Mid-Shore Mental Health Systems, Inc.

Community Mental Health Plan

Fiscal Years 2009 and 2010

Serving:
Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties

January 2008

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SECTION I – PROGRAM PLAN

1. EXECUTIVE SUMMARY

The scenic backdrop of Maryland's Eastern Shore portrays a relaxed, providential atmosphere of small-town America at its best. Given the beauty and bounty that exists for many in the five-county Mid-Shore region, the staff at Mid-Shore Mental Health Systems, Inc. (MSMHS) works tirelessly to help the State's Mental Hygiene Administration provide rich, fulfilling services for the public mental health consumers of our region. In collaboration, MSMHS reaches out to providers, consumers and related agencies in an effort to marry State and local priorities. Absent a number of valuable mental health services that are difficult to replicate in rural communities, the CSA uses the spirit of cooperation to break down barriers to access and choice whenever possible.

The CSA has worked hard to craft a plan with exceptional awareness of the needs within the "special populations" of our State. Already, MSMHS has several operating initiatives targeted towards specific populations including the Homeless Mentally Ill, Dually Diagnosed (mental illness and developmental disabilities), Co-Occurring Disorder (mental illness and a substance addiction), Deaf and Hard of Hearing, returning military veterans, Transitional Age Youth and individuals whose mental health needs are coupled with a forensic background.

MSMHS has focused efforts on the homelessness and affordable housing shortage issues related to consumers with mental health disabilities. Since its inception in 2001, the continuum of care now known as the Roundtable on Homelessness has been led by MSMHS. This group is comprised of stakeholders in the region that serve the very low income population which, each day, faces the spectre of homelessness. MSMHS through partnerships with a local provider and crucial grant funding such as PATH (Projects for Assistance in Transition from Homelessness) has provided an outreach case manager for prevention and homelessness assistance for consumers with a mental health diagnosis. Through the Roundtable's efforts, the mid-shore has received grants to provide homeless assistance through Supported Housing, Shelter Plus Care Housing and Homeless Management Information System (HMIS). The housing programs provide funds for rental assistance to consumers that are receiving mental health services through the PMHS. The HMIS program offers access to a centralized database to all providers in the region for recording and reporting activities related to homelessness in the region. The HMIS program is slated to begin statewide system integration in FY08, which will allow broader access and help to reduce the cost of maintaining multiple systems throughout the state in the coming years.

The Dually Diagnosed population is defined as individuals who have been determined to be developmentally disabled and have a mental health diagnosis (DDA/MHA). The mission of the region's DDA/MHA consortium is to coordinate services for adults in the community and prevent abuse, neglect, harm, and lower the potential risk of same by the coordination of several community based agencies that make a referral to the DDA/MHA Collaborative Team members or referrals from other community agencies no part of the DDA/MHA Collaborative Team. To date, the coalition has reviewed five cases. The group has utilized Dr. Lisa Hovermale, the psychiatric liaison between DDA and MHA, along with local professionals and family members

to problem-solve issues and return or maintain consumers to their home in the community. Four out of the five consumers have been able to remain successfully in the community. Partners include representatives from the Developmental Disabilities Administration, local health departments, a family advocate, the community hospital, mental health providers and any other agency involved with their care.

MSMHS continues to collaborate with the Dorchester County Drug Court to provide a mental health services recommendation when needed. The logic of the partnership developed from the recognition of the prevalence of co-occurring disorder and the need for a coordinated treatment response. MSMHS continues to work with regional stakeholders to implement the Comprehensive Continuous Integrated System of Care model for this population.

MSMHS, in partnership with Eastern Shore Hospital Center (ESHC), is developing a five (5) bed Transitional Residential Rehabilitation Program to provide opportunities for forensically involved consumers found not criminally responsible to meet the standard of their conditions of release while living in the community. MSMHS continues to contract for Jail Mental Health services in all five county Detention Centers, with trauma treatment offered in two of those centers. MSMSH has worked closely with the regions' Detention Centers and the Case Management provider to implement the practice standards outlined in House Bill 281 for this population.

For the past year, MSMHS has provided access to outpatient mental health services through the use of American Sign Language-proficient interpreters. While not optimal, this is the only current option. Investigation for the development and implementation of a culturally competent delivery model has yielded a Request for Proposals (released December 2007 by the CSA) to provide access to licensed social workers skilled in American Sign Language and cultural competency with this population. MSMHS continues to participate on the Office of Deaf and Hard of Hearing Mental Health Sub-committee, supporting the development of a statewide coordinated system of care for this population. MSMHS will use approved 'rollover' dollars to conduct a needs assessment for this population, and to offer training in culturally competent mental health care for this population.

MSMHS recognizes that the Veterans Administration's capacity to serve the increasing population returning from current engagements with high prevalence of mental health conditions will be woefully burdened. To that end, MSMHS continues to work with community organizations and advocacy groups to strategize methods for ensuring local resources can meet demand for the local Veterans population. MSMHS is invested in ensuring that local veterans have opportunities for recovery from the traumas they regularly experience.

Funds for Transitional Age Youth are available to promote independent living for individuals ages sixteen to twenty-one who are involved with the Division of Rehabilitation Services (DORS). This funding is used to provide supports other than those typically funded by DORS. MSMHS is also supporting the development of a chapter of Youth M.O.V.E .for the five mid-shore counties. Youth M.O.V.E. will promote the involvement of Transitional Age Youth in youth-serving systems throughout the community. Youth participation on the Boards of

agencies serving this population will provide their perspective for policy makers and service providers thereby prompting changes in service delivery that will better meet the needs of youth.

Efforts by MSMHS to utilize technology to increase rural access to specialty mental health care through the use of telepsychiatry have been initiated. Exploration of funding opportunity and resource capacity is ongoing. MSMHS is evaluating the possibility of using existing teleconferencing systems available at local health departments to provide telepsychiatry until equipment can be made available in local service delivery settings. Local travel will not be eliminated but longer commutes to urban area providers to receive specialty services will be reduced.

MSMHS continues to increase membership of the Consumer Council. Average attendance per meeting has grown from 3 in FY06, to 7 in FY07, to 12 so far in FY08. This has been a result of outreach to PRP programs, Chesapeake Rural Network, and local providers. MSMHS' focus with our local peer support organization, Chesapeake Rural Network, has been on developing stability, and expanding their presence in our region. Family representation on the DDA/MHA consortium continues. MSMHS supported the Local Management Boards in expanding Family Navigators positions across the region, and the development of the information and referral services warm line, Chesapeake Helps.

MSMHS' Crisis Services Network was developed for the purpose of strategizing systemic solutions for reducing the burden on our local emergency departments and maximizing the use of existing resources to assist consumers in crisis. The use of the MSMHS designed Same Day Evaluation program services continues to increase, diverting individuals from emergency departments as often as appropriate. While the program is currently just available in Easton, efforts are underway to secure resources that will enable the CSA to offer an alternative for the region's remaining two community hospitals in Cambridge and Chestertown.

MSMHS has long recognized the need for safe, affordable housing options for our local mental health consumers. We facilitated the transfer of properties previously managed by Crossroads Community, Inc through the Shore Alliance for Independent Living to Main Street Housing, Inc. This resulted in significant property improvements and the alignment of the project with Main Street's vision and mission will undoubtedly lead to the acquisition of additional properties to serve the consumer community.

In collaboration with Mid-Shore Council on Family Violence and For All Seasons, Inc., MSMHS funding ensures access for Spanish-speaking victims of domestic abuse to a mental health professional through the use of interpreters. In recognition of the increasing local Hispanic/Latino population, historically underserved, we will continue to collaborate with MHA and local providers to improve access.

The lack of community-based resources in our region has had a significant impact on family participation in treatment. In cooperation with the Local Management Boards and other child serving agencies, MSMHS participated in the proposal process for the creation of shelters, group homes, and diagnostic services for children and adolescents, particularly those in foster care. Additional community-based services are being accessed through the utilization of Community

Service Initiative and flexible funding resources to divert or support return from out of home placement. These funds supplied by the Governor's Office for Children (GOC) allowed 7 youth to be diverted from Residential Treatment Center (RTC) placement in FY07. There were 36 youth that required RTC placement in FY07, consistent with prior year numbers. Without GOC funding it is likely that the number of RTC placements would increase.

2. INTRODUCTION

In accordance with Maryland law, Mid-Shore Mental Health Systems, Inc. (MSMHS), the mental health authority for Caroline, Dorchester, Kent, Queen Anne's and Talbot counties, has prepared the Community Mental Health Plan for Fiscal Years 2009 and 2010. Local mental health authorities, also known as Core Service Agencies (CSA's), were created by State law to plan, monitor and evaluate publicly funded mental health services. The law requires Core Service Agencies to prepare a comprehensive plan with input from users of the Public Mental Health System (PMHS) and the community at large.

