

Baltimore Mental Health Systems, Inc.

(BMHS)

<http://www.bmhsi.org>

Core Service Agency

Annual Report

Fiscal Year 2007

July 1, 2006 to June 30, 2007

Jane Plapinger, MPH
President & CEO

Ben F. Mason
Board Chairperson

Preface

Baltimore Mental Health Systems, Inc.'s (BMHS) annual report for fiscal year 2007 reflects the organization's mission to advance the public mental health system in Baltimore City, and its values of innovation, access to quality care and accountability. The report describes a range of activities, including ongoing support and oversight of established projects, and the development of new initiatives. Through collaboration with State and City agencies on various projects and programs, BMHS has striven to improve access to services and coordination of care for individuals with mental illness.

Examples of these collaborative efforts are: the Behavioral Emergency Services Team (BEST) with the Baltimore City Police Department; the Mental Health Court with criminal justice agencies and the judiciary; mental health services for youth involved with the Department of Juvenile Services, including mental health assessments for Juvenile Court and mental health services for youth in juvenile detention facilities; Hands in Partnership for multi-agency coordination of street outreach to homeless individuals; implementation of uniform written performance expectations for Expanded School Mental Health Services; improving treatment services for individuals with co-occurring disorders; and the Forensic Assertive Community Treatment Team, the high utilizers program, and the Capitation project, all with the Department of Mental Hygiene. Two new initiatives being planned for implementation in fiscal year 2008 are the Multisystemic Therapy (MST) project in collaboration with the Baltimore City Health Department, and the hospital diversion initiative with Baltimore Crisis Response, Inc. All of these activities are described within the report.

BMHS' two subsidiaries have continued to do important work. The Mental Health Policy Institute for Leadership and Training has an ongoing projected focused on poverty and depression in collaboration with the University of Maryland School of Nursing, and is offering annual training and a certificate-training program for individuals working with juvenile sex offenders. Community Housing Associates continues to fulfill its mission to provide housing for individuals with mental illness.

This past year has been a time of transition for BMHS, with Sue Diehl serving as President, while the Board of Directors conducted a search for the next President. Her leadership provided critical continuity and support during this period. Following a rigorous search process, Jane Plapinger was hired to lead BMHS.

BMHS' accomplishments over the past year reflect the work of its staff, Board of Directors and its many partners: the providers in Baltimore City's Public Mental Health System (PMHS); consumers of mental health services and family members; the Mental Hygiene Administration; and other agencies in the City and State that recognize the need for mental health services for individuals they serve.

GOAL #1: Ensure that a wide range of mental health services are available and accessible
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ADULT SERVICES DIVISION

Objective 1A: Maintain a crisis response system that promotes diversion from hospitalization and incarceration through community treatment

Strategies: 1. Contract with local hospital emergency departments to promote diversion from inpatient through collaboration with Baltimore Crisis Response (BCRI) through shared service agreements.

2. Monitor and support the activities provided by BCRI.

Indicators: 1. Number of shared service agreements in place.

2. Number of mental health assessments provided and number of referrals to BCRI.

3. Number of hotline calls received.

4. Number of mobile crisis team interventions by locations and disposition.

5. Crisis bed occupancy and disposition.

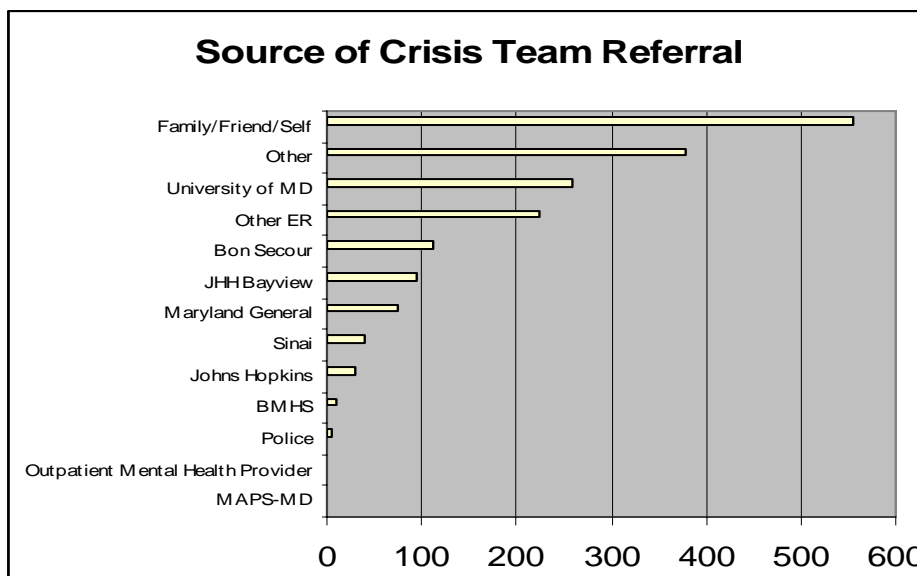
Progress: This objective was accomplished.

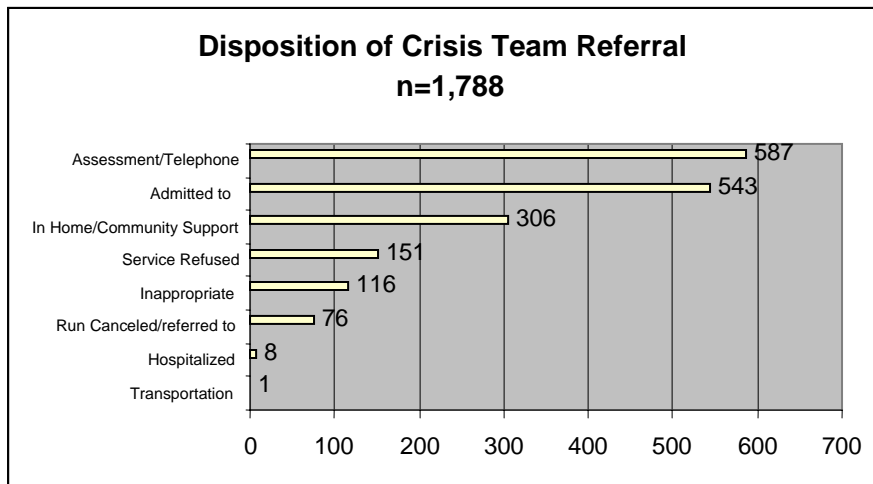
During this fiscal year, Adult Services staff has been working with Baltimore Crisis Response, Inc. (BCRI) to expand their services as part of the state-wide hospital diversion project for uninsured clients seeking inpatient psychiatric admission. Six crisis response teams at BCRI have expanded their hours to provide response capability from 7am to 10pm (previous hours were from 8am to 8pm). In June, BCRI moved its Crisis Response Unit (CRU) to the Walter P. Carter Center, increasing their bed capacity from 12 to 16. By October of this year, the crisis response team hours will be extended until midnight and the bed capacity at the CRU will expand to 21.

The state-wide hospital diversion initiative will begin this fall in Baltimore City and will target the four hospitals that do not have psychiatric inpatient units: Harbor, St. Agnes, Good Samaritan and Mercy. All uninsured clients presenting to these hospital emergency departments for inpatient psychiatric admission will be assessed face-to-face by BCRI for diversion to community treatment options. BMHS and BCRI staff has been meeting with the emergency departments of these hospitals to educate the staff about the diversion effort. BCRI has also conducted 37 trainings to community service providers on a variety of topics including the scope of BCRI services, managing aggressive behavior, and assessing and treating suicidal individuals.

Crisis bed admissions numbered 536 for FY 07. The occupancy rate was 81% and the average length of stay was 6 days. BCRI did not collect crisis bed disposition information. The number of referrals to BCRI is the same as the number of hotline calls received. The number of face-to-face mental health assessments performed was 1,712. The following is the disposition of hotline calls received for the fiscal year as well as the source and disposition of crisis team referrals.

Hotline Calls Received	
Information Only	13,472
Shelter Hotline	2,526
Crisis	2,253
Supportive Counseling	1,880
Baltimore Children and Adolescent Response System (BCAR)	1,679
Suicide	1,527
Referred to Other Resources	1,358
Detox	578
Homeless	226
Follow up Calls of Referral Sources	23
Total	25,522





BMHS has also begun an initiative in collaboration with MAPS-MD and BCRI to better meet the needs of high-cost consumers in the public mental health system. A full-time staff person was hired in Adult Services to coordinate this effort. MAPS-MD identifies clients from their database with recent histories of multiple inpatient admissions. BMHS is notified within 24 hours of each high-cost consumer’s admission to an inpatient psychiatric facility. The Adult Services Coordinator assesses the client’s needs through collaboration with the inpatient facility and establishes a link between inpatient and community services. The goals for this initiative are a reduced hospital length of stay and improved linkages to community-based services. BCRI has been utilized as an alternative to inpatient care for the identified high-cost consumers, often using their crisis beds as step-down to reduce the number of inpatient days and increase the probability of a successful transition to ongoing community supports.

Objective 1B: **Ensure that, in addition to Residential Rehabilitation Programs (RRPs), a wide range of housing options is available to persons with special needs.**

Strategy: 1. Contract with providers to offer a range of housing options for persons with special needs - e.g. Community Housing Associates, Inc. (CHA), At Jacob’s Well, My Sister’s Place Lodge, Shelter Plus Care, and the Safe Haven programs.

Indicators: 1. Number of providers identified
 2. Number of individuals served

Progress: **This objective was accomplished.**

Baltimore City has 8 Residential Rehabilitation Programs (RRPs) serving persons with severe and persistent mental illnesses (SPMI). There are total of 353 beds serving that many consumers at any given time. Approximately half of the consumers receive Intensive Level of Care (LOC) and the others receive General LOC. These levels reflect the needs of the consumers and the associated amount of staff coverage in the houses and apartments. All RRP referrals are

screened through BMHS to ensure eligibility and the wait list is maintained by Adult Services staff.

Some of the RRP's serve specialized populations. One program has an 8-bed group home facility for geriatric consumers. Two of the programs serve Transition Age Youth (TAY) consumers, ages 18 through 23; one has 8 beds and the other has 6 beds. Two different RRP's, with a combined total of 14 beds, have specially designated forensic beds, for persons found Not Criminally Responsible and are in the community on Conditional Release. In addition to these specialties, there are approximately 10 handicap accessible beds. All RRP providers receive reimbursement through the fee for service system. The TAY RRP providers receive enhanced funding through a contract with BMHS.

BMHS funds various other housing programs that are not a part of the fee for service system. Two of these are considered transitional housing: At Jacobs Well (AJW) and My Sister's Place Lodge (MSPL). Both serve persons with SPMI who are homeless and are transitioning to permanent housing and house consumers up to two years. AJW serves up to 30 men and women and MSPL serves 29 women. Both programs help consumers locate permanent housing and link them to services and benefits. BMHS is not the sole funder of these programs. A 100% occupancy rate has been maintained for those beds funded by BMHS in both programs.

The Ethel Elan Safe Haven which has 19 beds and University of Maryland's Safe Haven, which has 20 beds, served 33 and 55 individuals respectively during this past fiscal year. Both safe havens are transitional housing programs however; a maximum length of stay is not prescribed. Length of stay information has not been collected for AJW, MSPL or the safe havens.

Community Housing Associates, Inc. (CHA) provided a total of 256 units of housing for fiscal year 2007. Shelter plus Care units are subsidized with HUD Supportive Housing Dollars and are targeted for homeless individuals.

Services	Total Units	New 2007 tenants
Shelter + Care	211	25
CHA	45	12
Total	256	37

Objective 1C: Ensure that a wide range of services is available and accessible to elderly individuals with a psychiatric disability.

- Strategies:
1. Maintain and monitor two programs that provide mobile psychiatric assessment and treatment for elderly individuals with mental illness.
 2. Facilitate the discharge and transition of elderly residents from State hospitals to community placement through consultation, training and after-care coordination.

- Indicators:
1. Number of individuals receiving in home clinical treatment.

2. Number of elderly individuals discharged from State Hospitals to nursing home or assisted living.
3. Number of consultations provided to nursing home and assisted living providers.

Progress: This objective was accomplished.

BMHS provides funding for two programs that provide mobile psychiatric assessment and treatment for elderly individuals with mental illness: the Psycho-Geriatric Assessment & Treatment in City Housing (PATCH) program with teams located at Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, and the Senior Outreach Service (SOS) program of the University of Maryland Medical System. The PATCH program serves residents of public housing while the SOS program serves any Baltimore City resident not living in one of the 17 City Senior Housing Buildings. Both programs have the flexibility to see a client as frequently or infrequently as is clinically appropriate and there is no time limit on maintaining an active case. Some clients who are homebound may be seen as infrequently as every 3 months for medication management; most are seen at least monthly. Most clients do not meet the definition of Priority Population as defined by MHA and therefore the programs are not licensed as mobile treatment or ACT providers. Staffing requirements are less intensive in comparison to mobile treatment and ACT teams; thus they are significantly less costly than a COMAR-regulated team. This year the PATCH program model was identified by Dartmouth and SAMSHA as an evidence based practice (EBP) and is being included in their toolkit for geriatric practice. This fiscal year PATCH served 61 new clients and SOS served 51 new clients.

The BMHS Nursing Home Aftercare Coordinator continues to facilitate the transition of elderly individuals from State Hospital facilities to community placements in nursing homes and an increasing number of assisted living facilities. In addition, there have been more frequent requests from Adult Medical Day Care Centers (5) which serve these individuals to provide consultation and training. The services of the Nursing Home Aftercare Coordinator are statewide. Since 2001, Baltimore City, Baltimore County, and Anne Arundel County account for the majority of the consumers who have transitioned from State Hospital to community, 46%, 22%, and 18% respectively. In FY 2007 there were 17 individuals placed with the following distribution: 10 Baltimore City, 4 Baltimore County, and 3 Anne Arundel County.

Individuals received a minimum of once monthly face-to-face consultation within the first year of placement. Consumers placed for more than one year received a minimum of bimonthly consultation; while those placed longer than two years received at least quarterly consultation, depending upon the individual's presenting needs. Facilities where clients are placed receive formal and informal training on issues of behavioral management, stress management, psychopharmacological management and therapeutic environmental interventions.

Over the last several years, there has been an increase in the number of individuals with comorbid medical and psychiatric conditions, which has resulted in their movement among multiple care settings: nursing homes, acute care hospitals and assisted living facilities. This

increase in co-morbidity requires substantial effort not only to track the individual, but to provide ongoing monitoring and communication among agencies and family networks to facilitate stabilization. This trend was also observed in FY07 with 30% experiencing instability requiring one or more re-locations. Face-to-face and telephone consultation for these consumers is extensive with multiple contacts per day or per week as opposed to the monthly, bimonthly or quarterly consultation provided to more stable consumers. A positive trend includes a smaller number of patients who have moved from nursing home placements to community placements including residing with their families.

FY	State Hospitals Transfers to Community	Rehospitalized	Died	Moved Among Care Settings
'01	26	7%	16%	19%
'02	32	6%	13%	34%
'03	17	6%	0%	18%
'04	18	0%	5%	21%
'05	19	5%	11%	16%
'06	22	5%	5%	10%
'07	17	0%	18%	29%

Objective 1D: Maintain collaboration with MHA to ensure that individuals with Traumatic Brain Injury are served in the least restrictive environment.

Strategy: 1. Facilitate the utilization of community placements for persons with TBI

Indicators: 1. Maximum use of TBI waiver placements
 2. 90% utilization of available community placements for persons with TBI

Progress: This objective was accomplished.

Baltimore Mental Health Systems collaborates with MHA and Mary T Md. to facilitate community placements of persons with TBI from State Hospital facilities. A MHA grant currently serves seven clients who are not eligible for the Medicaid waiver. In FY'07, two clients obtained the waiver and were discharged from the grant. One has had to return temporarily to grant due to a Social Security back payment which put him above the financial resource limit allowed by waiver. Baltimore Mental Health Systems is in regular contact with the program, Mary T. Md., and Mental Hygiene Administration Special Populations Director to monitor the process. All new referrals come to Baltimore Mental Health Systems and Mary T., through and with the approval, of Mental Hygiene Administration. The grant has served 100% of those individuals approved by Mental Hygiene Administration.

Currently the program is serving six individuals and is working with one additional individual to transition to the community program. Three new clients were admitted to the program. Two have converted to the waiver; the third admission is also expected to convert to the waiver.

CHILD & ADOLESCENT SERVICES DIVISION

Objective 1E: Ensure the availability of a wide range of mental health services to children 0 - 6 and their families.

