan, one of the largest managed mental health services companies. One advantage of the fee-for-service managed care system is that there is clear accountability for the amount of service provided. That is, the provider doesn't get paid unless they certify that they have provided a service to the client. However, there are important disadvantages related to high administrative cost and complexity and to inflexibility to accommodate unique or changing client needs. These topics are discussed in more detail below.

If we attempt to classify managed care systems, they differ on several dimensions:

1. **Who is the payer?** In the case of the Public Mental Health System (PMHS), the payer is the taxpayer, that is, the public or the State government. In other cases the payer may be an employer or an individual policyholder.

2. **Who is the care manager?** The care manager is the person or organization responsible for making decisions about the amount of care the insured member is to receive. In some cases this may be the clinician, but in most cases there is a separate organization that must independently evaluate the appropriateness of the care. In the PMHS, the care manager is the Magellan Maryland Health Partners (MHP) organization. MHP, under contract with the Maryland Mental Hygiene Administration (MHA), makes decisions as to whether particular types of care and treatment are medically necessary and authorizes or denies them accordingly.

3. **What is the relationship between the clinician or other provider and the care manager?** In some of the early HMOs, like Kaiser Permanente, all of the clinician-providers were employees of Kaiser. This is called a staff model HMO. The relationship between the clinician-provider and the care manager is also how we define preferred provider organizations (PPO) and point of service (POS) type HMOs. In the case of the PMHS there is no clear relationship between the care manager, MHP, and the providers. Any provider who wishes, and who meets minimal standards, can serve clients in the system. This is what is called an Any Willing Provider arrangement. This arrangement is traditional in Medicaid fee-for-service plans but is used less frequently in contemporary managed care organizations.

   The theoretical advantage of an Any Willing Provider arrangement is that the consumer has the maximum flexibility in deciding who should provide their services. In practice, however, the low reimbursement rates and high administrative burden associated with the

PMHS means that relatively few providers are actually available and willing to provide services under the plan. While the State Mental Hygiene Administration reports high numbers of providers, few of these are actually willing to serve clients, particularly if the clients are adults with a serious mental illness or youth with a serious emotional disturbance. The clear and real disadvantage of an Any Willing Provider arrangement is that the provider may have no ongoing long-term relationship with the client. In the absence of a strong relationship between the client and the provider, there is less incentive to provide preventive care and less ability to evaluate the effectiveness of the care provided.

4. **How is the care authorized?** This is a critical point and one that bears heavily on any evaluation of the PMHS. The PMHS is a fee-for-service model that largely defines services based on traditional CPT codes. CPT codes are widely and traditionally used in private insurance and Medicaid systems. They describe very small units of service such as an hour of counseling or a medication evaluation session with a psychiatrist.

   There are two distinct disadvantages to this approach. The first is that the approach tends to be associated with a high level of paper work and administrative burden for the provider organization. This has been confirmed by an evaluation of the private clinics in Montgomery County that found administrative costs running as high as 40% of the total clinic budget, with an average administrative cost of 20%. The second disadvantage is that the CPT codes fail to provide a context to understand the services the client receives. For example, it is difficult to tell from CPT codes whether a client is being served within the context of an effective community support system, or whether the treatment services they are receiving are evidence based practices. The data collected within this type of fee-for-service system can tell you nothing about the quality of service the client is receiving.

   A fee-for-service system is not necessarily incompatible with implementing a treatment system based on best practices. However, the Maryland system as it is currently implemented with its basis in traditional CPT codes does not readily support a best practice system nor does not readily permit an evaluation of the extent to which best practices are employed within the system.

5. **Is there flexibility to use resources creatively to meet client needs?** This issue is closely related to the issue of how care is authorized. A potential advantage of capitation based or case rate models of managed care is that they provide a pool of money that can be used in creative ways to provide a package of services tailored to the individual client's needs. By contrast, in the fee-for-service based PMHS, the potential for flexibility and creativity is severely limited. Providers are paid solely based on the number of hours of individual care specified in services. Unless there is a CPT code for that service, there is no payment. For example, there is no CPT code for a clinician appearance in court, providing assistance to a client to obtain housing, assisting a client in obtaining access to a needed general medical evaluation or conducting a multi-family psycho-educational session. If the client's needs at a particular time exceed the pre

authorized level and type of care, the provider must either go back and request a change in the prior authorization or risk not being paid for providing the necessary services.

6. **Who bears the risk?** In the common sense of the word "risk," everyone—including clients and providers—is at risk in a system that is substantially under funded as the Public Mental Health System is. However, the term "risk" is used in a special, technical sense in the context of managed care systems. This question really amounts to the following: who is ultimately responsible for paying the bills for services provided? As discussed above, in a capitation based system the organization that receives the capitation fees must provide all medically necessary care with that amount of money or is "at risk" of losing money. The Magellan MHP organization operates under an Administrative Services Only (ASO) contract. They are paid a flat fee for their utilization management services and bear no risk. Nor, in this technical sense, do the providers in the Maryland system bear any risk. In the PMHS no one is at risk except the taxpayer, as represented by the State Mental Hygiene Administration. The importance of this fact is that it is only the Mental Hygiene Administration that has a financial incentive to limit the amount of care in the PMHS. The Mental Hygiene Administration exercises this responsibility by instructing the Magellan MHP organization to set stricter standards for authorizing care when the State is facing a budget shortfall.

To summarize, in the PMHS, the State Mental Hygiene Administration is the payer and is the only entity at risk. Care is managed by the Magellan MHP organization; this organization provides administrative services only, bears no risk, and is responsible only to follow the instructions of the State Mental Hygiene Administration. It is a fee-for-service system in which care is authorized by MHP, and units of service are defined by CPT codes. **This fee-for-service approach does provide accountability for the number and type of services provided to the client, however it does little to encourage quality and does not currently incorporate outcome measures. Furthermore, the fee-for-service system is inherently limited in its flexibility to accommodate unique client requirements and does not encourage the kind of linkage or coordination necessary to have a fully effective mental health system for adults or children.**

IV. SUMMARY OF BEST CLINICAL PRACTICES

Providing individualized care in a least restrictive or most integrated setting is a core value of community mental health. Individuals with serious mental illness who would have been long-term residents of psychiatric institutions a generation ago are now treated in community settings.

Because of the significance of mental illness as a public health problem, the National Institute of Mental Health (NIMH), Substance Abuse and Mental Health Services Administration (SAMHSA), and Agency for Health Care Policy and Research (AHCPR) have supported research to identify best practice models for both treatment of individuals with mental disorders and organization and delivery of mental health services within a public mental health system.

Using evidence-based treatment practices increases the functional stability of mental health consumers, reduces waste on costly ineffective treatments and promotes health policies that the public will endorse. Evidence based treatments include, among others, effective medications, individualized psychological therapies that focus on skills, family psycho-educational support, and Assertive Community Treatment (an outreach component). Communities that provide a culturally competent, family and consumer friendly, strength-based *system of care* have better outcomes and thus greater cost-efficiency.

Examples of effective approaches include:

- Cognitive behavioral treatments: Effective for both adults and children.
- Strength based family focused therapies: Therapies such as Multisystemic Therapy for children with conduct and impulse related emotional disorders are proven treatments.
- Comprehensive integrated treatment: Successful for adults and youth with both substance abuse and mental illness.
- Residential crisis services: More cost effective than comparable voluntary hospitalizations.
- Compliance therapy: Increases adherence to medication and aftercare.
- Dialectical behavior therapy: Reduces severely dysfunctional behavior and expensive hospitalizations for persons with borderline personality disorder and self-injurious behavior.
- Individualized placement support: Increases successful employment.
- School-based services: Increases treatment retention and reduces costly "no-shows." School-community integrated models have been shown to increase academic achievement and reduce delinquency.
- Community support model: Provides wraparound services to address housing, food, employment (education), as well as effective treatment, case management, and crisis assistance using an organized coordinated care team.

These and other evidence based practices, along with child and youth prevention programs, are detailed in Appendix B.

V. FINDINGS

The collapse of the Public Mental Health System has now reached crisis proportions. The redesign of the Public Mental Health System (PMHS) in 1997 was carried out with the goals of increasing the availability and accessibility of providers and increasing consumer choice in types of services and of providers available while containing costs. However, the system does not operate according to its own goals or as required under State law.

In Montgomery County, the system is in collapse, crippled by severe State underfunding, and lacking any coherent structure or plan to maintain accountability and insure a minimal humane safety net for the County's most vulnerable children and adults. The ten findings below illustrate this point.

1. The PMHS is both in financial collapse and fragmented, structurally unable to provide services to many individuals with mental illness or to ensure service continuity for its clients.

2. The large number of outpatient providers registered to provide services in the PMHS is a "phantom network"; in reality, only a small fraction of these providers is able and willing to accept new PMHS clients.

3. The consequence of the inability to serve individuals in the mental health system is that their care is shifted to other systems, such as jails, homeless shelters, and emergency rooms, some of which are not designed to target their mental health needs. The ultimate consequence is premature death by suicide and other unnatural causes.

4. Official information made available to the public regarding the state of the PMHS is misleading.

5. The Core Service Agency is not meeting its responsibility under State law to plan and provide accountability for the Montgomery County Public Mental Health System.

6. At present, there is no single agency or agent responsible to determine and coordinate services for children's mental health across the systems that serve them.

7. The fee-for-service system as currently structured does not comport with best practices.

8. The lack of parity in reimbursement rates for Medicare recipients places additional financial pressure on County level resources as the last resort to serve vulnerable individuals.

9. The lack of affordable housing is a major obstacle for people with mental illness.

10. Many mental health and substance abuse problems can be prevented, and effective early interventions and supports can reduce the impact of stress on all age groups.

1. **The PMHS is in both financial collapse and fragmented, structurally unable to provide services to provide services to many individuals with mental illness or to ensure service continuity for its clients.**

   - *It is reported that the State will end FY 02 with a $10 million to $20 million deficit in its PMHS.* In FY 01, the Governor repaid $36 million to cover previous years' PMHS deficits.

   - *Even a well-run outpatient mental health clinic will lose money on its operations under the current system.* An analysis by Health Management Consultants (HMC) of 13 State operated clinics conducted for the Maryland Department of Health and Mental Hygiene found that under the current State rate structure a well run clinic can only recover a maximum of 85% of the actual cost of delivering mental health services. William Hudock, consultant to DHHS, determined that due to the higher cost of living in the County, clinics in Montgomery County can expect to recover a maximum of only 80% of costs. See Appendix G.

   - *Vulnerable low-income individuals who have Medicare or are gray zone are facing limited access to services.* Because low-income clients are unable to pay State and Federally mandated copays, eight of the nine private clinics report that they are no longer accepting or have restricted acceptance for either or both gray zone and Medicare clients. Some clinics, threatened by losses, are asking for up-front copayments from the Medicare poor and gray zone clients who cannot afford them. This results in many clients unilaterally dropping out of medically necessary treatment. Also, Medicare and gray zone clients who do not qualify for pharmacy assistance have no reliable source of medications and must rely on samples obtained by their clinicians, who themselves must rely on pharmaceutical company sales staff to obtain what samples are available.

   - *To ensure continued access to outpatient mental health services for low-income clients, the County Council appropriated a total of $870,000 in local funds for FY 02 to provide administrative grant support to clinic providers.* These funds were made available in October 2001. In January 2002, the County Council heard again from providers that clinics continue to run significant operating deficits even above the County funds already provided for this fiscal year.[1]

   - *The relationship between Maryland Health Partners and its parent company appears to create a conflict of interest within the PMHS.* Magellan Health Services, Inc., a for-profit company listed on the New York Stock Exchange (MGL), is the largest provider of managed behavioral health care services to private sector employers and insurers in the State of Maryland and simultaneously fully owns Maryland Health Partners, the principle contractor to the PMHS. State officials indicate that cost shifting from the private sector contributes to a

[1] The Task Force submitted a report to the County Council's Health and Human Services Committee with additional findings and recommendations that address outpatient mental health clinics. This report is attached as Appendix H.

significant fiscal deficit resulting from unanticipated demand for services in the PMHS (Maryland Mental Health Block Grant Application, 2002; page 49). The Task Force found no evidence of oversight by the Maryland Attorney General to assess or prevent conflicts of interest that might arise pursuant to Magellan's substantial control of market share in both the private and public market sector of behavioral health managed care services in Maryland.

- *Neither the Montgomery County Public Schools (MCPS) nor DHHS are maximizing EPSDT (Early Periodic Screening Diagnosis and Treatment) and other Medicaid reimbursements.* In FY 01, the publicly managed Silver Spring Clinic for Children and Adolescents only received $100,000 in reimbursement under the fee-for-service system. This equates to 17% of the full operating cost of the clinic, with the balance paid with local tax-funds. Children with Medicaid account for 74 % of the total caseload at the clinic. It is estimated that additional funds, $400,000 for psychological services and $200,000 for school social work services, may be available for services already being provided in the schools to children receiving special education who are also Medicaid eligible. (Approximately 25% of children in special education are Medicaid eligible.) The County currently receives no Medicaid reimbursement for the Multi-cultural Center in Silver Spring, where DHHS reports that 55 % of individuals served are seriously and persistently mentally ill.

2. **The large number of outpatient providers registered to provide services in the PMHS is a "phantom network"; in reality, only a small fraction of these providers is able and willing to accept new PMHS clients.**

   - *Consumers and providers indicate that many providers who originally submitted their information to the network choose not to serve public mental health clients because of financial disincentives and administrative burdens described in other parts of this report.*

   - *Clients and families seeking services indicate that MHP often gives them the names and phone numbers of three providers that turn out to be unwilling or unable to accept new PMHS clients.* Many individuals and families seeking services become discouraged and give up in their efforts to find help after being turned down by several providers.

   - *Montgomery County Child Protective Services (CPS) workers have been unable to obtain medically necessary mental health services for families and children with whom they work.* Workers report being unable to locate therapists within the PMHS with the specialties required to meet the specific needs of families and children in the Child Welfare System. These needs can include culturally competent approaches, specific language capability, or therapeutic specialization.

   - *The capacity of County outpatient community support services is inadequate to support currently hospitalized individuals who are able to live outside of*

institutions. According to the State's written and oral testimony, approximately 100 Montgomery County citizens remain confined at Springfield Hospital Center in violation of their constitutional rights solely as a consequence of inadequate community support resources. In its *Olmstead vs. L.C.* decision, the United States Supreme Court stated that the denial of community placements for individuals with disabilities who can live in the community constitutes discrimination. This decision is a clear directive violated by continued, unnecessary institutionalization. Furthermore, the State reports that the annual cost of in-patient care at Springfield is $175,000. The annual cost of adults with serious mental illness served under the Baltimore Capitation Project is $27,000.

3. **The consequence of the inability to serve individuals in the mental health system is that their care is shifted to other systems, such as jails, homeless shelters, and emergency rooms, some of which are not designed to target mental health needs. The ultimate consequence is premature death by suicide or other unnatural causes.**

   - *When a mental health system fails to provide access to effective treatments, some individuals "fall between the cracks," only to re-emerge in jails, prisons, juvenile detention facilities, homeless shelters, wandering the streets, or dead.* Available evidence, as shown in the next four paragraphs, suggests that the number of adults and children in Montgomery County who "fall between the cracks" in these ways is increasing.

   - *The Department of Corrections Director estimates that the total mentally ill population in the Montgomery County Detention Center increased from 15% of all inmates in FY 99 to 21% of inmates in FY 01, and that in FY 01, 17% of mentally ill individuals admitted to the Montgomery County Detention Center were repeat admissions.* A County program was recently initiated to link incarcerated mentally ill persons to medically necessary aftercare services upon their release from the correctional system but does not yet address the full range of service needs for these individuals. While other Maryland counties have a State funded jail diversion program, Montgomery County has not yet taken advantage of this resource. State and County officials are currently discussing the possibility of initiating a program in Montgomery County.

   - *The Montgomery County Police Chief states that the total number of calls to police to transport mentally ill individuals has increased every year since 1997.* In 1997, police records indicate 550 calls; the annual amount for 2001 is 843 calls. Thus, since implementation of the new PMHS, calls to police for transport of mentally ill individuals increased 53%. These estimates exclude transport calls to the Sheriff and Fire and Rescue.

   - *Data collected by the Montgomery County Coalition for the Homeless (2000) indicate that 54% (425) of 786 single homeless individuals in Montgomery County have serious mental illness.* Of these individuals, 165 also have a co-

occurring substance abuse disorder. For families, 23% (230) of 988 persons have a serious mental illness. Of these, 70 also have a co-occurring substance abuse disorder.

- *State-imposed limits on admissions to Springfield Hospital result in an average of 16 Montgomery County citizens per month being refused admission.* As a consequence, between January 1 and September 30, 2001, a total of 143 Montgomery County citizens were transported to distant hospitals away from family and friends. These limits also exacerbate the problem of psychiatric clients having to routinely wait in emergency rooms while awaiting an appropriate placement or being inappropriately placed on hospital medical units.

4. **Official information made available to the public regarding the state of the PMHS is misleading.**

- *There is no comprehensive data base or tracking system that reports on the status or progress of adults with serious mental illness or children with serious emotional disturbances who are in need of mental health services from the PMHS.* As a consequence, no "hard" or reliable data exists to quantify whether the PMHS is succeeding or failing in meeting the needs of these citizens. However, material provided to the public by the State and County creates the unsubstantiated impression that both systems are accomplishing their stated goals of increasing access to needed services and generating successful outcomes.

- *The claims of increased access are questionable.* Montgomery County CSA data indicate an increase from 5,081 "served" in FY 98 to 12,218 "served" in FY 01, while State data indicate an increase in "consumers served" from 63,557 in FY 98 to 75,990 in FY 2000. However, neither the County nor State has been able to provide the Task Force with the specific meaning or definition of the "number of consumers served." Specifically, there is no clear indication of the proportion of children or adults with serious disorders who are receiving ongoing effective services.

- *While consumer satisfaction surveys are important and can be one element of system evaluation, for the past five years the PMHS uses these surveys as a major instrument of assessing system quality.* The State reports that it is developing outcome based evaluations for future implementation.

- *The State's model of conducting consumer satisfaction surveys is flawed and calls into question the validity of the survey results.* An unknown number of individuals who were unable to access services were excluded from the surveys. The survey results reflect data derived from less than 10% of individuals originally selected for the sampling frame.

- *Although a number of system reports have been conducted at both the State and County levels, no independent, impartial auditor has undertaken an assessment of*

the PMHS. Many of these reports have been commissioned and paid for by the entities to be assessed and have been conducted by agencies or organizations with strong ties to the PMHS. In many cases these evaluators are dependent on the system for funding.

5. **The Core Service Agency is not meeting its responsibility under State law to plan and provide accountability for the Montgomery County Public Mental Health System.**

   - *The CSA does not measure outcomes that indicate whether clients receive successful treatment.* The Core Service Agency's Annual report for FY 2001 provides output measures that count the number of people served rather than outcome measures that indicate whether those treated improve in areas such as acquiring stable housing or avoiding hospitalizations. For example, it is reported that nine children received in-home crisis intervention services, but there is no data on whether these services helped children to remain at home or avoid hospitalization.

   - *The location of the CSA within the Adult Mental Health and Substance Abuse Service Area inhibits its ability to coordinate planning for children and seniors, and does not facilitate strong, independent clinical leadership for the CSA.* The law specifies that all populations are within the responsibility of the CSA. The Task Force found a lack of coordination in planning and monitoring across service areas, especially in relation to children's services.

   - *Because it is a part of County Government, the CSA cannot function independently, including taking positions that may be contrary to existing County priorities.*

   - *Consumers and family members consistently stated that they felt uninformed about services, although the CSA reported taking actions to keep them informed.* This raises questions about the effectiveness of the CSA's information dissemination efforts. The steps CSA reported implementing included the following: distributing materials about the system, such as a brochure, a consumer handbook, and the annual report; holding twice monthly education and orientation meetings; and meeting regularly with consumers at On Our Own, a consumer based self help and socialization organization. CSA staff also stated that they plan to develop a web site.

   - *Organized care settings, such as CPC Health, that assemble a critical mass of skilled clinicians and trainees committed to the care of the seriously mentally ill represent important community assets, that once gone cannot be easily replaced.* There has been insufficient stewardship to monitor, detect, and avert collapse of these critical community assets and social capital that they represent to our community.

6. **At present, there is no single agency or agent responsible to determine and coordinate services for children's mental health across the systems that care for them.**

   - *While services for children are delivered across several systems (schools, welfare, juvenile justice, substance abuse services), there is no planning entity that is responsible for critical mental health service decisions.* Resolving issues such as who should receive child mental health services, how those services should be delivered, what constellation of services to provide, how the range of services should be aligned, or what the outcomes of those services should be is difficult without clear roles of responsibility.

   - *A lack of reliable data about children's needs and services inhibits the ability to adequately plan or monitor children's mental health.* In addition to gaps in treatment outcomes as noted earlier (Finding #5), there is no accurate information about the number of children with SED who are receiving both special education and public mental health services or how many children are eligible to receive mental health services under Medicaid and the Children's Health Insurance Program (CHIPS).

   - *Parents, psychiatrists, social workers, and advocates testified that children's mental health services are seriously fragmented, access is difficult, and the services made available are not those needed by children and families.*

   - *The school system is not fully meeting its mental health responsibilities in serving children with Serious Emotional Disturbance.* Fewer than 50 of the 1,200 children classified as SED have psychological services listed as a related service on their Individual Education Program (IEP). Although Federal law requires that mental health services be provided to these children in the least restrictive environment, there are insufficient services to meet the children's psychological needs in an integrated setting. For example, although many children with SED are segregated to one public school, Mark Twain, that facility has inadequate psychological services to meet the children's needs. Families state that school services are not family focused or outcome driven, and that the schools do not disclose to families the full range of reasonable and needed related services available to children.

7. **The fee-for-service system as currently structured does not comport with best practices.**

   - *The State's current fee-for-service system authorizes payment for services according to narrow, fragmented units that do not mirror what is known from evidence based practice nor what providers report as necessary services for this population.*

case management. The State maintains that the overall reimbursement rate for outpatient services includes case management and outreach. However, reimbursing such activities as a part of service overhead does not recognize that these activities are integral to successful treatment. Montgomery County public and private outpatient clinic providers state that the general outpatient reimbursement rate is inadequate to meet the cost of actually providing outreach, wraparound, and case management services.

- *The funding system places an administrative burden on providers that diverts resources from clinical efforts.* William Hudock, consultant to DHHS, found that administrative costs across private outpatient mental health clinics averaged 20 % of all revenues generated; for one clinic, these costs reached 40 %. Administrative costs include compliance with complex authorization, documentation, and billing requirements.

- *Neither the State nor the County has a structural or contractual relationship with mental health providers that would allow oversight and monitoring of provider operations or financial viability.* Because providers are reimbursed on a unit of service basis, there is no authority or mechanism to monitor individual agencies or to foresee or mitigate service disruptions caused by the financial difficulties of private agencies.

- *Contrary to best practices reported by the Surgeon General, the State does not integrate the delivery of services to individuals with co-occurring illnesses of substance abuse and mental illness.* When the State implemented managed care in 1997, it separated mental health services from substance abuse services. As many as 50 % of people with serious mental illness have a co-occurring substance abuse disorder. Integrated mental health and substance abuse treatment is essential for these people.

- *By not having psychiatric hospital beds available within the County for children under the age of 12, there is not a complete array of services for children.* Social workers reported that the incidents of suicidal and homicidal threats in that age group have increased dramatically over the years, with 147 incidents recorded in school year 2000-2001. During that year, 33 elementary age children in ED programs required psychiatric hospitalization, sometimes far from home.

8. **The lack of parity in reimbursement rates for Medicare recipients places additional financial pressure on County level resources as the last resort to serve vulnerable individuals.**

   - *Medicare provides reimbursement of 80 % of costs for treatment of somatic illnesses but only 50 % of costs for treatment of mental illness.* Clients are required to pay the balance as a copayment. This places an unrealistic expectation for low-income Medicare recipients who are in need of mental health treatment and who cannot afford the copayment. As a result, many are unable to

enter or remain in treatment. Under current Medicare law, it is illegal to directly supplement Medicare copayments.

- *Consumers, providers, and advocates have asked that there be local support to ensure treatment for Medicare recipients (and gray zone consumers) who are unable to afford copayments.* Although Federal legislation was under consideration this past fall to remedy the disparity between physical and mental health, this bill did not garner enough support.

9. The lack of affordable housing is a major obstacle for people with mental illness.

- *Evidence based practice has clearly shown that persons who have stable housing maintain their treatment at significantly higher rates.* The Community Support System, cited in the Surgeon General's report as a best practice model for maintaining mentally ill individuals in the community, lists housing as a critical component in helping an individual achieve good mental health treatment outcomes.

- *As a consequence of the tight housing market and landlords' ability to choose among the applicants, people with mental illness in need of housing face grave difficulties.* The Director of the Housing Opportunities Commission reported that there are about 12,000 individuals or families on the waiting lists for subsidized housing. He also said that the 'real demand' is probably closer to 18,000. Even if an individual receives a voucher for subsidized housing, landlords in today's market are selective. Individuals with serious mental illness often have harder times in finding landlords who are willing to rent to them. Consequently, they too often end up on the streets, in homeless shelters, or in jail for minor offenses.

- *An acute and dangerous shortage of supervised residential placements exists in Montgomery County.* Over 180 individuals with serious mental illness have been assessed by the Montgomery County Core Service Agency to be in need of a supervised residential rehabilitation placement. These persons remain on a waiting list that is over two years long.

- *As a result of State deficits, fewer new residential placements are being authorized.* The State has instituted a moratorium on adding new crisis beds except for individuals released from State hospitals. In addition, no new funds were available in FY 02 to authorize additional Residential Rehabilitation Placement (RRP) beds.

10. Many mental health and substance abuse problems can be prevented, and effective early interventions and supports can reduce the impact of stress on all age groups. Such prevention efforts do not currently exist.

- *Programs that help people across the life span to identify and build upon protective factors can help all respond adaptively to family, community, and*

situational stressors that otherwise could cause lasting depression or other mental disorders. Various references on the public health approach to mental health include a strong emphasis upon the promotion of mental health and the prevention of mental illness. In public health the promotion of mental wellness and prevention of mental illness should be designed to address the whole community.