The FY09 and FY10 Community Mental Health Plan document describes the MSMHS planning process, including a summary of the comprehensive Needs Assessment completed in FY08. With the input of stakeholders of the region, MSMHS has developed the goals, objectives and strategies for the upcoming years.

MSMHS is proud to present the fruits of a comprehensive planning exercise. This document represents the full commitment of our CSA staff, under direction from the stakeholders of our region, to pursue a system of public mental health that minimizes the stigma associated with mental illness and maximizes the individual's opportunity to recover. In aligning with The President's New Freedom Commission and the State of Maryland's Transformation Grant, MSMHS has embraced the philosophy and values that steer the system's mode of delivery to be more consumer and consumer-family inclusive.

3. SYSTEM MISSION, VISION AND VALUES

Mid-Shore Mental Health Systems, Inc. (MSMHS), in cooperation with the State of Maryland's Mental Hygiene Administration and APS Healthcare, is charged with insuring that the Public Mental Heath System provides appropriate, quality, and timely mental health services to the citizens of Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties.

MSMHS's mission is *to continually improve the provision of mental health services for residents of Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties through effective coordination of services in collaboration with consumers, family members, providers and community leaders.*

The board and staff of MSMHS believe that the mental health system should assure quality, cost-effective services that meet the needs of consumers. Consumers are the focus of MSMHS, and it is a primary goal through partnership with other agencies to develop a full array of easily accessible services for the consumer. MSMHS strongly believes in the empowerment of individuals, consumers and family members to help develop their fullest potential.

The vision of MSMHS is *to develop a model rural mental health delivery system with a continuum of mental health services that are, culturally diverse. These services ensure consumer empowerment, have a community focus, are cost effective for the system and are integrated to serve the community as a whole, private and public sector, regardless of cultural or ethnic background.*

MSMHS' vision is based on the fundamental values as articulated by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Mental Hygiene Administration and these are:

RECOVERY ORIENTED

Self-Direction: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

Individualized and Person-Centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions including the allocation of resources that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

Non-Linear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

Strengths-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner,

caregiver, friend, student and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

Peer Support: Mutual support including the sharing of experiential knowledge and skills and social learning plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

Respect: Community, systems, and societal acceptance and appreciation of consumers including protecting their rights and eliminating discrimination and stigma are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Hope: Recovery provides the essential and motivating message of a better future that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.

SYSTEM ORIENTED

Responsive System: Mental health care must be responsive to the people it serves, coherently organized, and accessible to those who require mental health care. Information must be readily available in order that individuals can appropriately enter and proceed through the system in a timely manner, and the pieces of the system must be linked to allow for continuity of care. The hospital is one part of the community-based mental health system. The mental health system must collaborate with other public and private human services systems in order to facilitate support with all activities of life.

Family and Community Support: The mental health system must provide families with the assistance they need in order to maintain or enhance the support they give to their family members. MSMHS will strive to provide services to persons within their communities with the availability of natural/family supports.

Least Restrictive Setting: Services should be provided in the least restrictive, most normative, and most appropriate setting. An array of services will be available throughout the State to meet a variety of consumer needs.

Working Collaboratively: Collaboration at the State and local level will promote a consistently acceptable level of mental health services. Collaborations with other agencies will be fostered so support to consumers is inclusive of all activities of life.

Effective Management and Accountability: Accountability is an essential management function, which includes monitoring and self-evaluation, rapid response to identified weaknesses in the system, and adapting to changing needs and improving technology. MSMHS must put the highest priority on measuring consumer satisfaction with the services they receive. Outcome measures will be a key component for evaluating and communicating program effectiveness.

LOCALLY DRIVEN

Local Governance: Local management of resources resulting from the implementation of Core Service Agencies will improve continuity of care, timely provision of needed services, better congruence of services and resources to needs, and increase economic efficiency because of closer proximity to the services delivery level.

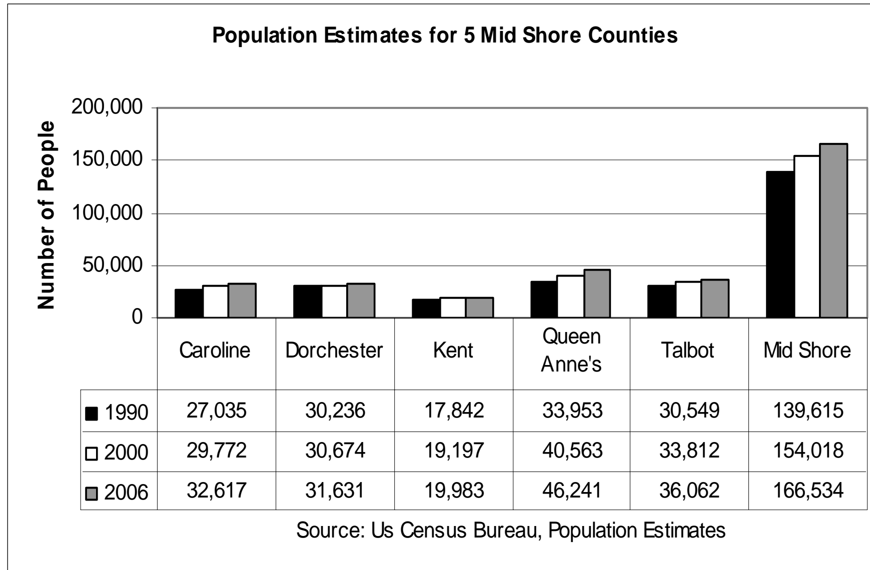
Staff Resources: The presence of a competent and committed staff is essential for the provision of an acceptable level of mental health services. Staff must be provided with adequate support systems and incentives to enable them to focus their efforts on the individuals who receive care from them. Opportunities must be provided for skill enhancement training or retraining as changes in the service system take place.

Community Education: Early identification and prevention activities for risk groups of all ages, public education, and efforts that support families and communities must be incorporated into the service system. Increased acceptance and support for mental health services can only come from increased awareness and understanding of psychiatric disabilities and the people affected. As MSMHS works to integrate and network services into its communities, eliminate the barriers of its rural setting, encourage new and innovative approaches to providing care, and expand consumer advocacy programming, the consumers and families will have available to them the tools they need to make informed choices.

4. DEMOGRAPHICS

The five counties of the mid-shore region of Maryland's Eastern Shore consist of Caroline, Dorchester, Kent, Queen Anne's, and Talbot. Its residents are spread over 1,798 square miles, or roughly 23% of Maryland's land mass, stretching 87 miles from North to South and 35 miles from East to West (Source: Salisbury University Department of Geography, July 2003). All five counties are predominantly rural and agricultural in nature, but Queen Anne's County was added to the Baltimore-Washington D.C. metropolitan region by the Maryland Office of Planning after the 2000 Census. This was due to the significant population increases, the commuter rates of workers to the metro areas, and the close proximity of the county to the Baltimore and Washington,

D.C. city centers. The five counties all feature major water ways such as the Chesapeake Bay and tributary rivers and the waterways have helped to position the area rich in maritime and Colonial history. As a result, the tourism and hospitality industries are critical to the economy of each county.



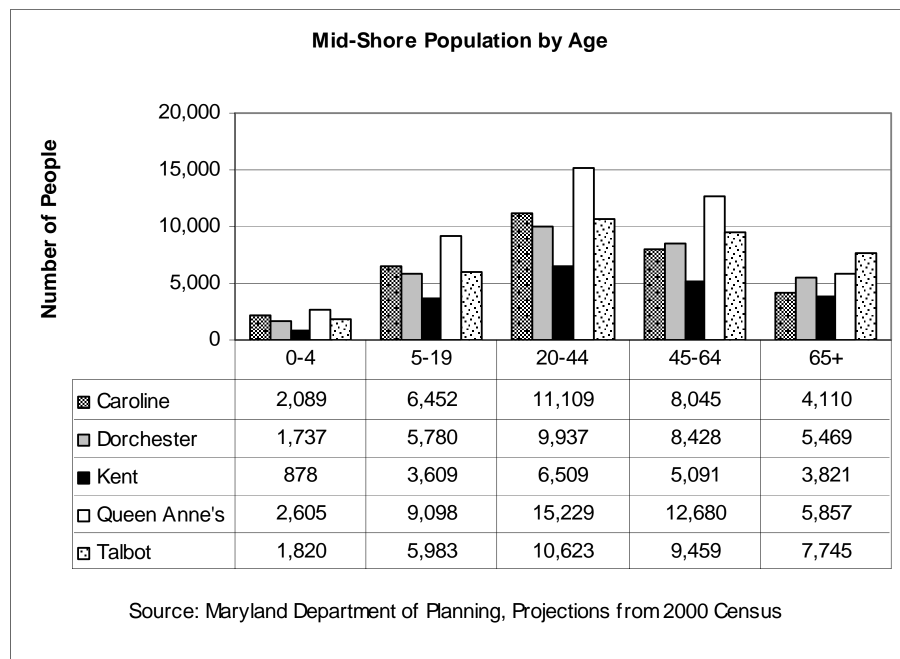
	Caroline	Dorchester	Kent	Queen Anne's	Talbot	Mid Shore
1990	27,035	30,236	17,842	33,953	30,549	139,615
2000	29,772	30,674	19,197	40,563	33,812	154,018
2006	32,617	31,631	19,983	46,241	36,062	166,534

Population

The US Census reported a total population of 154,018 for the 5-County region in 2000. Queen Anne's County has consistently hosted the largest number of residents at 40,563 in 2000, while Kent County hosted the least number at 19,197 for the same Census year. Growth in the number of residents between 1990 and 2000 occurred at a rate of 10% for Caroline County, 1% for Dorchester County, 8% for Kent County, 19% for Queen Anne's County, and 11% for Talbot County. Queen Anne's County has consistently shown the highest population increases between Census decades since 1970.