- Strategies:
1. Maintain collaborative relationship with Baltimore City Head Start to support the availability of mental health clinicians in selected Head Start centers.
 2. Contract with selected providers to offer a full array of early childhood mental health services on site at selected Head Start programs and a Judith P. Hoyer Early Childhood Center.
 3. Explore alternate funding strategies, including private foundation funding and possible alternate methods of reimbursement through the Public Mental Health System, to support the full array of early childhood mental health services.

- Indicators:
1. Number of Head Start Centers served and number of different providers receiving contracts to provide early childhood services in Head Start Centers.
 2. The number of children/families served by and/or consultations provided by clinicians in Head Start Centers, and in other early childhood programs (i.e. Judy Center) that receive BMHS funding.
 3. List of private foundations providing funding, and progress on other alternative funding methods.

Progress: This objective was accomplished.

BMHS continued its long-standing collaborative relationship with Baltimore City Head Start to provide early childhood mental health services to Head Start children and families. In FY07 the number of Head Start programs participating in the project increased from 12 to 13 with nine of the programs having the services of a mental health clinician on a full-time basis and four on a half-time basis.

The following chart reflects the range and amount of services delivered at the Head Start Centers:

ACTIVITY	FY07 Total
Referrals received	240
Children receiving early childhood clinical services	222
Child Prevention Activities	209
Classroom Observations	501
Family Consultations	
<ul style="list-style-type: none"> • Total (Child behavior/mental health) 	277
<ul style="list-style-type: none"> • Of the above, the number of children who received 3 or more (child behavior/mental health) 	23
<ul style="list-style-type: none"> • Other 	53
Family workshops/Groups	69
Staff Consultations	
<ul style="list-style-type: none"> • Total (Child behavior/mental health) 	776
<ul style="list-style-type: none"> • Of the above, the number of children who received 3 or more (Child behavior/mental health) 	73
<ul style="list-style-type: none"> • Other 	362
Staff Development sessions	26
Program meetings	236
Number of children discussed at program meetings	61

In addition to these services in collaboration with Head Start, Early Childhood Mental Health Services are also available at the Judy Center and at a Baltimore City Homeless Shelter. The Early Childhood Mental Health clinician at the Judy Center has provided 644 consultations and the clinician serving homeless children and families at a Baltimore City Shelter provided 224 consultations.

Early in FY07, BMHS had meetings with the Strauss and Blaustein Foundations to request funding for a pilot project to promote social emotional wellness in Head Start. Collaborative funding was secured from those two foundations to support The Baltimore City Head Start Enhancement Project, designed to support full implementation of the Positive Behavior Support (PBS) modules within one Head Start site. PBS provides a systematic approach to the promotion of appropriate behavior and the prevention of problem behavior. The model focuses on the instruction of social skills, the adoption of evidence-based practices within the classroom, and the use of data to understand issues related to problem behavior. The Krieger Fund had expressed interest in funding a second Baltimore City Head Start Enhancement Project in FY09 if partnership funding can be obtained. BMHS will continue pursuing partnership funding sources in FY08.

Objective 1F: Ensure the availability of mental health prevention and treatment services in selected Baltimore City Public Schools.

- Strategies:
1. Maintain the collaborative partnership with Baltimore City Public School System (BCPSS) to facilitate the accessibility of quality school-based mental health services and to maintain collaborative funding.
 2. Monitor the growth of providers new to the expanded school mental health services network.
- Indicators:
1. Number of schools with a school-based clinician; number of children, adolescents served by school-based clinicians and positive outcomes of the intervention.
 2. Number of additional schools served by school-based mental health providers for the first time in FY07.

Progress: This objective was accomplished.

During the 2006-2007 school year, mental health clinicians were assigned to 117 Baltimore City schools. FY07 data indicate that 5,161 unduplicated students received expanded school mental health services during the 2006-2007 school year, which is consistent with the 5,000 served in FY06. Three of the provider agencies that had participated in the Expanded School Mental Health (ESMH) services network in FY06 found it financially unfeasible to continue participation in FY07; one of those agencies discontinued all Outpatient Mental Health Center services. On the other hand, two schools that were proposed for state takeover received ESMH services for the first time in FY07. Outcome data for students seen four or more times, demonstrate the impact of ESMH services in the following areas:

- 83% attended school 90-plus % of school days after beginning services
- 95% did not receive any long-term suspensions after beginning services
- 94% did not get referred to the Child Study Team (which assesses for involvement in special education services) related to behavioral concerns.

The above indicators related to school attendance, suspensions, and inappropriate over utilization of the special education system were chosen at the request of the Baltimore City Public School System.

Given the reality that contract funding to support ESMH services has decreased since FY02, while the number of schools served has increased, many of the participating provider agencies had clearly indicated the need for additional funding to sustain the past level of service.

The chart below provides information on the percent change in contract funding and in number of schools served as compared to FY01 levels:

	FY01	FY02	FY03	FY04	FY05	FY 06
Total contract funding:	2,793,090	3,124,346	2,749,346	2,503,436	2,374,476	2,374,476
% change in funding		+12%	-2%	-10%	-15%	-15%
Number of schools	79	84	83	91	109	122
% change in number of schools		+6%	+5%	+15%	+38%	+54%

As a result of active advocacy efforts, for the first time in FY07 supplemental funding was allocated by the City of Baltimore to support Expanded School Mental Health services. This supplemental funding was provided to support ESMH services in schools that met one or more of the following criteria: 1) schools proposed for state takeover; 2) schools previously served by provider agencies that withdrew from participation in the ESMH network; and 3) schools previously served by provider agencies reliant solely on fee-for-service reimbursement. Unfortunately, this supplemental funding did not become available until the second quarter, resulting in some discontinuity in service provision. In an effort to reach out to all schools, including those that did not have an Expanded School Mental Health clinician on-site, some of the Baltimore City funding was allocated to establish a website (www.schoolmentalhealth.org) and to provide technical assistance via telephone. These resources were developed to assist educators, administrators, guidance counselors, and school social workers and psychologists in better meeting the emotional and behavioral needs of Baltimore City students.

The development of uniform standards for school based mental health services was initiated during the 2006-2007 school year. These standards established parameters for non-reimbursable mental health services in all participating schools, with 0.3 FTE as the minimum required staffing level. Service standards include quantifiable deliverables for group prevention activities for students, school staff/teacher consultations, in-service presentations for school staff, and school team/committee participation.

During FY07, an ESMH Services Advisory Committee was established, bringing together a variety of stakeholders. The activities of this committee promoted an increased awareness and understanding of various key issues such as funding strategies, policy development, and monitoring and accountability. A subcommittee comprised of representation from BMHS, the Baltimore City Public School System, the Family League of Baltimore City, and the Baltimore City Health Department developed a Request for Proposal (RFP) to assure an open process for determining which schools would receive ESMH services in FY08, and which licensed mental health agencies would be approved to participate in the ESMH provider network. Ninety-eight (98) schools partnered with provider agencies to submit a proposal requesting ESMH services for the 2007-2008 school year. Regrettably, no new funding was identified prior to this process; therefore only a limited number of proposals could be approved for funding to support a full-time clinician. As of the end of FY07, it appears that \$383,000 in supplemental funding will be

designated by Baltimore City to support ESMH services during the 2007-08 school year. With the addition of this funding, all 98 schools that participated in the RFP process will receive ESMH services at a minimum of the half-time (0.5 FTE) staffing level.

Objective 1G: Ensure the availability of a range of mental health services to transitional age youth/young adults ages 14 – 23

- Strategies:
1. Maintain the specialized Transition Age Youth (TAY) program funding capacity to serve 20 youth.
 2. Provide resource coordination and purchase of care support to children/families with needs that cannot be readily met through the fee-for-service system.

- Indicators:
1. Number of individuals served through the specialized TAY program.
 2. Number of individuals served through resource coordination and/or purchase of care.

Progress: This objective was accomplished.

The MHA Initiative for Transition Age Youth (TAY) in Baltimore City was awarded to People Encouraging People (PEP) several years ago. PEP serves 20 young adults between the ages of 18 and 23, who have serious and persistent mental illness (SPMI). Twelve of the TAY consumers are served by targeted case management and the other eight are served by Residential Rehabilitation Program (RRP), for a total of 20 transition age youth served. Beginning in FY07, the options of reducing DHMH grant funding and instead using the MHA and Medicaid funded Residential Rehabilitation Program beds were implemented. The residential program serves 6 males and 2 females in 4 two-bedroom apartments. Priority for referrals is given to those currently in Residential Treatment Centers or State Hospitals who are transitioning from child to adult services.

Another Baltimore City program, Harbor City Unlimited (HCU), has 6 RRP beds dedicated to this same age group. All beds are for male consumers. Both PEP and HCU receive grants from BMHS to assist with non-fee-for-service activities. All consumers are linked to mental health treatment, benefits, and either educational or vocational training. The PEP program maintains some flexible funding for purchase of other essentials.

Child and Adolescence Resource Coordinators continued to provide early identification of youth who may be eligible for specialized TAY program funding. During FY07, 12 of the youth served through the TAY program were identified by the BMHS C&A Resource Coordinator in collaboration with other child-serving systems through the Local Coordinating Council process, which reviews cases and makes recommendations for high-need children and adolescents.

Objective 1H: Ensure the availability of a psychiatric crisis response system for children and adolescents in psychiatric crisis, as an alternative to emergency room usage / psychiatric hospitalization.

Strategies: 1. Support the ability of the Baltimore Child and Adolescent Response System (BCARS) to serve more children and families by seeking increased funding; having the ASO involve BCARS in pre-admission screening of requests for inpatient admissions for children and adolescents to assure that alternatives to inpatient services have been considered; and increasing B-CARS role in offering step-down services to reduce the total number of in-patient bed-nights.

2. Monitor capacity of and services provided by BCARS

Indicators: 1. Report on progress / barriers to implementing the expansion of the child and adolescent crisis service. Number of any additional hours that a crisis response service is available.

2. Number of children and adolescents served.

Progress: This objective was not accomplished; future work will be on-going.

B-CARS experienced significant challenges in recruitment of qualified clinicians for the Child Mobile Crisis Teams in FY07. This difficulty in maintaining a full complement of Mobile Crisis Team staff was due to the intense nature of the service resulting in staff turnover; and the declining workforce trained for intensive community-based therapeutic services, resulting in increased competition for these individuals. During FY07, Villa Maria Continuum, the BCARS sponsoring agency, partially addressed the problem by using temporary agency employees to fill vacancies until full-time employees were hired.

Fiscal Year	Crisis Hotline requests	Number of Children / Families Served
2006	1,051	599
2007	1,375	535

Toward the end of FY07, BCARS was able to fill some Child Mobile Crisis Team positions after adjusting the salaries of clinical staff to facilitate recruitment. Additionally, Villa Maria and B-CARS administrative staff members are engaged in an on-going process to re-tool the B-CARS service delivery model to be more manageable and efficient, and support staff retention moving forward.

Objective 1I: Ensure the availability of trauma response services to children and families impacted by exposure to violence.

Strategies: 1. Continue to provide funding for the Child Development Community Policing Program (CDCP), to ensure that the mental health needs of

children and families that have been impacted by violence will be promptly addressed.

2. Monitor the capacity of and services provided by CDCP with the current funding level.

- Indicators:
1. Number of hours trauma response services are available.
 2. Number of staff available to provide trauma response services.
 3. Number of children and adolescents served.
 4. Monitor any requests for services that cannot be met due to CDCP's capacity to provide services.

Progress: This objective was accomplished.

The Child Development Community Policing Program (CDCP), which is operated by the East Baltimore Mental Health Partnership, is staffed by 3 team members: one licensed mental health professional and two community coordinators/trainers. CDCP works closely with the Baltimore City Police Department to respond promptly to situations in which someone under the age of 18 has been the victim of or witness to violence. The Trauma Response team is available daily from 8am to 6pm, and can be accessed after hours through an on-call pager system, for next day follow-up. During FY07, CDCP provided trauma responses for 343 situations that involved children or adolescents. Following the initial trauma response contact, parents of 317 children and adolescents agreed to follow-up intervention for their children. The chart below provides composite information about the CDCP trauma responses during FY07:

TYPE OF VIOLENT EVENT	FY07 # OF TRAUMA RESPONSES
<ul style="list-style-type: none"> • Community Violence 	331
<ul style="list-style-type: none"> • Domestic Violence 	4
<ul style="list-style-type: none"> • Other 	8

In addition to trauma response, CDCP provides a variety of training opportunities to mental health professionals, police staff, and community members. In FY07, the Police commissioner, Leonard Hamm, created a new unit within the Baltimore City Police Department to look more closely at youth violence and the number of youth involved in community violence. CDCP trained at least one designated Youth Services Officer from each of the city's 9 districts around issues relating to youth and mental health.

The following chart provides information on the training provided by CDCP during FY07:

TRAINING	YTD NUMBER OF TRAINING OPPORTUNITIES	YTD TOTAL PARTICIPANTS
3-Day Fellows Training (Designed to train police, mental health professionals, and community members to be part of the trauma response team)	3	42
Trauma Training with Youth Services Officers	1	18
Community Forum	3	601

Goal #2: Collaborate with other agencies to promote coordination of care.

ADULT SERVICES

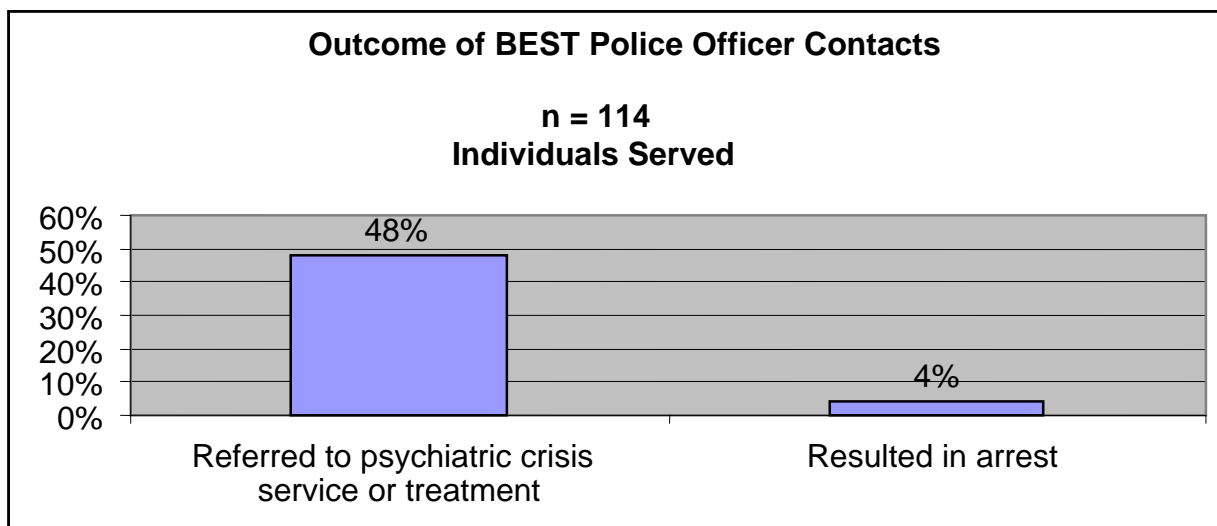
Objective 2A: Ensure that a wide range of mental health services is available to individuals involved in the criminal justice system.

- Strategies:
1. Increase the number of Baltimore City Police Department Officers, Downtown Partnership Safety Guides, and Baltimore City Sheriff Deputies trained as BEST officers.
 2. Ensure that 30% of individuals referred to FAST are assisted through Mental Health Court or FAST services.
 3. Work with Patuxent Institution to assist in development of a community plan for eleven defendants leaving its Mental Health or Transition units.
 4. Work with hospital social work staff to review and refer those individuals with forensic histories to appropriate residential rehabilitation programs.

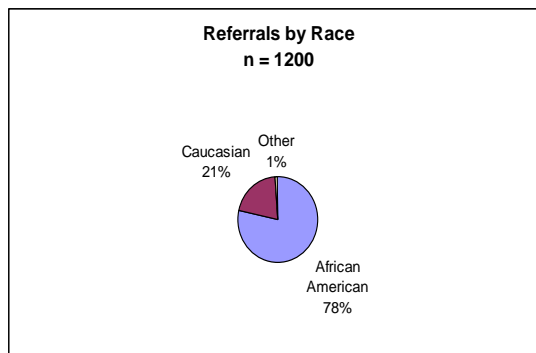
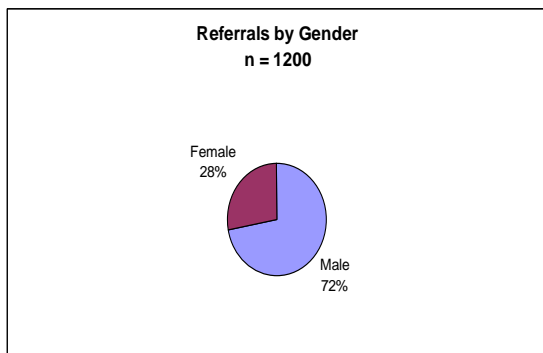
- Indicators:
1. Number of law enforcement personnel trained through the BEST initiative.
 2. Percentage of individuals referred to Mental Health Court or diverted from incarceration through FAST intervention.
 3. Number of Patuxent Initiative individuals with developed community plan.
 4. Number of individuals with forensic histories placed in residential rehabilitation programs.