- *For persons placed at risk by a variety of stress factors such as poverty, early and more intensive preventive interventions are necessary.* Persons with mental illness who receive effective treatment, housing, and support are prevented from becoming more seriously ill.

VI. RECOMMENDATIONS

As indicated in the previous findings, extensive and strong actions will be required to address major obstacles that interfere with the mission of serving low-income people who are in need of public mental health services. These recommendations will require action on local, State, and Federal levels and unprecedented commitment to eliminate barriers.

These recommendations are interrelated. Many will require simultaneous action to effect change and develop a mental health system.

The Blue Ribbon Task Force on Mental Health recommends the eleven actions below.

1. **Urge the State to adequately fund the public mental health system.**
2. **Request changes in the structure of the State's fee-for-service approach to managed care**
3. **Request a waiver from the State's fee-for-service system.**
4. **Plan and implement an integrated system for the delivery of public mental health services.**
5. **Implement a system of effective management and accountability.**
6. **Build up the service delivery system for children.**
7. **Address the range of housing needs for people with mental illness.**
8. **Explore all potential sources of revenue.**
9. **Ensure that the Core Service Agency makes full public disclosures on a regular basis.**
10. **Advocate strongly with Federal legislators to eliminate disparity in Medicare coverage and private insurance.**
11. **Incorporate prevention efforts in all aspects of community planning and mental health services.**

1. **URGE THE STATE TO ADEQUATELY FUND THE PUBLIC MENTAL HEALTH SYSTEM.**

- The public mental health system must have enough funds to pay for the delivery of effectively run, quality services. This includes dollars above the amount necessary to meet clinical service costs to ensure that providers are able to pay for management information systems and staff development.

- The State should pay for the full range of services needed and remove barriers that deter treatment for those in need. For example, the State should stop capping essential services, such as the number of crisis beds and residential rehabilitation beds; develop a way to serve low-income gray zone clients and Medicare only clients who are unable to meet required copayments; and provide treatment for low-income individuals that have private insurance with limited or no mental health coverage.

- The State and the County should work together to support Senate Bill 206 and House Bill 249 (Maryland Medical Assistance Program – Reimbursement for Out patient Mental Health treatment – Dual Eligibility) currently before the State legislature. These bills provides additional funding for required copayments for those low-income clients who have Medicaid and Medicare coverage.

2. **REQUEST CHANGES IN THE STRUCTURE OF THE STATE'S FEE-FOR-SERVICE APPROACH TO MANAGED CARE.**

2.1 **Urge the State to reconsider the use of the fee-for-service approach to managed care.** The State Mental Hygiene Administration's current form of fee-for-service managed care suffers from a number of deficiencies. MHA should seriously evaluate the feasibility of moving to an acuity adjusted case rate model or a capitation model in lieu of the current fee-for-service model.

2.2 **If the State retains a fee-for-service approach, it is recommended that they at least take measures to make the system conform better to the principles of a quality oriented best practice driven system of care**. A first step MHA could take in this direction might be to redefine services into broader, less elemental units clearly defined to represent evidence based practices. If done properly, this might serve both to rationalize the delivery of care and to lessen administrative burden for provider organizations. Approval would be for a coordinated program of services, rather than for individual service units.

2.3 **Restructure the treatment plan approval process so that the data already collected on client functioning could also serve as measures of client outcomes.** The forms currently used for this process represent a wasted opportunity, when they could be providing useful data for continuous quality improvement.

3. **REQUEST WAIVER FROM THE STATE'S FEE-FOR-SERVICE SYSTEM.**

- The County Council and the County Executive should ask the State for a waiver from the current fee-for-service system to implement an acuity adjusted case rate system in Montgomery County. The Mental Hygiene Administration has indicated its willingness to allow replications of case rate systems like the Baltimore Capitation Project.

- It is strongly suggested that Montgomery County seriously consider implementing case rate systems, particularly for the most seriously impaired adults and youth. A well structured case rate system for these populations could greatly increase the likelihood of an effective service coordination, while allowing the flexibility to tailor services to the needs of the individual client. An additional advantage of such a system is that the paperwork and administrative burden would be substantially less, leaving more resources available for treatment and related services.

  ⇒ An acuity adjusted case rate system should be phased in over a three year period and based on well-monitored best practice system. The CSA, in coordination with MHA, should develop a plan and timeline for implementation.

  ⇒ It is suggested that children and adults who are high end users of the public mental health system would be served in the first year. CSA should investigate the Baltimore adult capitation project and East Baltimore children's integration project as possible examples.

  ⇒ CSA would need to determine the criteria for who would be included in each year of the plan, number of children and adults meeting the criteria, cost to provide best practice services, and the outcome measures used to evaluate results. The report for those to be included in the first year of operations should be completed by December 1, 2002. This system would require the CSA to actively manage the public/private mental health system in Montgomery County.

4. **PLAN AND IMPLEMENT AN INTEGRATED SYSTEM FOR THE DELIVERY OF PUBLIC MENTAL HEALTH SERVICES**

4.1 <u>Consider delivering services within catchment areas</u>. Serious consideration should be given to contracting for mental health services in several geographically defined catchment areas around the County. Providers should be selected competitively. New clients would be referred to their local catchment area for services. However, the system should accommodate any client who preferred to seek treatment outside the designated catchment area. A consumer-driven system should allow and facilitate choice outside the residential catchment area. A catchment system would provide accountability and access because providers would be directly responsible for the outcomes of individual clients.

- Each catchment area should have a designated single point of entry with a no-refusal policy that provides resource coordination and, when feasible, co-locates mental health, somatic medical care, case management including assistance with obtaining Social Security, food, housing, and employment.

- Each catchment area should include a fail-safe measure for gray zone, Medicare, and under-insured individuals with mental illness to have access to treatment.

4.2 **Expand Outreach Efforts.** There should be aggressive efforts to reach those who have not succeeded in the traditional mental health system. Evidence based practice shows that those unwilling/unable to sign service agreements who may be under severe personal stress are most at risk and should be reached by assertive community treatment (Surgeon General, 1999).

- The County's ACT team needs to increase its caseload to national caseload benchmarks.

- There should be additional ACT teams to meet outreach needs.

4.3 **Develop approaches to facilitate delivery of integrated mental health and substance services for people with co-occurring conditions.** The system should stop the practice of separating mental health and substance abuse treatment systems so that evidence based integrated mental health treatment and substance abuse services can be provided.

4.4 **Use Memoranda of Understanding(MOU) among departments and agencies.** Memoranda of understanding should enable data and information to be shared across systems, access to be streamlined, and planning to be improved. For example, there should be MOU's among the CSA, Police, Corrections, and Sheriff's Office. For children's services, there should be interagency agreements among the CSA, Collaboration Council, and MCPS. Formal memoranda for data sharing and service coordination should be in place by July 1, 2002 and available for public review.

5. Implement a System of Effective Management and Accountability.

5.1 **Clarify the role and function of the CSA as the authority for all individuals with mental illness in need of public mental health services, regardless of their status with MHP.**

- All persons with serious and persistent mental illness and children with serious emotional disturbance must be considered "in the system." The definition must be expanded to include all seriously mentally ill Montgomery County individuals, not merely those enrolled in the PMHS through Maryland Health Partners. Clients diagnosed with serious mental illness in jails, shelters, and on the street should be considered the responsibility of the PMHS irrespective of their MHP enrollment

status. Children with serious emotional disturbance, regardless of whether or not they are receiving special education services, should also be considered "in the system."

- For the system to be inclusive, the Montgomery County Detention Center and Homeless Shelter system should be included as points of registration for clients with serious mental illness to enter the PMHS.

5.2 **Strengthen the leadership of the CSA**. The person in charge of the mental health system for the County should be a mental health professional who possesses expertise in the public health model of mental health, clinical knowledge of best practices, and be qualified and competent to provide forward thinking leadership. In addition, the CSA should include two chief clinicians – one to direct children's services and the other to direct adult services. These clinicians need to possess recent clinical expertise and be prepared to integrate best practices into the delivery of services.

5.3 **Move the CSA from its current location within the Adult Mental Health and Substance Abuse Service Area to a positiSon commensurate with its responsibilities for the entire public mental health system.** At present, the placement of the CSA within one service area dilutes its authority as the planning agent for all people – that is, children, adults, and seniors. The Task Force considered the option of moving the CSA to a position organizationally that reports directly to the Director of the Department of Health and Human Services. The other alternative is to move it outside of government entirely as a quasi-governmental, non-profit organization. There are pros and cons to each option. Regardless of its final location, it needs to be placed organizationally so that the leader has the unquestioned authority for planning and accountability of the total public mental health system. See Systems of Care Chart in Appendix I.

5.4 **Direct the CSA to implement a quality assurance program that includes continuous improvement, external evaluations of the system, reinforcement of appropriate behaviors, and an ombudsman for the entire system.** Functional outcome measures and an accounting of how dollars are spent are important and necessary tools to determine whether services are effective and to guide policy and budget decisions. The CSA should have access to and utilize expertise in contracting, accountability, quality assurance and grant writing.

5.5 **Use performance-based contracts with providers to deliver services.** Performance-based contracts will provide the CSA with information about how funds are spent, whether services are efficient and effective, and identify areas for improvement. These contracts will provide greater accountability with public dollars. The contracts could require a number of specific system improvement activities, such as:

- Coordination and linkage with homeless shelters, jails, criminal justice system, and acute care hospitals (including emergency rooms) where mental health clients require services not currently available;

- Coordination and linkage with State and private psychiatric hospitals to ensure communication of information relevant for treatment planning and smooth transitions between community and institutional settings;
- Comprehensive, coordinated treatment planning, case management, and service provision, especially for the most challenging youth with serious emotional disorders and adults with serious mental illness;
- Services to indigent clients not eligible for Medicaid;
- Provision of Assertive Community Treatment (ACT) services; and
- Data collection and reporting.

6. BUILD UP THE SERVICE DELIVERY SYSTEM FOR CHILDREN.

6.1 Formally link the CSA to the Collaboration Council for Children, Youth, and Families. The CSA should be legislatively linked to the Collaboration Council to ensure accountability to the County Council (and the public) for their overlapping responsibilities for planning, monitoring, and coordinating children's mental health services. If these State mandated entities become quasi-governmental non-profit corporations, their charters should require this connection. The planning and budget request processes for services should be based upon objective reported service outcome data and needs that are reported to their respective boards and the County Council.

6.2 Increase School-based Integrated Services. MCPS and the CSA should establish a 3-5 year plan to implement school/community mental health services. This should guide the efforts to monitor and ensure effective, coordinated, strengths based, culturally competent, individualized, family-driven services for children and youth who have mental, emotional, and behavioral disorders and who qualify for public mental health services under the PMHS or Individuals with Disabilities Education Act (IDEA). This plan should build on and integrate the current program resources in the systems, such as Linkages to Learning, Foundations for Success, Collaborative Action Process, and the Federal grant for systems care (Community Kids).

- Effective school mental health services would require a significant reorganization of student services resources and disability driven categorical special education services such as the current ED program.

- Effective school and preschool child mental health services require braided, multi-agency funding and maximizing Medicaid (and its EPSDT) for school-owned student support and clinical services.

7. ADDRESS THE RANGE OF HOUSING NEEDS FOR PEOPLE WITH MENTAL ILLNESS.

7.1 Direct the CSA to develop a housing plan in conjunction with HOC, State representatives, and private agencies. Local and State officials need to have an

accurate report that includes the scope of the housing needs, details the kind and level of needed housing, and includes a proposed timeframe and cost to meet demand.

- There needs to be an integrated and concerted effort to make housing a priority to reduce the number of mentally ill people living in homeless shelters and on the streets.

- Clients should not be confined at Springfield State Hospital solely as a consequence of inadequate community placements. The State and the County, along with housing officials, should develop and fund a plan to cease this practice within 12 months.

8. Explore All Potential Sources of Revenue.

8.1 Initiate local reviews to ensure that all available Federal, State, and private funds are captured. This action should include the hiring of a development officer to lead efforts to write and develop proposals for private funding sources.

8.2 Request State review of Maryland Health Partners. The Maryland Department of Health and Mental Hygiene and Maryland Attorney Generals Office should create a task force to evaluate whether Magellan, Inc., as the major private sector provider of managed behavioral health care services in Maryland, has profited from shifting the cost of care for privately insured individuals to the PMHS. Maryland Health Partners, a fully owned subsidiary of Magellan, Inc. manages the State's public mental health system. Every effort should be made to estimate and fully recover any shifted costs from Magellan, Inc. to the State of Maryland.

8.3 Explore the possibility of a product tax. Understanding that State law is needed, the Council should explore the possibility of a tax on products that could be earmarked for increasing funding of the public mental health system.

9. Ensure that the CSA Makes Full Public Disclosures on a Regular Basis

9.1 Develop a public report card that is issued regularly (preferably quarterly). The public should be provided with a full and open disclosure of the actual state of the public mental health system. This can be done by issuing a report card that includes data such as: summary client information, demographics, utilization rates, financial information, outcomes, and system accountability measures. Other local jurisdictions, such as King County (Washington) have developed such a mental health plan report card. The report card should also include an accurate description of the following:

- Recent reports such as the consultants' reports on the fundamental flaws in the underlying financial model and the expected financial failure of public outpatient clinic systems;
- Increase in the number of mentally ill persons confined in Montgomery County jails;

- Increase in the number of homeless mentally ill;
- Continued confinement of County citizens in Springfield hospital as a consequence of inadequate community services and supervised residential placements; and
- The number of people on waiting lists for subsidized and supervised housing.

9.2 Receive regular independent audits of the CSA and the State Public Mental Health System. To ensure fair and accurate oversight, audits by those who are not recipients of State or County funds or dependent in other ways should be involved with evaluating the State or local delivery system. It is recommended that the Council's Office of Legislative Oversight or an independent health consulting firm provide regular audits of the system. These audits should be presented to the County Council.

10. Advocate strongly with Federal legislators to eliminate disparity in Medicare coverage and private insurance.

- It is imperative that there be sustained and coordinated (State and County) efforts to work with our United States senators and representatives to ensure parity in reimbursement rates for mental health treatment.

- The Governor should be urged to use his leadership within the National Governors Association to lobby Congress to make mental health parity for Medicare a priority.

11. Incorporate prevention efforts in all aspects of community planning and mental health services.

- The County and the State should incorporate mental health goals in its action plans for dealing with disasters and tragedies including homicides, suicides, and tragic accidents, as well as terrorist attacks.

- Efforts should be made to replicate effective programs and eliminate those that are ineffective.

- Examples of effective prevention activities include the following:

  ⇒ Well supervised after school programs reduce the numbers of risk behavior opportunities unsupervised children and youth fall into.
  ⇒ School opportunities for families of all cultures and languages increase involvement and academic achievement.
  ⇒ Older adult senior activities, free transportation, and centers reduce depression among participating seniors.
  ⇒ Providing coping skill information for dealing with natural and man-made disasters may reduce post-traumatic stress disorders, domestic violence and substance abuse.
  ⇒ The County's programs to support pregnant teens and well-baby clinics have been shown to reduce child somatic and mental health problems.

⇒ Nurse visitation programs have reduced child abuse.

⇒ Well-administered early childhood and effective parent training programs have been shown to even improve intelligence and prevent conduct disorders and substance abuse among children and families at risk.

⇒ Other examples of effective prevention programs for children and youth are found in the expanded section on evidence based practice (Appendix B).

CROSSWALK BETWEEN FINDINGS AND RECOMMENDATIONS

FINDINGS	Corresponding Recommendations
1. The PMHS is both in financial collapse and fragmented, structurally unable to provide services to many individuals with mental illness or to ensure service continuity for its clients.	All
2. The large number of outpatient providers registered to provide services in the PMHS is only a "phantom network"; in reality, only a small fraction of these providers is able and willing to accept new PMHS clients.	1, 2, 3, 4
3. The consequence of the inability to serve individuals in the mental health system is that their care is shifted to other systems, such as jails, homeless shelters, and emergency rooms, some of which are not designed to target their mental health needs. The ultimate consequence is premature death by suicide and other unnatural causes.	1, 2, 3, 4
4. Official information made available to the public regarding the state of the PMHS is misleading.	5, 9
5. The Core Service Agency is not meeting its responsibility under State law to plan and provide accountability for the Montgomery County Public Mental Health System.	4, 5, 6, 9
6. At present, there is no single agency or agent responsible to determine and coordinate services for children's mental health across the systems that serve them.	3, 4, 6, 9
7. The fee-for-service system as currently structured does not comport with best practices.	1, 2, 3, 4, 5, 7, 11
8. The lack of parity in reimbursement rates for Medicare recipients places additional financial pressure on County level resources as the last resort to serve vulnerable individuals.	1, 8, 10
9. The lack of affordable housing is a major obstacle for people with mental illness.	7
10. Many mental health and substance abuse problems can be prevented and effective early interventions and supports can reduce the impact of stress on all age groups. Such prevention efforts do not currently exist.	4, 11

RECOMMENDATIONS	Corresponding Findings
1. Urge the State to adequately fund the public mental health system.	1, 2, 3, 7, 8
2. Request changes in the structure of the State's fee-for-service approach to managed care.	1, 2, 3, 7
3. Request a waiver from the State's fee-for-service system.	1, 2, 3, 6, 7
4. Plan and implement an integrated system for the delivery of mental health services.	1, 2, 3, 5, 6, 7, 10
5. Implement a system of effective management and accountability.	1, 4, 5, 7
6. Build up the service delivery system for children.	1, 5, 6
7. Address the range of housing needs for people with mental illness.	1, 7, 9
8. Explore all potential sources of revenue.	1, 8
9. Ensure that the Core Service Agency makes full public disclosure on a regular basis.	1, 4, 5, 6
10. Advocate strongly with Federal legislators to eliminate disparity in Medicare coverage and private insurance.	1, 8
11. Incorporate prevention efforts in all aspects of community planning and mental health services.	1, 7, 10

VII. Further Areas of Study

During the course of this review, the following topics were brought to the attention of the Task Force. Due to time constraints, the Task Force was unable to fully explore the following five issues. These topics merit further review.

1. **Need for an emergency psychiatric center.** Currently, people in crisis can wait many hours (legally up to six hours, but often more) in hospital settings when psychiatric staff is unavailable. The Police Chief and representatives from the Sheriff's Office discussed the burden it places on law enforcement officials who must often stay with people in crisis until a disposition is made. This situation could be alleviated by designating one hospital or an emergency psychiatric center that has trained mental health professionals, including a psychiatrist.

2. **Need for psychiatric hospitalizations beyond three to five days.** Due to average lengths of stay of three to five days, it is difficult for consumers who may require further hospitalization to stay within psychiatric units of general hospitals. Clients, therefore, may be prematurely discharged or sent to a State psychiatric facility outside the County.

3. **Need for psychiatric hospital beds for children under the age of 11.** Currently, there are no psychiatric beds for young children in Montgomery County. Placing children in need of hospitalization in Baltimore or other localities can make it difficult for some families to travel to visit and participate in treatment.

4. **Need for further examination of civil commitment laws.** There is a debate about civil commitment laws. Civil commitment in the State of Maryland requires that a person be assessed as a "danger to self or others." Many families testified to the Task Force that this threshold is too restrictive, and as a consequence they have been repeatedly told by representatives of both the mental health system and police that neither system could provide help until a loved one, be it child, relative, or spouse, threatens or commits an overt act of violence or self-injury. Family members provided vivid descriptions of the feelings of powerlessness and anguish experienced as they watched their children's conditions deteriorate while awaiting an overt act of violence or self-injury that would finally allow access to treatment services.

   On the other hand, the Task Force was also told that adults in crisis should have the right to make their own decisions and that the law should not compromise this right. One way to avoid civil commitment and keep individuals safe in the community is to strengthen intensive community treatment services. When communities utilize assertive community treatment, ensure access to medications, consumer self help organizations, and family supports, people at risk can be supported in a less restrictive environment.

5. **Need for a treatment system for individuals with mental illness and developmental disabilities.** These individuals face significant challenges in obtaining comprehensive services. The Task Force heard testimony from families and providers that these individuals are often shifted from one system to another without their needs being addressed.

APPENDIX

Resolution No.: 14-954
Introduced: July 17, 2001
Adopted: July 17, 2001

COUNTY COUNCIL
FOR MONTGOMERY COUNTY, MARYLAND

By: Council President Blair Ewing

Subject: Resolution to Establish a Blue Ribbon Task Force to Advise on Development of a Model Mental Health System

Background

1. In 1997, the State General Assembly enacted legislation to change the funding of the State public mental health system from a grant-funded system to a fee-for-service system. The State is responsible for funding and administering the public mental health system.

2. Four years after the transition to fee-for-service, the public mental health system is in crisis. Systemic problems regarding access to treatment, insufficient coverage for uninsured individuals, and timely and adequate payment for services present obstacles for both providers and individuals seeking treatment.

3. On December 12, 2000, the County Council unanimously supported a resolution calling for State action to improve the public mental health system. The resolution specifically called for the State to: 1) fund the County's FY 02 legislative agenda; 2) remove administrative obstacles to settling accounts promptly; and 3) develop increased access to treatment for individuals in the "gray zone" category. The State did not respond satisfactorily.

4. On May 1, 2001, the County Council took emergency action by appropriating County funds to shore up a failing mental health system and to provide public mental health care for County residents. In the FY 02 budget, the Council added funding for mental health services as well as a promise of a review of further needs in the fall of 2001.

5. According to the State Department of Legislative Services, the FY 02 appropriation to the Mental Hygiene Administration is estimated to be $18.1 million short. This figure could increase to $37.6 million when commitments to increase State rates to the free-standing psychiatric hospitals and a modest program growth of four percent are taken into account.

6. The Mental Health Advisory Committee and others have called for the establishment of a Blue Ribbon Task Force to advise the County Council on how to address the State and local crises in mental health services.

Action

The County Council for Montgomery County, Maryland approves the following resolution:

A Blue Ribbon Task Force to advise the County Council on the development of a model mental health system is established.

1. Responsibilities

The Blue Ribbon Task Force will have two charges. The first charge is to make recommendations for improvement to the State's public mental health system. The Task Force will present its recommendations in a written report to Governor Glendening.

The second charge is to advise the Council on the local funding and delivery of public mental health services. In the event that the State does not make changes to its current system, the Task Force will provide advice on: 1) how and under what circumstances Montgomery county should provide services; 2) to whom these services should be provided; 3) in what priority ranking; and 4) at what cost.

2. Membership

The Task Force will consist of no more than nine members, outside County and State government. Members are to include distinguished professionals in the field of mental health. Of the nine members, there will be one representative from the Montgomery Chapter of the National Alliance for the Mentally Ill (NAMI), one representative from the local chapter of the American Psychiatric Association, and the chair of the Mental Health Advisory Committee.

The County's Department of Health and Human Services and the State's Department of Health and Mental Hygiene will be asked to participate as observers and provide information to the Task Force. The Montgomery County Public Schools will be invited to participate through a special education staff member who would serve as an observer.

Council staff will provide staff support to the Task Force.

3. Time Frame

The Task Force will submit a written report to the County Council no later than February 1, 2002.

This is a correct copy of Council action.

Mary A. Edgar, CMC
Clerk of the Council

Resolution No.: 14-974
Introduced: July 31, 2001
Adopted: July 31, 2001

COUNTY COUNCIL
FOR MONTGOMERY COUNTY, MARYLAND

By: Council President Blair Ewing

Subject: APPOINTMENT - Blue Ribbon Task Force to Advise on Development of a Model Mental Health System

Background

1. Resolution 14-954 adopted on July 17, 2001, established the Blue Ribbon Task Force to Advise on Development of a Model Mental Health System.

2. The Task Force has two charges. First, the Task Force is charged with making recommendations for improvements to the State's public mental health system. Second, the Task Force will also advise the Council on local funding and delivery of public mental health services. In the event that the State does not make changes to its current system, the Task Force will provide advice on: 1) how and under what circumstances Montgomery County should provide services; 2) to whom these services should be provided; 3) in what priority ranking; and 4) at what cost.

3. The Task Force will submit a written report to the Council no later than February 1, 2002. The Task Force will also present its recommendations on the State system in a written report to Governor Glendening.

4. The Task Force will consist of no more than 12 members, outside County and State government. Members are to include distinguished professionals in the field of mental health. Of the 12 members, there will be one representative from the Montgomery Chapter of the National Alliance for the Mentally Ill (NAMI), one representative from the local chapter of the American Psychiatric Association, and the chair of the Mental Health Advisory Committee.

Action

The County Council for Montgomery County, Maryland approves the following resolution:

1. The membership of the Blue Ribbon Task Force is increased to 12 and the following individuals are appointed to the Task Force:

Dr. Kimberly Campbell
14820 Blackburn Road
Burtonsville, MD 20866-1304

Dr. Raymond Crowell
5517 N. Charles Street
Baltimore, MD 21210

Mr. Kevin Dwyer
National Mental Health Assoc.
1021 Prince Street
Alexandria, VA 22314-2971

Dr. Wayne Fenton
National Institute of Mental Health
6100 Research Blvd.
Rockville, MD 20852

Dr. William Lawson
Department of Psychiatry
Howard University Hospital
2041 Georgia Avenue, NW
Washington, DC 20060

Dr. Philip Leaf
105 Edgevale Road
Baltimore, MD 21210

Dr. Garrett Moran
Westat
1650 Research Blvd.
Rockville, MD 20850

Dr. Fred Osher
15221 Manor Lake Dr.
Rockville, MD 20853

Mr. Robert Trachtenberg
8108 Tomlinson Ave.
Bethesda, MD 20817

Mental Health Advisory Committee
Ms. Sandy Berman
804 Curry Ford Lane
Gaithersburg, MD 20878

American Psychiatric Association
Dr. Richard Gross
3208 Pickwick Lane
Chevy Chase, MD 20815

National Alliance for the Mentally Ill
Ms. Diane Sterenbuch
8314 Loring Dr.
Bethesda, MD 20817

2. Mr. Kevin Dwyer will serve as Chair of the Task Force and Dr. Wayne Fenton will serve as Vice-Chair of the Task Force.