Population Age Range

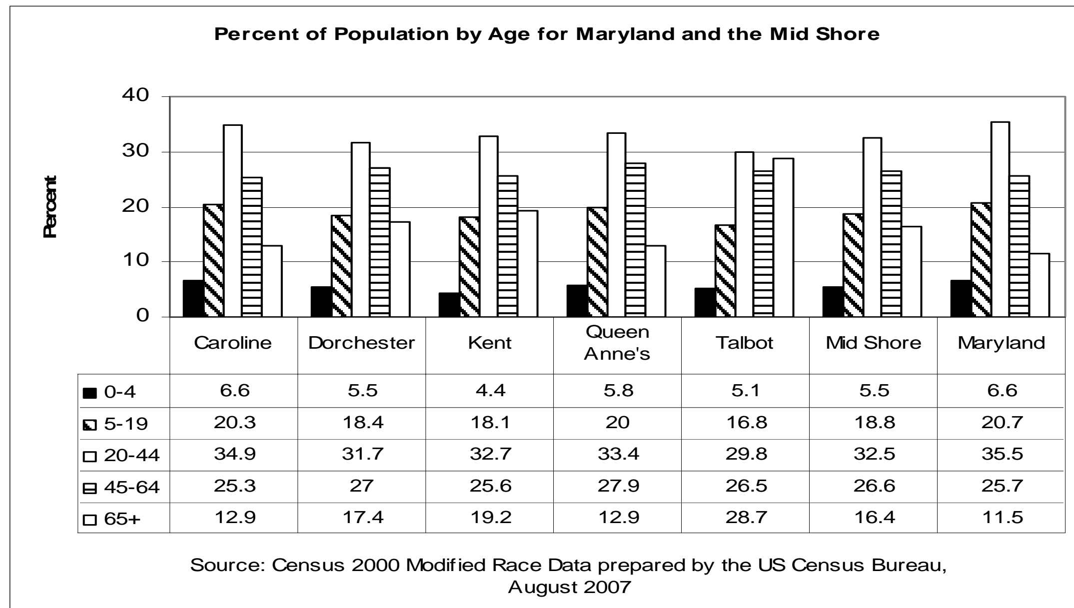
Of the total number of mid-shore residents in 2000, 40,051 residents or approximately 24% were ages 21 and under and 27,002 or approximately 16% were ages 65 and above. With the exception of those ages 65 and above in Talbot County, Queen Anne's County consistently housed the greatest number of residents in the other age groups.



	0-4	5-19	20-44	45-64	65+
Caroline	2,089	6,452	11,109	8,045	4,110
Dorchester	1,737	5,780	9,937	8,428	5,469
Kent	878	3,609	6,509	5,091	3,821
Queen Anne's	2,605	9,098	15,229	12,680	5,857
Talbot	1,820	5,983	10,623	9,459	7,745

In terms of percentages and distribution of age groups, Caroline County has the highest percentage of children and young adults ages 0-4, 5-19, and 20-44. Queen Anne's County has

the highest percentage of mid-aged individuals (45-64), and Talbot County has the highest percentage of elders ages 65 and above.

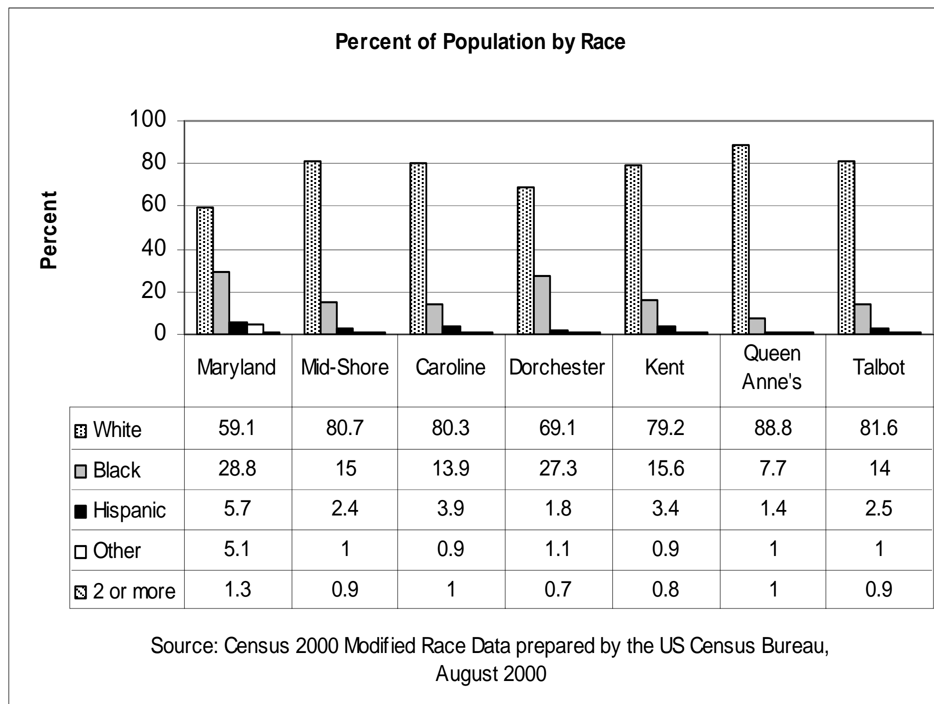


	Caroline	Dorchester	Kent	Queen Anne's	Talbot	Mid Shore	Maryland
0-4	6.6	5.5	4.4	5.8	5.1	5.5	6.6
5-19	20.3	18.4	18.1	20	16.8	18.8	20.7
20-44	34.9	31.7	32.7	33.4	29.8	32.5	35.5
45-64	25.3	27	25.6	27.9	26.5	26.6	25.7
65+	12.9	17.4	19.2	12.9	28.7	16.4	11.5

Source: Census 2000 Modified Race Data prepared by the US Census Bureau, August 2007

Population Ethnicity

Across the mid-shore region, an estimated 80.7% of the population is Caucasian, 15% is African American, 2.4% is Hispanic, and 1.9% is from other ethnic backgrounds or from a mixture of backgrounds. The greatest percentage of people with ethnicities other than Caucasian, reside in Dorchester County. Queen Anne’s County has the lowest percentage of minority residents. The mid-shore ethnic distribution is significantly different from the average distribution across Maryland with the State having 59.1% Caucasian and 40.9% minority (African American, Hispanic, and others) compared to 80.7% Caucasian for the mid-shore and 19.3% minority. Locally, providers have noted increases in the number of



	Maryland	Mid-Shore	Caroline	Dorchester	Kent	Queen Anne's	Talbot
White	59.1	80.7	80.3	69.1	79.2	88.8	81.6
Black	28.8	15	13.9	27.3	15.6	7.7	14
Hispanic	5.7	2.4	3.9	1.8	3.4	1.4	2.5
Other	5.1	1	0.9	1.1	0.9	1	1
2 or more	1.3	0.9	1	0.7	0.8	1	0.9

Source: Census 2000 Modified Race Data prepared by the US Census Bureau, August 2000

non-English speaking families across the mid-shore. Families from Mexico and other Spanish origin nations make up the majority of non-English speaking residents.