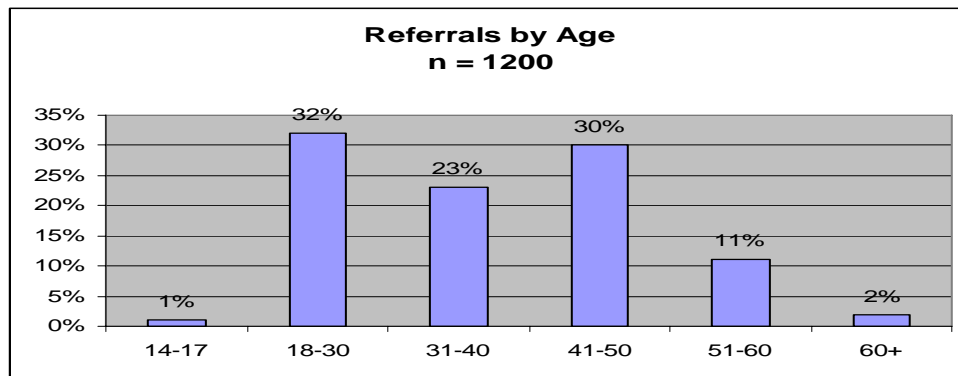
Progress: This objective was accomplished.

This year BMHS increased the number of Baltimore City Police Department Officers trained as BEST officers. Last fiscal year the BEST program trained 52 Baltimore City Police Officers; this year the BEST Program trained 86.



The FAST program continued to ensure that a wide variety of mental health services were available to individuals involved in the criminal justice system. The program processed 1,200 referrals, provided assistance to private citizens with emergency petitions, monitored defendants that were diverted from incarceration, and provided additional FAST services as needed.





Although the reporting measures implemented by the FAST program could not capture the total number of individuals referred to mental health court or diverted from incarceration through FAST intervention, 33% of all requests received some level of service. BMHS has been working with the program to better capture referral disposition data. The following chart reflects the range of services delivered:

ACTIVITY	FY07 TOTAL
Referrals received	1,200
Number of defendants placed and monitored that were diverted from incarceration	58
Additional services such as medication referrals, treatment plans, and competency evaluation requests	233
Number of emergency petitions processed	148

During this fiscal year, BMHS received 11 referrals for the Patuxent Initiative. Case managers were identified for all referred individuals to develop and implement a community transition plan. Of the eleven individuals referred, 7 have been successfully placed in the community.

BMHS receives Residential Rehabilitation Program (RRP) applications from state hospital facilities for consumers with forensic histories on a regular basis. The majority of individuals referred have been deemed Not Criminally Responsible or NCR. In recent years, BMHS has received an increasing number of clients that have been deemed Incompetent to Stand Trial or IST. Individuals with forensic involvement are referred to RRP for the structure and staff oversight, as well as the rehabilitation needs. All of Baltimore City’s 8 RRP have reviewed, accepted and placed persons on conditional release. In addition to the aforementioned consumers, RRP have been coordinating treatment planning and service delivery with Mental Health Court, the Forensic Alternative Services Team and probation or parole agents with increasing frequency.

During FY ‘07, forty-two (42) consumers were placed in RRP altogether. Of these, 10 were released with a forensic status from a state hospital facility: 2 IST and 8 NCR.

In addition to the above services for individuals involved in the criminal justice system, BMHS in collaboration with the women judges in Baltimore City, MHA’s Division of Special Populations and Department of Public Safety, awarded an RFP to Chrysalis House to start the

Women’s Transitional Center in April of this year. The program is funded through money from the Department of Public Safety that was originally used for the TAMAR Children’s project. The Chrysalis House Healthy Start program will identify pregnant women in the jails throughout the state. The client will be discharged to the program instead of being incarcerated. The goal of the program is to improve birth outcomes, increase bonding and reduce recidivism. The program became operational in May of 2007, and the first client was admitted in August.

Objective 2B: Collaborate with Baltimore Homeless Services (BHS) to provide services to homeless individuals.

- Strategies:
1. Acquire and monitor funding for mental health services to homeless persons.
 2. Coordinate with BHS, mental health service providers and the Rise Again Project to provide mental health outreach services to engage homeless consumers and refer them to the appropriate services.
 3. Maintain a current list of trained volunteers to provide services during Code Blue events.

- Indicators:
1. Amount of funding available for homeless services.
 2. Number of persons identified and number linked to services/housing
 3. Number of volunteers participating in Code Blue events.

Progress: This objective was accomplished.

BMHS continues to receive funding for homeless services at the same level as prior years to support BMHS staff and service delivery at the program level.

Source of Funding	Amount
Projects for Assistance in Transition from Homelessness (PATH)	\$206,248
Housing and Urban Development (HUD)	\$1,989,701
Total	\$2,195,949

Renewals for both funding sources were obtained in a timely manner. Both HUD and PATH conducted site visits during this fiscal year to BMHS and the contracted service providers. PATH recognized Healthcare for the Homeless’ SSI project as a best practice during this site visit.

HUD funding supports three mental health outreach teams, two safe havens, one consumer-run drop-in center, and 1 SSI outreach project, as follows:

FY 07 BMHS HUD Supported Program Activity		
Grantee	Amount of Funding	Number of clients served on last Annual Progress Report for HUD
Bon Secours	\$369,600	136
Ethel Elan Safe Haven	\$392,200	36
Helping Other People through Empowerment	\$251,783	762
Johns Hopkins Hospital	\$227,567	140
People Encouraging People	\$247,453	179
University of Maryland Safe Haven	\$341,498	63
University of Maryland SSI Project	\$159,600	213
Total	\$1,989,701	1529

PATH funding was distributed to four local programs: University of Maryland Medical System Case Management Program, Health Care for the Homeless (HCH), People Encouraging People Case Management Program (PEP), and TAMAR’s Community Project. Following frequent consultation with MHA’s Office of Special Populations, the award to Tamar’s Community Project was terminated early due to poor performance. PEP’s program was designed to provide support for individuals referred by TAMAR’s Community Project. PEP elected to terminate their services due to TAMAR’s difficulty identifying clients. The remaining funds were reallocated in the fourth quarter to Prisoner’s Aid in support of the newly developed Women’s Transitional Center. Each PATH grantee was responsible for completing quarterly and annual reports.

FY 07 PATH-Supported Program Activity	
BMHS	84 grants and 4 loans to individuals moving from homelessness into permanent housing
Chrysalis House	3 referrals screened with 1 woman receiving transitional services 50 clients received outreach services
Healthcare for the Homeless Outreach	720 outreach contacts to homeless men and women
Healthcare for the Homeless SSI project	60 individuals assisted with applying for Social Security benefits
People Encouraging People	11 women received case management services
TAMAR Community Project	62 homeless women received outreach and case management
University of Maryland Outreach	20 individuals received outreach services

Collaboration between BMHS, Baltimore Homeless Services (BHS) and Rise Again continued during this fiscal year. Several meetings were held with BHS to advocate for increased outreach coverage and better collaboration. For the last several years, BMHS’ mental health outreach teams significantly outnumbered the two staff on the Rise Again team. BHS experienced difficulty monitoring their Rise Again outreach workers and as a result reallocated the funding for outreach to Baltimore Healthcare Access (BHCA) at the end of this fiscal year. The goal continues to be to provide a means for providing outreach and linkages to services for homeless individuals in a coordinated manner. The vehicle to achieving this goal is Hands in Partnership

(HIP), the collaborative effort among homeless service providers coordinated by BMHS with the following participants: Downtown Partnership, Health Care for the Homeless, Baltimore Crisis Response and the Baltimore City Police Department.

BHCA and BHS are now partnering with BMHS to provide leadership for the HIP meetings and expand membership to include outreach workers from other homeless service organizations in the city. This group has increased its meetings from twice a month to weekly. The Supervisors of the line staff and other homeless service program administrators also meet monthly. The meetings are used as a place to coordinate schedules, monitor client progress, develop strategies, conduct trainings, and provide a means of support to each other.

HIP will also be working closely with the SAMHSA-funded Housing First Program in fiscal year '08 to coordinate client identification. In FY 07 BMHS collaborated with the Baltimore City Health Department, BHS, Baltimore Substance Abuse Systems, and Health Care for the Homeless (HCH) to expand access to the Housing First program. Through BHS, HCH was awarded a SAMHSA grant to expand upon their pilot housing first project. BMHS, through Community Housing Associates (CHA) has dedicated ten Shelter Plus Care certificates to the Housing First project and is providing technical assistance on the assertive community treatment model to HCH. To date, six clients have been housed in this expansion project. All six clients are housed through CHA Shelter Plus Care subsidies and are receiving ACT services through the public mental health system.

HOPE drop-in center, which serves the homeless mentally ill population, is a HIP member. It is a place for daytime shelter, connect to an outreach/case manager, as well as other services, have a snack, shower and do laundry. There are several social and education activities scheduled each month. This past fiscal year an average of 102 members utilized the center. The total attendance this past year was 1,152.

Two other HIP provider agency members, The Ethel Elan Safe Haven, which has 19 beds and University of Maryland's Safe Haven, which has 20 beds, served 33 and 55 individuals respectively.

The Johns Hopkins Hospital Case Management Program and Baltimore Crisis Response, Inc. provided training to Downtown Partnership's new safety guides. A total of 11 guides were given training on mental illness, how to identify possible mentally ill homeless persons, and what agencies in Baltimore city to contact for assistance.

Homeless Stat, which was a meeting held by BHS quarterly to provide them with homeless data, was put on hold until further notice. These meetings were attended by various city agencies, as well as the two Safe Havens, mental health outreach program directors and BMHS. These same individuals continue to receive ROSIE HMIS training and to attend HMIS user group meetings sponsored by BHS to ensure compliance with citywide data collection.

During FY'07, BMHS was responsible for coordinating the availability of trained mental health professionals to provide services at the Cold Weather Shelter on evenings that were designated as being "Code Blue," or a winter weather emergency, by the Baltimore City Health Department.

Services included counseling, referral to appropriate community resources, Emergency Petitions as necessary, and referral to Baltimore Crisis Response, Inc. for urgent care services. BMHS conducted a one-on-one training with all new volunteers. Volunteers who had previously received training were briefed on updated procedures.

Mental health professionals were recruited to volunteer for the Cold Weather Shelter through mass emails to providers, announcements at meetings, and a posting on the BMHS website. In total, 27 individuals responded to the request for volunteers. The contact information for these individuals was maintained on the Code Blue Mental Health Professional Code Blue List. Throughout the Code Blue season, these individuals were scheduled weeks in advance to be on-call for a particular evening. Once BMHS was notified of a Code Blue emergency, the worker was contacted.

BMHS scheduled mental health professionals to be on-call for 134 evenings during the FY'07 Code Blue season. The Health Department designated 67 evenings as being Code Blue and volunteers were provided by BMHS for 64 evenings. During this time, a duplicated number of 249 individuals were seen by a Mental Health Professional at the shelter. Individuals seen on repeated occasions by a mental health professional were referred to outreach workers for engagement and linkage to case management services. Mental health professionals referred 51 individuals to BCRI for urgent care assessment.

Objective 2C: Continue to provide leadership through the provision of training to community organizations that interact with individuals experiencing psychiatric emergencies.

- Strategies:
1. Collaborate with the Baltimore Police Department (BPD), Baltimore City Sheriff's Department, Downtown Partnership Safety Guides, NAMI, BCRI, and hospital emergency departments to ensure that the BEST program is operational.
 2. Work with the Baltimore City hospital emergency rooms to ensure that they have agreements in place with all community resources, including but not limited to BCRI and those Outpatient Mental Health Clinics with the capacity to provide urgent care.

- Indicators:
1. The number of training sessions provided and number of law enforcement personnel trained.
 2. Number of agreements in place.

Progress: This objective was accomplished.

This year BMHS continued to provide leadership to the BEST program and help facilitate four training sessions in which 86 Baltimore City Police Officers attended.

Ongoing collaboration continues with the Baltimore City Police Department (BCPD), Baltimore City’s Sheriff Department, Downtown Partnership, NAMI, BCRI, BSAS, and B-CARS to ensure that the BEST program is operational. Training Committee Meetings and TASK Force Meetings were held throughout the fiscal year. Additionally, the BCPD, BCRI, NAMI, and B-CARS participated in the development and implementation of the training curriculum. BCRI continued to provide real-time consultation and collaboration with Baltimore City Police officers on a routine basis. BCRI staff, NAMI, and the BCD BEST Coordinator participated in the 2nd annual Crisis Intervention Team conference as presenters. Match funding was secured for the \$100,000 Stuhlman award that supports the BEST activities for calendar year 2007. In addition, The Weinberg Foundation has given its approval to award an additional \$100,000 to the BEST project for calendar year 2008.

The BCPD BEST Coordinator was very active this year. Her accomplishments are listed below:

- educated 4 agencies/groups about the BEST project,
- presented the BEST project at 16 community meetings,
- assisted numerous community based agencies with emergency petition process
- provided assistance to the Mental Health Court, and
- implemented a plan to investigate repeat calls from individuals suffering a mental health crisis.

BCRI has shared service agreements with 13 facilities as outlined below. BMHS began contacting non-hospital based outpatient mental health clinics in the city to discuss the statewide hospital diversion initiative in order to better determine barriers to clients receiving follow up appointments in a timely manner. OMHCs have expressed concern about no-show rates for this population. This issue will be explored further when the diversion project begins in the fall.

BCRI Shared Service Agreements
Bon Secours Hospital
Gaudenzia
Harbor Hospital
Harford-Belair Community Health Center
Health Education Resource Organization, Inc. (HERO)
Helix Health, Inc.
Johns Hopkins Bayview Community Psychiatry Program (JHBCPP)
Johns Hopkins Community Psychiatry Program
Johns Hopkins Hospital Community Psychiatry Program
Johns Hopkins Hospital Program for Alcoholism and Other Drug Dependencies
Maryland General Hospital
Sinai Hospital of Baltimore
Total Health Care, Inc.

Objective 2D: Maintain a disaster preparedness response in coordination with City and State agencies.

- Strategies:
1. Coordinate and maintain a Disaster Mental Health Professional Corps of licensed individuals to respond in the event of an emergency in Baltimore City.
 2. Create a mental health plan for Baltimore Mental Health Systems, Inc. in coordination with the Baltimore City Health Department.
 3. Provide disaster related training for the Disaster Mental Health Professional Corps as well as BMHS staff.
- Indicators:
1. Number of mental health professionals on the Disaster Mental Health Corps
 2. A completed mental health disaster plan.
 3. Number of trainings held for staff and corps.

Progress: This objective was accomplished.

As specified in the Baltimore City Mental Health Disaster Plan, it is required that Baltimore Mental Health Systems, Inc., coordinate a team of mental health professionals to respond to disasters on a city and statewide level. BMHS is responsible for ensuring that all individuals on this Disaster Mental Health Corps attend any state or city mandated trainings.

The Baltimore City Mental Health Disaster Plan was completed and submitted to the Baltimore City Health Department as well as the Department of Health and Mental Hygiene on the required date of July 1, 2006. The BMHS Disaster Coordinator met with the DHMH Director of Behavioral Health Disaster Services to discuss the plan on January 24, 2007. The plan was approved during this meeting and has been updated throughout the fiscal year.

BMHS has coordinated, maintained and called upon the services of the Disaster Mental Health Professional Corps throughout the fiscal year. A list of mental health professionals who have volunteered to be in the corps is kept in the Baltimore City Mental Health Disaster Plan as well as a database on the BMHS network. Individuals have been recruited for the Corps through mass emails to providers, announcements at various meetings and participation in Code Blue events. To date, fifty-six mental health professionals have volunteered to provide services in the event of a disaster.