This is a correct copy of Council action.

Mary A. Edgar

Mary A. Edgar, CMC
Clerk of the Council

Resolution No.: 14-1065
Introduced: November 20, 2001
Adopted: November 20, 2001

COUNTY COUNCIL
FOR MONTGOMERY COUNTY, MARYLAND

By: Council President Blair Ewing

Subject: APPOINTMENT – Blue Ribbon Task Force to Advise on Development Model Mental Health System

Background

1. Resolution 14-954 adopted on July 17, 2001, established the Blue Ribbon Task Force to Advise on Development of a Model Mental Health System.

2. Resolution 14-974 adopted on July 31, 2001, appointed twelve members to the Blue Ribbon Task Force on Mental Health.

3. Since the time of resolution 14-974, two members of the task force have resigned.

4. Due to the scope of the charge, members of the task force have requested that the Council make two new appointments.

Action

The County Council for Montgomery County, Maryland approves the following resolution:

1. The membership of the Blue Ribbon Task Force is amended to add Dr. David Osher and Dr. Milton Shore and to accept the resignations of Dr. Fred Osher and Robert Trachtenberg.

2. The current membership is as follows:

Dr. Kimberly Campbell 14820 Blackburn Road Burtonsville, MD 20866-1304	Dr. David Osher American Institutes for Research Pelavin Research Center 1000 Thomas Jefferson St., NW Washington, DC 20007-3835
Dr. Raymond Crowell 5517 N. Charles Street Baltimore, MD 21210	Dr. Garrett Moran Westat 1650 Research Blvd. Rockville, MD 20850
Mr. Kevin Dwyer National Mental Health Association 1021 Prince Street Alexandria, VA 22314-2971	Dr. Milton Shore 1370 Lamberton Drive Silver Spring, MD 20902
Dr. Wayne Fenton National Institute of Mental Health 6100 Research Blvd. Rockville, MD 20852	Mental Health Advisory Committee Ms. Sandy Berman 804 Curry Lane Gaithersburg, MD 20878
Dr. William Lawson Department of Psychiatry Howard University Hospital 2041 Georgia Avenue, NW Washington, DC 20060	American Psychiatric Association Dr. Richard Gross 3208 Pickwick Lane Chevy Chase, MD 20815
Dr. Philip Leaf 105 Edgevale Road Baltimore, MD 21210	National Alliance for the Mentally Ill Ms. Diane Sterenbuch 8314 Loring Drive Bethesda, MD 20817

This is a correct copy of Council action.

Mary A. Edgar

Mary A. Edgar, CMC
Clerk of the Council

APPENDIX B. OVERVIEW OF EVIDENCE BASED PRACTICE FOR ADULTS AND CHILDREN

This chapter outlines information about best practices for the delivery of mental health services for adults and children. This material provides examples of scientifically based best practice in community care for individuals and systems-level interventions.

I. BEST PRACTICES FOR ADULTS

Overview

Providing individualized care in a least restrictive or most integrated setting is a core value of community mental health. Patients with serious mental illness who would have been long-term residents of psychiatric institutions a generation ago are now treated in community settings. In later stages of this deinstitutionalization, more disturbed patients continue to be moved from downsized or closing institutions to communities that are sometimes ill-prepared to care for them. Because of the significance of mental illness as a public health problem, the National Institute of Mental Health (NIMH), Substance Abuse and Mental Health Services Administration (SAMHSA), and Agency for Health Care Policy and Research (AHCPR) have supported research to identify best practice models for both treatment of individuals with mental disorders, and for organization and delivery of mental health services within a public mental health system.

Reliance upon evidence based treatment practice is one basis for rationally informing decisions about the allocation of scarce health care dollars. This approach assumes that health policies should promote access to treatments based on rigorous scientific information concerning the effectiveness (outcomes), costs, and cost-effectiveness of alternative treatment approaches. Although comprehensive surveys of the treatment outcome literature for particular disorders are periodically commissioned, no single scientific or governmental agency is responsible for defining "official" evidence based treatment practice for mental illness. Rather, ongoing support for treatment research aims to maintain a dynamic and growing body of scientific evidence bearing on the utility of new and existing treatments. Thus, knowledge of evidence based practice requires current and continuous familiarity with the scientific literature related to the treatment of mental disorders.

Important recent compilations of evidence based treatment practice for patients with the most common mental illness encountered in the Public Mental health System include:

1. U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institutes of Mental Health, 1999.

2. *American Psychiatric Association Practice Guidelines* for Treatment of Patients with Borderline Personality Disorder, Treatment of Patients HIV/AIDS, Treatment of Patients

Major Depressive Disorder (Second Edition), Treatment of Patients Eating Disorders (Second Edition), Evaluation Of Adults, Treatment Of Patients With Bipolar Disorder, Treatment Of Patients With Substance Use Disorders; Alcohol, Cocaine, Uploads, Treatment of Patients with Schizophrenia. Available at: **http://www.psych.org/clin_res/prac_guide.cfm**

3. Lehman AF, Steinwachs DM, and the Co-Investigators of the PORT Project: (1998) At Issue: Translating Research into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations *Schizophrenia Bulletin* 24:1-10.

4. Fenton WS and Schooler NR, Editors b (2000): Evidence-Based Psychosocial Treatment for Schizophrenia. *Schizophrenia Bulletin Special Issue* 26:1-153.

Nature of Outcome. Treatment outcome in serious mental illness is not a unitary concept. Rather, outcome is considered to consist of several semi-independent domains. At the level of the individual patient, treatment outcomes considered most important in evaluating mental health services include (in no particular order): 1) symptom improvement and relapse rates; 2) vocational functioning; 3) social functioning; 4) quality of life (access to opportunities, resources and choices); 5) family well-being; and 6) satisfaction with the intervention.

Specific treatments for mental illness target one or more particular outcome domains. Medications, for example, target symptom improvement and relapse and exert only a secondary or downstream effect on social or vocational functioning. Vocational rehabilitation primarily targets work functioning. Thus it is axiomatic that the constellation of treatments prescribed for any particular patient be individualized based on that persons specific symptoms, situation, functional impairment, and preferences.

Levels of Evidence in Assessing Treatments: The randomized controlled trial is the "gold standard" for assessment of treatment efficacy. In these studies patients are randomly assigned to two or more treatment options and outcome is assessed, often by independent raters who are unaware of what treatment the patient has received. Evidence is strongest for the effectiveness of treatments tested in many randomized clinical trials. Evidence is weaker for treatments where fewer formal trials are available, and data is supplemented by expert opinion.

Discussion and Examples of Evidence Based Practices

Considerable research has been done to document evidence based practices that achieve successful outcomes for adults with mental illness. It is critical to use this research as a guide in establishing effective service delivery systems. This section discusses specific examples of this research in four categories: 1) Schizophrenia Patient Outcomes Research Team (PORT) Recommendations; 2) Post-PORT (1995) Research; 3) System-Level Best Practice Principles; and 4) the Research Initiative of the Center for Mental Health Services.

1. Evidence based practice for Patients with Serious Mental Illness: Schizophrenia Patient Outcomes Research Team (PORT) Recommendations

Beginning in 1992, the AHCPR and NIMH funded the Schizophrenia Patient Outcomes Research Team (PORT) to develop and disseminate recommendations for the treatment of schizophrenia based on existing scientific evidence (Lehman et al, 1995). Among the severe and persistent mental illnesses treated in the public mental health system, schizophrenia and related psychotic disorders have been most extensively studied. Many science-based treatment principles derived from studies of these disorders can be generalized to other persistent disabling mental illnesses., Between 1992 and 1995, PORT investigators systematically reviewed all scientific studies conducted since 1965 (some 9000 studies) bearing on the treatment of schizophrenia, surveyed variations in clinical practice and systematically queried recognized national experts to define a set of 30 Evidenced Based Treatment Recommendations for this disorder (Lehman et al, 1998). Evidence supporting the efficacy of newer and older medications, psychological treatments, vocational rehabilitation models, case management models, and family interventions was comprehensively assessed, and treatments were rated based on scientific evidence of efficacy.

PORT recommendations represent evidence based best practice for Schizophrenia and other psychotic disorders. Evidence of efficacy for various treatments is schematically outlined in Table 1.

Table 1: Scientific Evidence Base to Support Efficacy of Treatments Across Outcome Domains for Schizophrenia and Other Psychotic Disorders

	Symptoms	Relapse	Functioning	QOL *
Older Medicines	YES	YES	NO	NO
Newer Medicines	YES	YES	YES	YES
Psychological Therapies	NO	NO	YES (SKILLS TRAINING)	NO
Family Psycho-education	NO	YES	NO	NO
Vocational Rehabilitation	NO	NO	YES, ACTIVITIES	NO
Assertive Community Treatment/ Case Management	NO	YES	YES, REHABILITATION	+/-

* Quality of Life

Specific psychological therapies have not been as extensively studied in randomized clinical trials as pharmacological interventions. This does not mean psychosocial treatments are less important than medication, only that we do not know as much about which particular treatments are effective for particular patient groups. Nonetheless, the available scientific evidence base with respect to specific psychological therapies allowed PORT defined assessments of psychological treatment efficacy, which are summarized in Table 2.

Table 2: Scientific Evidence Base to Support Efficacy of Psychological Treatments Across Outcome Domains for Schizophrenia and Other Psychotic Disorders

	SYMPTOMS	RELAPSE	FUNCTIONING	QOL*
Individual: Psychodynamic	NO	NO	NO	NO
Individual: Skills Training	+/-	+/-	YES	NO
Individual: Supportive	+/-	+/-	+/-	+/-
GroupTherapy	NO	NO	YES (social)	NO

* Quality of Life

Significant PORT Findings can be summarized as follows:

- **Substantial data support the efficacy of medications in reducing relapse and improving symptoms. Newer medications are associated with fewer side effects and *may* have enhanced impact on other domains of functioning.**

- **Supportive psychological therapies are widely used, but relatively little research is available to assess their efficacy.**

- **Family Interventions using psycho-education, problem solving and support are rarely used, although a strong body of scientific evidence supports their efficacy in reducing relapse and enhancing family well-being.**

- **Traditional vocational rehabilitation programs that emphasize long periods of pre-vocational 'readiness' exercises rarely yield impressive outcomes in the area of competitive employment.**

- **Assertive Community Treatment (ACT) is a highly efficacious means of organizing services for high-risk clients, but its effectiveness is based on the fidelity of implementation and its targeted application to persons at high risk for relapse.**

- **Scant evidence supports the use of many commonly applied approaches including non-specific case management models, group therapies, and non-specific individual therapies.**

2. Post-PORT (1995) Research Informing Evidence-Based Best Practice

In addition to identifying effective treatment practices that are inadequately disseminated and other treatments that are widely used, but ineffective, the Schizophrenia PORT called attention to areas of clinical practice (particularly psychosocial treatments) that had simply been inadequately specified and/or evaluated in scientific trials. During the past decade considerable new research has been conducted to fill these knowledge gaps. With respect to new scientific data informing evidence based practice for psychosocial treatment of severe and persistent

mental illness, many of these studies have been summarized in a recent issue of *Schizophrenia Bulletin* edited by Fenton and Schooler (2000). Across virtually all modalities of psychosocial treatment new approaches with demonstrated efficacy have been developed. Major recent developments bearing on evidence based best practice for severe and persistent mental illness are summarized below:

Individual Therapy

- A specific form of individual psychotherapy developed by Dr. Gerry Hoggarty, a social worker at the University of Pittsburgh, termed 'Personal Therapy', has demonstrated efficacy in improving functioning in patients with schizophrenia and other psychotic disorders once residential stability has been established (Fenton, 1997). This therapy addresses patients' needs in an individualized manner beginning with basic psychosocial support and relationship building and progressing through more challenging psycho-education and social skills training.
- A variety of cognitive-behavioral individual psychotherapies have been developed that demonstrate efficacy in reducing the severity of and distress associated with medication-resistant symptoms (Garety et al, 2000).

Family Psycho-education

- The documented efficacy of these interventions has now been extended to participants in a wide range of cultural and clinical groups and efficacy is established across a broader range of outcomes including self-efficacy, functioning, and family well-being (Dixon, 2000).

Dual Diagnosis (Substance Abuse and Mental Illness)

- More than half of patients with serious mental illness experience co-occurring substance use disorders. Traditional models of service delivery that provide mental illness and substance abuse treatment in separate systems are ineffective.
- In contrast, successful programs are characterized by a comprehensive integration of mental health and substance abuse services that include assessment, assertive case management, motivational interventions for patients who do not recognize the need for substance abuse treatment, behavioral interventions for those that are trying to attain or maintain abstinence, and the capacity to address basic medical and social service needs (Drake and Mueser, 2000).

Adherence with Medication and Aftercare

- A form of short-term individual psychotherapy termed Compliance Therapy has demonstrated efficacy in reducing medication non-adherence among recently discharged patients with serious mental illness (Kemp et al, 1998).
- A brief eight session community re-entry skills training program administered prior to hospital discharge significantly increases the proportion of patients attending first post-hospital discharge aftercare appointment (Kopelowicz et al, 1998).

Residential Crisis Services

- Two randomized controlled trials indicate that residential crisis services can deliver outcomes comparable to hospital care at significantly reduced costs for patients with

serious mental illness in need of hospitalization and willing to accept voluntary treatment (Sledge et al, 1996; Fenton et al, 1998).

Borderline Personality and Self-injurious Behavior

- An integrated group and individual psychotherapy approach termed Dialectical Behavior Therapy (DBT) has been developed and demonstrates efficacy in reducing severe dysfunctional behaviors that are targeted for intervention (e.g., parasuicide, substance abuse, and binge eating), enhancing treatment retention, and reducing psychiatric hospitalization (Koerner and Linehan, 2001).

Vocational Rehabilitation

- In contrast to traditional vocational rehabilitation models that are largely ineffective in achieving competitive employment as an outcome, an Individualized Placement and Support (IPS) model that integrates mental health counseling, rapid job placement, and job-site follow-along support including counseling, transportation and liaison with employers has demonstrated efficacy in assisting patients with serious mental illness achieve competitive employment (Drake et al, 1998).

Social Skills Training

- Data supporting the efficacy of social skills training continues to accumulate and these skills training approaches can enhance functioning in areas such as community adjustment, conflict resolution skills, social skills, communication with care-givers and HIV risk behavior. Results, however, often require prolonged periods of treatment and integration of skills training with medications and assertive case management (Heinssen et al, 2000).
- Combining better medications with psychosocial treatments yield synergies that enhance patient outcomes: better medications render patients more amenable to psychosocial treatments resulting in better symptomatic and functional outcomes (Rosenheck et al, 1998).

Mental Health Courts and Pre-release Case Management

- Various models of Mental Health Courts have been established in several jurisdictions with the goal of preventing criminalization and recidivism among mentally ill persons charged with minor crimes by providing critical mental health services. Court staff members collaborate with community providers to implement a therapeutic intervention that may include medication management, substance abuse treatment, housing, job training and rehabilitation. Defendants can have their charges or jail sentences deferred if they participate in services. Preliminary assessments of these models are promising, although more comprehensive studies are required (Watson et al, 2001).
- Providing case management that connects discharged mentally ill persons to medically necessary aftercare services is a critical element in the reduction of recidivism. Failure to provide this linkage is the basis for a suit in at least one state (Bernstein, 1999).

3. System-level Best Practice Principles: Community Support and Recovery Models

Community Support Model

As described in the 1999 Report of the Surgeon General (U.S. DHHS, 1999), a Community Support System (CSS) Model forms the conceptual basis of contemporary organization of services for patients with severe and persistent mental illness. This model is predicated on the belief that individuals with serious mental illness can become citizens of their communities if provided with support and access to both specialized mental health services along with mainstream resources such as housing and vocational opportunities (Goldman,1998). The CSS concept was designed by NIMH with extensive participation from the field and is defined as "an organized network of caring and responsible people committed to assisting a vulnerable population meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community" (NIMH,1980).

The CSS Concept delineates 10 essential components that are needed to provide adequate opportunities and services for persons with long-term mental illness (Stroul, 1987) as follows:

1. Location of Clients/outreach – assure access by outreach, arrange transportation if needed, or take services to client;
2. Assistance in Meeting Basic Human Needs – food, clothing, shelter, personal safety, general medical and dental needs;
3. Mental Health Care;
4. 24 Hour Crisis Assistance – including 24 hour quick response aimed at stabilizing emergencies;
5. Psychosocial and Vocational Services - including a continuum of high to low expectation services some of which should be available on an indefinite duration basis;
6. Rehabilitative and Supportive Housing – a broad enough range of options to allow each client the opportunity to live in an atmosphere offering the degree of support necessary along with incentives to assume increasing responsibility;
7. Assistance/Consultation and Education – provide back-up support, assistance and education to families, friends, landlords, and employers to maximize benefits and minimize problems for clients;
8. Natural Support Systems – high priority to facilitating natural support systems such as families, consumer and family self-help groups, consumer-run service alternatives, churches and community organizations;
9. Protection of Client Rights – meaningful grievance procedure to protect client rights both in institutions and in the community;
10. Case Management – designating a single person or team responsible for helping the client make informed choices about opportunities and services, assure timely access to needed assistance, and coordinate all services to meet clients goals.

The CSS model defines *principles* for the organization of mental health services that can be actualized in any number of specific administrative or oversight structures. Central to the model, however, is the concept of a coherent, responsible, and accountable system of care. Twenty years of experience attempting to implement the CSS model suggests factors that can

differentiate a functioning system from an incoherent or uncoordinated service configuration. Specifically, effective and successful systems are characterized by the following:

- Provision of a continuum of care that can flexibly provide individualized services to patients with varying levels of disability across the full spectrum from minimal support to comprehensive inpatient or long-term highly supervised community support;
- Continuity of care across service levels – in a system providing continuity of care one or more clinicians remain involved in an individual patients care irrespective of where in the system the patient is being treated at any particular time. Thus, for example, if a patient living in the community is hospitalized, the designated clinician responsible for coordinating the overall treatment plan, maintains contact with both the client and the hospital treatment team during the acute care episode, insures that hospital staff are adequately informed regarding the clients needs, and participates in discharge planning and aftercare;
- The system incorporates and integrates *all* components of the CSS model. Providing adequate mental health services is virtually useless, for example, in the absence of meeting basic human service needs for food, clothing and shelter.
- An effective and coherent system maintains responsibility and accountability for clients who fall into "overflow" care settings such as the criminal justice and homeless systems. Clients falling into these systems remain the responsibility of the CSS and a designated responsible clinician works to insure continuation of service provision and coordinated return to more stable and integrated living situations.
- An effective system insures accountability by incorporating a meaningful data management and quality assurance capacity. In addition to satisfaction surveys, accountability is assured by measuring and reporting 'hard process measures' (such as days to first appointment following hospital discharge, outreach visits to clients in jails and homeless shelters per month, percent of missed appointment followed up by outreach phone call or home visit) and measuring and reporting 'hard outcome measures' (such as hospitalization rates, rates of homelessness, rates of arrest and incarceration, suicide attempts, patient deaths, competitive employment rates and client functional status). A meaningful data management and quality assurance capacity insures that the CSS can proactively identify and correct deficiencies and creates a culture of continuous quality improvement.

Recovery Model

Recovery is a concept introduced in the lay writings of mental health consumers in the 1980's and in part reflects a turnabout in attitudes as a result of the consumer movement and self-help activities. Recovery has been described as a process, an outlook, a vision and a guiding principle (DHHS, 1999). The overarching message, supported by contemporary research, is that hope and restoration of a meaningful life are possible despite serious mental illness (Deegan, 1997). Beyond a narrow medical view of mental illness, recovery implies restoration of identity, self-esteem, and meaningful roles in society (DHHS,1999). On a practical level, the recovery movement is evidenced by: greater participation of consumers and families in the design and oversight of services and service systems; the creation and support of family and consumer

operated alternatives or supplements to traditional CSS care; active efforts to eliminate widespread stigma associated with mental illness; and the creation of new definitions of outcome that are expanded to emphasize self-esteem, empowerment, optimism and self-efficacy (Rogers et al, 1997).

In part, a Recovery Model encompasses a vision of a future service system that is more sensitive to and facilitative of self-management, participation in community life, and self-defined recovery as penultimate goals and values (Anthony, 1993). One positive effect of this perspective has been a reassessment of current services in relation to the potential unintended consequence of their impeding individual autonomy and recovery by undermining clients self-esteem and socializing individuals with mental illness into the sick role. Research exploring these potentially negative effects has had an important impact on policy and service delivery for several decades (Goffman, 1961; Estroff, 1981). Yet, in a time of fiscal scarcity, it is critical to guard against using the banner of the Recovery Movement as a pretext for fiscally motivated de-funding and dismantling of critical community support services for the most vulnerable and severely affected mentally ill adults.

4. Center for Mental Health Services National Best Practices Research Initiative

The U.S. Dept of HHS, through its Substance Abuse and Mental Health Services Administration (SAMHSA), is funding an extensive project to promote the implementation of effective interventions for the care of persons with severe mental illnesses in community-based mental health practice settings. Guidelines are being developed which will include educational and training materials for consumers, family members, clinicians, program leaders and public mental health authorities, and recommended implementation procedures.

Materials will be available in six areas: Assertive Community Treatment; Family Psycho-education; Supported Employment; Dual Diagnosis Treatment; Illness Self-Management; and Medication Management for Schizophrenia.

Additionally, the State of Maryland, as one of a few pilot states, will provide $200,000 in funding to implement the Family Psycho-education and Supported Employment Evidence based practices in six centers across the State.

Extensive empirical research, summarized in many professional reviews and practice guidelines, demonstrates that several pharmacological and psychosocial interventions are effective in improving the lives of persons with severe mental illnesses. However, the practices validated by research are not widely offered in routine mental health practice settings. The SAMHSA effort will make it easier for officials to provide effective, validated mental health interventions.

Bibliography

1. Lehman AF, Steinwachs DM, and the Co-Investigators of the PORT Project: (1998) At Issue: Translating Research into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations *Schizophrenia Bulletin* 24:1-10.
2. Lehman AF, Thompson JT, Dixon LB, Scott JE (1995): Schizophrenia Outcomes Research –
3. Editors Introduction. Schizophrenia Bulletin Special Issues 21:561-703.
4. Fenton WS and Schooler NR (2000): Editors Introduction: Evidence-Based Psychosocial
5. Treatment for Schizophrenia. *Schizophrenia Bulletin Special Issue* 26:1-153.
5. Fenton WS and McGlashan TH(1997): We Can Talk: Individual Psychotherapy for
6. Schizophrenia. American Journal of Psychiatry 154:1493-1495.
7. Garety PA, Fowler D, Kuipers E (2000): Cognitive-Behavioral Therapy for Medication-Resistant Symptoms. Schizophrenia Bulletin 26:73-86.
8. Dixon L, Adams C, and Luckstead A (2000): Update on Family Psychoeducation for Schizophrenia. Schizophrenia Bulletin 26:5-20.
9. Drake RE and Mueser KT (2000): Psychosocial Approaches to Dual Diagnosis. Schizophrenia Bulletin 26:105-118
10. Kemp R, Kirov C, Everitt B, Hayward P, David A (1998): Randomized Controlled Trial of Compliance Therapy:18 month follow-up. British Journal of Psychiatry 172:413-419
11. Kopelowicz A, Wallace CJ, Zarate R (1998): Teaching Psychiatric Inpatients to Re-enter the Community:a brief method of improving continuity of care. Psychiatric Services 49:1313-1316.
12. Sledge WH, Tebes J, Rakfeldt J, Davidson L, Lyons L, Druss B (1996): Day Hospital /Crisis Respite Care versus inpatient care I: Clinical Outcomes American Journal ofPsychhiatry 153:1074-1083.
13. Fenton WS, Mosher LR, Herrell JM, Blyler CR (1998) Randomized Trial of General Hospital and Residential Alternative Care for Patients With Severe and Persistant Mental Illness. American Journal of Psychiatry 155:4516-522.
14. Koerner K and Linehan MM (2001): Research on dialectical Behavior Therapy for patients with borderline personality disorder. Psychiatric Clinics of North America March 23 (1):151-67
15. Drake RE, Mercer-McFadden C, Mueser KT, McHugo GJ, Bond GR, Quimbly E (1999):A Randomized clinical trial of supported employment for inner-city patients with severe mental disorders. Archives of General Psychiatry 56:627-633.
16. Heinssen RK, Liberman RP, Kopelowicz A(2000): Psycosocial Skills Training for Schizophrenia: Lessons from the Laboratory. Schizophrenia Bulletin 26:21-46.
17. Rosenheck R, Tekell J, Peters J, Cramer J, Fontana A , XU W (1998) Does Participation in psychosocial treatment augment the benefits of clozapine?. Archives of General Psychiatry 55:618-625.
18. Watson A, Hanrahan P, Luchins D, Lurigo A (2001): Mental Health Courts and the Complex Issue of Mentally Ill Offenders. Psychiatric Services 52:477-481.
19. Bernstein N: Back on the Streets without a Safety Net. New York Times September 13, 1999 p B1.
20. U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse

and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institutes of Mental Health, 1999.
21. Goldman HH (1998): Deinstitutionalization and Community Care: Social Welfare Policy as Mental Health Policy. Harvard Review of Psychiatry 6:219-222.
22. National Institute of Mental Health (1980). Essential CSS Functions. In Announcement-Community Support Systems strategy development and implementation grants. Rockville, Maryland. NIMH.
23. Stroul BA (1987): Crisis Residential Services in a Community Support System: Report to the NIMH Crisis Residential Services Project. National Institute of Mental Health Rockville, Maryland, August 1987.
24. Deegan PE (1997) Recovery and Empowerment for People with Psychiatric Disabilities. Journal of Social Work and Health Care 25:11-24.
25. Rogers ES, Chamberlin J, Ellison ML, and Crean T (1997). A consumer-constructed scale to measure empowerment among users of mental health services. Psychiatric Services 48:1042-1047.
26. Anthony WA (1993): Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. Psychological Rehabilitation Journal 16:11-24.
27. Goffman E (1961) Asylums:Essays on the social situation of mental patients and other inmates. Anchor Books, Garden City, New York.
28. Estroff SE (1981): Making it Crazy: An ethnography of psychiatric clients in an American Community. University of California Press. Berkley and Los Angeles, California.