Median Household Income

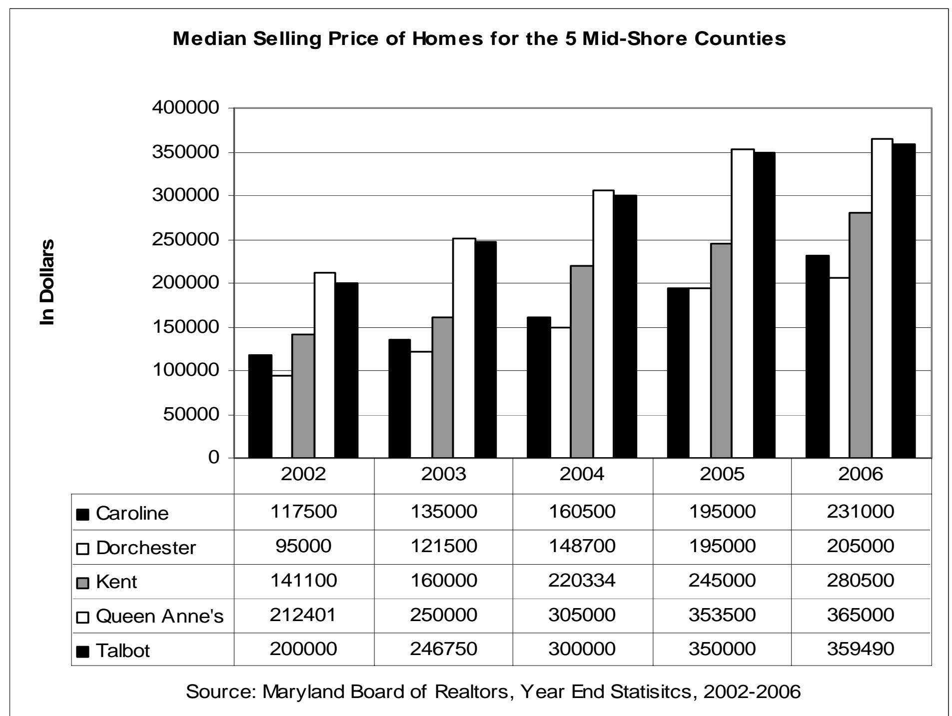
The Median Household Income for the entire mid-shore was $45,996 in 2000 and is estimated at $51,800 for 2005. Of the five counties, Queen Anne's County has consistently yielded the highest Median Household Income. Dorchester County has consistently yielded the lowest. The average for the mid-shore region in 1995, 2000, and 2005 has fallen below the state average for each reported time period. All counties except Queen Anne's have reported lower than Maryland averages.

Median Household Income (In Dollars)			
Name	**Est. 1995**	**Est. 2000**	**Est. 2005**
Caroline County	31,800	40,450	45,750
Dorchester County	29,500	36,200	41,300
Kent County	34,700	41,300	47,550
Queen Anne's County	45,100	62,150	71,550
Talbot County	38,100	45,500	52,850
Mid Shore (Average)	35,840	45,120	51,800
Maryland	45,450	56,250	64,450

Source: Maryland Department of Housing and Economic Development

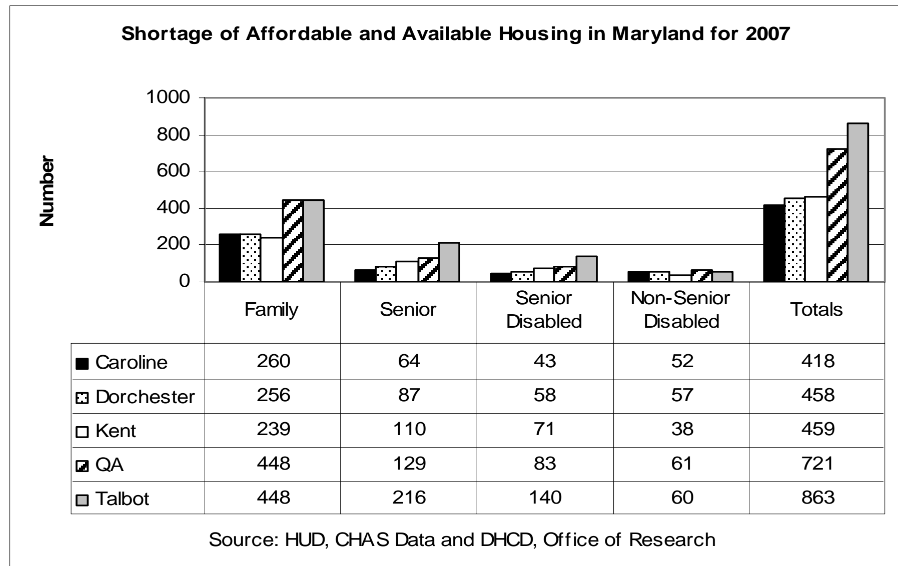
Affordable Housing

Affordable housing has become a critical concern for people earning limited income and for those who provide valuable services such as teachers, safety and emergency personnel, and nurses. Housing prices have increased at alarming rates, but the mid-shore has experienced an unprecedented boom in housing developments with housing costs averaging over $288,000 per home. Among the five mid-shore counties, home costs in Queen Anne's County were highest in 2006 at $365,000 and home costs in Dorchester County were lowest at $205,000. As a result of Dorchester and Caroline Counties



	2002	2003	2004	2005	2006
Caroline	117500	135000	160500	195000	231000
Dorchester	95000	121500	148700	195000	205000
Kent	141100	160000	220334	245000	280500
Queen Anne's	212401	250000	305000	353500	365000
Talbot	200000	246750	300000	350000	359490

with the lowest home prices, public agencies from both counties are reporting a significant influx of lower-income residents from neighboring Queen Anne's, Talbot, and Kent Counties which has put an unplanned strain on demand for public services.



	Family	Senior	Senior Disabled	Non-Senior Disabled	Totals
Caroline	260	64	43	52	418
Dorchester	256	87	58	57	458
Kent	239	110	71	38	459
QA	448	129	83	61	721
Talbot	448	216	140	60	863

Source: HUD, CHAS Data and DHCD, Office of Research

Queen Anne's County conducted an affordable housing study in early 2007 and determined that the county is deficient in affordable housing by 1700 units (QAC Department of Housing and Community Services). The federal government's Department of Housing and Urban Development (HUD) maintains housing shortage projections in their Office of Research and provides projections for all U.S. counties. From their research it is estimated that an affordable housing shortfall of 2919 units exists currently across the five mid-shore counties.

5. DESCRIPTION OF PLAN DEVELOPMENT PROCESS

MSMHS was the beneficiary of a considerable number of regional and county-based needs assessments prepared within the months leading up to our own assessment and planning exercise. Local Management Boards and the 5 county Departments of Social Services, for example, had comprehensive processes in which the CSA, among many other participants, identified the current and future needs of the region's consumers of public mental health services. These participants included providers, consumers, family members, agencies and businesses.

Accordingly, MSMHS adjusted the scope of our project to allow for an exhaustive meta-analysis of these recent studies. Before our independent consultant began work on the project, CSA staff was scouring the various studies for common themes surrounding needs and opportunities for improving the region's capabilities. The consultant built upon this work, shifting the focus of her engagement with the stakeholder community away from covering the same ground (re-identifying needs). Instead, the bulk of the process included focus groups, key informant interviews and a large community meeting to discuss strategies for overcoming the issues we face.

In summary, the community's valuable time was spent taking joint ownership of our region's needs and planning solutions rather than renaming the weaknesses previously noted. Therefore, the goals, objectives and strategies that follow in our document are community-crafted. The burden of overcoming the difficulties we face is also acknowledged to lie beyond the scope of just the CSA, as well.

6. REPORTING AND ANALYZING DATA

An analysis of the data yields a snapshot of activity and clues to the future direction within this jurisdiction. There are numerous ways to assess the information contained within the data. The information used to create the charts and graphs on the following pages came from two main APS (MAPS-MD) reports, "Statewide Dollars, Service Units and Unduplicated Consumer Counts by Procedure Groups" and "Fee-For-Service Expenditures by Procedure Groups, Coverage Type, Age and Fiscal Year."

In the discussion to follow, there are several considerations of which a reviewer should be aware.

- Unless otherwise stated as the source, the data represented in the charts and graphs below came from the two reports listed above, generated on 9/30/2007.

- The totals and sub-totals within these reports and graphs will differ dependent upon how the data is used. For example, unduplicated consumer counts are higher when viewed by either pay source or treatment type than when compared as a total number because a consumer may receive services from more than one category or may change pay source within the year. However, they are only counted once within each of these subcategories.

- Fiscal Year 2007 billing activity remains open until March 31st, 2008; this is known as lag time. The CSA does believe, however, that about 98% of the billing to be anticipated is reflected in the activity as of 9/30/2007. Fiscal years will be noted as FY05, FY06 and FY07.

- Required data charts provided by MHA are attachment found after page 26.

- The Uninsured population, previously called "Gray Zone", is also referred to as "Medical Assistance Ineligible," sometimes shown as Ineligible or MAI. The care for these consumers comes solely from State-only funds; there is no Federal match. Medicaid-eligible consumers may use State-only funds if the service type is not reimbursable by MA. These funds are represented, regardless of who accesses them as "State-Only."