In FY'07, the BMHS Disaster Mental Health Professional Corps was called upon by DHMH to provide services at BWI Thurgood Marshall Airport for American citizens who were evacuated from Lebanon during the conflict between Hezbollah and Israel. Services available at the airport included counseling, referral to local resources and support for other volunteers and workers. Fifteen members of the BMHS Disaster Mental Health Corps responded to the need for

volunteers and at least two members of the corps were present at each flight throughout the four days that DHMH requested services. In addition to scheduling volunteers and coordinating mental health services from Baltimore City, the BMHS Disaster Coordinator worked closely with the DHMH Director of Behavioral Health Disaster Services to secure and distribute informational brochures.

In compliance with DHMH requirements, BMHS held a National Incident Management System (NIMS) training for BMHS staff as well as the Disaster Mental Health Professional Corps participants on July 12, 2007. This training included incident management, standard command and management structures, and mutual aid and resource management. Thirty-six individuals attended the five-hour training: 15 BMHS staff, 12 volunteer and nine BCRI staff. The BMHS Disaster Coordinator is in the process of scheduling another NIMS training for Baltimore City.

In addition, the BMHS Disaster Coordinator has aided in the planning of several disaster-related trainings for DHMH facilities during FY'07. These trainings include the topics of Quarantine and Isolation, Triage and Treatment, NIMS, and Pandemic Flu.

Objective 2E: Assist State Hospital Centers and other institutions to transition individuals, or individuals to secure and maintain residence in Baltimore City by offering a variety of housing options.

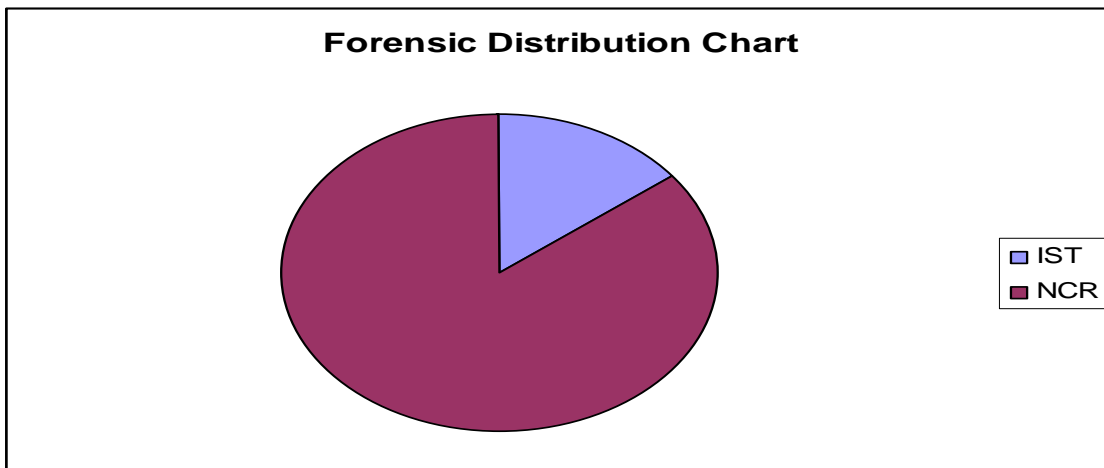
- Strategies:
1. Continue to work with the 8 Baltimore City Residential Rehabilitation Programs (RRPs) to streamline the referral and placement process and maintain a 95 % level of occupancy.
 2. Collaborate with State Hospital Centers to maximize referrals to a wide range of community programs including but not limited to the Baltimore Capitation project and the newly established FACTT initiative.

- Indicators:
1. Number of State Hospital referrals
 2. Number placed by housing option
 3. Occupancy Rate for RRP Programs

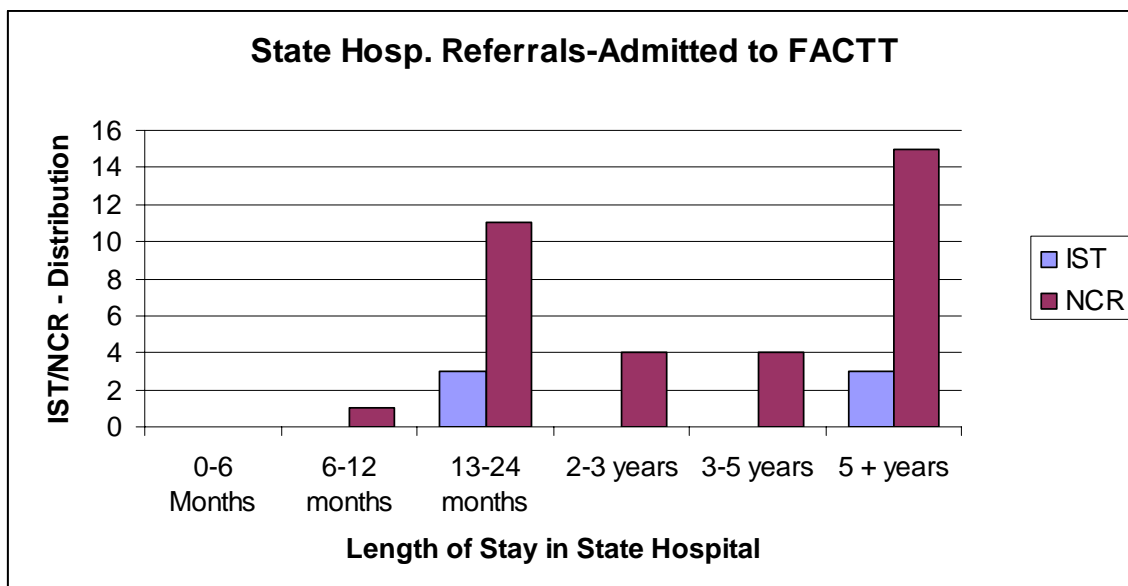
Progress: This objective was accomplished.

During FY 07 year, the Forensic Assertive Community Treatment Team (FACTT) operated by People Encouraging People, Inc. (PEP) admitted a total of 71 consumers with court involvement, with 41 being transitions from state hospital facilities. All state hospital referrals were screened through BMHS for eligibility prior to intake by the program. The condition of award from MHA stated a goal of ten consumers with a greater than six month of stay and a legal standing of either Incompetent to Stand Trial (IST) or Not Criminally Responsible (NCR). The actual number of consumers served was more than 4 times the initial goal.

The majority of individuals admitted into the FACTT program during FY07 had the legal standing of NCR. NCR rulings represented 35, or 85% of the total referrals. The remaining six, or 15%, represented those that were deemed to be IST.



Of the 41 total state hospital admits, almost half had a length of stay (LOS) in the state hospital of more than 5 years, and more than one-third had a LOS of 13-24 months.



This year the Capitation Project continued to assist state hospital facilities to transition individuals to the community and secure residence in Baltimore City. The project admitted 45 clients during FY07.

Referral Source	Number Admitted in the Capitation Project
Spring Grove Hospital Center	10
Springfield Hospital Center	6
Walter P. Carter Center	5
Community	24

All clients admitted from a state hospital facility had been residing in the facility for at least six consecutive months. This year 47% of the clients admitted to the project were transitioned from a state hospital. Housing placement was provided for all state hospital clients admitted to the Capitation Project.

BMHS has continued to maintain open communication with all eight of Baltimore City’s RRP’s. As it is a coveted service, the waiting lists have grown every year with an approximate wait time of two years for an intensive level placement. By the time a consumer comes to the top of the list, they may have other housing in place, cannot be found, or may not want the service any longer. The delays and time involved in determining continued appropriateness led BMHS staff to create a profile update tool that is sent to all referral sources for consumers that have been on the list for 6 months or longer. This has streamlined the waiting list and allowed for more efficient placement. Fifty-two new referrals were made to BMHS for RRP in FY’07 from state hospitals, and 42 clients were placed in RRP during FY’07.

BMHS staff has met regularly with state hospital staff to assure their access to the CSA. Trainings have occurred and more are scheduled for social work staff at state hospital facilities that refer for services in Baltimore City. BMHS staff are also deployed to the facilities to interview and make recommendations for patients that have had multiple failed attempts at community placement, or need multiple services in order to succeed in the community. BMHS staff are available at any time to consult with state hospital staff about individual cases and discuss other options.

It has been the longstanding expectation of the CSA that all RRP’s maintain a 90% occupancy rate. Because of the fee-for-service system, the RRP providers would prefer to maintain as close to 100% occupancy as possible to maximize billing. Given the turnover of consumers in the service, the exchange of new referral material and the need for transition visits, maintaining an occupancy rate in the 90%+ is appropriate and realistic. In FY’07 Baltimore City RRP’s were able to maintain an overall occupancy rate of 94%.

FY 07 RRP Occupancy Rate	
Alliance	86%
Glenmore	95%
Harbor City	92%
Harford-Belair	95%
Keypoint	94%
New Phases	94%
NBC	98%
PEP	97%
VOA	93%
Total	94%

CHILD & ADOLESCENT SERVICES DIVISION

Objective 2F: Collaborate with other child-serving systems, to better meet the mental health needs of children and adolescents in Baltimore city

- Strategies:
1. Participate in the Local Coordinating Council (LCC) to provide input on available mental health resources in the community and to offer alternatives to placement.
 2. Review Certificate of Need (CON) packets to assure that available community resources have been utilized including the expanded Child-Wrap-Around initiative.
 3. Participate in interagency projects such as Operation Safe Kids, to advise other child-serving systems about available mental health services

- Indicators:
1. Number of children and adolescents reviewed at LCC
 2. Number of CON packets reviewed and tally of recommendations.
 3. List of interagency initiatives that support at risk children and adolescents, in which BMHS participates.

Progress: This objective was accomplished.

BMHS continued its collaborative work with other child-serving agencies in order to assist in meeting the mental health needs of children and adolescents in Baltimore City. Many of these collaborative efforts, such as Early Childhood Mental Health with Baltimore City Head Start, and Expanded School Mental Health with the Baltimore City Public School System, as well as significant collaborative work with the Department of Juvenile Justice, are addressed elsewhere in the plan. BMHS regularly participated in Operation Safe Kids (OSK) meetings sponsored by the Baltimore City Health Department (BCHD) to provide additional resources and technical

assistance to meet the needs of identified, Baltimore City youth, who are committed to DJS; and in the Child Fatality Review Committee, also sponsored by BCHD. Additionally, BMHS provides perspective on the mental health and social/emotional needs of children and adolescents through regular participation in a variety of committees convened by the Family League of Baltimore City, including the Youth Development Committee, Family Support Strategy Committee, Young People Making Healthy Choices Committee, Children Successful In and Completing School Committee. Late in FY07 a Healthy Children – Healthy Bodies and Minds Committee was established, with the BMHS Child and Adolescent Director serving as co-chair along with a representative of the Baltimore City Health Department. This new committee has brought together representation from a diverse set of organizations that provide and/or oversee somatic care, mental health care, safe housing, public welfare, juvenile justice, and educational services. Using a results-based accountability framework, the Committee has been charged with identifying and monitoring indicators of child well-being (inclusive of both physical and mental health) for Baltimore City children and adolescents.

As an assigned member of the Local Coordinating Council, BMHS participated in the 465 scheduled reviews in FY07 to assure that all least restrictive community-based resources were considered before approval for a residential treatment center placement was recommended. The chart below identifies the types of reviews that occurred in FY07:

Type of Review	Number
Initial	172
Community Services Initiative (CSI) Assessment Results	45
Annual Review– Out-of-State Placement	44
CSI Bi-Annual Review	31
Re-determine eligibility	31
Discharge Planning / Review	24
Update	18
CSI Annual Review	17
Annual Review– In-State Placement	15
RTC to RTC Transfer	15
Request for CSI Services	10
Emergency	5
Voluntary Placement	4
Approval – Out-of-State Placement	3
CSI Extension Request	3
CSI Updates	2
Postponed and Cancelled Reviews	26
FY07 Total # LCC reviews scheduled	465

During FY07, the BMHS Child and Adolescent Division has continued to review the Certificate of Need (CON) packets to assure that all appropriate less restrictive, community-based resources had been exhausted prior to admission to a Residential Treatment Center (RTC). BMHS received a total of 99 CON packets. Of those received, 98 were appropriately placed in an RTC, 2 of which were for an out-of-state placement. One request was rejected due to a primary

medical condition, which made the client inappropriate for placement in an RTC. In addition to the CON packets reviewed, BMHS provided significant technical assistance and resource coordination for an additional 100 children and adolescents, whose families would have otherwise requested an RTC placement. These youth were served through a variety of programs and services including B-CARS, Intensive Family Preservation, Respite, and Mt. Claire House; as a result of these interventions, CON packets were never generated for those youth, and RTC placements were diverted.

BMHS continued its utilization of Client Support funding to assist child and adolescent consumers and their families in obtaining needed resources not reimbursed by fee-for-service. Two child and adolescent consumers were provided with medication during a time when the Medical Assistance coverage was not active. Transportation support was provided on 6 occasions to enable a parent to visit their child at an RTC and participate in family sessions. BMHS Resource Coordination staff has identified other resources for families so as to reserve the limited DHMH Client Support funding for last-resort situations. BMHS has connected families of children with mental health needs with the following initiatives to provide additional support for at-risk children and adolescents:

- Family League of Baltimore, GOC Flex Fund
- Family League of Baltimore, Baltimore Families First
- Helping Families Stay Together, Baltimore City DSS
- Maryland Coalition of Families for Children's Mental Health

Objective 2G: Work collaboratively with the Department of Juvenile Services (DJS) on the development and support of programs and services targeted to address the mental health needs of youth involved in the juvenile justice and court systems.

- Strategies:
1. Continue to provide technical assistance and resource coordination to youth and families appearing in Juvenile court.
 2. Oversee the provision of mental health assessments of post-adjudicated youth as requested by DJS or the judges / masters.
 3. In partnership with the Department of Juvenile Services, monitor the mental health provider responsible for mental health services at the reorganized detention center located on the campus of the Charles Hickey School, to assure that provider is meeting contractual deliverables.
 4. Continue to work collaboratively with the Department of Juvenile Services and MHA to provide services, through the Family Intervention Specialist (FIS) initiative, to youth returning to the community following detention.
 5. Work with DJS to determine if behavioral health services at the Baltimore City Justice Center should be contracted through BMHS.

- Indicators:
1. Numbers of children/families served in facility, community and court-based programs.
 2. Monitor the mental health services being provided on the grounds of Hickey through required reports and various meetings.

Progress: This objective was accomplished.

Both of BMHS's long term projects, LINKS and the Family Intervention Specialists, continued in FY07. The LINKS initiative served over 142 youth and their families at the time of their court appearance. The Project Coordinator has made tremendous efforts to assure families referred to LINKS receive assistance with accessing the program's recommended services. This goal was accomplished by having social work student interns provide home visits as well as providing transportation tokens when needed for families. Additionally, LINKS sponsored specialized support groups for males and for females and a parent support group at The Juvenile Justice Center. Through the Family Intervention Specialist Project seven (7) mental health professionals participated on aftercare teams with DJS staff and served 159 youth to support their successful return to the community.

Two projects, which began in FY06, have continued in FY07.

- The Court Medical Evaluation Team provided 513 mental health assessments for post adjudicated youth as requested by judges, masters, and DJS staff.
- FY07 was the start of a full year of contracting for mental health services for youth housed in detention within the juvenile justice system. Both detention centers serving Baltimore City youth, the Charles Hickey School and the Baltimore City Juvenile Justice Center (BCJJC), now have licensed mental health providers working within those facilities. BMHS manages these contracts, provides monitoring, and facilitates monthly oversight meetings, which include DJS staff as well as the identified provider for the site.

At the Charles Hickey School, Glass Health Programs, in collaboration with the Department of Juvenile Services, has created a new mental health assessment tool. This tool was utilized to perform a total of 181 mental health assessments along with on-going services to all new admissions. Programmatically, there has been an addition of new groups for the youth, each of which occur three times weekly. These six-month cyclical groups include independent living skills groups, which are provided in conjunction with an additional DJS journaling curriculum and hip-hop therapy.

At BCJJC, Hope Health Systems has conducted mental health and substance abuse assessments to a total of 605 youth. During FY07, Hope Health Systems implemented psycho-educational groups for both Detained and Pending Placement youth addressing both their mental health and substance abuse treatment needs. In addition to providing services to detained youth, Hope Health Systems worked with families of detained youth to discuss discharge plans and provide mental health and substance abuse educational activities during DJS scheduled family days.

Objective 2H: In collaboration with BSAS develop a strategy to better meet the needs of school-age youth with co-occurring disorders.

- Strategies:
1. Train selected school-based mental health clinicians and substance abuse counselors in an evidence-based model.
 2. Clinicians in a limited number of schools, where substance abuse counselors are also assigned, will begin screening for co-occurring disorders.