II. Best Practices for Children and Adolescents with Serious Emotional Disturbance and Their Families

Overview

The best practices for children and youth with serious emotional disturbance have been known for several years. Many of these practices are noted in the 1999 report "Mental Health: A Report of the Surgeon General" (U.S. DHHS, 1999). The Task Force reviewed the Surgeon General's report and other best practice documents from Federal agencies, including a matrix developed by SAMHSA, programs published by the U.S. Department of Education and Justice (Dwyer & Osher, 2000), materials funded by CMHS of SAMHSA (Greenberg, Domitovich & Bumlarger, 2001), and reviews by Hagwood and Erwin (1997).

Professionals have partnered with family run organizations to establish systems recommendations to support, implement, and monitor best practices in Maryland, and these principles are found in the Maryland Coalition of Families for Children's Mental Health's "Public Policy Goals 2002.

Who is the child with serious emotional disturbance? The Federal definition of a child or youth with serious emotional disturbance is:

> "persons from birth up to age 18 who currently or at any time during the past year had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-III-R, (or DSM-IV) and that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities." (SAMHSA, 1993, p. 29425).

This definition would include children identified as emotionally disturbed under the Individuals with Disabilities Education Act of 1997 (IDEA) as well as other children whose mental, behavioral or emotional disorder is secondary to another disability. Children who are not identified eligible for IDEA may also have serious emotional disturbance.

Principles of Community-Based Models. Mental health services need to be provided in the least restrictive, natural settings utilizing principles of community-based service models and comprehensive, culturally appropriate, family friendly best practices that provide meaningful, positive, measurably functional outcomes. Schools and homes must be included as natural settings and "least restrictive environments" for services. A full array of services must be available in a planned system that aligns services for effective transition among child service systems. Restrictive settings and out-of-home placements should be based upon severe mental health needs that are not possible in less restrictive settings and not upon system convenience or cost (Silver et al, 1992).

Mental health services and other child and youth services must be evaluated using functional data to evaluate service plans, revise plans, determine long and short-term service needs, and better integrate services. Aggregated data should be utilized by the systems to ensure the effectiveness of the child mental health system. Systematic planning, monitoring, and evaluation are management responsibilities that enable discrete best practices to be effective in

community settings. Many system structured measures enable easy evaluation of service effectiveness.

Functional measures frequently used in child and youth mental health service research include:

- School data – such as grades, achievement scores, discipline referrals, suspensions and expulsions, attendance, participation in activities, and family contacts, as well as behavioral observations, socialization, and social skill development among others (Adelman & Taylor, 2000).
- Home data – such as parent ratings of target behaviors and functional symptoms. Several rating scales are available. Observations and other intensive ratings may be included.
- Individual clinical data – symptom scales are also used, as well as services used including hospitalizations, emergency room visits, arrests, referrals to protective services and out-of-home placements including detention facilities.

I. Best Practice Programs

This section provides examples of best practices in prevention and early and intensive interventions. Many of these can be provided in natural settings, such as schools and homes, where children and youth reside. Coordinated child and adolescent mental health services using best practices are effective.

Child mental health problems are common and can be successfully treated.

At any given time, 21% of children and adolescents will suffer some functional impairment from mental and addictive problems. 11% of children and adolescents have significant functional impairment and 3-5% have *extreme* functional impairment from **mental,** emotional and behavioral problems (Satcher, 1999). In some communities in poverty, 2 out of 3 children with severe mental health impairments receive no mental health services (Leaf et al. 1996).

In any classroom of twenty children, two children will be socially or academically impaired by a mental health problem and one of those two may have extreme impairments.

Surgeon General Satcher (1999) reported that child and adolescent mood disorders (depression) and anxiety disorders account for the majority of mental illnesses among 9-17 year olds. Conduct disorders and attention deficit disorder with hyperactivity are more commonly diagnosed in school and more commonly referred for special education and related services.

The rate of suicide among 10-14 year old youth has increased 100% between 1980 and 1996.

Suicide is the third leading cause of death among youth ages 15-19. Self-report data show that nearly one-in-four within this age group seriously contemplate suicide and that female

teens attempt suicide about twice the rate of males whereas males are twice more likely to complete a suicide. Over 90% of those youth who complete a suicide have a mental disorder (Schaffert et al, 1996). The threefold increase in completed suicides since 1960 among white male adolescents has been attributed to the combination of easy access to handguns and increased substance abuse.

Many child mental health problems can be prevented.

Emotional and behavioral problems and addictive disorders are preventable. Even the negative effects of depression, with early diagnosis and effective treatment, can be reduced.

Child mental health problems are found among all economic, ethnic, racial groups, sexes, and preschoolers through adolescents. They know no geographic boundaries. Prevalence is greater among adolescents and among children exposed to the stresses of poverty, social neglect, community violence and trauma.

Schools are the natural environment to promote mental wellness, and to prevent and treat most mental and emotional problems.

Research shows that those few children who receive mental health services receive those services in schools. Nationally, school psychologists and counselors provide between 70-80% of child mental health services in schools (Burns et al, 1995).

Schools already are the nation's mental health provider for children and adolescents, but more services and a greater array of coordinated prevention and intervention services are required.

Although a school's staff and its mental health providers should be focused on prevention and early intervention services, few schools have identifiable mental health promotion and prevention programs. With greater demands for educational accountability for higher academic achievement, schools have progressively lost sight of the affective elements required to best ensure those high academic standards (Adelman, 1996). Children with SED have more serious academic failure than children with other disabilities (Anderson, 1999; Wagner, 1995).

Research has shown that there are techniques for teaching reading and math that are more effective than others (Learning First Alliance, 1999). The same is true for teaching behavioral skills and for the treatment of mental and behavioral problems (Department of Health and Human Services, 1999, 2000). We can encourage mental health practitioners, agencies and schools to use practices that have been shown to be effective (Adelman & Taylor, 1999). Measuring effectiveness is a critical component for any intervention plan.

All school, agency, and community providers should deliver prevention and intervention services that are theory based, evidence based, provided with fidelity, and evaluated.

Local and State polices should enable funding to be pooled to maximize access to both the prevention of mental health problems and the full array of treatment services for all children.

Successful programs integrating prevention and intervention services in the schools have been implemented in rural, suburban and urban school districts. Individual examples of research supported integrated school-based mental health programs are found in many states, including Rhode Island, Maryland, Louisiana, Kansas, Colorado, and California among others (Dwyer & Osher, 2000; Dwyer & Bernstein, 1998; Treder et al, 2000; Woodruff, Osher, Hoffman, Gruner, King, Snow & McIntire, 1998).

Examples:

Westerly High School (RI). This program combines the local mental health agency services with its student service team to provide a full array of preventive and intensive mental health services. School pupil service staff (school psychologists, counselors and social workers) work in collaboration with special and regular educators, clinic staff, and families to provide prevention and early and intensive interventions. Funds are blended to ensure that no youth is excluded from services.

Lafoucher Parrish Public Schools (LA). Utilizing school psychologists and psychiatric residents from the University Medical School (LA), the schools provide in-school mental health services to every child and family needing service. The effectiveness of proactive (prevention and early intervention) mental health services provided within the district are monitored by using "natural markers of student performance." The indicators are: Student Attendance; Grades (defined as progress in the general education curriculum); Discipline Referrals; Removals (hospitalizations and incarcerations); and Parent Feedback. Mental health treatment services are evaluated in terms of length of time from "need known" to "services begun," student/family outcomes, and the length of time from problem to termination of service(s). Medicaid, EPSDT funds are used to serve most children.

Linkages to Learning (Montgomery County, MD). This program is a school-based health and mental health model jointly developed and implemented by Montgomery County Public Schools, Montgomery County Department of Health and Human Services, and the local Mental Health Association. It provides multiple preventive services to children and families placed at risk by poverty, language and other barriers to learning and adjustment. The program provides multiple language supports and health and welfare services. The program has the potential to better link to intensive treatment services for children with SED.

Cherry Creek Schools (CO). The school system utilizes school psychologists to coordinate an array of mental health services provided by school and has extended day support and family support programs located in community schools to enhance access and ensure best practices. Outcomes are measured quarterly for each child, school and cluster.

II. The Public Health Model for School Mental Health

In Surgeon General Satcher's *Children's Mental Health: A National Action Agenda*, (2000), mental health concepts were integrated into a call for child and family centered best-practice interventions framed within the "public health prevention and intervention model."

To address these child mental health needs, Surgeon General Satcher developed a "national action agenda for children's mental health" (U.S. Department of Health and Human Services, 2000). This report stressed the importance of prevention and the role of schools in developmental learning for the promotion of mental health. The overarching vision of that report states:

> **"Mental health is a critical component of children's learning and general health. Fostering social and emotional health in children as a part of healthy child development must therefore be a national priority. Both the promotion of mental health in children and the treatment of mental disorders should be major public health goals. To achieve these goals, the Surgeon General's National Action Agenda for Children's Mental Health takes its guiding principles and commitment to:**
>
> 1. **Promoting the recognition of mental health as an essential part of child health;**
> 2. **Integrating family, child and youth-centered mental health services into all systems that serve children and youth;**
> 3. **Engaging families and incorporating the perspectives of children and youth, in the development of all mental healthcare planning;**
> 4. **Developing and enhancing a public-private health infrastructure to support these efforts to the fullest extent possible." (p. 3)**
>
> **U.S. Department of Health and Human Services, Public Health Service, *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*, (2000)**

Understanding the application of the public health model in the preschool and school-community setting is not rocket science. Child care facilities, Head Start, and schools teach children skills. The public school is the only governmental service that is designed to serve all children ages six through late adolescence, in preparation for adult life. Research has shown that listening, caring, and communicating with preschool children improves their mental wellness and may even improve their general intelligence (IOM, *Neurons to Neighborhoods, 2001*). This and other reports suggest that effective early interventions for mental, emotional and behavioral disorders reduce life-long functional disabilities (see also, USDHHS, 1999).

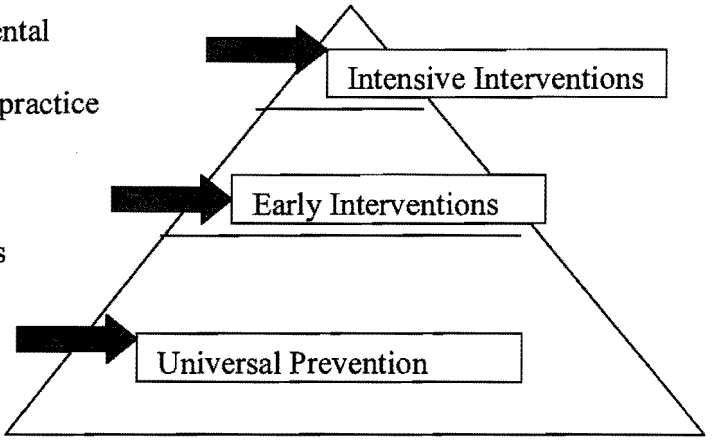
The model proposed to address all school children has been diagrammed as follows:

Mental Health Need of Children & Adolescents

3-5% seriously disabled by emotional & mental health problems. Need comprehensive, culturally/family friendly, coordinated best practice services.

15% placed at risk for mental health & academic problems. – Early interventions

80% of children and adolescents – socially and academically able. Caring school environment, high academic & behavioral standards, social skill training, family involvement for *all*



Typical Public School Population

For a complete explanation of this prevention, intervention school-based model consult: *Safeguarding Our Children: An Action Guide.* (Dwyer & Osher, 2000).

A fundamental principle noted above requires that mental health services be provided in the least restrictive, natural environment (such as child-care facilities, schools, and homes). Unlike adult services, child and adolescent services require active informed consent and involvement of responsible caregivers (parents).

III. Effective Programs

The following interventions and programs have been reviewed by expert panels, and are listed in several federal documents as "evidence-based" or "promising." When implemented with fidelity to their prescribed design, these programs and interventions have positive effects on the mental health of children.

The programs listed are not exhaustive of all possible interventions that are based on evidence. It is critical to avoid investing in unproven programs or programs that have been shown to have no positive effects. The following programs are divided into programs and strategies that are designed for universal prevention, those for children and youth at risk, and interventions for children and youth who have serious mental health problems (SED) blocking learning and adjustment.

School-wide Universal Prevention

Project ACHIEVE: (batsche@tempest.coedu.usf.edu) (Knoll & Batsche, 1995)
Project ACHIEVE is a school-wide reform program that includes several integrated components designed to enhance academic and social success for children in elementary and middle schools. It uses strategic planning to help the school determine its vision, goals, and its resources and needs to accomplish those goals. It uses whole-school

professional development training, teaching critical staff instructional and intervention skills to address the immediate and long–term needs of all children.

The Good Behavior Game (http://www.bpp.jhu.edu)
The Good Behavior Game reduces classroom disruption, aggression, and shyness. The Good Behavior Game is an easy and effective classroom management strategy, not a full-fledged school discipline program, per se. The program helps to create a strong school-wide foundation, but does not provide any early or intensive interventions. Although there is little data on other applications, the game could easily be adapted and expanded beyond the classroom to involve other personnel and other parts of the school day—e.g., rewarding good behavior on the part of lunchroom teams, etc. Data from Baltimore, MD also indicates that the game can be used as one component of a comprehensive academic and behavioral intervention plan.

PATHS (Promoting Alternative Thinking Strategies)
(www.psu.edu/dept/prevention/PATHS) (Elliot, 1998)
PATHS is a comprehensive curriculum designed to be used by classroom teachers with elementary school-aged students for the instruction of social and emotional literacy. PATHS promotes the internalization of pro-social values and reduces aggression, behavior problems, and emotional distress in children, while simultaneously enhancing the educational process by cultivating a caring, respectful, classroom environment.

Social Decision Making/Problem Solving Program (http://www.umdnj.edu/spsweb & http:/www.Eqparenting.com)

Social Decision Making/Problem Solving Program is a school program designed to teach children to think clearly and make emotionally intelligent decisions in academic and complex social and emotional real life situations.

I Can Problem Solve (www.researchpress.com)
I Can Problem Solve (ICPS) is a school-based primary prevention program designed to teach children ages four through twelve how to think through and solve interpersonal problems with peers and adults. It has also been shown to reduce the functional symptoms of anxiety and depression.

Early Interventions for Children At-risk

Aggression Replacement Training (ART) Arnold R. Goldstein Director, Syracuse University Center for Research on Aggression
Aggression Replacement Training is a response to anti-social behavioral excesses and prosocial behavioral deficits. It consists of three interventions: Skillstreaming, Anger-Control Training, and Moral Reasoning Training, which seek to enhance interpersonal skill competence, enhance self-mediated ability to control anger, and enhance the youth's moral reasoning/social problem skills (respectively).

First Step to Success
First Step to Success is an early intervention program designed to address the needs of kindergarten children identified as having antisocial or aggressive behavioral problems. The model includes three components: a kindergarten screening process, a classroom-based skills training curriculum called CLASS, and a family intervention program called HomeBase. First Step to Success uses trained consultants who work directly with students, teachers, and parents to help coordinate the intervention efforts between the home and the school.

IOWA Strengthening Families Program: For Parents and Youth 10-14
(www.extension.iastate.edu/sfp)
The Strengthening Families Program: For Parents and Youth 10-14 (SFYP 10-14) is designed to bring parents together with their children with the goal of reducing substance abuse and other problem behaviors in youth.

High/Scope Preschool Curriculum Framework (www.highscope.org)
The purpose of the High/Scope preschool curriculum framework is to contribute to young children's intellectual, social, and physical development so as to prepare them for success and responsibility in school and in life.

Intensive Interventions

Children with serious emotional disturbance require intensive interventions generally provided or supervised by clinical mental health professionals. Intensive interventions that meet best practice standards of evidence-based programs are few. The Surgeon General's report and other reports from NIMH and SAMHSA parallel those noted in the adult section. Other interventions subject to pre-post testing are included as "promising practices" noted in the above mentioned reports. Evidence-based practices noted in the 1999 and 2001 Surgeon General's *Mental Health* and *Youth Violence* Reports include:

Conduct Disorders
- Behavioral/substance abuse and conduct disorder and disruptive impulse disorder diagnoses (Behavior and conduct disorders are more commonly diagnosed and more likely to be served in special education as SED and/or in the juvenile justice system)

Multi-systemic Therapy (www.mstservices.com)
Multi-systemic Therapy (MST) is an intensive family-and community-strength based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. MST is significantly more effective than traditional therapies in reversing conduct and delinquent behaviors. MST requires 24/7 access to treatment in non-traditional settings such as the home. The average MST family services is 60 hours over 4 months.

Functional Family Therapy (FFT) (www.fftinc.com)
Functional Family Therapy (FFT) is an intensive intervention therapy designed to reduce delinquency, conduct disorder, drug and alcohol abuse, and family conflict that may

support these individual problems. FFT, like other successful interventions requires intensive family participation and treatment in natural settings.

Parent Education & Support. Manualized parent training programs have been shown to be effective for a variety of conduct disorders including ODD. When treated early, with intensive parent support and training, outcomes are shown to be positive (for research on parent training, see Peters & McMahon, 1996; Olds et al, 1997; Ramey & Ramey, 1992).

Wraparound Services: Identified as a Promising Practice in the Youth Violence Report, Wraparound includes a definable planning process involving the child and family, community agencies, and school staff that results in a unique set of school and community services and supports tailored to meet the needs of the child and family (for researsch on Wrapaournd see Burns & Goldman, 1998; Kendziora, Bruns, Osher, Pacchiano, & Mejia, 2001;)

Anxiety and Depression

- Anxiety disorders, social phobia and major depression comprise the largest number of child mental health disorders and are the largest untreated group. For youth with conduct disorder and delinquency, non-institutional individual counseling and interpersonal and behavior skill programs appear more effective than the same services in detention facilities.

Cognitive Behavioral Treatments (CBT)

These psychosocial therapies include individual or small group training in cognitive restructuring, social skill and assertiveness training, relaxation and imagery, self-control and other behavioral training techniques. Alone or in combination with specific medications, these treatments are more effective than traditional therapies. Family problem-solving treatment has also been seen as promising in addressing suicidal threats and ideation. Crisis Hotlines (similar to the MCMHA County funded hotline) may have merit in connecting teenagers to services but research has failed to show they reduce suicides. CBT therapies are more likely to be used by existing clinical and school mental health professionals.

Obsessive-Compulsive Disorders

- This disorder is less common than the affective disorders but can be functionally severely limiting in school, and socially. Specific medication (SSRIs) has been shown to be effective with both children and adults. CBT may be promising when used in natural settings.

Attention-Deficit Hyperactivity Disorder

- Children with ADHD are the most frequently diagnosed group and are the most frequently served with accommodations and special education support in the public schools.

Medications (psycho stimulants) and behavioral treatments have been reported to be effective in improving some functioning of children with this disorder. Peter Jensen and colleagues have reported that behavioral treatment alone is insufficient to produce positive effects. Parent (and school staff) education and training has shown promise in reducing the functional academic problems related to this disorder. Impulsivity related to

ADHD is more successfully addressed using treatments for disruptive disorders (see #1 above).

Substance Use Disorders

- 50% or more of youth with mental health disorders have a co-morbid substance abuse problem.

  Family oriented integrated treatments are preferred. See also the treatment programs for conduct disorders. An integrated treatment plan would focus on both the abuse problem and the coexisting mental health disorder.

IV. Summary

Change in the delivery of mental health services is frequently generated by a crisis such as a scandal concerning poor access to treatment, a class-action lawsuit against the schools for inadequate services for children under the Individuals with Disabilities Education Act, or a rash of violence or youth suicides. Crisis driven planning can be difficult since many in the community may over-react and look for a "quick-fix" for an identified symptom rather than to develop a significant interagency service-system change. Initial interest can also be secured by publicly presenting preliminary community based information that is easily accessible.

Montgomery County has about 135,000 children and youth enrolled in public schools and another 10-15,000 in private and other school settings. We can estimate that between 4,500 and 7,500 of those children have serious (functionally disabling) mental health problems. As many as 13,500 or 10% will have a disabling or *significant* problem and need some interventions. Other children and youth may - at some time - have an emotional or substance abuse problem that may require an intervention.

Bibliography

1. Adelman, H. S. (1996) Restructuring educational support services and integrating community resources: beyond the full service school model. School Psychology Review. (25), 431-445.
2. Adelman H. & Taylor, L. (2000). *A sampling of outcome findings from interventions relevant to addressing barriers to learning.* Los Angeles, CA: Mental Health in the Schools Training and Technical Assistance Center. Department of Psychology, UCLA.
3. Adelman H. & Taylor, L. (1999). Mental health in schools and system restructuring. Clinical Psychology Review. (19), 137-163.
4. Anderson, J. (1999). Comparing academic progress in students with emotional and behavioral disabilities and students with learning disabilities. *12th Annual Proceedings: A System of Care for Children's Mental Health: Expanding the Research Base.* Tampa FL: The Research and Training Center for Children's Mental Health University of South Florida.
5. Armbruster, P., & Lichtman J. 1999. Are school based mental health services effective? In Adelman & Taylor [eds.] *Technical Assistance Sampler: A sampling of outcome findings from interventions relevant to addressing barriers to learning.* Los Angeles, CA: The Center for Mental Health in Schools.

6. Bazelon Center for Mental Health Law. (2000). Medicaid documents. Washington DC.
7. Burns, B.J., Costello, E.J., Angold, A., et al. (1995) Children's mental health services use across service sectors. *Health Affairs*, 14, 147-159.
8. Burns, B.J. & Goldman, S.K. (Eds.) (1999). Promising practices in wraparound for children with serious emotional disturbance and their families. *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume IV.* Washington D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.
9. Dwyer, K.P. & Bernstein, R. (1998). Mental health in the schools: Linking islands of hope in a sea of despair. *School Psychology Review.* 27 (2), 277-286.
10. Dwyer, K.P. & Osher, D. (2000). *Safeguarding our children: An action guide.* Washington D.C. U.S. Departments of Education & Justice, American Institutes for Research.
11. Elliott, D.S. (ed). (1998). *Blueprint for violence prevention. Book 10: Promoting Alternative Thinking Strategies (PATHS).* Boulder, CO: Institute of Behavioral Science.
12. Kelleher, K.J., McInerny, T.K., Gardner, W.P., et al. (1999) Increasing identification of psychosocial problems: 1979-1997. University of Pennsylvania Medical School Consensus Conference on Attention Deficit Hyperactivity Disorder. Philadelphia PA. kelleherkj@msx.upmc.edu
13. Kendziora, K., Bruns, E., Osher, D., Pacchiano, D., & Mejia, B. (2001). Wraparound: Stories from the field. *Systems of Care: Promising Practices in Children's Mental Health, 2001 Series, Volume I.* Washington D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.
14. Knitzer, J., Steinberg, Z., & Fleisch, B. (1990*). At the schoolhouse door: An examination of programs and policies for children with behavior and emotional problems.* New York: Bank Street College of Education.
15. Knoff, H.M. (1996). The interface of school, community and health care reform: Organizational directions toward effective services for children. *School Psychology Review.* (25) 4, p 446-464.
16. Knoff, H.M., & Batsche, G.M. (1995). Project ACHIEVE: Analyzing a school reform process for at-risk and underachieving students. *School Psychology Review,* 24, 579-603.
17. Koyanagi, C. & Gaines, S. (1993). *All systems failure: An examination of the results of neglecting the needs of children with serious emotional disorder.* Alexandria, VA: National Mental Health Association.
18. Kumpfer, K.L., Molgaard, V. & Spoth, R. (1996) The strengthening families program for the prevention of delinquency and drug use. In R.D.Peters & R. J. McMahon (eds.), Preventing childhood disorders, substance, and delinquency (pp. 241-267). Thousand Oaks, CA: Sage.
19. Lawson, H. & Briar-Lawson, K. (1997). *Connecting the dots: Progress toward the integration of school reform, school linked services, parent involvement and community schools.* Oxford, OH: Danforth Foundation & Institute for Educational Leadership.
20. Lodge, .D. (1998) *California's Healthy Start: Strong Families, Strong Communities for Student Success.* Santa Barbara CA: California Department of Education.
21. Making the Grade (1995) Issues in financing school-based health centers: A guide for state officials. Washington, DC: The George Washington University.
22. Marx, E. & Wooley, S. (Eds.) (1998). *Health is academic.* New York: Teachers College Press.