- Unless otherwise specified, the treatment type of Rehabilitation (REHAB) includes Psychiatric, Residential, Crisis, Supported Employment and Respite.

- The following abbreviations will be used for service types in the following charts:

CM = Case Management	IP = Inpatient
PH = Partial Hospitalization	OP = Outpatient
PR = Psychiatric Rehabilitation	RR = Residential Rehabilitation
RS = Respite Services	SE = Supported Employment
RTC = Residential Treatment Centers	ER = Emergency Room

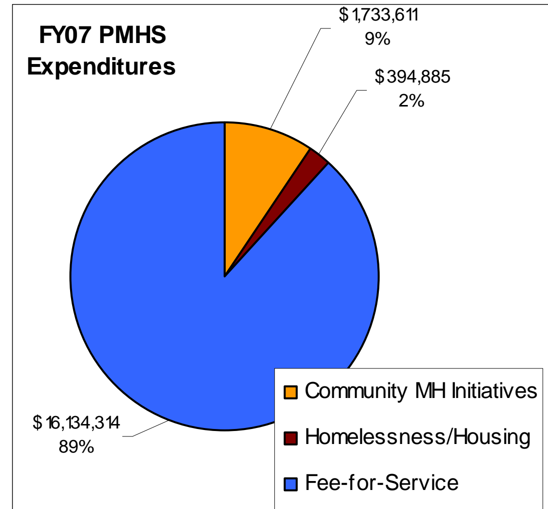
6a. General Cost Data:

This segment looks at overall cost trends and the total expenditures for the mid-shore region. Cost control analysis generally looks for a stabilization of costs or a plateau appearance over

the course of time. Once the plateau is reached, then continuing increases can be attributed to ongoing variables rather than the disproportional increases due to outlying anomalies.

The ongoing variables include:

- Increases in rates paid
- Increases in consumer enrollment
- Increases in service intensity
- Introduction of new services.



Overall Expenditures by Proportion of Funds

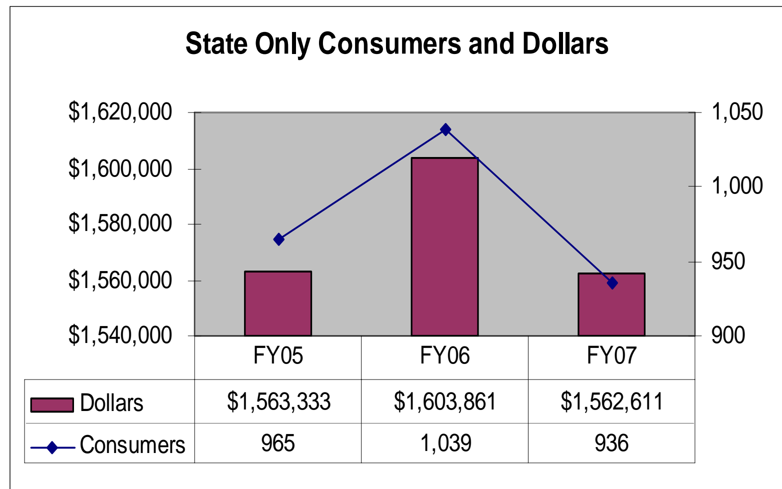
Fee-for-service (FFS) expenditures account for 89% of the funds that Mid-Shore Mental Health Systems monitored for FY07. These FFS expenditures are largely authorized and disbursed by Maryland's Administrative Service Organization and include Federal match monies but MSMHS is responsible for monitoring and watching trends in the use of the services. In addition, there are grants for community mental health initiatives and housing that are administered through MSMHS to local agencies to provide programs and services not covered in the FFS system. Some of these programs are geared toward special populations such as the Deaf and Hard of Hearing, the homeless, survivors of trauma and mental health consumers with forensic involvement. A portion of the funds are used to maintain a consumer-run peer support program and to educate the public about mental health and the stigma with which it is often accompanied. There is a Client Support (special needs) fund which allows the CSA to pay for items needed to further their recovery that are not otherwise covered. This includes Pharmacy, Lab and Transportation dollars to assist Medical Assistance Ineligible consumers with prescriptions, lab tests and transportation for mental health treatment appointments. A portion of these funds can also be used to help ease consumers through crisis-specific situations when all other community resources have been exhausted (including but not limited to utility assistance, household needs, clothing, one time rental assistance, etc.) The chart below shows what the total budget is for each category of the fund and how many consumers from each county were eligible and received assistance in FY07.

	Special Needs	**Transportation**	**Labs**	**GZ Pharmacy**
Budgeted Dollars	$20,000.00	$2000.00	$500.00	$20,000.00
Caroline	19	2	2	34
Dorchester	11	0	0	63
Kent	2	0	0	0
Queen Anne's	0	0	0	4
Talbot	10	0	0	8

Fee-For-Service Claim Expenditures by Fiscal Year
Mid-Shore regional FFS expenditures started to decrease in FY03 from around 17 million to just over 15 million in FY06. These expenditures are up 6% in FY07 because due to a combination of factors. Overall consumer counts rose during the period, there was a rate increase for Psychiatric Rehabilitation Services and Partial Hospitalization for youth has increased since the provider began marketing the service. Partial Hospitalization has not been consistently available in the region over the last few years.

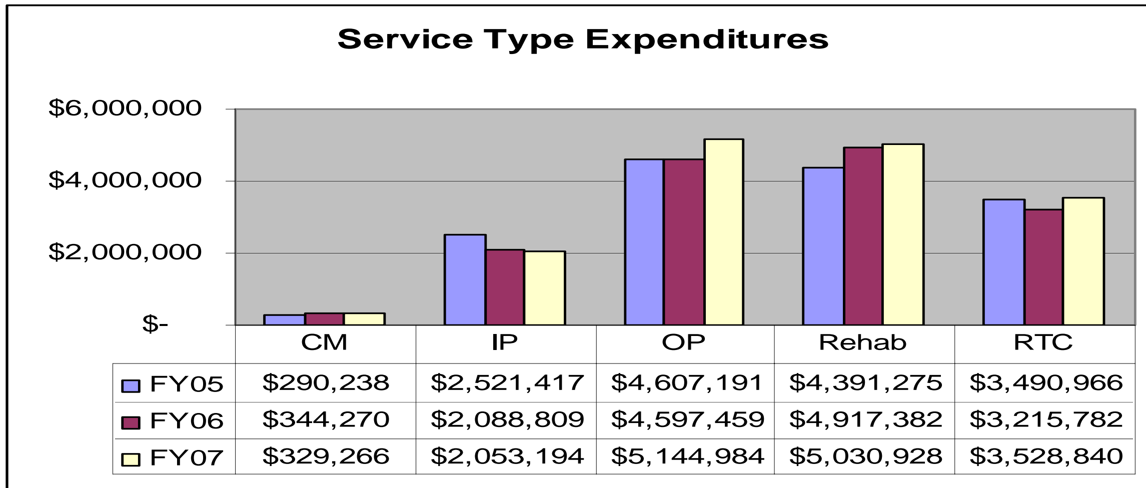
Overall Expenditures of (non grant-funded) Fee-for-Service:
These are dollars spent for billable services assigned to the Mid-Shore counties either when the MA benefit originates and is linked to one of the counties or if the provider is located in one of the counties and the consumer is receiving long term services such as the case for RTC and Inpatient. For this reason, there are also services that a consumer that resides in one of the counties will receive services from an "out of area" provider that will be shown in these dollars. Examples of these services include Crisis and Mobile Treatment which are not currently available in this region. Medicaid dollars are those that are Federally matched to state dollars, Medicaid State Funded are used when a consumer is Medicaid eligible but the service is not covered under Medicaid and Uninsured is used when a consumer is ineligible for Medicaid or in the process of establishing eligibility.

State-Only Expenditures
"State-Only" dollars represent non-Federally matched funds used for Medicaid State Funded and Uninsured consumers. There was a 7% increase in consumers in FY06 with only a 3.6% increase in expenditures. In FY06 the Primary Adult Care (PAC) program was introduced to replace the previous Maryland Pharmacy Assistance Program (MPAP) and increased the scope of coverage to include Outpatient Mental Health Services. When applicants are qualified for the program, costs are 'shifted' in to the Medicaid category. In fact the CSA, when approving client support requests for gray zone pharmacy, checks to determine that an application has been filed for PAC to create sustainability. In FY07, 283 mid-shore consumers received Federally funded services through the PAC program in FY07, a 27% penetration rate of those that are eligible for PAC. Combining the PAC program with the oversight and authorization by the CSA, there was an 11% decrease in consumers and 7.3% decrease in dollars used for the MAI population in FY07.



PAC data was provided by MHA (by request) in addition to the standard reports mentioned above.