- Indicators:
1. Number of mental health clinicians and substance abuse counselors trained.
 2. Number of clinicians implementing the screening procedure.
 3. Number of students screened and assessed for co-occurring disorders.

Progress: This objective was not accomplished.

Collaboration with BSAS on developing a strategy was initiated; however, work has not been completed.

Objective 2I: Continue to work with other city and state agencies on the implementation of a high-end/high-cost service initiative for children and adolescents.

- Strategies:
1. Work with the Family League of Baltimore City (FLBC) to implement Phase I of the Child Wrap-Around initiative as a community alternative to Residential Treatment Centers (RTC). In partnership with FLBC and DHMH, work to ensure that the Child Wrap-Around initiative is prepared to move to Phase II as a case rate program for FY'08.
 2. In partnership with the Department of Juvenile Services (DJS), continue to serve the youth identified for the Community Success Program (CSP) either through the Child Wrap-Around program or through some other set of services that will provide an alternative to Therapeutic Foster Home / group home placement. Service packages will also be developed for a small number of identified CSP youth who need independent living services, and for up to two adjudicated sex offenders.
 3. Conduct site visits to in-state Residential Treatment Centers (RTCs) to monitor length of stay and any discharge concerns related to Baltimore City children and adolescents in residence.

- Indicators:
1. Number of children and adolescents and their families served by the Child Wrap-Around program

2. Number of DJS youth served through the Community Success Program through Child Wrap-Around program and through other service packages.
3. Number of site visits to Residential Treatment Centers (RTC).

Progress: This objective was accomplished.

BMHS continued to work with city agencies to implement wraparound as an alternative to RTC placements for high-need youth during FY07. Through a combination of funding from the Governor's Office for Children through the Community Services Initiative (CSI) and the Department of Juvenile Services, a total of 226 children and adolescents were diverted from higher levels of care and instead served by Maryland Choices, the care management entity selected to provide high fidelity wraparound services.

During FY07, 98 unduplicated DJS-involved youth received high fidelity wraparound services, through a combination of DJS funding which had been issued directly to the Family League of Baltimore City (FLBC), and DJS funding issued to BMHS for the Community Success Program (CSP). As agreed by DJS, BMHS's Community Success Program focused on two populations: youth being diverted from Therapeutic Foster Care or Group Home placement and youth being prepared for independent living. BMHS continued its contract with FLBC, which subcontracted with Maryland Choices to provide high fidelity wraparound services for this target population. Initially, referrals from Department of Juvenile Services were slow, but by February 2007, the Community Success Project had reached its goal of serving 20 youth concurrently.

As preparation for moving into Phase II of the Child Wraparound initiative, BMHS participated on the 1915 C Waiver Committee convened by DHMH. This committee was developed to assist DHMH in crafting a proposal for federal funding for the implementation of a Medicaid reimbursable case rate for high fidelity wraparound; however it appears that this funding strategy is not achievable at this time and is no longer being pursued. A demonstration pilot will be implemented in identified jurisdictions, which includes Baltimore City. BMHS will continue to work with DHMH as plans are developed for implementing the demonstration pilot using the identified funding strategy.

BMHS continued to participate in monitoring RTC utilization and providing technical assistance on discharge planning, which increasingly included consideration of Wraparound as a way to support youth in successfully returning to the community. In FY07 the BMHS Resource Coordinator participated in visits to the following RTCs to monitor the length of stay and discharge planning for Baltimore City youth:

- Sheppard Pratt
- Woodbourne
- RICA Baltimore
- RICA Rockville

In FY 07 Mental Hygiene Administration (MHA) raised the standards for therapeutic group homes by redefining the types of therapeutic services provided and staffing patterns. Core Service Agencies were asked to make site visits to ensure that the therapeutic group homes within their jurisdiction were in compliance with the new regulations and that services delivered in each group home matched their MHA approved budget. BMHS conducted site visits to the following Therapeutic Group Homes:

Therapeutic Group Homes	# of Sites
Better You Better Me	1
Children's Guild	3
Guide	1
Genesis Family Homes	1

GOAL 3: Ensure the availability of affordable and quality housing for individuals with psychiatric disabilities.

COMMUNITY HOUSING ASSOCIATES

Objective 3A: Ensure the availability of affordable housing for individuals with psychiatric disabilities.

- Strategies:
1. Maintain currently owned housing stock as attractive affordable housing units.
 2. Develop new units when opportunities become available. During FY06, strategize around funding and planning for increased housing.
 3. Ensure that the additional project based Section 8 certificates are in place.

- Indicators:
1. Number of available housing units and number of units leased.
 2. Units have project-based Section 8 certificates.

Progress: This objective was accomplished.

Community Housing Associates currently provides housing to 245 heads of households. CHA continues to own and operate 106 units of housing throughout Baltimore City. An additional 139 units are leased through the Shelter Plus Care program with community landlords. Of the 245 units owned or operated by CHA, 93% are subsidized through a variety of programs including Shelter Plus Care, HUD 811 and Section 8.

In addition to better managing existing units, CHA has begun to explore additional opportunities for development, and currently participates in the Greater Baltimore Housing Consortium (GBHC). GBHC, made up of CHA, Empire Homes of Maryland and People Encouraging People, is seeking to identify and capitalize on operating efficiencies that may be obtained by working together toward the same goal of developing housing for people with disabilities.

QUALITY IMPROVEMENT & OPERATIONS DIVISION

Objective 3B: **Inspect 100% of housing units operated by Residential Rehabilitation Programs (RRP) in Baltimore City to ensure compliance with Code of Maryland Regulations (COMAR).**

- Strategies:
1. Conduct initial, annual and follow up inspections of RRP housing.
 2. Provide technical assistance as needed.
 3. Submit written reports of inspections to providers and Office of Health Care Quality.

- Indicators:
1. Total number of RRP units.
 2. Number/percent of RRP units inspected.
 3. Number of housing units in compliance by June 30.

Progress: **This goal was accomplished.**

Baltimore City residents with psychiatric disabilities have access to a limited number of affordable, quality housing licensed and/or certified by the State of Maryland. Residential Rehabilitation Program housing consists of one to three bedroom units. Adult Group Homes have four or more bedrooms. Housing is located in apartment complexes or individual homes throughout the City. Persons living in these units have daily access to staff and individualized clinical and psychiatric rehabilitation services, including independent living skills training, medication monitoring, health and wellness education, crisis planning, and more. Services are designed to promote and support the individuals' ability to engage and participate in their communities.

Code of Maryland Regulations (COMAR) 10.21.22 requires Core Service Agencies to conduct initial, annual, and follow up inspections of Residential Rehabilitation Program (RRP) housing operated by community mental health providers in their local jurisdiction. The purpose of the inspections is to ensure that housing meets minimum safety standards outlined in State regulations and provide basic comforts and support to residents. Baltimore City has 136 Residential Rehabilitation Program housing units operated by eight (8) providers. In addition, BMHS requires inspections of a limited number of Residential Crisis Services housing

(1 provider) and Adult Group Homes (2 providers). Together these providers operate 144 housing units which represent separate addresses. The combined units have a capacity to serve 392 adults. There were 346 residents at the time of QI annual inspections. The number of residents fluctuates throughout the year as admissions and discharges occur. The tables below summarize the number of housing inspections and type of approvals through June 30, 2007. A general approval means no violations were found. A provisional approval is granted if violations were found.

FY07 Housing Inspections				
	Initial	Annual	Follow Up	Total
Residential Rehabilitation Programs	23	130	32	185
Residential Crisis Services	-----	6	-----	6
Adult Group Homes	-----	2	1	3
TOTALS	23	138	33	194

FY07 Housing Approvals at Year End			
Programs and Services	*Units	General Approval	Provisional Approval
Residential Rehabilitation Programs	136	130	6
Residential Crisis Services	6	6	-----
Adult Group Homes	2	2	
TOTALS	144	138 (96%)	6 (4%)

The overall housing conditions are adequate. No major health or safety violations were found. Most deficiencies were addressed quickly. One exception was severe damage to an apartment building because of a fire set by a resident. Fortunately, no one was injured. However, the program was forced to relocate seven (7) residents for several months until repairs were completed and the house re-inspected. The provider did an excellent job in the emergency evacuations and implementing the relocation plan previously approved by BMHS. The six units with *provisional approval* at year-end were the result of extensions granted due to administrative changes within the program.

Objective 3C: Interview one third of residents in Residential Rehabilitation Program (RRP) housing in Baltimore City to evaluate satisfaction with housing conditions and services.

- Strategies:
1. Conduct one-on-one interviews with residents living in Residential Rehabilitation Programs in Baltimore City.
 2. Prepare written reports of the interview findings and submit to providers and BMHS.

- Indicators:
1. Total number of consumers in RRP housing at the time of inspections.
 2. Number/percent of consumers interviewed.
 3. Level of consumer satisfaction reported.

Progress: This objective was accomplished.

Code of Maryland Regulations (COMAR) require Core Service Agencies to conduct face-to-face interviews with one-third of the residents living in Residential Rehabilitation Programs (RRP). Documents submitted by program directors indicated that 346 residents were living in RRP housing during the annual inspections. The number of residents may fluctuate throughout the year as admission and discharges occur. Quality Management Coordinators interviewed 190 (55%) residents, which exceeds the State requirement. Interviews were conducted using a 23-item survey that assesses satisfaction with housing conditions, mental health services, family support, neighborhood, etc. Participation is voluntary. Staff meets with residents in a private area when possible. Overall, residents reported being satisfied with housing and services. The results of the interviews were discussed at the end of each site visit and written reports submitted to providers, Mental Hygiene Administration, and the Department of Health and Mental Hygiene’s Office of Health Care Quality. The table below is a sample of items included on the Consumer Satisfaction Survey and resident responses. For purposes of this report, questions have been abbreviated.

CONSUMERS SATISFACTION WITH RESIDENTIAL HOUSING SAMPLE OF RESPONSES							
Survey Items	N=	Agree	%	Neutral	%	Disagree	%
Services are helpful to me	190	185	97	0	-----	5	3
Satisfied with the amount of food and drink	190	185	97	3	2	2	1
Satisfied with the hot and cold water for my shower, bath and sink	190	184	97	2	1	4	2
Satisfied with the condition of my stove, refrigerator and sink	190	176	93	10	5	4	2
Feel safe in this neighborhood	190	172	90	1	1	17	9
Satisfied with my heating unit, it keeps my house warm	190	163	86	25	13	2	1
Satisfied with my air conditioner, it keeps my house cool	190	156	82	25	13	9	5
Family is supportive of me	190	149	78	5	3	36	19
Visit/spend enough time with my family	190	128	67	11	6	51	27
No job but I would like to work	190	88	46	9	5	93	49
Consider this my permanent home	190	71	37	12	7	107	56
Have a job and earn a pay check	190	37	19	0	-----	153	81

GOAL #4:	Ensure efficient & accountable financial management.
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Objective 4A: **Ensure that BMHS' fiscal contractor is performing its required functions.**

- Strategies:
1. Review the vendor's performance on a regular basis.
 2. Compare actual results to budgets on a quarterly basis.

Indicator: 1. Annual audit reports

Progress: **This objective has been accomplished.**

BMHS' Finance Committee has met quarterly and has been provided with financial statement updates and analysis. The fiscal year 2006 audit was completed with no findings reported.

Objective 4B: **Improve the financial stability of Community Housing Associates, Inc.**

- Strategies:
1. Continue improvements made in expenditure containment; continue seeking outside sources of funding; continue efforts to expand supporting subsidies. Continue increased board oversight of financial conditions.
 2. Comprehensive review of CHA involvement in outside housing programs to determine the financial efficiencies of continuing participation.

Indicator: 1. Financial statements on an interim basis; FY audits as a final determinant.

Progress: **This objective has been accomplished.**

The Board of Directors of Community Housing Associates, Inc. was provided monthly financial statement updates on all housing entities. The audits for Community Housing Associates, Inc. and Community Housing Associates Limited Partnerships I and II contained unqualified opinions on the financial statements and had no reportable conditions for the years ended June 30, 2006 and December 31, 2006, respectively. CHA increased its unrestricted net assets for the fiscal year ended June 30, 2006 and continues to improve its financial position by focusing on improving efficiency and accountability of its affiliate corporations. In addition, due to the end of the compliance period for one of the oldest projects, CHA and its Board have decided to divest itself of one project, which has been financially draining on the organization. It is anticipated that this transaction will be completed in FY08. This will have an immediate and positive impact on the financial operations of CHA as a whole.

GOAL #5: Maintain a quality management program to continuously evaluate and improve Baltimore Mental Health Systems, Inc's activities.

ADULT SERVICES DIVISION

Objective 5A: Identify changes in the outcome measures from COMAR-approved service providers in Baltimore City.

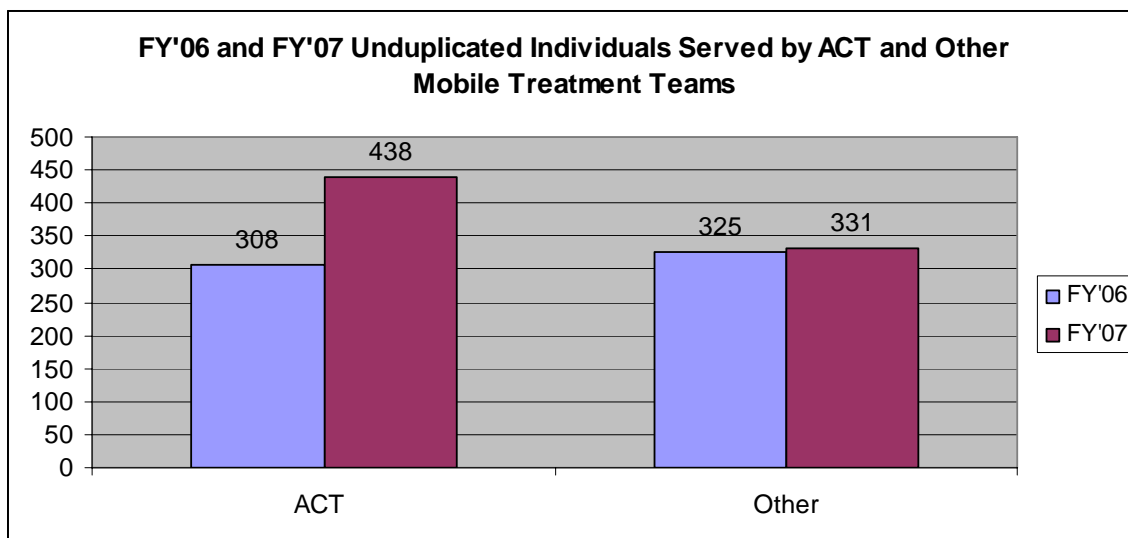
- Strategies:
1. Collect quarterly reports from Psychiatric Rehabilitation Programs, Mobile Treatment Providers, Supported Employment Programs and Intensive Case Management Programs from 100% of programs.
 2. Meet with providers quarterly to identify changes and shifts in outcomes as indicated from data reported.
 3. Continue development of outcome measures for OMHC with the providers.

- Indicators:
1. Number of quarterly reports received from COMAR licensed Baltimore City providers and reviewed.
 2. Report on changes and trends on outcomes measured.

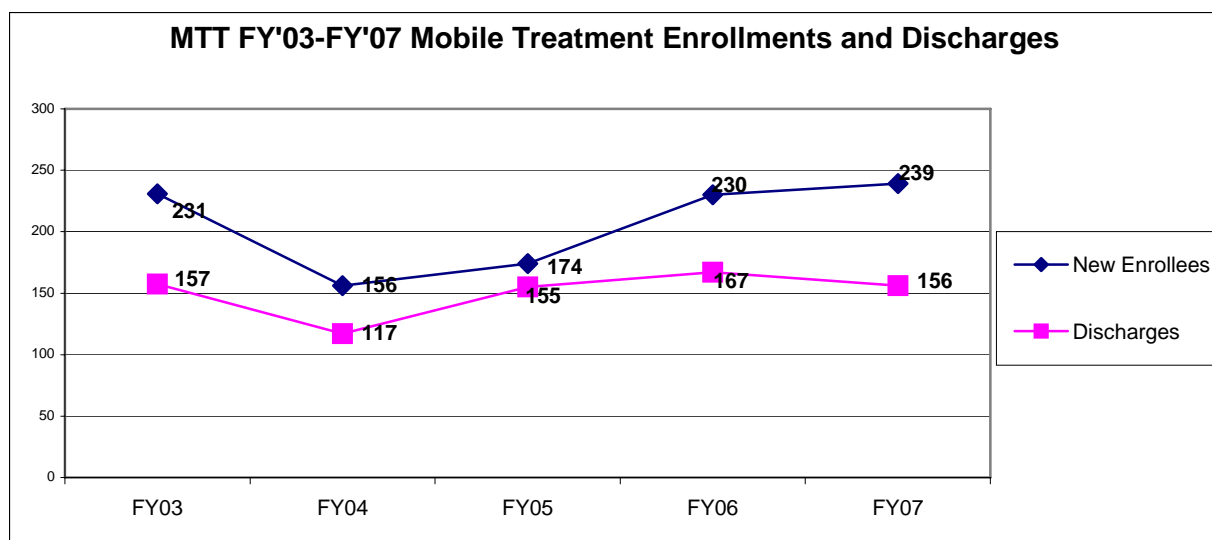
Progress: This objective was accomplished.