23. Nastasi, B.K., Varjas, K., & Bernstein, R. (1998). *Exemplary Mental Health Programs: School Psychologists as Mental Health Service Providers.* Washington, DC: National Association of School Psychologists.
24. National Association of School Based Health Clinics (September, 2000. Personal communication).
25. National Association of School Psychologists. (2000). *Guidelines for the Provision of School Psychological Services.* Bethesda, MD.
26. Olds, D.L., Henderson, C.R., Phelps, C., Kitzman, H. & Hanks, C. (1993) Effect of prenatal and infancy nurse home visitation on government spending.
27. Olds, D.L. et al. (1997). Long term effects of home visitation on maternal life course and child abuse and neglect. *Journal of the American Medical Association,* 278 (8), 637-643.
28. Peters, R.DeV., & McMahon, R.J. (1996). *Parent training: Foundations for research and practice.* New York: Guilford.
29. Ramey, C.T. & Ramey, S.L. (1992) Effective early intervention. *Mental Retardation,* 30 (6), 337-345.
30. Shaffer, D. et al. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry,* 53, 339-348.
31. Silver, S.E., Duchnowski, A.J., Kutash, K., Friedman, R.M., et al. (1992). A comparison of children with serious emotional disturbance served in residential and school settings. *Journal of Child and Family Studies.* 1, 43-59.
32. Treder, D., Kutash, K., Duchnowski, A., et al. (2000). School and community study: Exemplary school models and student outcomes over time. In C. Liberton, C. Newman, K. Kutash, R. M. Friedman (Eds) *A system of care for children's mental health: Expanding the research base.* Tampa FL. University of South Florida. 99-102.
33. US Department of Health and Human Services (1999). Mental Health: A Report of the Surgeon General. Rockville, MD.
34. US Department of Health and Human Services (2001). Youth Violence: A Report of the Surgeon General. Rockville, MD.
35. US Public Health Service (2000). Children's Mental Health: A National Action Agenda. Washington, DC.
36. Wagner, M. (1995). Outcomes for youth with serious emotional disturbance in secondary school and early adulthood. *The future of children: Critical issues for children and youth.* 5 (4), 90-112.
37. Walker, H.M. & Rankin, R. (1983). Assessing the behavioral expectations and demands of less restrictive settings. *School Psychology Review.* (12) 274-284.
38. Woodruff, D.W., Osher, D., Hoffman, C. C., Gruner, A., King, M., Snow, S. & McIntire, J. C. (1999). The role of education in a system of care: Effectively children with emotional and behavioral disorders. *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume III.* Washington D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

Appendix C. Selected Inventory of Reports Available to the Montgomery County Blue Ribbon Task Force on Mental Health

1. Montgomery County Health and Human Services 2002 Fiscal Budget
2. Annual Report on the Health Insurance Carrier Appeals and Grievances Process, 2002
3. Maryland Department of Health and Mental Hygiene Fiscal Year 2002 Community Mental Health Services Block Grant Application
4. Baltimore Mental Health Systems, Inc. Annual Report, Fiscal Year 2001
5. Annual Report on the Health Insurance Carrier Appeals and Grievances Process, 2001
6. Montgomery County DHHS Mental Health Core Service Agency Fiscal Year 2001 Annual Report
7. Mental Health: Culture, Race, and Ethnicity - A Supplement to Mental Health: A Report of the Surgeon General, 2001
8. Dis/satisfaction Among On Our Own of Maryland Members Regarding Maryland's Public Mental Health System, September, 2001
9. Maryland Mental Hygiene Administration: Health Choice Evaluation: Public Mental Health System, September 2001
10. Key Recommendations: Assessment of Mental Health Needs of Montgomery County Children and Youth with Serious Emotional Disturbances and Their Families, May, 2001
11. Listening and Learning from Families in Juvenile Justice: A Project of the Maryland Coalition of Families for Children's Mental Health, January 2001.
12. Mental Health Association 2000: Framework for the Future
13. Privatization of Outpatient Mental Health Services: An Assessment of the Montgomery County Experience (Lewin Report), August 2000
14. Maryland Public Mental Health System: Adults with Serious Mental Illness/Face-to-Face Survey Results: Time 1 and Time 2 Comparison, June 2000
15. Assessment of Mental Health Needs of Montgomery County Children and Youth with Serious Emotional Disturbances and Their Families. Prepared for: Mental Health Core Service Agency of Montgomery County. Linda Nanis, Consultant, May 2000.
16. The Assignment Group (TAG) Organization Performance Report, March 2000
17. U.S. Department of Health and Human Services. *Mental Health*: A Report of the Surgeon General, 1999
18. Statewide Assessment for Mental Health Services and Mental Hygiene Administration's Five Year Plan for Downsizing and Consolidating of State Psychiatric Hospitals, July, 1999
19. At Issue: Translating Research into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations, 1998
20. Report on Maryland Public Mental Health System: Consumer Satisfaction and Outcomes, February 1998
21. Core Service Agency Plans from FY97-FY01

Appendix D. Blue Ribbon Task Force on Mental Health Roundtable/Discussion Participants

Roundtable #1:

Captain Robert Cordes, Sheriff's Office
Dr. John J. Kenney, Chief, Aging and Disability Services, DHHS
Agnes Leshner, Manager, Child Welfare Services, DHHS
Sharan London, Executive Director, Montgomery County Coalition for the Homeless
Chief Charles Moose, Police Department
Ron Rivlin, Manager, Juvenile Justice, DHHS
Corrine Stevens, Chief, Crisis, Income, and Victim Services, DHHS
Art Wallenstein, Director, Department of Corrections and Rehabilitation

Roundtable # 2:

Pamela Cudahy, President and CEO, St. Luke's House (representing outpatient clinic providers)
Gary Fried, Clinical Director, Regional Institute for Children and Adolescents (RICA)
Sharon Friedman, Executive Director, Mental Health Association
Marilyn Kresky-Wolff, Director, Homeless Programs, Mental Health Association
Laura Von Tosh, Consumer Consultant
Eileen Weiner-Dwyer, Federation for Families
Toni Wood, Mark Twain, Montgomery County Public Schools

Roundtable #3:

Irene Devin, Suburban Hospital
Claire Gilbert, Springfield State Hospital
Dr. Larry Kline, Psychiatrist, Suburban Hospital
Lynne Lucas-Dreiss, Suburban Hospital
Susan Reider, Parent, Collaboration Council for Children, Youth, and Families
Dr. Fuller Torrey, Psychiatrist, Stanley Foundation

Informal Discussion Participants

On Our Own (Consumer Group)
Federation for Families
Private Providers
National Alliance for the Mentally Ill (NAMI)

Other Participants

Bill Atkins, Health Management Consultants
Theresa Bennett, Manager, Core Service Agency, DHHS
Alease Black, Operations Manager, Core Service Agency, DHHS
Peggy Bradley, Clinical Coordinator, DHHS
Miriam Chase, Supervisor, Child and Adolescent Clinic, DHHS
Bennett Connelly, Chief, Children, Youth, and Families, DHHS
Lillian Durham, Housing Opportunities Commission
Jennifer Crawford, Director, Community Kids
Howard Goldman, M.D., University of Maryland
William Hudock, Consultant, Department of Health and Human Services
Joe Kilner, Health Management Consultants
Scott Minton, Director, Housing Opportunities Commission
Oscar Morgan, Director, Mental Hygiene Administration, DHMH
Daryl Plevy, Acting Chief, Adult Mental Health and Substance Abuse, DHHS
Lorraine Rogstad, Director, Collaboration Council for Children, Youth, and Families
Tim Santoni, Deputy Director, Mental Hygiene Administration, DHMH
Charles Short, Director, DHHS
Kevin Simpson, State Ombudsman, Office of the Attorney General
Rita Vancivort, MSW, Senior Public Health Analyst, Office of Managed Care, SAMHSA

In addition to these individuals, families and staff from Community Kids participated. Although staff was unable to record their names, their participation was valued.

Appendix E. Summary of Testimony to the Task Force

Date	Speaker's Name	Representing	Summary of Comments
10/18	Lih Young*	Individual	Supported changes to the current public mental health system.
10/18	Steven Zepnick*	Individual	Present mental health system is overloaded. Supports return to county operated outpatient mental health clinics.
10/18	Dr. Peter Cohen*	Individual	Presented reasons for problems in the public mental health system. Offered solutions including County operated outpatient clinics, concentrating resources on the "high-end" user, and reorganizing DHHS so that clinical experts participate in senior management.
10/18	Katherine Crane*	Individual	Supported change in outpatient commitment laws to help those who do not understand how to help themselves
10/18	Jeff Carswell*	Affiliated Sante Group	Public mental health system is under-funded.
10/18	Audrey Koch*	Individual	Parents of the seriously mental ill are undervalued.
10/18	Claire Weinberg*	Individual	Supported Assertive Community Outreach Teams to help prevent suicide.
10/18	Joel Kanter*	Individual	Discussed need for comprehensive and coordinated array of services. Recommended that the County take responsibility, reorganize services to 4 to 6 geographically integrated community treatment teams, reduce the number of agencies providing other supportive services and align them geographically, and professionalize the staff of mental health programs.
10/18	Evelyn Burton*	Individual	Supported change in outpatient commitment laws to help those who do not understand how to help themselves.
10/18	Tim Farrell	Springfield State Hospital	Answered questions about services provided at Springfield. Discussed the reduction in census and the attempt to connect discharged patients to community resources.
10/25	Laura Van Tosh*	Individual	Discussed the increased need of quality housing for the mentally ill. Recommended that the CSA take on greater responsibility for public health services. Supported greater collaboration and communication between the advocacy community and HHS and CSA agencies. Supported consumers being equal partners in developing and sustaining

			the county mental health system.
10/25	Albert Arcand	Individual	Supported better services for people suffering from depression.
10/25	Mary McCausland	Individual	Supported public dollars for a suicide prevention program in the schools for adolescents.
10/25	Ellen Menis*		Discussed the journey of her son who suffers from schizophrenia. Would like to bring him to Maryland but there are inadequate residential services here.
10/25	Bill O'Brien*	NAMI-State	Need adequate funding for assertive outreach programs, changes in treatment laws, and rates of pay for direct care mental health commensurate with the effectiveness of services provided.
10/25	Neal Potter*	Individual	Supported change in outpatient commitment laws to help those who do not understand how to help themselves.
10/25	Sylvia Reiff*	Individual	Discussed the need to change the public school system's IEP (Individualized Educational Plan) to reduce stress in the lives of families who are already dealing with an unrelieved grieving process.
10/25	Geronimo Robinson	Institute for Family Centered Services	Discussed need for comprehensive mental health services to adolescents. There is a lack of mental health professionals in the schools.
10/25	Joan Harris*	Bethesda Cares	Stated that there is inadequate, insufficient, and inappropriate shelter to meet the needs and demands. Discussed the ACT rules that potential clients must sign forms before treatment is available.
10/25	Donald Boardman	Individual	Advocated for a legal standard that could apply more leverage for those trying to help people with mental illness. Supported the use of the least restrictive plan.
10/25	Rose Blondell	Individual	Supported improvement in long term residential services.
10/25	Jeff Hoffman* Linda Polsikin*	MC School Psychologist Assn	Supported lowering the student/psychologist ratio in the schools to use psychologists for mental health support in schools, instructional consultation and work in the area of primary prevention.
10/25	Eleanor Kajeckas*	Individual	Supported public dollars to insure a full range of services to children at risk, including children in the child welfare system

10/25	Colm Gage	Individual	Discussed lack of hospital beds for children 9 to 11 years old and need for mobile crisis team for children.
10/25	Trude Lawrence*	Individual	Advocated for persons with developmental disabilities who also have mental illness. Discussed lack of authority of a guardian for a person with mental illness even if established properly under the legal system.
10/25	Jean Brady	Individual	Supported requesting the state to fully fund the mental hygiene budget. Supported an end to the current state freeze on residential rehabilitation beds.
10/25	Karen O'Brien*	Individual on behalf of Carolyn Sanger	Reverse elements of the restructured organization of DHHS, fund ACT Team to operate 24 hours a day, create position of mental health for the entire County.
10/25	Melpi Jeffries*	League of Women's voters	Previously completed study of the public mental health system for children. Currently studying the adult public mental health system. Learned that two of the problems are delay and /or inadequate compensation.
10/25	Dr. Paul Williams	Individual	Discussed CPC Health and the problems leading to its bankruptcy. Recommended more state and local oversight.
10/25	Nancy Susel*	Susel House, Inc.	Supported dollars for housing subsidies for adults with mental illness.
Written Testimony			
10/26	Glenn A. Flittner	Individual	Discussed revolving-door nature of current mental health system, and how this system does not offer help for noncompliant persons. There is a lack of supervised housing for mentally disabled persons; County Police need more training. Supported legislation that would work to establish medical courts, police teams, and a follow-up structure that assists with medical compliance.
10/25		Commission on Children and Youth	Discussed how the present mental health system is not adequately meeting the needs of children. The fee-for-service system does not adequately reimburse providers. There is a current need for bilingual and multicultural providers. Concerned over the plan by MHP to exclude some diagnoses from reimbursement.

10/25	Christopher Brian Coles	Individual	Discussed the importance of having available residential programs for the mentally ill.
10/19	Marg Collins	Individual	Applauded the services provided by the ACT team. Supported further development of outpatient services, specifically a long-term dual diagnosis program.
10/25	Jim and Marce Welch	Individual	Discussed the need for improved rehabilitation programs for the mentally ill, with an emphasis on vocational training and support.
10/8	Bill Wallace	Individual	Discussed the importance of county mental health clinics in assisting the mentally ill.
10/25	Jonathan Gubits	Individual	Protested the current privatization of mental health services, stating that the quality of service should be more important than cutting costs.
10/25	Deborah Ehrenstein	Individual	Supported returning the county to a system of county run clinics, or increasing funding for the current private clinic system.

Department of Health and Human Services
CORE SERVICE AGENCY
FY02 Approved Budget

DESCRIPTION	TOTAL FY02 BUDGET	WYs	COUNTY FUND	CMHG* GRANT	FMHBG** GRANT	PATH*** GRANT	DESCRIPTION OF SERVICES
PERSONNEL COSTS:	$ 1,135,110		$ 26,000	$ 1,109,110	$ -	$ -	
CSA Director		0.5		X			
County Clinical Coordinator		1.0		X			
Fiscal Manager		1.0		X			
Accountant		0.5		X			
Manager of CSA Operation		1.0		X			
Coordinator for Child, Adolescent, and Transitioning Age Youth Svs.		1.0		X			
Coordinator for Adults and Elderly Services		1.0		X			
Grievances/Complaints and Residential Services Supervisor		1.0		X			
Residential Specialist		2.0		X			
Contract Monitor		1.5	X	X			
Data Analyst		1.0		X			
Staff Liaison to Mental Health Advisory Committee (VACANT)		1.0		X			
Office Services Coordinator		1.0		X			
Total Personnel Costs	$ 1,135,110	13.5	$ 26,000	$ 1,109,110	$ -	$ -	
OPERATING COSTS:							
After Care Services:							
After Care Project	100,000		-	100,000	-	-	Community integration for serious and persistent mentally ill adults.
Adult/Elderly Services:	-						
Case Management	90,270		90,270	-	-	-	Services to serious, persistent mentally ill adults and seniors.
Employment Training	145,232		40,912	104,320	-	-	Services to serious, persistent mentally ill adults and seniors.
Housing Facilitator	33,600		-	33,600	-	-	Services to serious, persistent mentally ill adults and seniors.
Transportation Services	50,000		-	50,000	-	-	Services to serious, persistent mentally ill adults and seniors.
Child & Adolescent Services:	-						
In-Home Crisis Intervention Services	20,000		-	20,000	-	-	Home based crisis intervention and stabilization for SED children and adolescents.
Summer Camp Program	40,000		-	40,000	-	-	Therapeutic summer camp program for SED children and adolescents.
Youth Suicide Hotline Services	25,590		-	25,590	-	-	Provides a telephone counseling, referral services, and clinical crisis intervention for youths.
Noyes Youth Detention Center	210,000		-	-	210,000	-	Mental health evaluation and treatment for youth placed in detention.
**** Child & Adolescent Respite Care Services:	-						
Site Based Respite Care Services	100,000		-	100,000	-	-	Out of home respite care in a group home environment for SED adolescents.
Family Support and Education	7,500		5,000	2,500	-	-	Education and support programs for families of SED children and adolescents.
Consumer Services:	-		-	-	-	-	
Consumer-Operated Drop In Services	208,000		-	208,000	-	-	Consumer operated drop-in services for serious and persistent mentally ill adults and seniors.
Special Consumer Needs Fund	65,000		-	65,000	-	-	Special consumer needs (eye glasses, dental work, cleaning, etc.)
Homeless Services:	-						
Extended Case Management	174,840		-	-	174,840	-	Services for serious and persistent mentally ill adults and seniors.
Outreach Services	162,430		-	127,430	-	35,000	Services for serious and persistent mentally ill adults and seniors.
Transitional Sheltered Housing for Homeless men	171,020		-	-	171,020	-	Services for serious and persistent mentally ill homeless men.
Transitional Sheltered Housing for Homeless Women	245,681		163,181	57,500	25,000	-	Services for serious and persistent mentally ill homeless women.
Vocational Training	10,000		-	-	10,000	-	Services for serious and persistent mentally ill adults and seniors.
Pharmacy and Laboratory Services:	-						
Pharmacy Services	311,460		188,460	93,000	30,000	-	Pharmaceutical products for uninsured/underinsured serious and persistent mentally ill persons.
Laboratory Services	7,000		-	7,000	-	-	Laboratory testing for uninsured and underinsured serious and persistent mentally ill adults and seniors.

DESCRIPTION	TOTAL FY02 BUDGET	WYs	COUNTY FUND	CMHG GRANT	FMHBG GRANT	PATH GRANT	DESCRIPTION OF SERVICES
Residential Services:	-						
Adult Group Home	34,290		-	34,290	-	-	Specialized residential placement for an individual with a serious and persistent mental illness.
Assisted Living Program	594,740		-	594,740	-	-	Residential placement for serious and persistent mentally ill adults and seniors.
Supportive Housing (HOC Turnkey)	139,600		-	139,600	-	-	Rental subsidies to 16 seriously mentally ill consumers who are active participants in MH treatment.
Supportive Housing (HOC McKinney VI & IX)	72,430		-	72,430	-	-	Matching HUD rental subsidy funds for 35 persons who are mentally ill and homeless.
Head Injured	209,560		-	209,560	-	-	Provides highly intensive supervised beds for four (4) mentally ill and head injured adults.
Residential Subsidy	931,460		931,460	-	-	-	Funding for higher maintenance, capital improvement, and property insurance costs for RRP Providers.
**** Transition Age Youth (TAY) Services:	-						
Career Transition Services	116,618		41,618	75,000	-	-	Vocational training, employment, and higher education support for young adults.
Residential Services (Community Connections, Inc.)	132,690		72,690	60,000	-	-	Residential rehabilitation beds specifically designated for transition age youth.
Residential Services (Guide, Inc.)	144,455		30,290	114,165	-	-	Residential rehabilitation beds specifically designated for transition age youth.
Supported Education	32,720		-	32,720	-	-	Vocational training, employment, and higher education support for young adults.
**** Community Enhancement Initiative Services:							
Assisted Living Program	377,320		-	377,320	-	-	Residential placement for serious and persistent mentally ill adults and seniors.
Consumer Support Specialist	9,250		-	9,250	-	-	Funding for three (3) Consumer Support Specialists.
Interpreter Services	58,500		-	58,500	-	-	Interpreter services for five (5) multicultural mentally ill adults and seniors.
Residential Staff Training	2,000		-	2,000	-	-	Training on the "Behavior Management" to residential program staff.
Other Services:							
OMHC Subsidy	870,000		870,000	-	-	-	Administrative and managerial subsidy to Outpatient MH Clinics.
Other Professional Services	98,309		98,309	-	-	-	Purchase of professional services.
Other Operating Costs:	29,900		-	29,900	-	-	Support daily operation of business (office supplies, telephones, copier, etc.)
Total Operating Costs	6,031,465	-	2,532,190	2,843,415	620,860	35,000	
TOTAL FUNDING FOR CORE SERVICE AGENCY	**$ 7,166,575**	**13.5**	**$ 2,558,190**	**$ 3,952,525**	**$ 620,860**	**$ 35,000**	

* CMHG = Community Mental Health Grant
** FMHBG = Federal Mental Health Block Grant
*** PATH = Projects for Assistance in Transition from Homelessness.
**** These are non-flexible funds, so-called, "Categorical Funds."

CSA funding also supports the following programs/services in DHHS. These dollars are allocated by Service area.

PROGRAM NAME	SVS. AREA	AMOUNT	WORK YEARS	GRANT TYPE
1. Child Welfare Services (Court Related Services)	CYF	100,000	-	CMHG
2. Child Welfare Services (Undocumented Children & Families)	CYF	33,000	-	CMHG
3. Therapeutic Nursery Services for C & A	CYF	143,210	-	CMHG
4. C & A Forensic Evaluation Services (CAFES)	CYF	150,910	(2.0 WYs)	FMHBG
5. Senior Outreach Mental Health Services (SORT)	A & D	220,850	(1.9 WYs)	SORT
6. Crisis Center	CIVS	677,440	(9.5 WYs)	CMHG
7. Multicultural Program	AMHSA	206,180	(2.5 WYs)	CMHG
8. Chief Psychiatrist	AMHSA	64,670	(0.5 WY)	CMHG
9. Community Re-Entry	AMHSA	130,730	(2.0 WYs)	CMHG/PATH
10. Client Assessment Services Coordination	AMHSA	141,650	(2.0 WYs)	CMHG
11. Access Team	AMHSA	75,000	(1.0 WY)	CMHG
		1,943,640	(21.4 WYs)	

Solutions Consulting Group
Specializing in Healthcare
Financial Strategy & Implementation

To: Daryl Plevy

From: Bill Hudock

Date: 12/21/01

Re: Management Review of Outpatient Mental Health Clinics

This report summarizes the findings of the management reviews that were conducted at the eight private outpatient mental health clinics that provide services to publicly funded clients in Montgomery County. This report is separated into three sections: findings; public policy implications; and recommendations. The outpatient clinics are part of a much broader system that provides care to the mentally ill in Montgomery County. As such, the clinics do not operate in a vacuum and should not be evaluated only in a stand-alone context.

FINDINGS:

- When combined, the private outpatient mental health clinics serve about 2900 adult and child clients. The range of services varies somewhat between clinics, but typically includes both medication management and mental health therapy. While both private practitioners and the County government provide similar services to some Montgomery County residents, the private outpatient mental health clinics serve the vast majority of the severely mentally ill publicly funded population.

- It is possible for a given individual to receive services from more than one of the private outpatient mental health clinics. This is consistent with the concept of consumer choice, but it does add cost, complexity and increased risk to that individual's care. While there are known instances of a person receiving services from more than one clinic, the extent of this phenomenon is not tracked. This lack of tracking probably is not material to identifying the size of the population served.

- Government (either Medicaid or Medicare) funds over 95% of the adult population served by the private outpatient clinics. This is due to the fact that this population typically is poor and/or the extent of their disability has precluded maintaining a steady job. Government funds in excess of 90% of the children served by the outpatient mental health clinics. The cost of the high intensity of services required by this population, coupled with Medicaid eligibility rules results in this heavy reliance on government funding.

- Many, but not all, of the private outpatient mental health clinics offer additional services such as housing and/or rehabilitative services to better serve their target population. Many of these companies also offer services in jurisdictions other than Montgomery County.

- Seven of the eight clinics are structured as non-profit corporations. One of the clinics is a for profit company. One of the eight clinics reviewed operates as a program within a hospital setting. The others operate as stand-alone companies.

- All of the private outpatient mental health clinics are losing money on their Montgomery County clinic operations. The extent of losses ranges from 16-225% of revenue. Most, but not all, of the clinics cover these losses through profits from other programs, including those in other jurisdictions. In total, most of the parent firms of the clinics are operating at close to or at break-even. The clinics lose money for several reasons:

- Reimbursement levels do not adequately pay the cost of the services provided. A State commissioned report (released in September 2001) found that a loss of approximately 15% is caused by inadequate funding levels. I echo these findings but believe that the extent of this structural deficiency is somewhat greater (probably closer to 20%) for Montgomery County clinics since operating costs (e.g. rent, salaries, etc.) are higher here than in other Maryland jurisdictions.

- No clinic makes money serving Medicare clients. Medicare reimburses clinics 50% of the cost of care. The client is required to pay the other 50%. Virtually all of the clients are unable and/or unwilling to pay the full copayment. Additionally, Medicare has complicated administrative requirements and heavy sanctions for non-compliance. Reimbursement rates for dual eligible clients (both Medicare and Medicaid) are reduced to 62.5% of Medicaid rates with no ability to collect copayments. As a result, total revenue from Medicare funded clients is the lowest of all payors.

- Private insurers and HMOs typically limit the amount of reimbursable treatment and reimburse only a portion of the total cost of care. As such, private insurance reimburses the clinic at a lower unit rate than does Medicaid.

- Many needed services are completely unreimbursed. For example, case management and care coordination between multiple providers is not considered reimbursable. The seriously and persistently mentally ill need more case management and care coordination services than less ill clients. As such, there are financial disincentives for the clinics to treat the most needy of clients. To their credit, the clinics have generally not avoided clients that need intensive services of this kind.

- There is a gap between what the providers believe to be an adequate level of care for people with serious and persistent mental illness and what the payors are willing to financially support. The clinics have been struggling to determine how to responsibly adjust their treatment approaches to align with this economic reality. Most of the clinics have failed to take the actions needed to keep costs and revenues in alignment.

- The clinics lack the automated tools necessary to efficiently and effectively bill for their services. The rules for billing and collecting for services vary by payor and are much more complex than the systems and personnel in the clinics currently are prepared to efficiently handle. Most of the clinics are in the process of evaluating and/or installing new systems to address this problem. Unfortunately, most of the clinics also lack the expertise and experience to plan and execute systems installation and conversion. As such, they are relying on a combination of consultants and their new staff to address this critical need. Unless their system work is successful they are likely to continue and possibly worsen their financial shortcomings.

- Business practices at some clinics de-emphasize the importance of effective administration and billing. While I observed efforts to change this, workflows and business policies at many of the clinics still support clinical needs to the exclusion of effective billing and administration. Many clinics do not receive reimbursement for all of the services that they provide.

- The speed and reliability of collections on Medicaid billings has improved dramatically over the last two years. However, some of the clinics continue to report delays and unjustified denials from MHP (the company that administers the Medicaid fee-for-service system). Based upon my review, the most severe of these problems are the result of the clinic's billing inadequacies rather than those of MHP. However, the clinics do correctly note that MHP continues to make errors and lose submitted bills. Several of the clinics report that MHP has delayed

payment for no reason in some instances. The clinics experience severe cashflow problems when they do not receive payment in a timely fashion.

- The clinics usually lack the management tools and training required to track and control their business. Most are making decisions based on limited or incomplete information.

- Most of the clinics have experienced turnover in many of their key management jobs. Across all clinics, the average tenure of a clinic manager is under one year; and, key financial and administrative staff have an average tenure of under six months. This provides an opportunity for the clinics to improve their financial and administrative business practices, but also means that key staff at most clinics are in a steep learning curve. Most of the clinics have little or no capacity to train new management staff. Therefore, it is reasonable to predict that it will take time for the clinics to address their deficiencies.

- The more financially successful clinics receive a substantial portion of their revenue from grants or from contracts that do not require fee-for-service billing. When clinics have been able to supplement their fee-for-service treatment with a significant amount of grant or contract funded services they have been able to operate at a breakeven or slightly profitable level.