Comparison of Fiscal Year Expenditures by Service Type



	CM	IP	OP	Rehab	RTC
FY05	$290,238	$2,521,417	$4,607,191	$4,391,275	$3,490,966
FY06	$344,270	$2,088,809	$4,597,459	$4,917,382	$3,215,782
FY07	$329,266	$2,053,194	$5,144,984	$5,030,928	$3,528,840

The above chart shows the contribution of the five major treatment areas. Rehab includes Psych Rehab Program, Crisis, Respite, Supported Employment and Mobile Treatment. These are some of the comments regarding the changes in expenditures across the three years.

Case Management (CM)

Both consumer counts and expenditures for this treatment category are down from the previous year. Statewide the numbers did the opposite, increasing 4.1% in consumers and by 6.4% in expenditures. With small numbers (the maximum case load for the mid-shore's sole providing agency less than 200), staff changes, restructuring of case loads and fewer referrals combined to create the 7.3% decline (13 consumers) in consumer counts for FY07. Beginning in early FY08, this treatment type transitioned from Fee-for-Service to grant funded and authorizations are being handled by the ASO, albeit with CSA input when needed.

Inpatient (IP)

Consumer counts for Inpatient are up 5% (12 consumers) over FY06 within the region while the statewide direction is opposite at -5.2%. The average length of stay has changed over this span from 8 days in FY05, 9 days in FY06 to 7 days in FY07. With the average length of stay decreasing, beds become available more often therefore increasing the number served. Even with the increase in number served during the year, expenditures for this treatment type are down 1.7% from the previous year. The average cost per consumer for Inpatients decreased by 8% in FY05, by 5% in FY06 and 6% in FY07. Over the last 3 years, the Mid-Shore consumers in Inpatient services have accounted for only 3% to 3.5% of the total consumers served statewide. Inpatient data is from private acute psychiatric hospitals only.

Outpatient (OP)

Although growth in consumers served regionally is slightly higher than statewide, that is a small numbers issue. Mid-Shore consumer counts make up only 4.8% of the statewide total for the outpatient treatment type. As community based services and the PAC program continue to grow, this treatment type should continue to increase.

Partial Hospitalization (PH) is included as an Outpatient treatment type. With the transition of the region's only Residential Treatment Center to Potomac Ridge in September of 2006, there has been an effort to increase the use of the day program for adolescent and younger children. This assists in decreasing RTC placements and accounts for the large increase in consumers served in PH.

Rehabilitation (Rehab)
Psychiatric Rehabilitation (PRP) – Small changes in numbers in this category were realized in the Uninsured population, decreasing from 102 served in FY06 to 99 in FY07. This was a continued effort to keep these expenditures controlled, authorization for services had to be reviewed by the CSA and new clients to the program had to have clearance through MHA for that authorization.

Respite Care (RE) – The Mid-Shore region uses a large portion of the overall state funds in this category. Grant funding is used to recruit, train and retain providers in this region. The expenditures increased disproportionately to the number of consumers served because the average days per quarter used by each consumer increased from 5 to 13 days in FY06 to 9 to 13 days in FY07. The CSA believes that increased use of this valuable service is an important factor in avoiding far more costly inpatient stays.

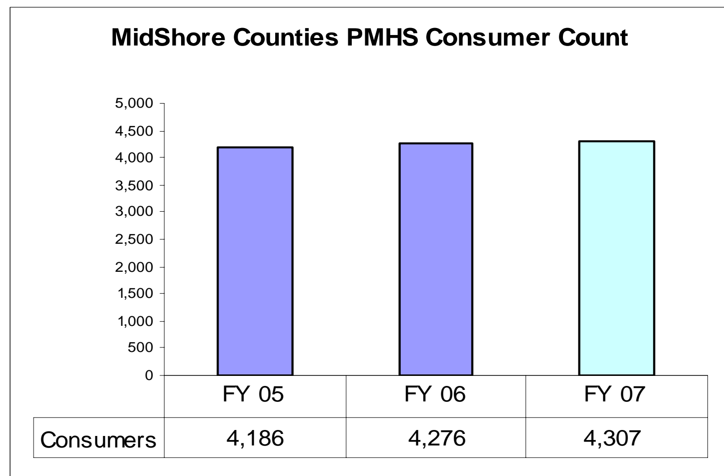
Crisis and Mobile Treatment – These categories of service remain small and relatively unchanged as there are no true providers located in the region. The 5 Crisis cases reported for FY07 were cases where the MA originated in one of the 5 counties in the region but no services were received from a provider located within these counties. Additionally, in FY07 there were concentrated efforts to address crisis services and hospital Emergency Department diversions through promotion of the Same Day Appointment program contracted through one of our providers. This program offers a diversion from hospital admission to a mental health professional in Easton. Utilization has increased from serving 8 consumers in FY05 to serving 57 in FY07. The CSA hopes to locate resources to expand the program to weekend days as well as other points within its jurisdiction in the coming year.

Residential Treatment Centers (RTC)
PMHS numbers show that there were 54 youth served in our region in FY07 which is a continued decline since FY05 when 70 youth were served. This trend was complicated by transition of management of the RTC facility to a new provider. This transition resulted in the short term loss of 30 beds, 15 of which are still not back online. The Local Management Boards reported 36 cases in FY07 who have residence in this region prior to admission; the remainders are youth from other areas that are placed in the treatment center located in the Mid-Shore region.

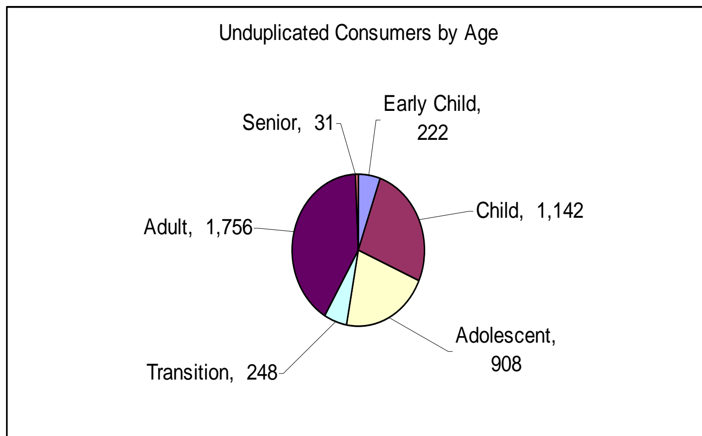
6b. General Consumer Data:

Consumers Served by the PMHS

FY07 consumer count for the Mid-Shore region has increased slightly over the last 3 years, yet the change from FY05 is just 2.8%. The Child, Adolescent and Transitional Age Youth (anyone under the age of 22) populations account for 58.5% of the total consumers. Of that number, 45.3% are between the ages of 6-12. Early identification through school based programs has increased this percentage from 44% reported in FY00. The Early Child category (0 to pre-school age) had a 12.3% decline from the 253 served in FY06 to 222 served in FY07; there are no identified events that triggered this change.



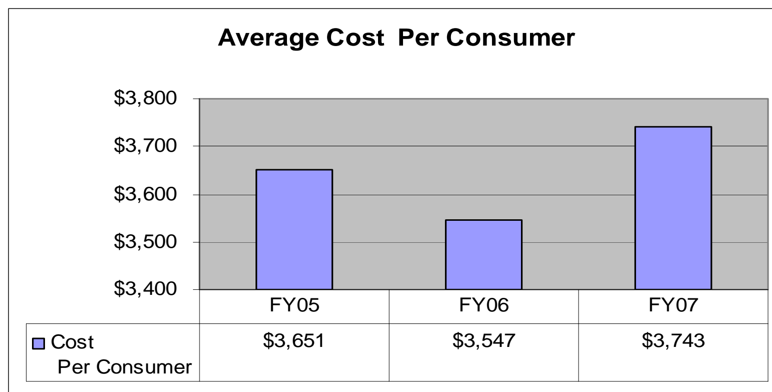
	FY 05	FY 06	FY 07
Consumers	4,186	4,276	4,307



The number of geriatric consumers accessing the PMHS began to decline in FY01 and dropped by about 30% in FY04. This decline was seen with the change in Medicare crossover billing procedures where MA co-payments are no longer counted in the PMHS data. The total consumers served in this age category have been between 30 and 40 since that change.