Mobile treatment, supported employment, and psychiatric rehabilitation providers submitted data and met quarterly to discuss findings. The quarterly meetings became a forum for the respective service lines to collaborate and share information in addition to discussing outcomes. Outcome measures were not developed for OMHCs due to MHA mandating all clinics to participate in the Outcomes Measurement System or OMS project with MAPS-MD. The OMS data is just being provided to the core service agencies and will be analyzed in FY 08. Case management outcome discussions were tabled until data duplication problems could be resolved. Several case management providers are required, due to HUD funding, to collect data in ROSIE, the city-wide Homeless Management Information System (HMIS) database.

Mobile treatment outcome reports were received from all of the licensed mobile treatment and Assertive Community Treatment (ACT) teams: Harford-Belair, Bon Secours, People Encouraging People, University of Maryland Medical System, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and the North Baltimore Center. In FY 07 there was an increase in clients being served by ACT teams. This is due to PEP's FACTT program, their second ACT team, starting at the end of FY 06 and Bon Secours receiving their ACT certification this year. This trend supports the emphasis that MHA has been placing on mobile treatment programs converting to ACT teams.

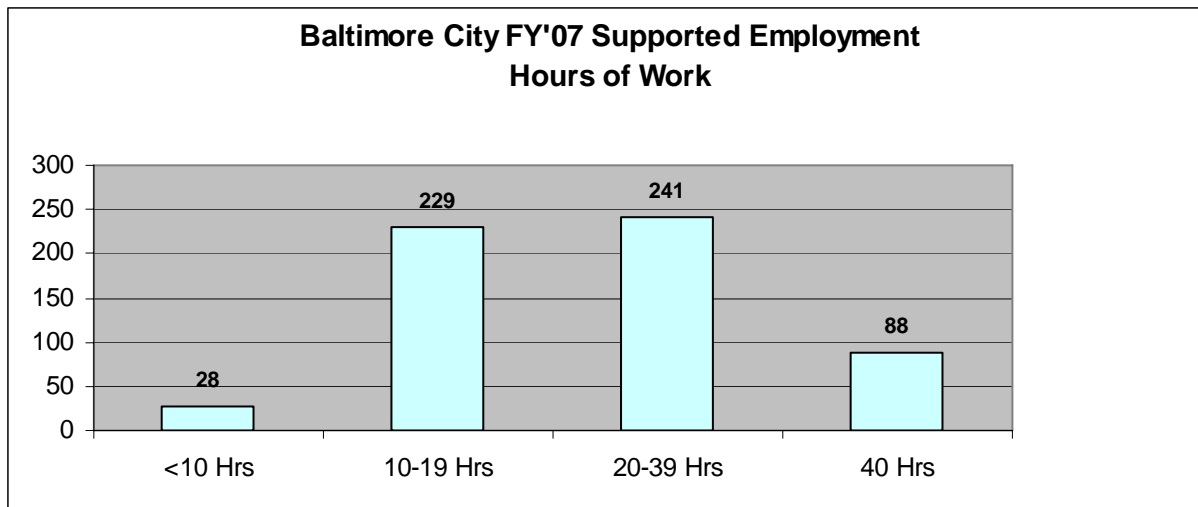


In FY 07 the total number of mobile treatment ACT clients served increased over FY06, 83 and 63 respectively. The chart below shows the steady net gain in mobile treatment since FY03.

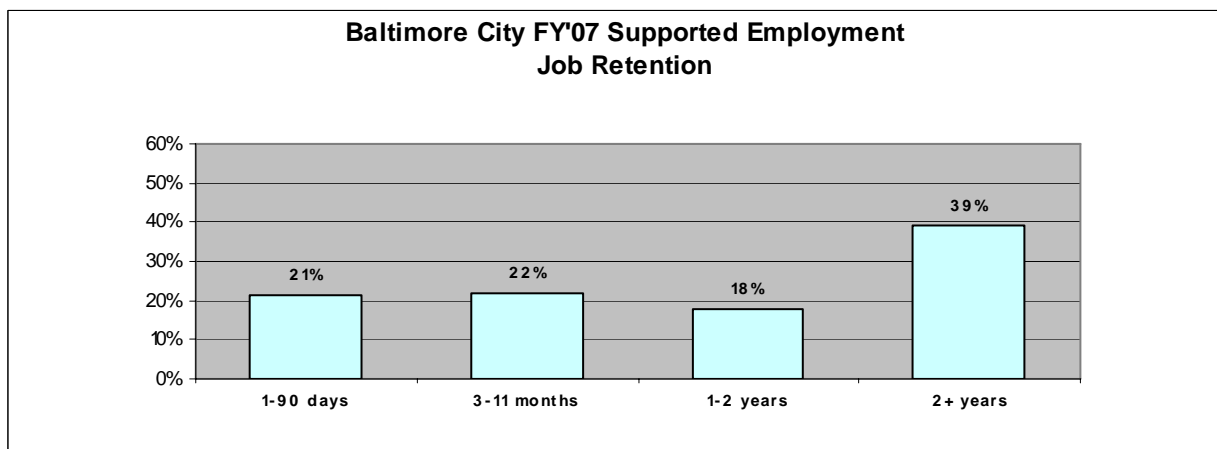


Supported Employment outcomes reports were collected from Alliance, Crossroads, Chesapeake Connections, Harbor City Unlimited, Humanism, Mosaic, North Baltimore Center, People Encouraging People and STEP.

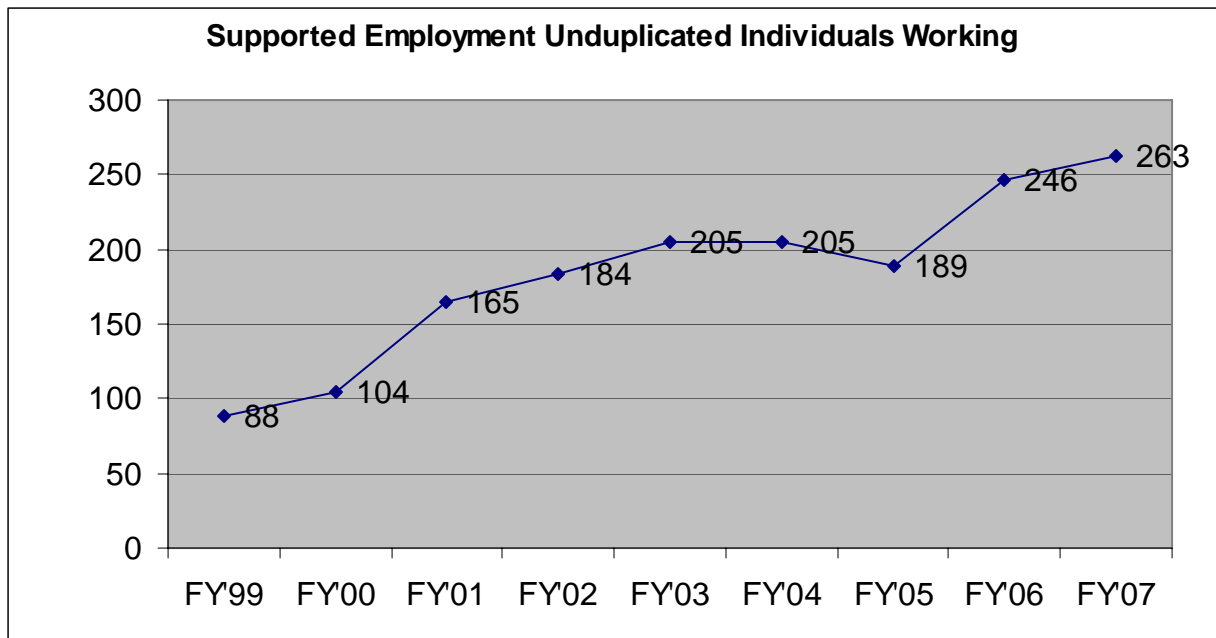
The majority of consumers through Supported Employments Programs in Baltimore City work a significant numbers of hours per week, exceeding the basic expectations of MHA (10 hrs./wk). See chart below.



A large number of individuals in the Supported Employment Program have maintained the same job for two or more years. Furthermore, many represented in the 1-90 day category have been newly enrolled. These positive trends are indicative of the success that the Baltimore City Supported Employment Programs have made in helping individuals find and maintain jobs for an extended period of time.

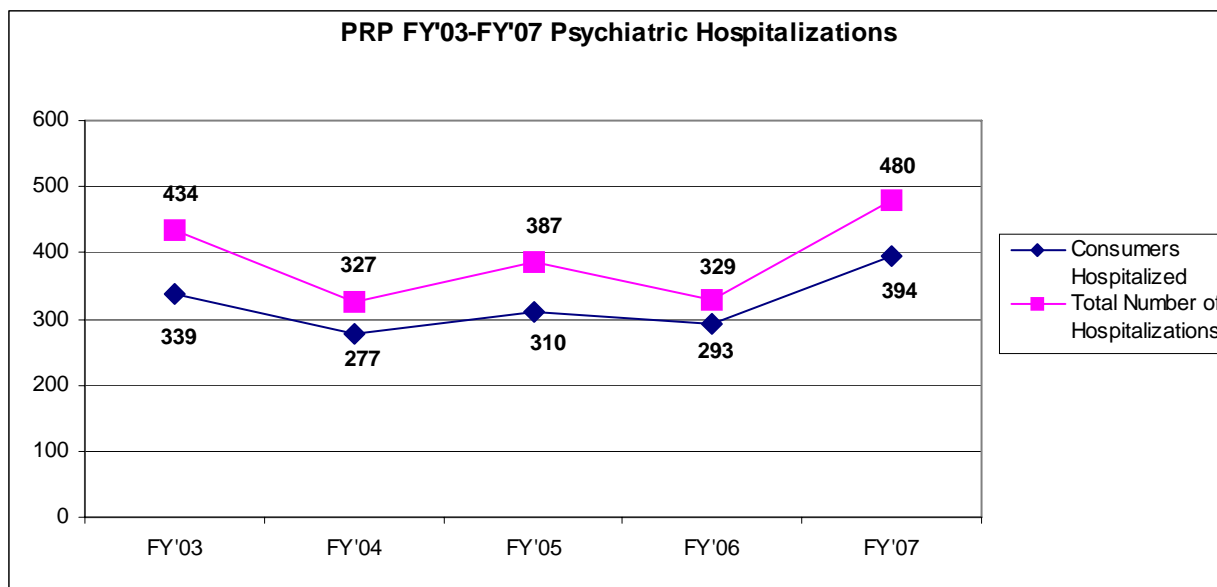


Since FY'99, when BMHS began collecting outcome measures from the Supported Employment Programs, there has been a significant increase in individuals securing competitive integrated employment.

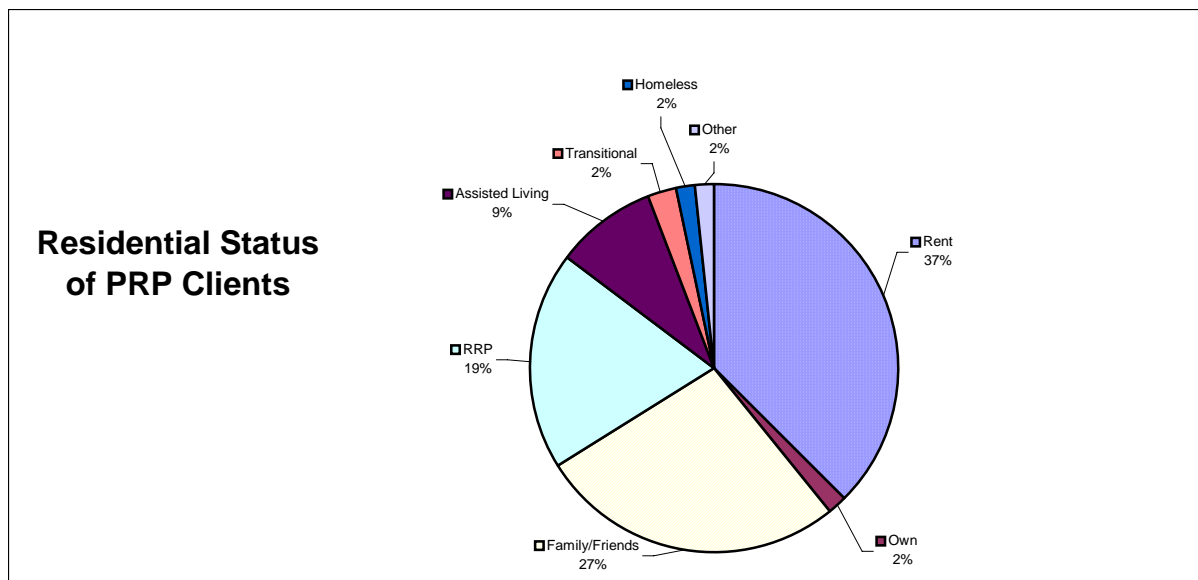


PRP outcomes were collected from the following providers: New Phases, VOA, Johns Hopkins Bayview, Haven, Jewish Family Services, Alliance, Harbor City Unlimited, People Encouraging People, Mosaic, NBC, STEP.

The trend in this chart shows a slight increase in individuals with psychiatric hospitalizations as well as a slight increase in total hospitalizations during FY'07. This has been influenced by many factors such as more consistent reporting of hospitalizations as well as increased enrollment in PRP.



As shown in this graph, during FY'07, a large majority of individuals enrolled in the PRP program lived in positive housing placements such as renting, owning, RRP and living with family and friends. A very small amount of individuals were homeless or lived in transitional housing.



MANAGEMENT INFORMATION SYSTEMS

Objective 5B: Utilize data from the Public mental Health System (PMHS) to monitor and improve services

- Strategies:
1. Collaborate with MAPS -MD to identify reports currently available and develop new reports as needed.
 2. Provide regular reports to BMHS staff
 3. Provide technical assistance and education on interpreting data reports to division directors
 4. Collaborate with MAPS-MD and develop a database consisting of persons in the public mental health system arrested daily in Baltimore City.
 5. Maintain BMHS's data for PMHS to ensure that the data is accessible and useable

Indicator: 1. Reports developed and shared with BMHS staff, technical assistance provided.

Progress: This objective was accomplished.

As MAPS-MD has commenced with the development of reports, BMHS' MIS director provided technical assistance and education on interpreting data and obtaining the reports for division directors and staff. The reports are downloaded on a regular basis and provided to management staff for review.

MIS Director set up a new FTP server for the Data -Link Project that allowed MAPS-MD to upload data on consumers enrolled in the public mental health system and arrested in Baltimore City. Future plans include making the daily list available for interested parties.

Objective 5C: Ensure BMHS' Network Server, Web Server, and Email Server are maintained, upgraded as needed, and regularly backed up with necessary security safeguards.

Strategy: 1. Perform the necessary procedures to ensure the objective is met.

Indicator: 1. BMHS computer systems are in operation or problems addressed in a timely manner.

Progress: This objective was accomplished.

MIS director updated BMHS Network server, WEB server and email. Systems have been operational with minimal down time throughout the year. Additional upgrades included Great Plains software used to track fiscal transactions and budgets. BMHS upgraded computers that are used to access the Great Plains information. As demands for increased data continue, MIS director upgrades BMHS computers and software to respond to the needs.

Objective 5D: Provide continued support to providers using the Mental Health Information and Billing System (MHIS).

Strategy: 1. Respond to Mental Health providers' requests for technical assistance as available.

Indicator: 1. Documentation of support.

Progress: This objective was accomplished.

The MIS Director designed a mental health information system (MHIS) several years ago to track client demographic information, service, and process billing. A select number of providers continue to use the system to manage their client information and submit electronic claims to MAPS, Medicare and other payors. During FY07 the MIS Director continued to redesign and upgrade the system to be compliant with Health Insurance Portability and Accountability Act (HIPAA) form 837.