- None of the clinics has an endowment to help fund their operations or cover the cost of improving their infrastructure. None of the clinics receive a large portion of their revenue from contributions. Consequently, they are almost completely reliant on fee-for-service and grant based revenue to fund their operations. Most of the clinics have severely limited financial reserves. Some have used loans against lines of credit to fund their operations.

- Several of the clinics have chosen to limit or stop accepting Medicare and/or underinsured clients. The remaining clinics may lack the capacity or interest in expanding their Medicare funded client base. This decision is driven by the harsh economics of treating these populations rather than a lack of commitment by the clinics. In the absence of change in the level of funding and/or the administrative burden associated with these clients, I expect to see capacity continue to shrink.

- The State recently tightened authorizations for rehabilitative services. In the past, several of the clinics have relied on profits from these rehabilitation programs to subsidize their money losing clinic programs. This change in State funding and authorizations will add additional strain to the financial underpinnings of the private outpatient mental health clinics.

- There is a very limited capacity in the private outpatient mental health clinics to provide services to those who do not speak English. Moreover, the clinics do not have a multi-cultural core competency. The clinics indicate that they cannot identify and/or hire clinicians capable of filling this gap. Payors offer no higher reimbursement level for multi-lingual and/or multi-cultural services. As such, there is no financial incentive for the clinics to build this capacity.

PUBLIC POLICY IMPLICATIONS:

- The mental health system in Montgomery County relies on the private outpatient mental health clinics to provide Montgomery County residents with needed services. These clinics treat the vast majority of the County's most severely mentally ill adults and children. Through its funding of these services, the State and Federal governments have indicated that they accept responsibility to provide a safety net of care to this population. The County has been asked by the State to serve as a vehicle for channeling State and Federal dollars to programs. The County has accepted this responsibility and also is a direct funding source for some mental health services. Assuming no change in this structure, the State and/or County needs to take steps to help ensure that well managed clinics can financially survive.

- Montgomery County has a larger number of private outpatient mental health clinics than do most other jurisdictions in the State. Most of these clinics are small stand-alone non-profit agencies. Most got their start during that period of time in which grants and contracts were used to fund services. Their recent financial troubles appear to be directly tied to the State's use of a fee-for-service system of reimbursement and its related choices concerning the level and nature of services that will be reimbursed. The more profitable clinics (i.e. those which are losing the least money on a unit basis) either are large or have established a service mix that continues to rely on grant or contract revenue to supplement the fee-for-service reimbursements. The financial health of the clinics could be improved through selective mergers into larger companies and/or by diversifying the range of their services and their revenue streams through strategic use of grants and contracts.

- There is little public accountability for the public money that is used to fund private mental health services. Accrediting agencies, such as COMAR, focus on procedural aspects of care. MHP's authorization process focuses on determinations of whether additional care is justified. There is no current process for assessing the efficacy of care or the outcomes that are derived from care. This especially is important since a large portion of the seriously mentally ill are believed to have life long diseases that require ongoing monitoring and treatment.

- The seriously mentally ill usually have a variety of needs including housing, job assistance, medication management, development of life skills and a need for appropriate therapy to control their disease. The private outpatient clinics typically provide only some of these services. Currently, there are no effective and reliable processes to integrate and coordinate delivery of these multiple services among multiple providers. The quality and cost effectiveness of care is compromised by this lack of integration. In some instances, this can result in increased risk to the client, their family or the community.

- Increasingly, the private outpatient clinics are opting out of treating clients who have no or inadequate payor sources. As Federal and State budgets are trimmed, there will be more pressure to tighten eligibility, authorization criteria and/or rates paid for services. This will increase pressure on the private outpatient clinics to choose who they can afford to serve and to alter the type of services provided based on economic realities. In the absence of corrective actions, it is likely that there will be a larger number of unserved or underserved people in the County.

- The cost of administration and overhead at all levels of the mental health system is high. In some clinics only 60% of the dollars collected are used to pay the cost of direct care. In addition, administrative costs are added at MHP, and through the regulatory work of government. The County and State should work to ensure that all administrative, financial and oversight functions are focused on and limited to those elements that are essential. Ensuring public accountability and protecting against potential abuse and fraud does not need to be this resource intensive.

- The private clinics and the public oversight bodies lack the basic information to manage their respective functions. A great deal of time and resources are expended to manually collect data that often proves incomplete or unreliable. There is a lack of consensus concerning what data is needed to support decision-making, management control and legitimate oversight. There is a lack of coordination in ensuring that needed data is available, reliable and accessible.

- The economics of the outpatient clinic system are poor and reflect different cost containment strategies by the various payors. Medicare pays for all medically necessary services but requires a 50% co-payment from the individual who receives treatment. This co-payment level is a deterrent to receiving care. Many clinics choose not to try to collect any or all of the copayment, thereby cutting their revenue stream and potentially putting them at risk for charges of Medicare fraud. Medicaid employs a managed care model in which treatment must be pre-authorized in order to receive payment. The processes for eligibility, authorization and payment are complex and resource intensive. As such, the clinics all report receiving less than full reimbursement for serving Medicaid and "gray zone" (those who are uninsured, but whose income is above the poverty level) clients. Private insurers employ a pre-authorization process. They also place limits on their financial liability through the use of policy limitations on the amount of care that it will pay for (regardless of need) as well as the rate that it will pay.

- The problems faced by the private outpatient mental health clinics are similar to, and in many cases identical to those faced in other Maryland jurisdictions and nation-wide. Advocates for increased funding increasingly are at odds with those who have limited the size of the public mental health budget. This lack of consensus has a negative impact on Montgomery County's and the State's efforts to plan and integrate the various elements of the mental health system. In this context, there is great risk that the private clinics will make business decisions that are counterproductive to the needs of the overall system.

RECOMMENDATIONS:

- When viewed in total, the clinics are all money losers. However, the agencies that run outpatient mental health clinics are generally sound. Some of the agencies are financially stronger than others. Some are better run than others. It is likely that one or more of the clinics or agencies will fail unless they receive ongoing government (State and/or County) subsidies. Government's interest is to ensure that the system has an adequate and sustainable capacity to serve the existing and projected population in need. Government is not obliged to ensure that each private clinic or agency survives. Additional government funding, if available, should be directed to strengthening the system's sustainability and capacity to serve.

- The County should informally support the merger of some of these agencies. Several of the clinics and their parent agencies share similar missions and would be strengthened financially and administratively through combination.

- Insofar as it is possible, County controlled State funding and available County funding should be directed to programs that ensure that target populations receive adequate and integrated services that produce definable outcomes. These definable outcomes should focus on controlling government costs (e.g. reducing criminal justice involvement, decreasing the number and length of hospital stays, reduction in the intensity of outpatient care, etc.) as well as on producing better quality of life (e.g. increased job availability, better school attendance, reduced school dropout rate, etc.). By focusing outcomes in this manner, there can be an emphasis on reducing the need for care as well as government's unit cost of care. The County also should support preventative care where it can be shown to have verifiable positive outcomes.

- The County should actively lead and/or support efforts to ensure that the State adequately reimburses the private clinics for their work. My experience is that the State is committed to making the system work. Unfortunately, the Medicaid fee-for-service system is complex and difficult to navigate. The County has been helpful in supporting the clinic's efforts to get paid. Continued assistance in this regard is needed to resolve the outstanding issues as soon as possible.

- Too little of the government money being spent on mental health services is directed to pay the costs of direct care. Too much money is being spent on administration, finance and oversight .The County should work with the State to streamline processes and reporting requirements. It may be possible to share and use either a standard automated platform or at least standard protocols to facilitate needed information gathering/sharing, client transfers, care coordination, outcomes measurement as well as eligibility, authorization and billing.

- Determine whether CSA funds could be redirected as a grant to clinics that agree to treat those who are least compliant with treatment and/or require the most case management support. There is a consensus that about 5-10% of the seriously mentally ill population falls into this category. Currently, the clinics are financially disincentivized for treating these individuals.

- As funding can be found or redirected, create a grant-funded or pilot program to pay the clinics to develop multi-cultural competency and to hire and retain bilingual or multilingual staff to provide treatment to this portion of Montgomery County's population. Similar grants or pilot programs could be justified for developing the expertise and for providing service to dual diagnosed populations.

SUMMARY:

The private outpatient mental health clinics provide a needed capacity to care for Montgomery County residents who have severe mental illness. The economic foundation of the outpatient clinic business is poor. The clinics are able to survive only because they are part of larger agencies that profitably provide related services to the same target population. The County can and should take steps to help strengthen the capacity and sustainability of the private outpatient mental health clinic system, but should not use government funds to ensure that all existing clinics survive. The County should work with the State to review and minimize (whenever possible) the cost and administrative requirements associated with the provision and oversight of care. The County and State should support prevention, early intervention and treatment programs that can demonstrate that they produce meaningful outcomes. The County and State should seek ways to fund programs directed towards serving multi-cultural populations and those clients who are treatment resistant or who suffer from dual diagnosis disorders.

BLUE RIBBON TASK FORCE ON MENTAL HEALTH Appointed by the Montgomery County Council

MEMORANDUM

January 21, 2002

TO: Health and Human Services Committee

FROM: Kevin Dwyer, Chair, Blue Ribbon Task Force on Mental Health KD
Wayne Fenton, Co-chair, Blue Ribbon Task Force on Mental Health WF

RE: Outpatient Mental Health Clinics

The Blue Ribbon Task Force on Mental Health has studied the issues pertaining to the two public and seven freestanding outpatient mental health clinics. Although the final report will include our findings and recommendations, we thought the following information might be helpful as you discuss the current situation with clinic providers and the Core Service Agency in the Committee work session on January 24.

Given the importance of timely access to treatment, it is critical that there is an adequate supply of mental health clinicians able and willing to provide treatment to low-income and no-income individuals and families in need of publicly funded mental health services. Mental health treatment is the first point of contact for many people in need of treatment, providing help in the least restrictive environment.

The immediate goal at this juncture is for the system to have enough providers to avoid any disruption in treatment for those currently in treatment and timely access to treatment for those needing to obtain services. The situation has become acute for individuals who are unable to afford required co-payments, that is, those above the income eligibility for Medicaid but unable to afford treatment (referred to as gray zone clients) as well as those low-income individuals who have Medicare only.

Findings:

1. The State funded an independent review of 13 public outpatient clinics in the State of Maryland. (This review did not include any of the clinics in Montgomery County.). William Atkins and Joseph Kilner of Health Management Consultants concluded that the State rates are inadequate to cover the costs of operating an outpatient clinic. Even when utilizing the most efficient management practices, these researchers found that clinics could only recoup 85 percent of costs, leaving a shortfall of 15 percent. The study concluded that the reimbursement rate for psychiatrists was a major contributing factor in the inability of clinics to cover expenses.

2. This past fall, the County hired an independent consultant, William Hudock, to review the financial status of the privately operated outpatient clinics in Montgomery County. Mr. Hudock reported that providers in Montgomery County could only recoup 80 percent of costs, leaving a shortfall of 20 percent. The larger percentage deficit is due to the higher cost of living in Montgomery County.

3. Neither the County nor the State review examined the quality of the clinical services provided or the client outcomes achieved at the clinics they reviewed. They only reviewed financial and management issues. Therefore, there is no basis to make conclusions about how well the clinics are accomplishing their mission of serving indigent mentally ill consumers.

4. Oscar Morgan, State Director of Mental Hygiene Administration, stated to the Task Force that he has provided additional funds and/or technical assistance to these 13 publicly funded clinics (outside of Montgomery County). Mr. Morgan also indicated that the State is reviewing the compensation level for psychiatric care.

5. The Core Service Agency reports that there are over 400 individual providers certified as Medicaid providers. The task force heard from numerous people testifying—professionals, family members, consumers—that this is a "phantom network" since it is difficult to find a provider who is actually willing to provide services to clients in the public mental health system. One consumer indicated that he just recently contacted 15 psychiatrists on the list and found only one psychiatrist that accepted Medicaid and Medicare assignment. Mr. Morgan reported to the task force that he was surprised by this situation and that he would look into it. Disruptions in services can have disastrous consequences to adults or children with serious mental illness or emotional disturbance and to their families.

Recommendations:

1. The County Council's actions in the short run should be guided by the goal of maintaining continuity of care and adequate service levels for those in need of publicly funded mental health services, even if this means providing additional funding to clinics at risk of closing or those planning to curtail services to individuals who cannot afford required co-payments – gray zone and Medicare clients. So long as inadequate State funding means that clinic providers lose 15 to 20 cents for each dollar of service they provide, it is highly unlikely that private providers can (will) absorb large numbers of additional clients if more clinics cut back services or go out of business.

2. Several factors should be considered to determine the appropriate level of support to provide for each clinic. These factors should include the organizational viability of the clinic, and the organization's ability and willingness to take meaningful steps to change their financial situation over time. A clinic should demonstrate an equal commitment to strengthening the quality of clinical services over time.

Each clinic should provide a brief proposal that outlines the measures it proposes to take to strengthen its financial and clinical position, and each should agree to report regularly to the Core Service Agency and the County Council on its progress in achieving their stated goals. The Council should not continue support for organizations that are demonstrably ill managed in either the financial or clinical spheres.

3. On an average basis, the reasonable level of supplement to clinics might be about 20 percent of costs, based on the State and local findings about the inadequacy of reimbursement rates for even the most efficiently run clinic. However, the needs of individual clinics will probably vary widely about this average figure. These differences can be attributed to the level of management efficiency and to the distribution of clients served. Examples of measures that might be examined include:

    - *The proportion of filed claims that are paid.*
      Well run billing systems will have higher rates of paid claims. This information is available from the PMHS claims data base and could be provide by the State Mental Hygiene Administration or by the Core Service Agency.
    - *The proportion of clients served who are indigent but not covered by Medicaid.*
      It is in the public interest to serve gray zone and Medicare clients and clinics that do so should be compensated for the additional financial sacrifice they make. The proportion of gray zone clients is available from the claims database.

    A disposition should be made about the fiscal viability of each organization requesting supplemental funds.

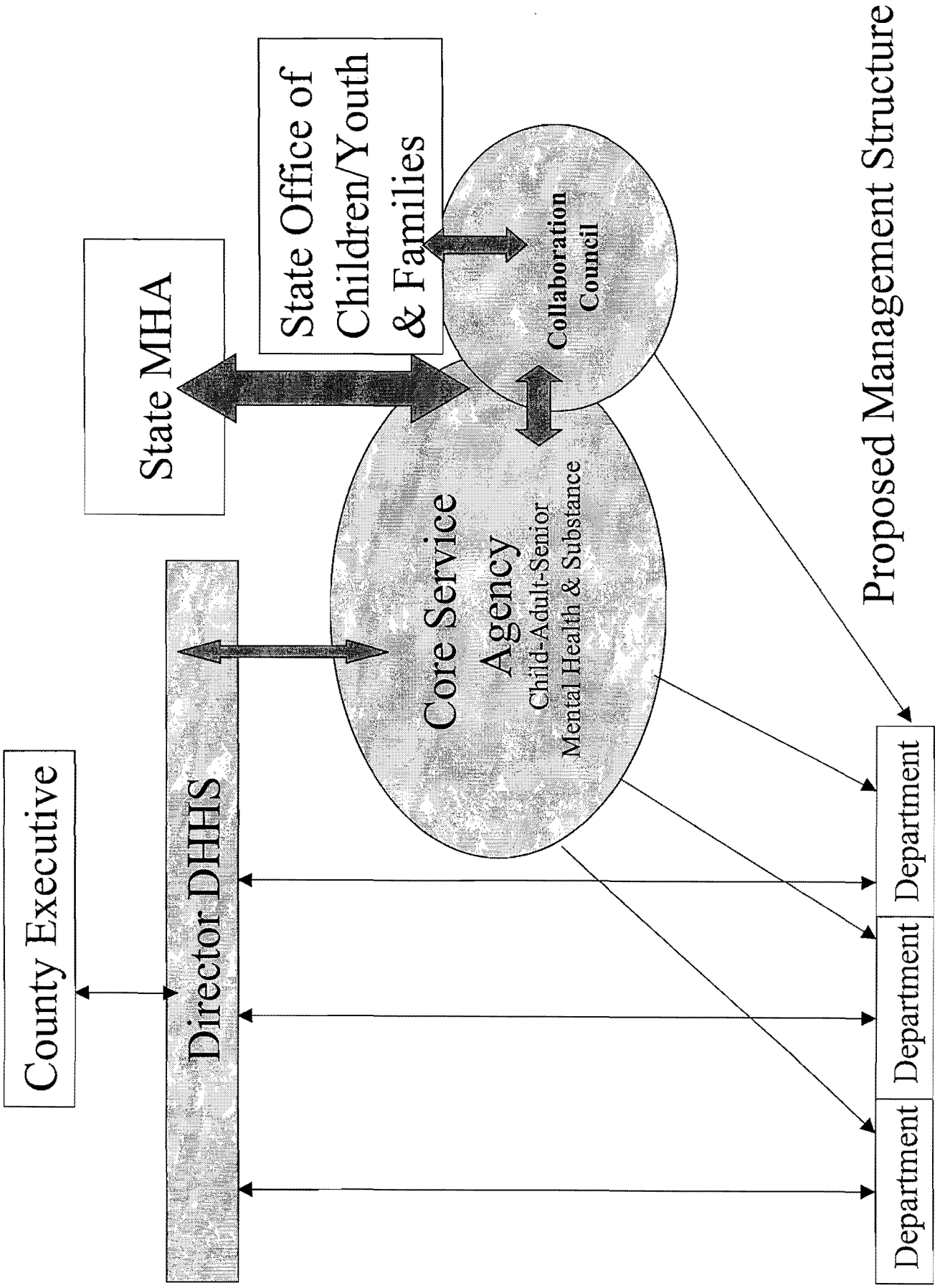
4. In addition to fiscal solvency, funding decisions should take into account clinical performance measures. The information presented by both the State and County audit reviews only speaks to financial issues. Clinical measures examined might include:
    - The proportion of clients served who have the most serious and challenging disorders. These are generally thought to be adults with serious mental illness and children with serious emotional disturbance. Clinics that serve a larger proportion of clients with these diagnoses should receive additional funding in compensation for the efforts. The information on the diagnosis of clients served is available from the claims database.
    - The quality of services provided, as indicated by the degree of conformance to principles of Evidence Based Practices; and
    - The proportion of clients who fail to appear for scheduled appointments. This "no show rate" is considered a reasonably good measure since it is demonstrably possible to implement practices to improve the no show rate and a low no show rate is essential for both economic and clinical viability.

5. The contract for additional funds should include an agreed upon improvement plan and a requirement that progress toward accomplishing its goals be reported regularly. These reports should be submitted quarterly or semi-annually and reviewed by the Core Service Agency, who would in turn report to the Council. The CSA should identify the staff person(s) responsible for this review, reporting and, technical assistance (see #6 below) and provide adequate support to accomplish these tasks.

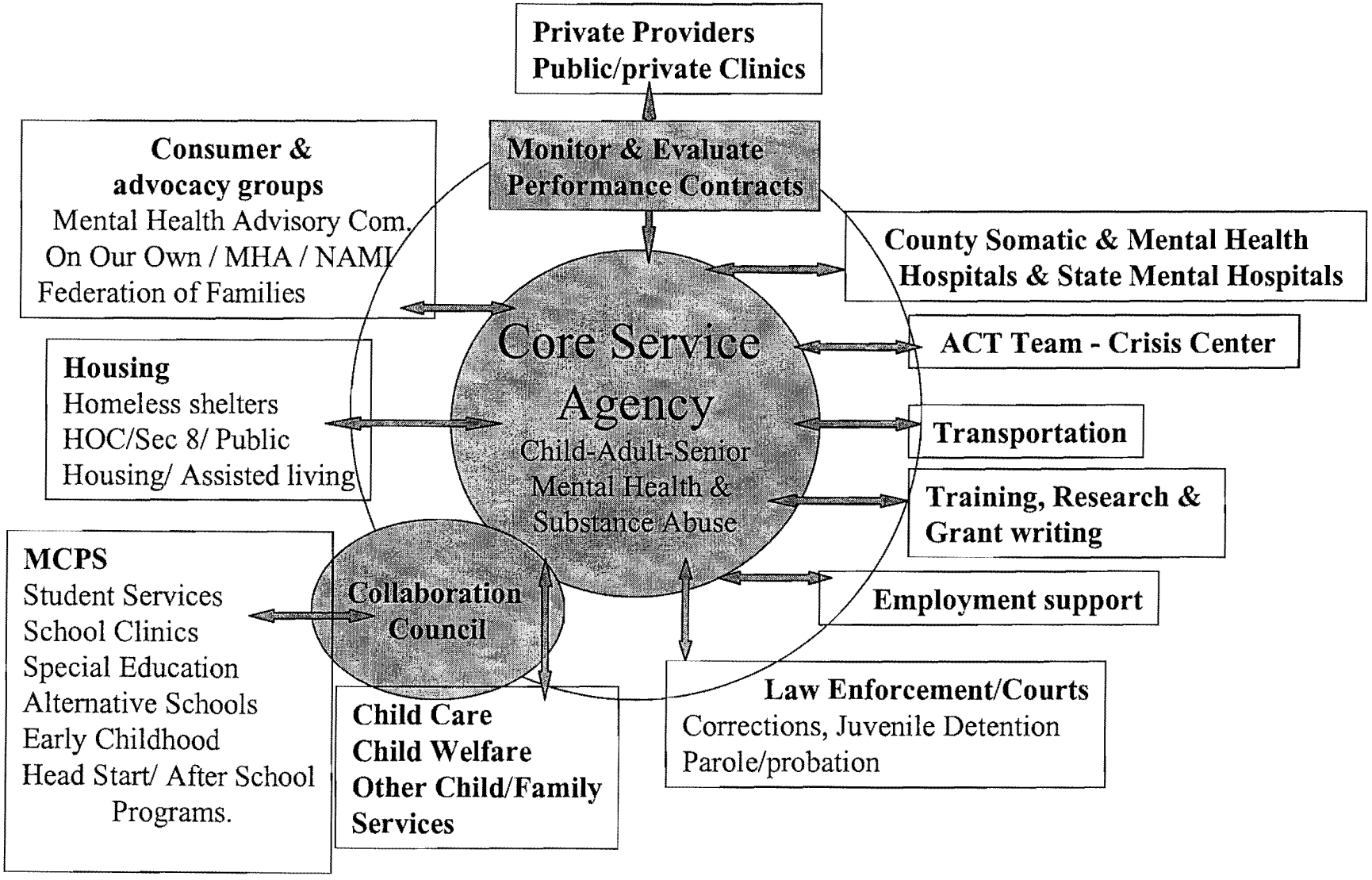
6. To facilitate clinics achieving the goals of their improvement plan, the Core Service Agency should provide technical assistance. Depending on the identified problem areas, the technical assistance might address ways to improve clinical and financial performance.

7. Before using local dollars to supplement the clinics or provide technical assistance, the Core Service Agency should make a written request to the Director of the Mental Hygiene Administration for State funds and ask for a written response. The request and the response should be documented. The State has provided both dollars and technical assistance to other clinics in the State.

We hope that this information has been helpful to your discussion on January 24. The final report from the Task Force scheduled for release on February 5 addresses long-term solutions for the delivery of local mental health services. We look forward to discussing our overall findings and recommendations with the full Council.


Proposed Management Structure
State MHA
State Office of Children/Youth & Families
Collaboration Council
Core Service Agency
Child-Adult-Senior
Mental Health & Substance
County Executive
Director DHHS
Department
Department
Department

Core Service Agency *System of Care* for Mental Health Planning & Implementation Includes Coordination & Collaboration:



CSA - responsible for planning, monitoring & appeals process for all MCPMHS

HHS COMMITTEE #1
June 24, 2009

ADDENDUM

MEMORANDUM

June 23, 2009

TO: Health and Human Services Committee

FROM: Linda McMillan, Senior Legislative Analyst

SUBJECT: **Briefing and Discussion: Blue Ribbon Task Force on Mental Health (2002)**

Those expected for this session:

Uma Ahluwalia, Director, Department of Health and Human Services
Scott Greene, DHHS Behavioral Health and Crisis Services
Kevin Dwyer, Chair, Blue Ribbon Task Force on Mental Health (2002)

Attached to this memo is information provided by the Department of Health and Human Services in preparation for this briefing and discussion.

Circles 3 through 9 provide an overview of the current array of services as well as identified needs and gaps. With regards to child and adolescent services, the Department notes that alternatives to hospital beds are needed for crisis situations. Additional resources for community placements, such as therapeutic group homes, are also needed, particularly for youth who are not in the child welfare or juvenile justice system that do not have access to the resources currently in place. A local respite program is suggested. Many of the needs and gaps for adults revolve around the need for permanent, supportive housing. There are gaps in services for adults over the age of 60. There are also difficulties treating undocumented adults who do not qualify for residential treatment or affordable housing programs.

Information on © 9 says that the percentage of inmates needing mental health services remains at about 15%. In terms of the community at-large, the Core Service Agency data indicates that 5,081 persons were served in FY 1998 and that this grew to 7,690 in FY 2008; an increase of about 50%. State data reports that 63,557 consumers were served in FY 1998 compared to 99,812 in FY 2008; an increase of about 57%. The DHHS memo questions the reliability of this data.

BRIEFING PAPER

Update on Public Mental Health System

For Council HHS Worksession on Review of 2002 Blue Ribbon Task Force Report

June, 24, 2009 9:30am

Table of Contents

I. Overview of Public Mental Health System

The following is a current list (6-24-09) of Behavioral Health and Crisis Services in Montgomery County. This list identifies services, needs, gaps and barriers for children, adolescents and adults.

A. Current Mental Health Services for Children, Adolescents, & Adults

Note: Please also refer to Section II of this briefing paper which contains a detailed grid of all services, funding sources and funding amounts.