Average Cost per Consumer

The Average Cost per consumer is calculated as the total expenditures divided by consumer count for the year. In a region this size, extremely high cost consumers can dramatically skew this calculation (e.g. single consumers that have contributed upwards of 5% to total cost). The 5000 highest cost consumers across the state are ranked and reported to each jurisdiction (only those in the jurisdiction) annually. For FY07, this region had 90 consumers on that list. RTC placements account for 22 of the 24 of those with total expenditures greater than $100,000. On the other end of the scale, there were 50 consumers



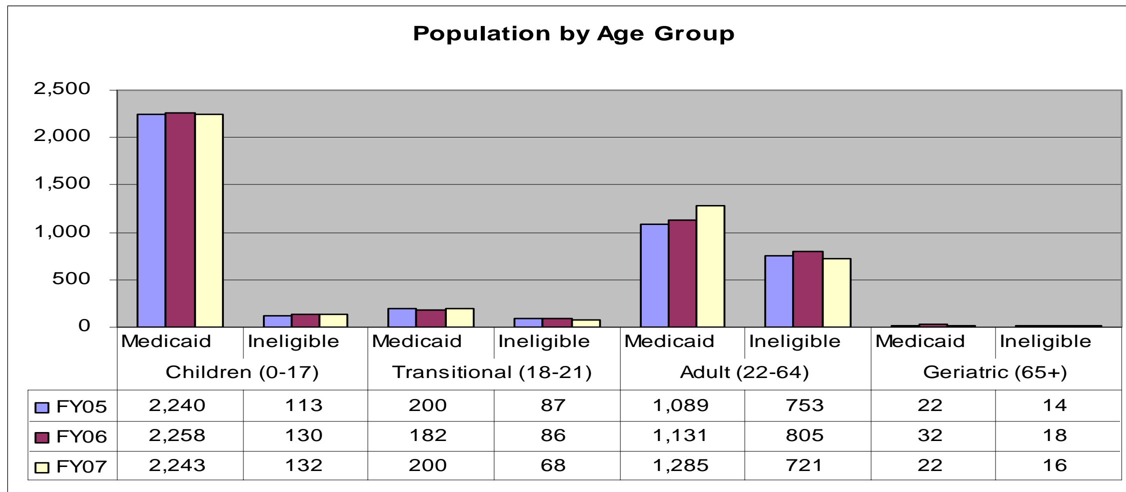
	FY05	FY06	FY07
Cost Per Consumer	$3,651	$3,547	$3,743

with total spending under $50,000 and the majority of that spending was directed at Rehabilitation services; 70% Residential Rehabilitation. In both cases the treatment is expected to be of long duration and includes housing. The other major categories depicted in this report are Case Management, Inpatient and Outpatient. No one was on the report with only Case Management expenditures; they were only a contributing factor to other expenditures.

Consumers Served by Population and Age Group

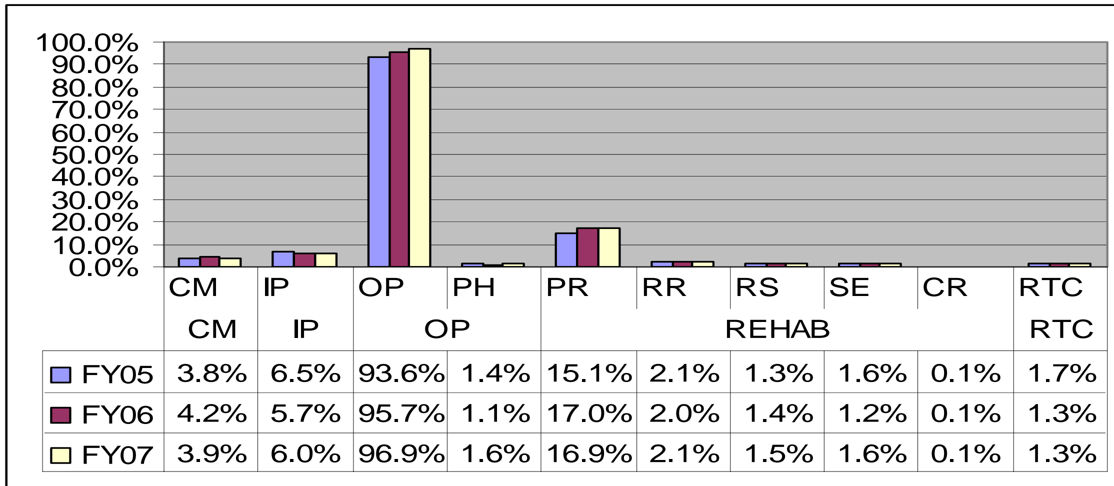
The US Census predictions predict meaningful nationwide growth in the geriatric population over the next two to eight years. This will, naturally, increase the number of consumers in that category but since Medicare stopped crossover billing in 2004 these numbers have remained relatively the lowest of all age categories. The Child and Adolescent population showed the least amount of change from FY06 to FY07 with both MA and MAI counts registering less than a 1% change. As seen below, MAI and age category are directly correlated. In FY07 the percentage of the age group that is MAI is as follows:

Children 0-17	5.6%
Transitional	25%
Adult	41.5%
Geriatric	42%



	Children (0-17)		Transitional (18-21)		Adult (22-64)		Geriatric (65+)	
	Medicaid	Ineligible	Medicaid	Ineligible	Medicaid	Ineligible	Medicaid	Ineligible
FY05	2,240	113	200	87	1,089	753	22	14
FY06	2,258	130	182	86	1,131	805	32	18
FY07	2,243	132	200	68	1,285	721	22	16

Utilization Data and Length of Stay

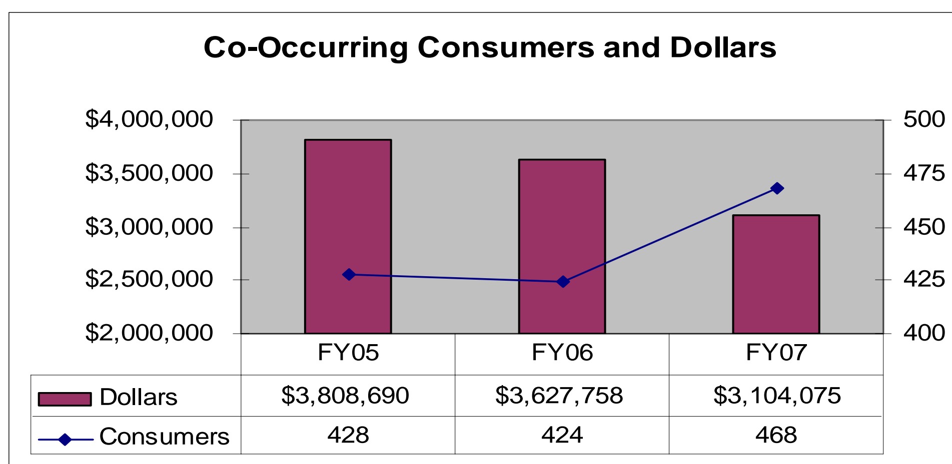


	CM	IP	OP	PH	PR	RR	RS	SE	CR	RTC
	CM	IP	OP		REHAB					RTC
FY05	3.8%	6.5%	93.6%	1.4%	15.1%	2.1%	1.3%	1.6%	0.1%	1.7%
FY06	4.2%	5.7%	95.7%	1.1%	17.0%	2.0%	1.4%	1.2%	0.1%	1.3%
FY07	3.9%	6.0%	96.9%	1.6%	16.9%	2.1%	1.5%	1.6%	0.1%	1.3%

This chart compares the numbers of consumers by service type to the total number of consumers who received any service. Note that as consumers use a variety of services, duplication will occur across service categories. Also, ER visits are included as Inpatient if they lead to an admission; otherwise they are included as Outpatient.

Co-Occurring (Dually Diagnosed) Consumers

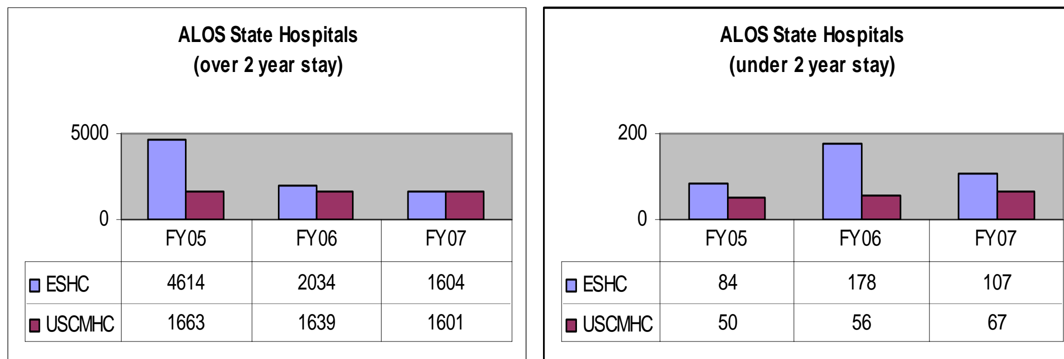
This region includes two state hospitals, one of which has a "Red Unit" running a 28 day program for those diagnosed with co-occurring (mental health and substance abuse) disorder. All 5 of the Mid-Shore county detention centers are involved in the Jail Mental Health program, funded principally through the CSA, where screening is done for mental health and substance abuse history. In FY07, 86% of the inmates assessed were determined to have a substance abuse history. These inmates are referred to community based treatment during the discharge planning process. The largest portions of consumers with co-occurring disorder reported fall in the 18 to 64 age group. In FY07, 6.1% (55) of the reported cases were in the 13-17 age group, down slightly from the two prior years (FY05 had 66 cases and FY06 had 57 cases). The local mental health program for youth detained in a juvenile facility reports that, on average, they screen 340 youth per year and 90% of those screened report substance use or abuse.