MIS Director completed the design of data base for the FAST and Mental Health Court Program, in order to monitor mental health consumers arrested in Baltimore City. This system includes

demographics, and allows the program to track consumer through the court systems. Data also includes clinical information.

CHILD & ADOLESCENT SERVICES DIVISION

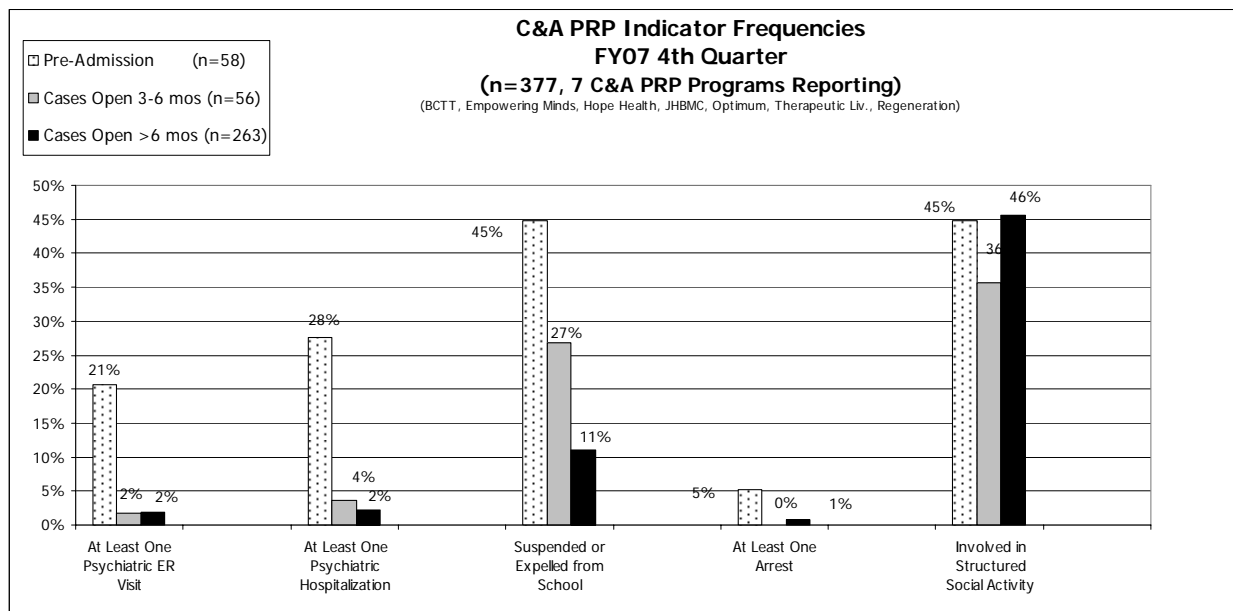
Objective 5E: Begin to identify areas of positive impact of child and adolescent Psychiatric Rehabilitation Program services.

Strategy: 1. Fully implement collection of data on a quarterly basis from Psychiatric Rehabilitation Programs (PRPs) that serve Baltimore City children and adolescents.

Indicator: 1. Number of PRPs consistently reporting data; identify indicators from data reports that appear to demonstrate positive impact.

Progress: This objective was partially accomplished and future work is ongoing.

Provider compliance with submission of PRP data for children and adolescents continues to be problematic. During FY07, an average of seven out of 27 Baltimore City programs licensed to provide PRP services to children and adolescents supplied data to BMHS for review. The chart below provides data on 377 children and adolescents, who received PRP services during the 4th quarter of FY 07:



In FY07 a new indicator was added on to the data reports in order to show a positive impact PRP programs have on the youth being served. This indicator, which was the child’s ability to remain in a structured activity for a given period of time, has shown a slight overall increase during the 6+ month marker; however, it is unclear whether providers are correctly interpreting this item, as a greater increase in ability to be involved in a structured social activity would be expected. This will be explored further during FY08.

Other indicators, including decreased hospitalizations, decreased interaction with the justice system, and decreased visits to the emergency room, indicated positive outcomes for the children and adolescents who were involved in the PRP programs as compared with the three months prior to receiving these services.

QUALITY IMPROVEMENT & OPERATIONS DIVISION

Objective 5F: 100% of BMHS contracts will be executed on or before the date services began (DHMH by July 1).

- Strategies:
1. Chair vendor contract committee meetings and monitor timeliness and compliance with contract policies and procedures. Develop strategies for improvement as needed.
 2. Program monitors will follow-up with vendors in a timely manner if there are problems with executing contracts by due dates.
 3. Conduct annual training for staff to ensure consistency in the implementation of contract procedures.

- Indicators:
1. Total number of contracts executed.
 2. Number of DHMH contracts and Non-DHMH contracts.
 3. Number of DHMH contracts executed by July 1.
 4. Number of Contracts executed by date services began.

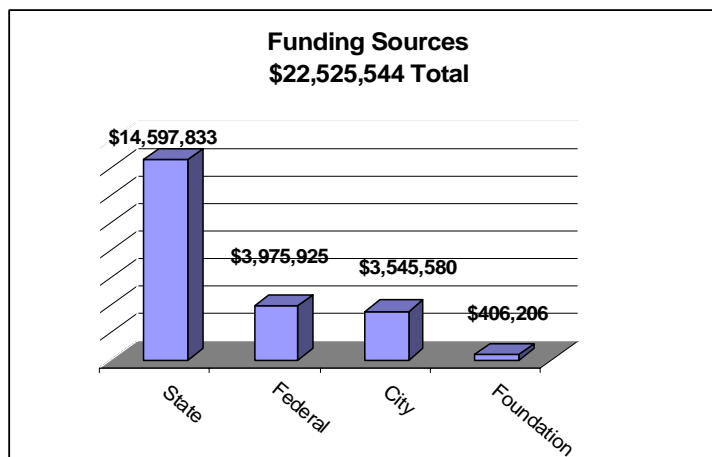
Progress: This objective was partially accomplished.

In FY07 Baltimore Mental Health Systems, Inc. allocated \$22,525,544 to fund a full array of community-based mental health services for Baltimore City residents. FY07 was the third year the Quality Improvement and Operations Division assumed responsibility for coordinating agency contract management functions. The change was implemented to increase efficiency and accountability. Features of the contract management process include policies and procedures that establish internal controls throughout the process, timeframes for the submission of timely detailed reports, standardized reporting and performance ratings, ongoing collaboration and feedback from vendors, and monitoring and tracking of vendor contract documents and performance. A weakness in the process has been the lack of consistent and/or timely follow up with vendors on missing reports and performance issues. Improvements are also needed in complying with existing policy whereby BMHS withholds payments when there are problems with reporting and/or performance. BMHS is reviewing internal procedures and will be working with providers to improve compliance next year.

Funding

BMHS’ ongoing collaboration with key stakeholders resulted in new or/and expanded funding. The agency receives funding from government at the City, State, and Federal levels, and private foundations. The table below lists major public and private funding agencies and funding amounts.

FY07 CONTRACT FUNDING SOURCES			
CITY	STATE	FEDERAL	FOUNDATION
<ul style="list-style-type: none"> ▪ Baltimore City Health Department ▪ Family League Baltimore City ▪ Department of Juvenile Services ▪ Baltimore City Department of Social Services. ▪ Baltimore City Head Start ▪ Mayors Office of Employment Development -Youth Opportunity 	<ul style="list-style-type: none"> ▪ Department of Health & Mental Hygiene (FBG, SBG, Path, Olmstead) ▪ Mental Hygiene Administration ▪ The AIDS Administration ▪ Governor’s Office of Crime Control and Prevention 	<ul style="list-style-type: none"> ▪ Housing Urban Development ▪ Dept. of Human Resources 	<ul style="list-style-type: none"> ▪ Open Society Institute ▪ Blaustein Foundation ▪ Abel Foundation ▪ Stuhlman Foundation ▪ Weinberg Foundation



Timeliness of Contract Execution

The Department of Health and Mental Hygiene requires that their contracts be executed by the start of the fiscal year (July 1). BMHS performance on execution of DHMH contracts was consistent with FY06 (81%) with a slight decrease in the timely execution of Non-DHMH contracts from 15 % to 12 %. Delays were the result of internal and external factors (such as late submissions, ongoing negotiations on conditions of award, vendors not returning contracts).

All contracts should be executed by the date services begin. Although this standard is high, it is in the best interest of all parties to have a legal contract in place when services begin. The table below details BMHS performance on timely execution of contracts.

TIMELINESS OF CONTRACT EXECUTION

	FY07 DHMH	FY07 Non-DHMH	FY06 DHMH	FY06 Non-DHMH
Total contracts	120	52	114	48
Executed by July 1	97 (81%)	6 (12%)	92 (81%)	7 (15%)
Executed by start-date	97 (81%)	5 (10%)	93 (82%)	13 (27%)

Objective 5G: Establish contractual agreements with vendors who provide quality services and comply with BMHS contract deliverables.

- Strategies:
1. Conduct annual and bi-annual site visits to verify services delivered, quality of services and issue written reports to vendors and BMHS.
 2. Provide technical assistance to vendors to support compliance with contracts and improve performance as needed.
 3. Require vendors to maintain documentation of contractual services, financial records and make these documents available upon request.
 4. Require vendors to submit progress reports and/or invoices that document performance and compliance with contract.
 5. BMHS Board of Directors QI committee will meet and review monitoring activities and vendor compliance reports. Make recommendations as needed.

- Indicators:
1. Total number of contracts executed.
 2. Number of contracts in compliance with submitting progress reports.
 3. Number of contracts in compliance by June 30th.

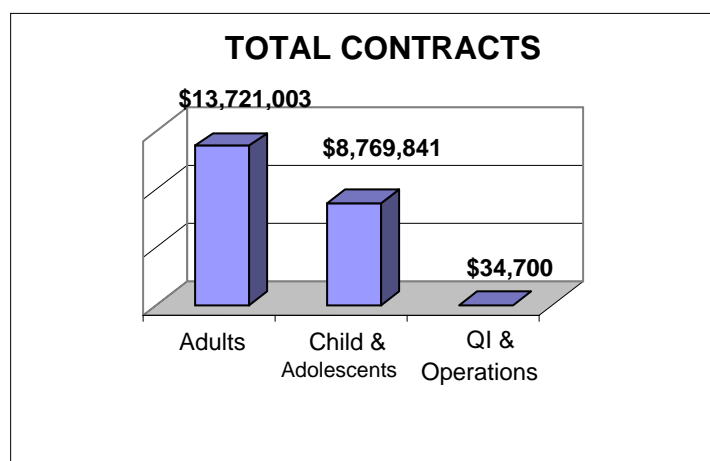
Progress: This objective was accomplished.

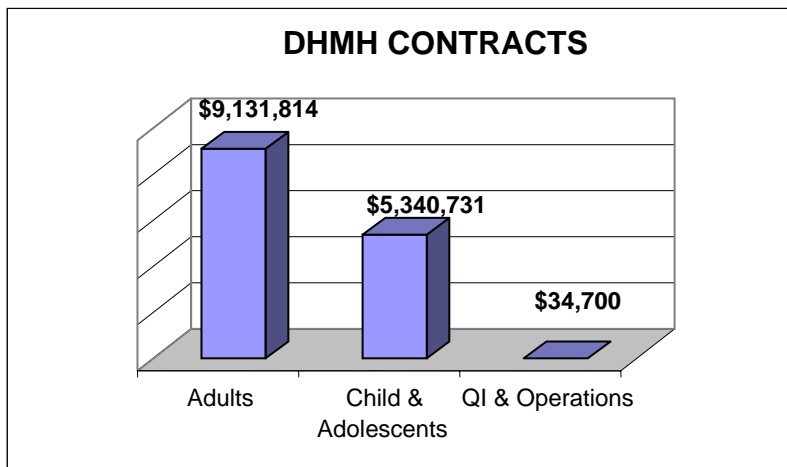
Contract Services

BMHS issued 172 contracts to 77 vendors. Most contracts were awarded to providers with existing contracts who continued to meet performance requirements. It is the policy of BMHS to use a procurement process that fosters competition, is creatively responsive to client needs, and allows participation of minority businesses. The agency reserves the right to “sole source” contracts using established criteria. Contract services addressed the needs of residents from

infants to older adults. The majority of grant funds allocated to BMHS were for adult services (61%). The table and charts below lists the major contract services, total contract funding by services and DHMH funding by services. The list of services in the table is not exhaustive.

FY07 CONTRACT SERVICES		
ADULTS	CHILD & ADOLESCENTS	QI & OPERATIONS
Emergency Dept. Psychiatric Consultations	School-Based Mental Health Services	Compliance Monitoring
Community-based Crisis Teams	High Risk Child WRAP Around Initiative	Level III Appeals
Police- Behavioral Emergency Service Teams	Community-based Crisis Teams	
Data Link Projects	Family Support	
Integrated Care For Co-occurring Mental Health & Substance Abuse	Department Juvenile Services -Mental Health Assessments	
Poverty and Depression Initiative	Child Mental Health Community Education	
Adult Capitation Project	Community Partnerships	
	Early Childhood Mental Health	
	Respite Care	





Vendor Progress Reporting and Performance Ratings

Performance reporting has been standardized with few exceptions. The majority of contracts (162) are required to use the *Appendix A Contract Deliverables And Provider Progress Report* (Appendix A Progress Report), which includes contract deliverables, performance indicators, and fiscal reporting requirements. The remaining ten contracts are required to submit invoices as proof of services delivered. Frequency of reporting ranges from monthly to annually with most vendors submitting quarterly reports and year-end reports showing cumulative performance. Vendors’ overall compliance with submitting Appendix A Progress Reports improved compared to FY 06 from 61% to 73%. DHMH contracts performed slightly higher (77%) than non-DHMH contracts (62%). Reports are routinely submitted late. For example, nearly half (43%), of the year-end progress reports were submitted 60 days past the due date. Steps will be taken in FY08 to improve compliance, including training of BMHS employees, and technical assistance and training of vendors on contract policies. The table below compares DHMH and non-DHMH contracts compliance with submitting Appendix A Progress Reports.

SUBMISSION OF CONTRACT APPENDIX A- PROGRESS REPORTS				
	FY 07		FY 06	
Compliance	DHMH	Non-DHMH	DHMH	Non-DHMH
Required to Submit	117 (98%)	45 (87%)	109 (96%)	37 (77%)
Number Submitting	90 (77%)	28 (62%)	65 (60%)	24 (65%)

Contract monitors in both Adult Services and Child and Adolescent Services Divisions review the Appendix A Progress reports throughout the year to determine level of compliance, and assign a performance rating. Performance ratings range from “Met” to “Not Met.” Year-end reports are rated as “Met” if contract deliverables are completed as stated in the contract, and the quality of the services is acceptable. A rating of “Not Met” is assigned if deliverables are not

completed or completed but the quality is less than desired. Corrective action is required for ratings of “Not Met.” In all instances, BMHS works with vendors to improve services and correct deficiencies. Serious deficiencies may result in financial sanctions and/or termination of contract. The majority (79%) of contracts delivered services as outlined in their contracts. DHMH contracts performed slightly higher (80%) than non-DHMH contracts (70%). The table below lists the number of DHMH and non-DHMH contracts rated as “Met” or “Not Met” in compliance at the end of the fiscal year (June 30, 2007).

CONTRACT RATINGS-YEAR END (through June 30th)		
RATINGS	DHMH	Non-DHMH
# Contracts rated as “Met”	74 (80%)	14 (70%)
# Contracts rated as “Not Met”	2 (2%)	1 (5%)

Vendor Reporting Insurances and Fidelity Bonds

Most contracts required vendors to submit proof of general liability insurance, professional liability insurance and/or fidelity bonds. These documents protect BMHS’ interest and must be kept on file. Data were not available in FY06, however vendor compliance in FY07 was excellent. This was accomplished by tracking these documents and ongoing follow up with vendors and program monitors. The table below summarizes vendor compliance.

INSURANCES	REQUIRED	SUBMITTED
General and Professional Liability	138	134 (97%)
Fidelity Bonds	77	77 (100%)

Contract Site Visits

Per BMHS policy, Quality Management Coordinators conducted annual visits of contracts funded at \$200,000 or more. Bi-annual site visits are conducted on remaining contracts. Exceptions to this schedule include contracts that required a Performance Improvement Plan at the last site visit. Flexibility is granted based on the professional judgment of staff in instances where corrections needed were minor (i.e. missing form) and vendor submitted documents with their Program Improvement Plan.