1. Children and Adolescents

- **Mental Health Services for Young Children (0 to 5 years)**
  - The Reginald Lourie Center for Infants & Young Children is the provider of services for this special population. This agency specializes in the provision of comprehensive mental health treatment services to young children. They are a licensed Outpatient Mental Health Clinic (OMHC) that participates in the State of Maryland Public Mental Health System. They also provide a Therapeutic Nursery Service for children ages 3 to 4 years that is funded through a contract with the Core Service Agency. The purpose of the Therapeutic Nursery is to provide early intervention to young children who are demonstrating social/emotional disturbances that are negatively impacting their readiness for school. Most of the children have been unsuccessful in regular day care or nursery school environments. The desired outcome of the therapeutic nursery is the children's readiness to enter a regular education kindergarten class environment.

- **Early Childhood Mental Health Project (0 to 5 years)**
  - Assistance is provided to child care centers and families to address the needs of young children who are in child care settings and are at risk for removal due to behavioral issues. Services are provided through contracted therapists and the Lourie Center, Jewish Social Services, Mental Health Association, and Family Services, Inc. Therapists work with the child care staff to develop alternative approaches and works with child and family to address concerns and behavioral issues.

- **Mental Health Services for Children (6 to 12 years)**
  - *Outpatient Treatment Services*
    - ✓ Outpatient treatment services for this age group are available through several Outpatient Mental Health Clinics (Ohms)), group practices, and through the school-based programs connected to Linkages to Learning.
  - *Inpatient Treatment Services*
    - ✓ Potomac Ridge Behavioral Health—12-bed unit for young children 6 to 12 years
    - ✓ Children's National Medical Center (CNMC)
  - *Residential Treatment Center*
    - ✓ Villa Maria RTC
  - *Wraparound* - Comprehensive wraparound services are provided to children as young as 6 years
    - ✓ Maryland Choices

- **Mental Health Services for Adolescents (13 to 18 years)**
  - *Outpatient Treatment Services*
    - ✓ Several of the OMHCs in the county serve this age (see attached service list)

- ➢ *Inpatient Treatment Services & Residential Treatment Center Services*
  - ✓ (See attached service list)

- ➢ *Wraparound*
  - ✓ Maryland Choices

- **Home Based Treatment Team (7 to 21 years)**
  - ➢ Provides specialized in-home treatment service for children and families involved with the Child Welfare System

2. Adult Behavioral Health Services

- **Access to Behavioral Health Services**
  Provides centralized addictions treatment screening and referrals to outpatient mental health clinics.

- **Outpatient Mental Health Services**
  Outpatient mental health treatment services are available through outpatient mental health clinics, group practices, and private practitioners. To access outpatient mental health clinics, consumers can contact the Access to Behavioral Health Services team or contact providers directly.

  - ➢ Outpatient Mental Health Clinics (located in or serving Montgomery County residents)
    - ✓ Adult Behavioral Health
    - ✓ Affiliated Sante Group
    - ✓ Contemporary Therapeutic Services, Inc.
    - ✓ Family Service Agency, Inc.
    - ✓ Family Trauma Services, Inc.
    - ✓ Institute for Life Enrichment
    - ✓ St. Luke's House
    - ✓ Threshold Services, Inc.
    - ✓ Vesta, Inc.

  - ➢ Outpatient Group Practices
    - ✓ Affiliated Community Counselors
    - ✓ Child Center & Adult Services
    - ✓ Jewish Social Service Agency (Provides specialized services for deaf and hearing impaired)

- **Case Management**
  Case management services are provided in shelters, on the street, in the community, and in individuals' homes.

  - ✓ *Community Case Management* (serves individuals in the community and serves individuals currently incarcerated who are homeless and are re-entering the community)
  - ✓ *Senior Outreach Team (via a contract with Affilated Sante)* provides bi-lingual outreach and mental health services for homebound seniors
  - ✓ *St. Luke's House Case Management* (via a special contract with the Core Service Agency) provides case management to individuals who do not have insurance and/or who do not qualify for PRP services)
  - ✓ *Volunteers of America* (serves homeless individuals only)

- **Assertive Community Treatment**
  Assertive Community Treatment services provide intensive wrap-around treatment services to individuals in shelters, on the street, in the community, and in individual's homes.

  - ✓ People Encouraging People

- **Psychiatric Rehabilitation Programs (PRP)**
  Psychiatric rehabilitation services are provided as either "on-site" services, meaning that the services are provided in a facility managed by the provider; or as "off-site" services, meaning that the services are rendered in the consumer's home and in the general community. Adult PRPs currently operational in Montgomery County include:
  - ✓ Affiliated Sante Group
  - ✓ CBH Behavioral Health
  - ✓ Family Trauma Services, Inc.
  - ✓ Institute for Family Centered Services, Inc.(Off-site PRP)
  - ✓ Montgomery Station
  - ✓ Rock Creek Foundation
  - ✓ St. Lukes House
  - ✓ Threshold Services, Inc.
  - ✓ Vesta, Inc.

- **Residential Rehabilitation Programs (RRP)**
  Residential rehabilitation programs provide supervised living. The services are provided in housing units owned or leased by the provider. Clients receive a range of psychiatric rehabilitation services in a home or apartment.
  - ✓ Community Connections
  - ✓ Guide, Inc.
  - ✓ Mar-Lyn, CBH Behavioral Health
  - ✓ Montgomery Station
  - ✓ Rock Creek Foundation
  - ✓ St. Luke's House
  - ✓ Threshold Services, Inc.

- **Supported Employment Services (SEP)**
  Supported employment services include employment skill building, supportive counseling, and job coaching and placement.
  - ✓ Montgomery Station
  - ✓ Rock Creek Foundation
  - ✓ St. Luke's House
  - ✓ Vocational Support Services, Inc. (VSSI)
  - ✓ (Computer Learning Center is a consumer-run organization that does not provide supported employment services, but does provide computer training to consumers.)

- **Emergency Services**
  Psychiatric emergency services for adults in Montgomery County are available through:
  - ✓ *Crisis Stabilization Service (Crisis Center)* telephone and walk-in services include:
    - ❖ Crisis prevention, intervention, and stabilization
    - ❖ 24/7 Mobile Crisis Team
    - ❖ Services to individuals and/or families experiencing domestic violence
    - ❖ Victim and Sexual Assault services
  - ✓ *Designated Emergency Facilities* (Hospital Emergency Room)
    - ❖ Washington Adventist Hospital
    - ❖ Suburban Hospital
    - ❖ Holy Cross Hospital
    - ❖ Montgomery General Hospital
    - ❖ Shady Grove Adventist Hospital

- **Residential Crisis Services**
  Residential crisis services include crisis prevention and stabilization, an alternative to hospitalization as well as step-down to the community from inpatient hospitalizations.

  - ✓ Crisis Center Triage & Evaluation beds.
  - ✓ Fenton House (Formerly McAuliffe House)

- **Partial Hospitalization Services**
  The partial hospitalization programs located in Montgomery County for adults are:

  - ✓ Montgomery General Hospital
  - ✓ Suburban Hospital
  - ✓ Washington Adventist Hospital

- **Inpatient – Hospital Psychiatric Services**
  - ➢ *The inpatient psychiatric hospitals located in Montgomery County* that serve adults include:
    - ✓ Montgomery General Hospital
    - ✓ Potomac Ridge Behavioral Health
    - ✓ Suburban Hospital
    - ✓ Washington Adventist Hospital (Serves adolescents on a mixed adolescent/adult unit)

  - ➢ *Hospitals outside of Montgomery County* that serve Montgomery County adults include:
    - ✓ Bon Secours Hospital
    - ✓ Brooklane Hospital
    - ✓ Clifton T. Perkins Hospital
    - ✓ Finan Center
    - ✓ Sheppard Pratt Hospital
    - ✓ Springfield Hospital Center
    - ✓ Spring Grove Hospital Center (State hospital that serves adolescents. Primary facility for inpatient competency and dangerousness evaluations for court involved youth)

Note: There are other hospitals that Montgomery County adults may utilize. The facilities listed above are the major facilities that serve Montgomery County adults.

B. Mental Health Needs, Gaps, and Barriers for Children and Adults

I. Children and Adolescents

A. *Needs*:

- Expanded child-focused crisis services, including crisis alternatives to hospitalization beds.

- Increased availability of evidence-based practice treatment protocols such as Trauma-Focused Cognitive Behavioral Therapy, Parent-Child Interaction Therapy, Multi-System Therapy, and Multi-Dimensional Treatment Foster Care. Many of these protocols are very expensive to implement and are not currently reimbursable through the PMHS.

- Expansion of school-based mental health services.

- Have a local respite care option as currently the only respite program is located in Frederick, Md.

B. *Gaps*:

- Less restrictive residential options for children and youth who, due to emotional/behavioral disturbances cannot remain in the family home. These children and youth could be served in a non-institutional environment such as a therapeutic group home or a treatment foster home if there were a funding source for the services. Currently, only children and youth in the custody of an agency such as Child Welfare Services or the Department of Juvenile Services have access to these less restrictive alternatives.

- In Child Welfare Service cases when the case is closed or the child returns home, it can be difficult for the parent to receive ongoing mental health service since may not meet the criteria to be eligible for the public mental health system.

C. *Barriers* to service:

- Financial ineligibility for publicly funded services

- Immigration status (Undocumented children and youth cannot receive PMHS services)

- Private insurance policies will not pay for non-traditional support services such as respite care, in-home behavioral supports, etc.

II. Adults:

A. *Needs*:

- Affordable housing for individuals with criminal records, particularly those with sex offender histories; it is difficult to find housing for these individuals as many landlords do not rent to individuals with criminal records.

- Integration of psychiatric and somatic care in Outpatient Mental Health Clinics (Ohms), and for services provided to the homeless.

- Integration of behavioral health care and primary care into a single setting to better treat the "whole" person at one location.

- Seriously mentally ill individuals who are undocumented do not qualify for the public mental health system, which includes residential rehabilitation services. These individuals also do not qualify for affordable housing programs.

- Need for behavioral health treatment for low-income senior residents, and for expanding access for screening for substance abuse and mental health problems for persons over age 60.

- Better coordination of services and funding to support people exiting from acute inpatient psychiatric hospitals, released from incarceration, and/or entry into the homeless system of care.

- Day treatment support including behavioral and somatic healthcare, employment services, and general case management for the Guide Drive Shelter System.

- Services to engage and link clients who overuse the acute care hospital system as a way to obtain mental health services. These individuals could benefit from services that are less costly, if the individuals had outreach services to engage and link them to the appropriate services.

- Need to increase the number of behavioral health providers who are co-occurring competent in providing evidenced-based best practice continuous and integrated services to individuals with co-occurring psychiatric and substance abuse disorders.

- Need for a range of and increased capacity for housing options for individuals with co-occurring substance abuse and mental health disorders. This would include a range of housing for individuals based on their Stage of Change. Specifically:
  - *'Wet'* housing for individuals in the pre-contemplation stage. Wet housing means housing where the goal is to get an individual who is actively abusing substances off the street and into shelter. There are no expectations for sobriety as the goal here is to meet the client where they are at and attempt to engage them into wanting to accept help. The expectation is that the individual will continually relapse until they are ready to move onto the next stage of change.
  - *'Damp'* housing for individuals in the contemplation and preparation stages. This is housing whereby the client is moving from pre-contemplation to contemplation and is starting to take steps toward more actively engaging in treatment. Damp housing means that while in general the expectation is that the individual will abstain from substance use, there is acknowledgement that the client may relapse and should not have their housing jeopardized if they do.
  - *'Dry'* housing for individuals in the action and maintenance stages. Dry housing is for individuals who are further along in their treatment. These individuals are actively engaged in treatment and have an extended period of sobriety. The expectation in these homes is that the individual will remain clean and sober. If they relapse, they may go back to 'damp' housing.
  - The idea is that an individual may move through, or back and forth from the different housing options based on treatment progress.

- Housing for individuals who are too physically compromised to live in a traditional residential rehabilitation program, yet who are too psychiatrically comprised to live in a traditional 'mom and pop' assisted living group home.
  - There is a need to develop a new housing program specifically for individuals physically and psychiatrically compromised; OR
  - There needs to be a way to take existing services and develop a system for cross training staff in traditional residential rehabilitation programs to provide some assisted living services, and a system to train staff in assisted living facilities on how to work with psychiatrically compromised individuals.

- Housing for individuals who either have not actively engaged in treatment, or who do not want services.

- Housing for serious mentally ill individuals who have reached their highest level of stability, with the need for 24 hour supervision. This type of housing would be devoted to individuals who are not in need of rehabilitation, but rather who need support to maintain their current stability through a low demand, highly structured living environment.

B. *Gaps*:
- Insufficient supply of a range of housing for individuals planning for discharge from a residential crisis facility.

- Insufficient supply of shelter/housing for individuals with assisted living needs who are seriously mentally ill and are too physically frail for residential rehabilitation programs, yet are too psychiatrically comprised for traditional assisted living group homes.

- Insufficient supply of case management services, particularly for individuals coming out of inpatient psychiatric hospitals. This is especially true for undocumented and/or uninsured individuals who are not eligible for entitlements, and therefore not eligible for a variety of public mental health programs.

C. *Barriers*:

- Many psychiatric rehabilitation programs are closed to grey zone (uninsured) referrals. This is an unmet need and limits the range of support services available to uninsured individuals living with mental illness.

- Difficulty in diagnosing and treating substance abuse and mental health problems in seniors. Seniors are more likely to report physical complaints rather than psychological distress to their physician and are more likely to have a pre-existing medical condition mimic or mask psychological disorders.

- Individuals with serious and persistent mental illness who have sexual offender histories often cannot find housing. Many landlords will not rent to them and many neighborhoods oppose having them live in their community. As a result, many of these clients are living in shelters or on the street.

- Addiction, mental health, behavioral health, developmental disabilities, and somatic health are not integrated; individuals caught between these systems often do not receive timely and clinically appropriate treatment.

C. Stats Brief

Corrections:

- Montgomery County Clinical Assessment and Triage Services (CATS) program data reports:
  - Mentally ill population among arrested individuals assessed in the Montgomery County Detention Center remained at a stable rate around 15% -16% from FY 03 to FY 08.
  - There were 964 inmates in FY 08 that were either housed in CIU and/or received psychiatric medication. In FY 09 year to date, the number recorded is 776.
  - In FY 08, 154 inmates were placed in community-based mental health treatment facilities.

MAPS-MD State Report:

- The claims of increased access are questionable.
  - Montgomery County CSA data indicate an increase from 5,081 served in FY 98 to 7,690 served in FY 08, while State data indicate an increase in consumers served from 63,557 in FY 98 to 99,812 in FY 08.

Residential Rehab Program Placement and Waitlist data:

- An acute shortage of residential rehabilitation program (RRP) vacancies exists in Montgomery County. In FY 09 (year to date), 55 clients have been placed in Raps. As of May 31, 2009, 197 persons remain on the supervised housing waiting list for Montgomery County.

Adult Drug Court:

- The Adult Drug Court began operations in November 2004. In FY 05, 21 individuals entered the program and 0 graduated. However, in FY06, the Adult Drug Court served 34 individuals and graduated 10. Since its inception, 51 individuals out of 121 in the program have graduated which suggests that the Adult Drug Court has been a very successful program.

Section II. Grid of Public Mental Health Services & Funding Levels

Behavioral Health and Crisis Services Resource Table
June 11, 2009

I. ACCESSING SERVICES

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
Access Team	Information and Referral for Mental Health and Substance Abuse Services	County and State	$1,440,072

II. ADMINISTRATION AND MANAGEMENT OF SERVICES

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
CSA	Local Mental Health and co-occurring (mental health and substance abuse) Authority	County and State	$5,094,029

III. ADVISORY BOARDS, COMMITTEES AND COUNCILS

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
Mental Health Advisory Committee	serves as advocacy committee for a comprehensive mental health system for consumers of all ages	not applicable	not applicable
Alcohol and Other Drug Advisory Council	Goals of this Council is to express the view of the community in the formulation and administration of alchol and other drug abuse prevention and treatment services in Montgomery County.	State ADAA	$5,000
Victims Services Advisory Board	reviews available services and facilities for victims and their families; determine needs of the victim and family services; makes recommendations for appropriate aoolocation of funds.	not applicable	not applicable

IV. ADDICTION SERVICES

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
Outpatient Addiction Services	Substance abuse treatment for adults focused on abstinence. Outpatient and intensive outpatient treatment services are available.	County, State ADAA, State M.A.	$1,975,014

Behavioral Health and Crisis Services Resource Table
June 11, 2009

IV. ADDICTION SERVICES (CONTINUED)

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
Adult Drug Court	Remedication of criminal behavior and/or drug and alcohol use.	County, State ADAA, SAMHSA, Circuit Court	$1,241,688
Avery Road Combined Care (ARCC)	Two levels of care available: Residential and 20 hour per week intensive outpatient treatment for invidividuals with co-occurring disorders.	State ADAA	$1,051,069.00
Avery Road Treatment Center (ARTC)	Two levels of care available: detoxification and intermediate care. Mental health treatment available to co-occurring individuals.	County, State ADAA	$2,457,561.00
Community Case Management	Provides targeted case management to multi-need consumers.	County, State ADAA	$1,419,218
Journeys for Women	Intensive outpatient treatment for women and women with children.	County	$230,120.00
Medication Assisted Treatment (MAT)	Medical management of methadone maintenance therapy and counseling	County, State ADAA	$1,416,258
Montgomery General Hospital	Medically managed hospital-based detoxification.	County	$10,000.00
Outpatient Treatment (Suburban and Counseling Plus)	Individual, group, family, addiction education and relapse prevention with motivational enhancement strategies.	County, State ADAA	$550,000.00
Urine Monitoring Program	Provides random and weekly collection and testin gof urine samples for drugs of abuse.	County, State ADAA	$759,934

Behavioral Health and Crisis Services Resource Table
June 11, 2009

V. RESIDENTIAL TREATMENT FOR ADDICTION SERVICES

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
Lawrence Court	Half way house for men/women	County	$405,564
Avery House for Women and Children	Half way house for women and their children under age 12	County, State ADAA	$445,050
Phoenix	Long-term residential program	State ADAA	$10,000
Second Genesis	Therapeutic community	State ADAA	$38,470

VI. CRIMINAL JUSTICE BEHAVIORAL HEALTH SERVICES

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
Jail Addiction Services (JAS)	Substance abuse treatment servics for individuals incarcerated at the County Correctional Facility	County, State ADAA	$879,590
Clinical Assessment Triage Services (CATS)	Mental health and substance abuse assessment and diversion services for indiviudals entering the Detention Center in Rockville	County, MH Grant	$734,979
Community Re-entry Services (CRES)	Coordination of substance abuse and mental health referral services for incarcerated indiviudals who are preparing to return to the community.	County	$593,024

VII. CONSUMER SERVICES

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
Office of Consumer Affairs (CSA-SPM)	The OCA staff are available to provide education and problem solving strategies regarding mental health and/or mental health/substance abuse (co-occurring disorders)	County	$2,000
Pharmacy and Lab	psychotropic medications on a short term basis. The lab service provides free laboratory and EKG services to	County and State	$250,025
Pharmacy Access Hotline for medicaid recipients	This hotline provides help with pharmacy related issues or problems	County	$40,000

Behavioral Health and Crisis Services Resource Table
June 11, 2009

VII. CONSUMER SERVICES (continued)

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
Transportation Services	The Mental Health Association of Montgomery County is contracted by Montgomery County to provide transportation services for consumers and their families to travel to and from Springfield Hospital Center.	State	$44,000
Wellness and Recovery Center On Our Own (OOO)-Gaithersburg	a consumer-run, self-help, drop-in center for adults with serious and persistent mental illness.	State	$283,555
Wellness and Recovery Center Silver Spring Drop in Center	a consumer services center in Silver Spring that provides peer support services, educational forums and social/ recreational activities for its members	County and State	$108,120

VIII. CRISIS SERVICES

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
Montgomery County Crisis Center	The Montgomery County Crisis Center provides immediate responses to crisis situations for all residents of Montgomery County, Maryland.	County	$4,052,836
	•Telephone and walk-in crisis intervention •Psychiatric consultation, evaluation and stabilization •Assessment of children and adolescents •Mobile Crisis Team •Critical Incident Stress Management		

14

Behavioral Health and Crisis Services Resource Table
June 11, 2009

VIII. CRISIS SERVICES (continued)

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
Public Inebriate Initiative	The Public Inebriation Initiative Team provides outreach on the streets of several areas - Crossroads, Takoma Park, and Downtown Silver Spring to engage those individuals who are publicly intoxicated in addictions treatment. Those who are unwillling to participate in treatment are engaged from a safety perspective to prevent them from becoming a victim of crime, pedestrian fatality, or victim of hypothermia or hyperthermia. A second PIIT Team that will work in the Wheaton area has been funded for start-up in 1/10.	County	$258,495
Hospital Diversion	Hospital Diversion is a State funded program to provide screening in the emergency departments of general hospitals that do not have inpatient psychiatric units. All uninsured patients at risk of psychiatric hospitalization are screened to determine if they could benefit from less restrictive community based services.	State	$263,445
T&E Beds (Residential Crisis)	Alternative to psychiatric hospitalization	County	
McAuliffe Fenton House (Residential Crisis)	Alternative and prevention to psychiatric hospitalization	State and Federal?	Fee for Service

IX. MENTAL HEALTH SERVICES

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
Acute Inpatient Hospitalization (Appendix A)	Local acute inpatient hospitalization for adults and children living with mental illness.	State FFS	0
Career Transitions for Transition Age Youth (18-24)	Specialized vocational and post secondary education support for TAY.	CMHG	86,616
Home Based Treatment Team	Specialized in-home treatment service for children and families involved with the Child Welfare System. 6 full time therapists and .75 wy psychiatrist. 3 of the therapists are bilingual.	County General Funds.	

Behavioral Health and Crisis Services Resource Table
June 11, 2009

IX. MENTAL HEALTH SERVICES (continued)

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
MARYLAND CHOICES: Care Coordination and Wraparound Services for At Risk Children & Adolescents.	Wraparound services for children and adolescents at risk of out-of-home placement due to emotional or behavioral disturbance	County General Funds.	$1,355,581
Mental Health Services for Children & Families in the Child Welfare System	Funding for assessments of attachment and bonding, mental health consultation to foster care providers, court evaluations and outpatient treatment for CWS involved children and families.	County General Funds.	$157,000
Mental Health Specialty Services-Safety Net Clinic	Located in the MC Crisis Center, provides short term treatment to children and adults who are temporarily unableto obtain services elsewhere in the system	County General Funds.	
Montgomery Cares	The Montgomery Cares Behavioral Health Pilot was established to provide mental health services in a primary care setting using an evidenced based Collaborative Care model		
Outpatient Mental Health Treatment (Appendix A)	Outpatient Treatment services for individuals living mental illness and co-occurring disorders (children and adults)	County and State FFS	600,000
Partial Hospitalization (Appendix A)	Intensive short term outpatient services on-site at acute hospitals for adults living with mental illness. .	FFS	0
Private Providers and Group Practice	Private providers with approval to bill the PMHS for services.	FFS	0
Psychiatric Rehabilitation (Appendix A)	Psychiatric rehabilitation services for individuals living mental illness and co-occurring disorders (children and adults)	FFS	0
Respite Services for Children	Camp Journey--8 bed respite group home	CMHG	110,000
Substance Abuse Assessment for Adolescents	Full time therapist to provide substance abuse screening, assessment and referral for adolescents.	FMHBG	
Supported Employment Programs (Appendix A)	Support service to seek employment and maintain employment (for adults living mental illness and co-occurring disorders)	FFS	0
Therapeutic Nursery Services	TNP for 12 young children to prepare for K	CMHG	214,313
TREE HOUSE: Mental Health Assessment for Victims of Child Abuse or Neglect	Full time therapist to provide mental health assessment and referral for children and adolescents who are victims of child abuse..	FMHBG	

Behavioral Health and Crisis Services Resource Table
June 11, 2009

X. RESIDENTIAL SERVICES FOR ADULTS

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
Residential Rehabilitation Program (Appendix A)	Supervised housing	County and State FFS	910,190
Assisted Living (Appendix A)	Intensive supervised housing for individuals who need the highest level of supervision in a residential setting.	State	676,739
Landlord Based Housing	independent permanent housing.	County, State	113,760

XI. RESIDENTIAL SERVICES FOR CHILDREN AND TRANSITION AGE YOUTH

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
Residential Services for Children and Transition Age Youth (Residential Treatment Centers)	135 RTC beds in Montgomery County, however MC children may go to other RTCs	FFS	0
Residential Rehabilitation Program for TAY	22 TAY RRP beds	County and FFS	271,966

XII. SPECIALIZED SENIOR SERVICES

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
The Senior Outreach	This program offers short-term mental health treatment for seniors who are homebound or who cannot or will not access office based services.	State and County	State 50,565 and County 125,043
Hispanic Senior Outreach	This program offers short-term mental health treatment for Spanish speaking seniors who are homebound or who cannot or will not access office based services.	County	100,505
The Prevention and Early Intervention Program	This program provides direct services to seniors via psycho-education groups, drop-in groups at 5 senior centers and 3 pre-admission visits. This program also works with providers of services to seniors such as Senior Center Directors, HOC residential counselors, and assisted living providers.	County	89,912

3

Behavioral Health and Crisis Services Resource Table
June 11, 2009

XIII. VICTIM SERVICES

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
Abused Persons Program	serves victims of domestic violence in Montgomery County	County and State	3,326,437
Victim Assistance and Sexual Assault Program	serves victims of crime, their family and significant others.	County and State	2,571,299

XIV. Housing Stabilization and Shelter Services

PROGRAM	DEFINITION	FUNDING STREAM	FUNDING AMOUNT
Homeless Services	Staff coordinate referrals, placements and oversees services for homeless families placed in emergency shelters and motels. Staff also provide assessment and case management services to homeless single adults in the emergency shelter system.	State	72,430

Summary of FY2009 System Planning and Management Budget (SPM)					
	Budget	Program Title	General Fund	Grants	Total
System Planning and Management	$ 10,160,047	($707,457 - SORT & $1,226,703 - Hospital Diversion)	36%	64%	100%
FY09 HHS Budget	$ 273,513,150				
% of CSA over HHS overall Budget	3.71%				

Sources Reference: Montgomery County, Office of Management and Budget, Operating Budget (BH&CS and DHHS Budget Summary)