Staff conducted site visits of 56 contracts at the location where services were delivered. The majority (45) of contracts did not require a performance improvement plan. The 11 contracts requiring a performance improvement plan were for non-serious issues. During the site visits staff reviews records including medical, personnel, fiscal, training, and payroll. Staff compares documents at the site to Appendix A Performance Reports and/or invoices previously submitted to BMHS for payment. Staff retains copies of select documents from the site visit for the contract file. Staff interviews consumers and/or family members as appropriate to obtain their opinions

of services. Feedback from interviews is shared with vendors. Staff submits reports to vendors after discussing findings and recommendations with the contract monitors. In some instances contract monitors from Adult Services Division or Child and Adolescent Services Division accompany QI staff on the site visit. Technical assistance for vendors is provided upon request and usually relates to helping the vendor improve documentation at the site. Contract monitors oversee implementation of the Performance Improvement Plan.

Contract Vendors Compliance with OHCQ Plan of Correction

Quality Improvement staff uses the annual contract site visit as an opportunity to monitor vendor's licensed/certified as a community mental health program under Code of Maryland Regulations. Staff reviews continued compliance with Performance Improvement Plans previously approved by Office of Health Care Quality (OHCQ). This oversight function by BMHS has become increasingly more important as OHCQ decreases staffing and increases the time frame between site visits, which can extend up to 3 years.

Objective 5H: Assist community mental health providers in Baltimore City in complying with Code of Maryland Regulations (COMAR).

- Strategies:
1. Provide technical assistance to providers submitting applications for new or expanded services in Baltimore City and submit recommendations to the Office of Health Care Quality (OHCQ).
 2. Participate in site visits conducted by OHCQ.
 3. Review program performance improvement plans (PIP) and provides technical assistance as needed.
 4. Monitor providers granted deemed status by the Mental Hygiene Administration to ensure compliance with conditions for continued of the approval. Report findings to MHA and OHCQ.
 5. Conduct compliance audits to COMAR providers in collaboration with MHA, OHCQ and MAPS-MD. Issue reports.

- Indicators:
1. Number of applications.
 2. Number of OHCQ site visits, number/percent attended.
 3. Number of programs requiring performance improvement plans.
 4. Number of deemed status site visits.
 5. Number of compliance audits.

Progress: This objective was accomplished.

Quality improvement staff worked closely with the Office of Health Care Quality and Mental Hygiene Administration to monitor provider’s compliance with Code of Maryland Regulations (COMAR). 154 community mental health providers operate 167 programs (e.g. outpatient mental health clinics). A major issue for the past few years has been the credentialing and privileging of unlicensed staff working in outpatient mental health clinics (OMHC). Mental Hygiene Administration (MHA) previously allowed the OMHC to develop transition plans for credentialing of un-licensed staff performing clinical work. QI staff assisted MHA in monitoring the OMHC implementation of the transition plans. MHA expectation going forward is that all staff performing clinical work must be properly licensed by their respective practice boards. The table below shows the number of community mental health programs and providers in Baltimore City at year-end. A detailed list of providers including contact information is available upon request from QI and Operations Division.

Baltimore City Community Mental Health Programs			
Type of Programs		Number of Programs	Number of Providers
Adult Group Homes	GH	6	6
Children’s Therapeutic Group Homes	TGH	6	6
Mobile Treatment Services	MTS	9	6
Outpatient Mental Health Clinics	OMHC	49	45
Psychiatric Rehabilitation Programs	PRP	59	55
Residential Rehabilitation Programs	RRP	8	8
Residential Crisis Services	RCS	3	3
Respite Care Services	RPC	1	1
Mental Health Vocational Programs	MHVP	10	9
Targeted Case Management	TCM	7	7
Partial Hospitalization Programs	PHP	9	8
Total		167	154

Office of Health Care Quality Site Visits

The Office of Health Care Quality (OHCQ) is the state agency responsible for issuing licenses and certification for all mental health programs operating under Code of Maryland Regulations. OHCQ staff conducted 11 site visits in Baltimore City to evaluate providers’ compliance with COMAR regulations. QI staff participated in seven of the visits. Performance Improvement Plans (PIP) were required of all the providers reviewed. QI staff provided education and technical assistance to the providers. Education focused on understanding Medicaid regulations and documentation of services. QI staff conducted site visits at seven programs with deemed status approval from Mental Hygiene Administration. Deemed status approval is granted to programs who have accreditation from the Joint Commission on Accreditation of Health care Organizations or the Commission On Accreditation of Rehabilitation Facilities. Responsibility for monitoring programs granted deemed status is delegated to Core Service Agencies. Baltimore Mental Health Systems, Inc. reports findings to MHA and the OHCQ.

Applications for New/Expanded Services

Providers submitted nine applications for new or expanded mental health services. QI staff reviewed all applications which included: one Outpatient Mental Health Clinic (OMHC), seven

Psychiatric Rehabilitation Programs (PRP) and one Therapeutic Group Home (TGH). BMHS was in compliance with reviewing applications within the required time-frame. QI staff provided technical assistance to providers throughout the application and approval process.

Compliance Audits

The Mental Hygiene Administration (MHA) continues to place an increased emphasis on compliance monitoring during FY07. MHA in collaboration with MAPS and Core Service Agencies conducted compliance audits across the State. The purpose of compliance audits are to, identify provider compliance with State and Federal rules and regulations related to health care programs and payments, review quality of services, and provide technical assistance. MAPS takes the lead on most audits. The director of QI and Operations serves on Mental Hygiene Administration's Compliance Committee which is responsible for coordinating compliance audits across the state. The committee meets monthly and develops audit schedules, oversees the development of standardized audit tools, and reviews significant issues from prior audits and dissemination of information to CSA, MAPS, provider and other stakeholders.

Compliance Audit Follow Up Site Visits

Mental Hygiene Administration expanded the compliance responsibilities of the Core Service Agency in FY06. As a result, QI staff assumed new responsibilities for conducting follow up compliance audits of Baltimore City programs to assess if they implemented the performance improvement plan submitted to MHA and the CSA. The follow up compliance audits consist of reviewing compliance with quality standards that were rated as noncompliant during the prior audit. Staff reviewed a minimum of 20 consumer case records. BMHS conducted 19 follow up compliance audits this year.

A total of 39 compliance audits representing 12 community mental health providers were conducted in Baltimore City with 90% participation by QI staff in audits led by MAPS. Staff was unable to attend remaining audits because of scheduling conflicts or short notice. However, there was ongoing communication with MAPS and MHA Office of Compliance on all vendors who were audited. BMHS was able to assist in pre-visit planning for audits and post-visit meetings to discuss findings and recommendations. Compliance audits consist of reviewing a minimum of 20 consumer case records randomly selected using pre-determined criteria. These audits are based on: quality standards that have been developed for outpatient mental health clinics and psychiatric rehabilitation programs, residential treatment centers, in-patient hospitals; evidence-based practices; state and federal regulations; and industry standards.

Fraud and Abuse

Increased monitoring activities have led to the identification of a limited number of cases where providers were suspected of fraud and abuse. Suspected fraud and abuse cases were referred to Mental Hygiene Administration, Maryland's Office of Inspector General or Maryland's Attorney General's Medicaid Fraud Control Unit (MFCU) for investigation and possible prosecution. Mental Hygiene Administration Office of Managed Care Compliance was successful in obtaining prosecutions of six community mental health providers serving Baltimore City residents. QI staff initiated one investigation and referral for fraud that ended in prosecution and

collaborated with Mental Hygiene Administration on compliance concerns in Baltimore City. Staff also attended administrative hearings for providers appealing sanctions by MHA.

Objective 5I: Establish a Consumer Satisfaction Team (CST) to interview consumers receiving public mental health services in Baltimore City

- Strategies:
1. Collaborate with advocacy organizations to develop ideas.
 2. Develop a proposal and submit with requests for funding
 3. Recruit staff if funding is awarded.

- Indicators:
1. Submission of proposal.
 2. Approval of funding.
 3. Recruitment of staff.

Progress: This objective was accomplished.

Baltimore City, Anne Arundel County and Howard County were selected as the initial pilot sites for the Consumer Quality Team Project which has been in the planning stages for several years. The mission of the CQT is to “*empower consumers as partners with providers, policy makers and family members to improve care in the public mental health system to ensure services meet the expressed needs of the consumers.*” This project is a collaboration of the Mental Health Association of Maryland, Baltimore Mental Health Systems, On Our Own of Maryland, Mental Hygiene Administration, Department of Disabilities, Howard County Mental Health Authority, Anne Arundel County Mental Health Authority and Community Behavioral Health. Representatives from these agencies continue to serve on an oversight committee providing technical assistance and support to the project. The project is bringing the voices of consumers together with mental health officials responsible for funding and oversight of the public mental health systems to ensure timely follow up on identified concerns. Mental Hygiene Administration has approved funding to expand the pilot project State-wide.

The Executive Director was hired in June 2006 followed by peer interviewers in December. A total of 110 interviews were conducted in Baltimore City from January through June 2007. Adults enrolled in Psychiatric Rehabilitation Programs were the first consumers interviewed. CQT staff prepared written reports for providers, CSA, MHA and the oversight committee. CSAs followed up with providers on consumer comments. Baltimore City providers have been responsive when contacted by QI about the CQT Team and the process. BMHS has consistently received positive feedback and providers have made changes in response to consumer comments. Programs are establishing (and re-establishing) consumer councils to increase consumer involvement in planning activities and issues of importance to consumers. The Director of QI and Operations serves on the over-sight committee which meets regularly to discuss the feedback from consumers and suggestions from CQT. As the project moves forward, more discussion will occur on how the data collected can be used by BMHS in planning for services.

Objective 5J: Monitor and Report Sentinel Events (consumer deaths, level III appeals, complaints, help calls, unusual incidents)

Strategies: 1. BMHS staff will respond to complaints, help calls, etc. and forward forms QI staff for compilation and reporting.

Indicators: 1. Number of MHA death reports.
 2. Number and type of complaints.
 3. Number of help calls.

Progress: This objective was accomplished.

DHMH Death Reports

Quality improvement staff reviewed 76 DHMH Report of Deaths from community mental health programs. The reports reflect known deaths of consumers actively enrolled or recently discharged from services. It is possible that the actual numbers may be higher than reported. Providers are not always notified by third parties until months after the death occurred, if at all. QI staff collaborated with Mental Hygiene Administration on the reviewing and investigating of suspicious or unexpected deaths. BMHS’ role in investigations is very limited. QI staff may meet with program staff and providers to review documentation and circumstances surrounding the death. This information is forwarded to the Mental Hygiene Administration who has a formal Morbidity and Mortality review committee. On occasion the committee may ask BMHS to follow up and obtain additional information. The table below is a summary of death reports.

FY07 Summary of Consumer Death Reports					
Consumer Deaths	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	Total
Total Reported	17	18	17	24	76
Males	10	11	10	12	43
Females	7	7	7	12	33
Cause of Death Known	12	12	10	14	48
Cause of Death Unknown	5	6	7	10	28
Mean Age	52	57	55	55	55

Complaints

BMHS received 21 complaints from consumers and family members. Complaints related to quality of care and treatment issues. There are problems with internal tracking and reporting of complaints. Staff sometimes receive complaints and forget to forward to QI. This will be addressed in the upcoming year.

Help Calls

The majority of help calls were for information and referrals for services. An increase in the second quarter was related to increase data collection in the month of October 2006 for Maryland Association of Core Service Agencies.

FY07 Help Calls Received				
1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	Total
767	1711	950	855	4,283

Level III Appeals/Grievances

QI staff processed 17 grievances for non-emergency inpatient services. Code of Maryland Regulations (COMAR 10.09.70.08) provide mental health consumers with the right to file a grievance and request review of a previous medical necessity decision that resulted in non-authorization of services. Consumers or providers may file an appeal on behalf of the consumer. Only psychiatrists can deny services. There are five levels in the appeal process. Level I is reviewed by psychiatrist advisor on staff at MAPS-MD. Level II is a review by the Medical Director at MAPS-MD. Level III Appeals are sent directly to Baltimore Mental Health Systems, Inc. for a review by a psychiatrist. Consumers may file a Level IV appeal to Mental Hygiene Administration. If a consumer has Medical Assistance they may file a Level V appeal to the Office of Administrative Hearings.

FY07 Summary of Level III Grievances Received						
Total Grievances	Adults	Child & Adolescent	Inpatient	Outpatient	Approved	Denied
17	15	2	17	0	0	17

Goal #6: Provide education to key stakeholders, providers, and staff.

The table below is a summary of the number of trainings sponsored or coordinated by BMHS.

Education Training				
Community and Provider Training	Attendance	Staff Development Training	Number of Staff Attended	Community Health Fairs
56	900	25	20	90

ADULT SERVICES DIVISION

Objective 6A: Educate public mental health system (PMHS) providers in Baltimore City on a range of mental health issues and topics.

- Strategies:
1. Provide orientation workshops to providers and community groups about the role of BMHS in the PMHS.
 2. Provide 3 trainings on a variety of topics to case managers and outreach teams.
 3. Coordinate a forensic conference.

- Indicator:
1. Number of PMHS provider staff that receive training and the number of training opportunities provided.

Progress: This objective was accomplished.

BMHS has conducted a variety of outreach and educational activities to community groups:

- Trainings of social workers at Springfield Hospital, Clifton T. Perkins, Walter P. Carter Center, and Spring Grove Hospital.
- Presentations to the Maxie Collier Scholarship program at Coppin State on the overview of the public mental health system, the role of police and forensics in mental health and the Capitation Project.
- Participation with the Health Department and the Baltimore City Police Department in Operation Protect and Safe Zones through regular attendance by outreach workers coordinated by BMHS.
- Joint presentations with BMHS, MAPS-MD and BCRI to inpatient units and emergency rooms on the high-cost consumer initiative.
- Joint presentations with BMHS and BCRI to emergency room staff to educate providers about the statewide hospital diversion project.

- Outreach to outpatient mental health clinics to educate staff about the role of BMHS in the public mental health system and identify barriers to timely intake.
- Presentations to other community service providers on the role of BMHS in the public mental health system, including but not limited to: Helping Other People through Empowerment, Baltimore City Health Department, and the Family Leagues' Family Reunification Project.
- Presentation to policy students at the School of Social Work at University of Maryland Baltimore on community mental health services.
- Two presentations to University of Maryland Medical Center Geriatric Psychiatry Department on the role of BMHS and the public mental health system.
- The annual forensic conference was held in May of this year. The title was: Addressing Trauma in the Lives of Consumers in the Criminal Justice System. The conference was attended by 170 individuals.

CHILD & ADOLESCENT SERVICES DIVISION

Objective 6B: Provide and/or support opportunities for community education on children's mental health targeted to providers, consumers and the Baltimore City community.

- Strategies:
1. Provide Early Childhood Mental Health training opportunities to the Public Mental Health System provider community.
 2. Hold informational and training sessions for school-based mental health service providers.
 3. Support parent/family advocacy organizations in providing training/educational opportunities for the public on children's mental health issues.

- Indicators:
1. Number of Early Childhood Mental Health training opportunities provided; number of attendees.
 2. Number of school-based mental health training opportunities provided; number of attendees.
 3. Number of training sessions offered to the public (parents / family members) by parent/family advocacy organizations that receive funding from BMHS.

Progress: This objective was accomplished.

BMHS continued its sponsorship of the highly successful Early Childhood Mental Health Training Series. The chart below provides the topics presented and total number of attendees at each training:

Early Childhood Mental Health Training Series Topics	Number of Mental Health Professionals Trained
Let's Just Play: Using Art and Theraplay® Techniques	45
Engaging Families in Early Childhood Mental Health	45
Early Childhood Mental Health Consultation Model	45

In addition to the Early Childhood Mental Health Training Series, a series of three professional development training sessions were conducted during the 2006-2007 school year for mental health professionals providing Expanded School Based Mental Health (ESMH) services. In August 2006, a session was held to orient new mental health clinicians, and welcome back returning staff to ESMH. In November 2006, Ed Burns, co-producer of “The Wire” presented a provocative presentation that provided insights into the daily challenges that confront the students served by the ESMH clinicians. “Necessary Strategies and Implementation Guidelines for Evidence Based Practices” was the topic during the spring 2006 professional development session. Approximately 85 clinicians attended each session.

BMHS also provides funding and support to the Maryland Coalition of Families for Children’s Mental Health and for the Mental Health Association of Maryland. Both organizations provide various community education programs around children’s mental health as well as advocacy and family support services. The Mental Health Association of Maryland conducted 309 performances of Kids On The Block, a program designed to teach children about mental health in a non-stigmatizing way, and distributed 32,922 pieces of literature to the community on children’s mental health. In addition, the Maryland Coalition of Families for Children’s Mental Health provided advocacy and support to 384 families and responded to 684 requests for information from families, professionals, and providers.