Section III. Provider List

ATTACHMENT A

Montgomery County FY2008 Year to Date Number of Private Providers

Provider Type	count_of_providers
Certified MH Practitioner	204
Psychiatrist	344

Montgomery County FY2008 Year to Date Mental Health Provider List

Provider_Type	PROVIDER	ADDRESS	PHONE
Acute Hospital	ADVENTIST HEALTHCARE	WASHINGTON ADVENTIST HOSP 7600 CARROLL AVENUE, TAKOMA PARK, MD 20912	(301)891-7600
Acute Hospital	HOLY CROSS HOSPITAL	1500 FOREST GLEN ROAD , SILVER SPRING, MD 20910	(301)754-7000
Acute Hospital	MONTGOMERY GENERAL HOSP	18101 PRINCE PHILIP DR , OLNEY, MD 20832	
Acute Hospital	SUBURBAN HOSPITAL	CASHIER'S DEPT 8600 OLD GEORGETOWN RD, BETHESDA, MD 20814	
CASE MANAGEMENT	COMMUNITY CASE MANAGEMENT SERVICES	255 ROCKVILLE PIKE, ROCKVILLE, MD 20850	(240)7774710
CASE MANAGEMENT	COMMUNITY RE-ENTRY SERVICES (CRES)	751 TWINBROOK PARKWAY 2ND FLOOR, ROCKVILLE, MD 20851	240-777-3316
CASE MANAGEMENT	ST LUKE'S HOUSE INC	6040 SOUTHPORT DRIVE , BETHESDA, MD 20814	(301)493-4200
CASE MANAGEMENT	VOA, HOMELESS CASE MANAGEMENT		301-438-0092
MTS (ACT)	PEOPLE ENCOURAGING PEOPLE	1301 PICCARD DRIVE, ROCKVILLE, MD	(240) 777-4204
OMHC	CONTEMPORARY THERAPEUTIC SERVICES, INC.	GERMANTOWN AND WHEATON	(240)686-1971
OMHC	FAMILY BEHAVIORAL SERVICES LLC	6475 NEW HAMPSHIRE AVENUE SUITE 610, HYATTSVILLE, MD 20783	(301)270-3200

ATTACHMENT A

Provider_Type	PROVIDER	ADDRESS	PHONE
OMHC	FAMILY TRAUMA SERVICES INC	11160 VIERS MILL ROAD , WHEATON, MD 20902	(703)549-4000
OMHC	INSTITUTE FOR LIFE ENRICHMENT	4700 BERWYN HOUSE ROAD , COLLEGE PARK, MD 20740	(301)439-3600
OMHC	MARYLAND TREATMENT CENTERS INC	MOUNTAIN MANOR TREATMENT 9701 KEYSVILLE RD PO BOX 136, EMMITTSBURG, MD 21727	(301)447-2361
OMHC	MONTGOMERY COUNTY CHILD-ADOL MH SVC	8818 GEORGIA AVENUE 1ST FLOOR STE 500, SILVER SPRING, MD 20910	(240)777-1450
OMHC	MONTGOMERY COUNTY MHC	751 TWINBROOK PKWY 2ND FLOOR, ROCKVILLE, MD 20851	(240)777-1444
OMHC	MONTGOMERY COUNTY MHC SILVER SPRING	8818 GEORGIA AVE SUITE 200, SILVER SPRING, MD 20910	(301)565-7567
OMHC	REGINALD S LOURIE CENTER	12301 ACADEMY WAY , ROCKVILLE, MD 20852	(301)984-4444
OMHC	RESOURCES FOR HUMAN DEVELOPMENT INC	14701 AVERY ROAD , ROCKVILLE, MD 20850	(800)894-9925
OMHC	ST LUKE'S HOUSE MHC	6040 SOUTHPORT DRIVE , NORTH BETHESDA, MD 20814	(301)581-0301
OMHC	THE AFFILIATED SANTE GROUP	1961 EASTERN AVE #1 , SILVER SPRING, MD 20910	(301)589-2303
OMHC	THRESHOLD SERVICES INC	751 TWINBROOK PARKWAY 1ST FLOOR, ROCKVILLE, MD 20851	(301)838-4100
OMHC	UPPER BAY CSS-MHC	200 BOOTH STREET , EKLTON, MD 21921	(410)996-5104
OMHC	VESTA INC	20410 OBSERVATION DR SUITE 108, GERMANTOWN, MD 20876	(301)528-7927
OMHC	VILLAGE FAMILY NETWORK	12703 THRUST PLACE SUITE A , UPPER MARLBORO, MD 20772	(301)574-2488
PHP	MONTGOMERY GENERAL HOSP	18101 PRINCE PHILIP DR , OLNEY, MD 20832	
PHP	SUBURBAN HOSPITAL	CASHIER'S DEPT 8600 OLD GEORGETOWN RD, BETHESDA, MD 20814	
PHP	WASHINGTON ADVENTIST HOSPITAL	WASHINGTON ADVENTIST HOSP 7600 CARROLL AVENUE, TAKOMA PARK, MD 20912	(301)891-7600
PRP	AFFILIATED SANTE GP INC	1961 EASTERN AVE #1 , SILVER SPRING, MD 20910	(301)572-6585

ATTACHMENT A

Provider_Type	PROVIDER	ADDRESS	PHONE
PRP	BUILDING COMM TODAY FOR TOMORROW	2901 DRUID PARK DR A210, BALTIMORE, MD 21215	(410)467-6600
PRP	CBH HEALTH LLC	9605 MEDICAL CENTER DRIVE SUITE 270, ROCKVILLE, MD 20850	(301)251-4702
PRP	COMMUNITY CONNECTIONS	801 PENNSYLVAIA AVE SE STE 201, WASHINGTON, DC 20003	(301)585-6118
PRP	FAMILY SERV AGENCY INC	640 E DIAMOND AVE #A , GAITHERSBURG, MD 20877	(301)963-1700
PRP	FAMILY TRAUMA SERVICES INC	11160 VIERS MILL RD , WHEATON, MD 20902	(301)176-3674
PRP	GUIDE MC PRP	18321 LOST KNIFE CIRCLE #101 , GAITHERSBURG, MD 20886	(301)948-1000
PRP	PARTNERSHIP DEVELOPMENT GROUP INC	804 LANDMARK DRIVE SUITE 118, GLEN BURNIE, MD 21061	(410)863-7213
PRP	ROCK CREEK FOUN-ACHIEVEME	12120 PLUM ORCHARD DRIVE SUITE E, SILVER SPRING, MD 20904	(301)572-6585
PRP	SAFE JOURNEY HOUSE	RESIDENTIAL CRISIS SERVICES 1106 CEDAR HEIGHTS SUITE 303, CAPITAL HEIGHTS, MD 20743	
PRP	ST LUKE'S HOUSE INC	6040 SOUTHPORT DRIVE , BETHESDA, MD 20814	(301)493-4200
PRP	THRESHOLD SERV ALTERNA DP	RENAISSANCE CRP 1398 LAMBERTON DR #1, SILVER SPRING, MD 20902	(301)593-7040
PRP	VILLA MARIA CONTINUUM HOME INTERV	PRP SERVICES 1118 LIGHT STREET, BALTIMORE, MD 21230	(410)252-4700
PRP	VOCATIONAL SUPPORT SYSTEMS INC	4 PARK AVENUE SUITE 150, GAITHERSBURG, MD 20877	(301)740-7448
PRP	VOLUNTEER OF AMER CHES-PG	KAMALA VIA 7901 ANNAPOLIS ROAD, LANHAM, MD 20706	(301)459-2020
RRP	FAMILY SERV AGENCY INC	640 E DIAMOND AVE #A , GAITHERSBURG, MD 20877	(301)963-1700
RRP	ROCK CREEK FOUN-ACHIEVEME	12120 PLUM ORCHARD DRIVE SUITE E, SILVER SPRING, MD 20904	(301)572-6585
RRP	ST LUKE'S HOUSE INC	6040 SOUTHPORT DRIVE , BETHESDA, MD 20814	(301)493-4200
RRP	THRESHOLD SERV ALTERNA DP	RENAISSANCE CRP 1398 LAMBERTON DR #1, SILVER SPRING, MD 20902	(301)593-7040
RRP (TAY)	COMMUNITY CONNECTIONS	801 PENNSYLVAIA AVE SE STE 201, WASHINGTON, DC 20003	(301)585-6118

ATTACHMENT A

Provider_Type	PROVIDER	ADDRESS	PHONE
RRP (TAY)	GUIDE MC PRP	18321 LOST KNIFE CIRCLE #101 , GAITHERSBURG, MD 20886	(301)948-1000
RTC	CHESAPEAKE TREATMENT CENTER	2400 CUB HILL RD , BALTIMORE, MD 21234	(410)663-8500
RTC	GOOD SHEPHERD CENTER	4100 MAPLE AVENUE , BALTIMORE, MD 21227	(410)247-2770
RTC	P R B H AT CROWNSVILLE	15 ROMIG DRIVE , CROWNSVILLE, MD 21032	(301)912-2770
RTC	POTOMAC RIDGE BEHAVIORAL HEALTH	14901 BROSCHART ROAD , ROCKVILLE, MD 20850	(301)251-4500
RTC	THE JEFFERSON SCHOOL	2940 POINT ROCKS ROAD , JEFFERSON, MD 21755	
RTC	THE PINES RTC	FHC OF PORTSMOUTH 1801 PORTSMOUTH BLVD, PORTSMOUTH, VA 23704	(804)398-0300
RTC	VILLA MARIA	320 CATHEDRAL STREET , BALTIMORE, MD 21201	(410)547-5462
RTC	WOODBOURNE CENTER INC	ATTN-FINANCE DEPT 1301 WOODBOURNE AVE, BALTO, MD 21239	(410)433-1000
SEP	FAMILY SERV AGENCY INC	640 E DIAMOND AVE #A , GAITHERSBURG, MD 20877	(301)963-1700
SEP	ROCK CREEK FOUN-ACHIEVEME	12120 PLUM ORCHARD DRIVE SUITE E, SILVER SPRING, MD 20904	(301)572-6585
SEP	ST LUKE'S HOUSE INC	6040 SOUTHPORT DRIVE , BETHESDA, MD 20814	(301)493-4200
SEP	VOCATIONAL SUPPORT SYSTEMS INC	4 PARK AVENUE SUITE 150, GAITHERSBURG, MD 20877	(301)740-7448

Section IV. Budget Overview

Behavioral Health and Crisis Services

FUNCTION

The mission of Behavioral Health and Crisis Services (BHCS) is to foster the development of a comprehensive system of services to assist children, youth, adults, and families in crisis or with behavioral health needs. Services incorporate evidence based or best practices along a continuum of care. BHCS works with the State's public mental health and substance abuse system to ensure children, adults, and families receive integrated treatment. Crisis Services are available twenty–four hours, seven days a week along with victim services. Victim services provide treatment for victimization that occurs in schools, home, or community. Access to behavioral health specialty services provide screening/referrals along with treatment on an outpatient basis. System Planning and Management monitors various services provided to families with public health insurance including, outpatient mental health clinics, psychiatric rehabilitation, and residential rehabilitation programs. BHCS is committed to providing culturally and linguistically competent care in the least restrictive environment.

PROGRAM CONTACTS

Contact Uma Ahluwalia of the HHS - Behavioral Health and Crisis Services at 240.777.1058 or Trudy-Ann Hunter of the Office of Management and Budget at 240.777.2778 for more information regarding this service area's operating budget.

PROGRAM DESCRIPTIONS

System Planning and Management

As the State mandated local mental health authority, this program is responsible for the planning, management, and monitoring of Public Mental Health Services for children with serious, emotional impairments (SEI), and adults with a serious and persistent mental illness (SPMI). This include persons with co-occurring mental illness and substance abuse disorders, homeless persons with SPMI, and persons with SPMI who have been incarcerated and/or are on conditional release. This program is responsible for the ongoing development of a resiliency and recovery oriented continuum of quality mental health services that provide for consumer choice and empowerment, while assuring consumers have access to clinically appropriate and cost-effective behavioral health services.

Program Performance Measures	Actual FY07	Actual FY08	Estimated FY09	Projected FY10	Projected FY11
Number of clients served in Outpatient Mental Health Clinics	1,241	1,516	1,583	1,403	1,403
Percentage of customers receiving services who report an increase in well being -Outpatient Mental Health Clinics	70	70	70	70	70

FY10 Recommended Changes	Expenditures	WYs
FY09 Approved	**8,225,890**	**18.8**
Decrease Cost: Lab Services based on historical spending	-6,000	0.0
Decrease Cost: Consumer Affairs Fund	-8,000	0.0
Decrease Cost: Training in Systems Planning and Management	-11,540	0.0
Reduce: Contract services for parent and child bonding	-28,900	0.0
Decrease Cost: Abolish vacant Administrative Specialist II Position -Behavioral Health & Crisis Services (1/2 of position is in BHCS)	-34,590	-0.5
Decrease Cost: Residential Supplement based on historical spending	-35,000	0.0
Decrease Cost: Pharmacy Assistance Services	-40,000	0.0
Decrease Cost: Federal Block Grant	-204,980	0.0
Miscellaneous adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting more than one program	-341,930	-4.5
FY10 CE Recommended	**7,514,950**	**13.8**

Notes: Miscellaneous adjustments include four workyears moved to Community Health Services as part of a reorganization and one workyear adjustment for an abolished split funded position.

Behavioral Health Specialty Services

Behavioral Health Specialty Services includes both the Adult Behavioral Health and the Access to Behavioral Health Services programs. The Adult Behavioral Health program provides a comprehensive range of mental health services including assessment, diagnostic evaluation, psychotropic medication evaluation, and medication monitoring. Individual, family, and group psychotherapy including family psycho-educational support are available, as well as case management services. Eligibility is limited to Montgomery

County residents who have a high level of acuity and are involved in multiple systems in the Community. Many of these individuals are unable to receive Public Mental Health System services or the level of care necessary to effectively stabilize their illness. This program has expanded capacity to provide services to Limited English proficiency (LEP) clients and those with specialized cultural and language needs. The Access to Behavioral Health Services program provides clinical necessity and financial assessments f consumers needing outpatient mental health services including those with a co-occurring disorder, and linkages to those eligible t the Public Mental Health System or community resources. This program also provides for Montgomery County adult residents, walk-in substance abuse assessments including co-occurring disorders and linkages to the range of services in the Addiction Services continuum. Safety Net Services, a service within Access to Behavioral Health Services, provides immediate, brief psychiatric, and case management services (16 hours a week) until those clients who are eligible for the Public Mental Health system and have been discharged from a psychiatric hospital can be linked to a community Outpatient Mental Health Clinic.

FY10 Recommended Changes	Expenditures	WYs
FY09 Approved	**2,786,700**	**22.5**
Decrease Cost: Abolish a filled Program Specialist II Position at the Access to Behavioral Health Program (ABHS)	-105,740	-1.0
Miscellaneous adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting more than one program	82,280	0.0
FY10 CE Recommended	**2,763,240**	**21.5**

Notes: Miscellaneous adjustments includes grant increases of $114,100 to the Community Mental Health Grant.

Behavioral Health Community Support Svcs

Behavioral Health/Community Support Services is composed of three sub-programs: Community Case Management Services, Urine Monitoring Program, and Program/Contract Monitoring Unit. These programs provide: 1) case management services to Temporary Cash Assistance (TCA) clients, women who are homeless, adults incarcerated at the Montgomery County Correctional Facility, and other clients who are "high-end" users of services and involved in multiple programs within HHS; 2) urine testing services to clients referred by the courts, child welfare, the criminal justice system and others required to submit to urine surveillance or who require or request urine screening and testing; and 3) the Program/Contract Monitoring Unit monitors contract compliance for addiction and co-occurring treatment with certified providers who contract with the Department to provide detoxification, outpatient, intensive outpatient, residential halfway house, combined care, and long-term residential treatment services to enhance the quality of care available to Montgomery County residents.

Program Performance Measures	Actual FY07	Actual FY08	Estimated FY09	Projected FY10	Projected FY11
Number of persons served in Level 1 Outpatient Treatment	525	734	600	516	516
Percentage of decrease in substance abuse for patients completing treatment (Level 1 Outpatient Treatment)	84	74	68	68	68

FY10 Recommended Changes	Expenditures	WYs
FY09 Approved	**5,623,890**	**22.5**
Increase Cost: Alcohol and Drug Abuse Administration (ADAA) Block Grant	1,400,300	2.9
Decrease Cost: Facility Maintenance Funds in Addiction Shelters	-15,000	0.0
Decrease Cost: Level III Addiction Treatment Services Contract	-20,000	0.0
Reduce: Contract funding for Level 1 Outpatient Treatment Services and serve approximately 84 fewer clients	-70,000	0.0
Reduce: Behavorial Health Community Support Services- Therapist in Program Monitoring Unit	-124,850	-1.0
Shift: Temporary Cash Assistance Substance Abuse	-204,030	-2.2
Shift: CRF for Addictions Treatment	-1,260,000	-0.7
Miscellaneous adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting more than one program	2,080,250	0.0
FY10 CE Recommended	**7,410,560**	**21.5**

Criminal Justice/Behavioral Health Services

Criminal Justice/Behavioral Health Services is composed of three programs: (1) Clinical Assessment and Triage Services (CATS), (2) Community Re-Entry Services (CRES), and (3) Jail Addiction Services (JAS). CATS provides assessment and post-booking diversion services within 24 hours of booking to inmates with behavioral health issues upon entry into the Montgomery County Detention Center. JAS is an intensive jail-based residential addiction treatment program for inmates who suffer with substance related disorders at the Montgomery County Correctional Facility. CRES provides court advocacy and release planning for inmates at the Montgomery Correctional Facility by assessing inmates' behavioral health needs and coordinating services in the Community.

FY10 Recommended Changes	Expenditures	WYs
FY09 Approved	**2,354,830**	**19.2**

	Expenditures	WYs
Decrease Cost: Transitional Housing Services for Mentally Ill Offenders as the program was not operational	-40,000	0.0
Miscellaneous adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting more than one program	154,840	0.0
FY10 CE Recommended	**2,469,670**	**19.2**

Notes: Miscellaneous adjustments includes $28K in grant increases.

Outpatient Addiction Services (OAS)

OAS provides comprehensive and quality outpatient, intensive outpatient drug court and medication assisted treatment services to adult residents of Montgomery County, who are diagnosed with substance use disorders or co-occurring mental health and substance use disorders. Priority populations include people who are indigent, homeless, medically compromised, women who are pregnant or those with infants, individuals involved with the criminal justice system, and people with HIV/AIDS.

FY10 Recommended Changes	Expenditures	WYs
FY09 Approved	**5,854,770**	**30.3**
Add: Montgomery County Adult Drug Court Capacity	300,000	0.0
Reduce: Outpatient Addiction Services (OAS) Acudetox Contract	-6,250	0.0
Reduce: Abolish Outpatient Addiction Services (OAS) Vocational Services Program Specialist	-84,360	-1.0
Miscellaneous adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting more than one program	-2,018,590	0.0
FY10 CE Recommended	**4,045,570**	**29.3**

Notes: Miscellaneous adjustments includes the realignment of Alcohol and Drug Abuse Administration (ADAA) Block Grant Funds from Outpatient Addiction Services to Behavioral Health Community Support Services.

Victims Assistance and Sexual Assault Services

This program provides information, referral, support, psychiatric evaluations, criminal justice advocacy, court accompaniment, crisis, and ongoing counseling services to persons subjected to sexual assault (exclusive of partner abuse), as well as to persons victimized by crimes in general. 24-hour outreach is provided through volunteer support to rape and sexual assault victims at hospitals and police stations, and compensation is provided to eligible victims of crime

Program Performance Measures	Actual FY07	Actual FY08	Estimated FY09	Projected FY10	Projected FY11
Percentage of adult victims of sexual assault and general crime who show a decrease in symptoms after treatment (as measured by PCL-C clinical scales)	84	85	85	85	85
Percentage of child victims of sexual assault and general crime who show a decrease in symptoms after treatment (as measured by the CRTES clinical scales)	70	81	76	77	76

FY10 Recommended Changes	Expenditures	WYs
FY09 Approved	**2,586,450**	**19.2**
Increase Cost: Victims Compensation Fund Match	7,990	0.0
Eliminate: Silver Spring Courthouse Victim Assistance	-17,300	-0.7
Miscellaneous adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting more than one program	42,890	0.0
FY10 CE Recommended	**2,620,030**	**18.5**

Child and Adolescent Mental Health Services

Child and Adolescent Mental Health Services is comprised of three components that provide or support comprehensive mental health treatment and care coordination services to children, youth, and their families that are individualized, culturally, and linguistically appropriate and administered in the least restrictive, most conducive environment. The Child and Adolescent Outpatient Mental Health Service provides assessment, psychiatric, and therapeutic treatment to children and adolescents with serious emotional impairments. The Home-based Treatment Team for Child Welfare Services provides specialized, evidence-based mobile treatment specifically for children and families involved with Child Welfare Services. The System of Care Development and Management Team collaborates with Local and State partners to plan, develop, and manage publicly-funded (State and County) mental health and care coordination services for children and adolescents. All three components are guided by the principles that services should be hild focused, family driven, and culturally competent.

FY10 Recommended Changes	Expenditures	WYs
FY09 Approved	**3,272,960**	**17.3**
Add: Mental Health Association, Inc. - Support N*COMMON Multicultural Mental Health Initiative	60,000	0.0
Decrease Cost: Child and Adolescent Mental Health Care Coordination Operating Budget	-10,810	0.0
Reduce: Contract for Family and Caregiver Support Services	-30,960	0.0
Reduce: Child and Adolescent Mental Health Service Care Coordination funds and serve approximately 12 to 15 fewer children	-73,000	0.0
Miscellaneous adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting more than one program	86,140	0.0
FY10 CE Recommended	**3,304,330**	**17.3**

24-Hour Crisis Center

This program provides telephone, walk-in, mobile crisis outreach, and crisis residential services to persons experiencing situational, emotional, or mental health crises. The Crisis Center provides all services, twenty-four hours/day seven days/week. Much of the work of the Crisis Center is focused upon providing the least restrictive community-based service that is appropriate to the client's situation. Many of the services provided are alternatives to more traditional mental health services. Psychiatric crisis resources are used to prevent hospitalizations and suicides. Disaster mental health services include crisis management and consultation for disasters and community crises. The Crisis Center coordinates the mental health response during disasters and community critical incidents. During the off-hours (after 5:00 p.m., weekends, and holidays), crisis back-up services are provided for various health and human services needs when the clients' primary service providers are not available.

The Assertive Community Treatment (ACT) Team provided community-based mental health services for those individuals with the highest level of acuity. This service was transitioned to the private/not for profit sector during FY09.

The Public Inebriate Initiative is a pilot program to intervene with those individuals who are drinking on the street. It is comprised of two components. The first is outreach workers who engage these individuals on the street, or in an emergency department. The second component is sobering beds. The beds are available for up to 24 hours with possible transfer to detoxification if available.

FY10 Recommended Changes	Expenditures	WYs
FY09 Approved	**5,149,170**	**43.1**
Decrease Cost: Operating budget for supplies	-19,890	0.0
Shift: Crisis Center - Assertive Community Treatment (ACT) Team	-899,800	-5.5
Miscellaneous adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting more than one program	-46,090	-1.0
FY10 CE Recommended	**4,183,390**	**36.6**

Notes: Micellaneous adjustment includes one workyear reduction as part of the RIP.

Mental Health Svcs: Seniors & Persons with Disabilities

This program provides mental health services to seniors, persons with developmental disabilities, persons with hearing impairments and individuals in a Psychiatric Crisis. Services include evaluation, treatment, outreach counseling, provider training, caretaker support, and referral services. In addition, this program provides a countywide response to screen uninsured individuals who are at risk of needing publicly funded hospitalization and who present at any of the five local emergency departments. The focus of this program is to provide the least restrictive and most appropriate community disposition possible for these individuals.

FY10 Recommended Changes	Expenditures	WYs
FY09 Approved	**1,934,160**	**11.0**
Replace: Grant Funds with general fund support to cover a grant shortfall in SORT- Senior Mental Health and preserve services for 35 clients	25,430	0.0
Shift: Senior Outreach (SORT)	0	-1.0
Reduce: Services to 15 Hearing Impaired clients	-17,600	0.0
Decrease Cost: Dedicate savings from eliminated contract (Affiliated Sante) to cover the grant shortfall in SORT-Sr. Mental Health	-25,430	0.0
Decrease Cost: Contract for Mental Health Services for Persons with Developmental Disabilities and/or Mental Retardation based on historic actuals	-76,500	0.0
Miscellaneous adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting more than one program	14,960	0.0
FY10 CE Recommended	**1,855,020**	**10.0**

Partner Abuse Services

The Abused Persons Program is a comprehensive domestic violence program that provides community education, crisis intervention, safety planning, legal advocacy, on-going counseling, and emergency shelter to victims and families of partner-related physical abuse. Assessment and counseling are also provided to those who have been abusive towards their partners.

FY10 Recommended Changes	Expenditures	WYs
FY09 Approved	**3,346,210**	**18.8**
Add: Gudelsky Foundation	15,000	0.0
Decrease Cost: Abolish a vacant Supervisory Therapist Position in the Abused Persons Program (APP)	-100,770	-1.0
Miscellaneous adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting more than one program	-2,180	0.0
FY10 CE Recommended	**3,258,260**	**17.8**

Service Area Administration

This program provides leadership, oversight, and guidance for the administration of Behavioral Health and Crisis Services.

FY10 Recommended Changes	Expenditures	WYs
FY09 Approved	**601,380**	**3.9**
Decrease Cost: Advertising expenses in BHCS Chief's budget	-6,000	0.0
Decrease Cost: Temporary Services Budget in Behavior Health and Crisis Services	-10,000	0.0
Miscellaneous adjustments, including negotiated compensation changes, employee benefit changes, changes due to staff turnover, reorganizations, and other budget changes affecting more than one program	-150	0.0
FY10 CE Recommended	**585,230**	**3.9**