	FY05	FY06	FY07
Dollars	$3,808,690	$3,627,758	$3,104,075
Consumers	428	424	468

Average Lengths of Stay
Length of stay for adolescent acute care is impacted by a number of children who have been "stuck kids" or have been awaiting RTC placement. Dorchester General Hospital's average length of stay for adolescents was 15 days in FY05 and 1 day in FY06 and FY07. Generally, adolescents are released to community services to await RTC placement rather than extending acute hospital stays. For Residential Treatment, the average stay regionally is 14 months (approximately 420 days).

Eastern Shore Hospital Center (ESHC) length of stay averages are generally higher than Upper Shore Community Mental Health Center (USCMHC) because of the complexity of the populations that each serves.



ESHC has a 20 bed forensic unit and a 20 bed gero-psych unit which typically involve lengthier stays. USCMHC has what is called the "Red Unit" which is a 28 day co-occurring unit with relatively short stays and a general population. Some discharges are prolonged as the consumer awaits a community beds to become available in group homes known as Residential Rehabilitation programs. There are 65 beds currently in the region and, although the hospital discharges have priority over community placements, the wait for an opening can be 10 months to 2 years. In FY08, the "Yellow House" project will bring 5 additional beds to the area, specifically for meeting the need to transition the Not Criminally Responsible (NCR) inpatient back into the community.

7. NEEDS ASSESSMENT PROCESS AND RESULTS

Public Participation
Six focus groups were scheduled during the month of July with two groups each dedicated to consumers, providers and related agencies. The purpose of the focus groups was to collect opinions about the strengths and challenges of the public mental health system on the mid-shore and to generate solutions for meeting the challenges. In total, 27 adults participated in the focus groups. Of that number, nine were consumers and 18 were agency or provider representatives. There were 17 females and 10 males, 23 Caucasians and four African American participants. Three primary questions were posed: 1) What are the strengths of the public mental health system?; 2) What are the challenges of the public mental health system?; 3) What strategies or solutions do you have for overcoming the challenges? After offering responses, participants were given an opportunity to vote for their top three choices in each question category.

Using the same priority questions posed for the focus groups, Chesapeake Helps phoned at least 40 influential community stakeholders across the mid-shore during the first three weeks of August. Twenty providers returned calls or agreed to engage in a key informant interview.

And finally, on September 11th, 60 key stakeholders gathered at the Elks Club in Easton to review primary indicators and develop a strategic plan using Mark Friedman's "Results Based Accountability" framework. Emphasis was made to spend group activity time addressing solution strategies rather previously identified needs. The results of this planning opportunity are available in a separate document.

Description of Findings

Highlights of hard data findings were discussed by Mid-Shore Mental Health staff on August 31, 2007 and considered by consumer and provider stakeholders during the September 11, 2007 planning retreat hosted by MSMHS. The following priority findings were highlighted by the staff, consumers, providers, or supporting agencies:

- Population changes must be taken into account when planning for services. Overall, since 1990, the U.S. Census office estimates that the population of the mid-shore increased from 139,615 people to 166,534 or 19% between 1990 and 2006. Caroline County has the highest percentage of residents in the age range of 0-4, 5-19, and 20-44. Queen Anne's County has the highest percentage of residents ages 45-64 and Talbot County hosts the highest percentage of citizens 65 and older. Housing prices have seen the greatest increases in the three counties where families are migrating away. Families and individuals with income challenges from Queen Anne's, Talbot, and Kent Counties have shifted to Caroline and Dorchester Counties in search of affordable housing. Because both African American and Hispanic residents are disproportionately represented in the lower income range, the representation from these ethnic groups is increasing in both Caroline and Dorchester Counties, while decreasing in Kent, Queen Anne's, and Talbot Counties. This is leading to a strain on public services in the two in-migration counties as more and more people with income challenges move in. Four out of five of the Mid-Shore counties have Median Household Incomes that are lower than the Maryland level, with Dorchester and Caroline at the lowest household income level. Queen Anne's County is at the highest. Individuals who speak Spanish are growing in numbers in all Eastern Shore Counties as is the trend statewide and nationally. As a result, providers for all services are competing to secure bi-lingual personnel.

- The number of youth known to the juvenile justice system for the five mid-shore counties increased by 3% between 2004 and 2005, but decreased by 7% between 2005 and 2006. Juvenile Services intakes is important as a county demographic feature because the literature points to at least a 65% prevalence rate of mental health disorders among youth in juvenile detention centers. The importance of early intervention is apparent here.

- In 2007, 72 high school seniors from the Mid-Shore declared intentions to enter the military. The two counties with the highest percentage of youth declaring military plans were Caroline and Dorchester. While numbers of active military from the Mid-Shore could not be ascertained at the time this report was prepared, the number of current and projected military

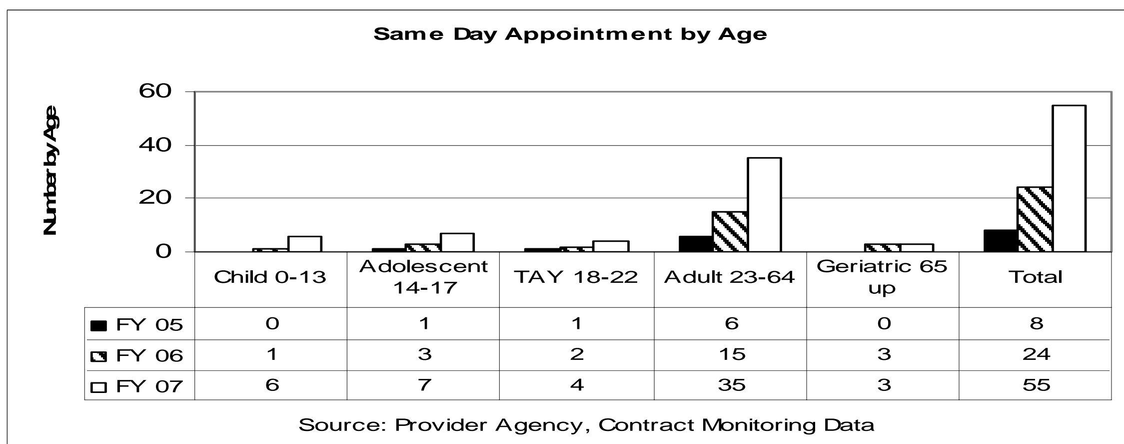
veterans was available. In 2007, Veterans Affairs reported 15, 971 veterans from the region, down by 11% from 18,007 in 2007. The decrease is projected to continue through 2014, most likely due to the numbers of World War II and Viet Nam vets whose life spans are ending. Based on a study conducted by the Veterans Administration, the federal government has recently issued a call for support of the increased number of soldiers returning from the Middle Eastern conflicts who may be suffering from mental health disorders such as Post Traumatic Stress Syndrome. While both Dorchester and Cecil Counties on the Eastern Shore have VA facilities for soldiers who need mental health support, the distance and capacity may be a factor in veterans seeking service.

- Prevalence rates for mental disorders among Americans was reported in 2002 by the U.S. Surgeon General's office. In any given year, at least 28 to30% of adults have a mental or addiction disorder, 20% of children, and nearly 20% of adults over age 55.

- A mental health provider inventory shows shortages in the following areas: licensed mental health professionals (also dual licensed for co-occurring disorders), physicians who accept Medical Assistance, psychologists (there is only one), and residential youth centers (there is only one). Critical services that are not available are crisis beds, crisis respite, 24/7 crisis response and mobile treatment.

- Individuals without insurance or Medicaid who receive public mental health Services are counted as public mental health consumers. Consumer numbers overall have increased by 9% when comparing the mid-shore consumer total for 2003 to the total for 2007. Caroline, Dorchester, and Talbot Counties are showing increasing numbers of consumers, while Kent is leveling off and Queen Anne's is decreasing. For all age groups except the geriatric population, a linear projection of the future trend in service use reveals a steady increase through the year 2010.

- Same Day Appointments is a program used to divert persons who go to a primary care physician or the emergency room, who do not qualify for acute care but need urgent mental health support. Between FY05 and FY07, the number of individuals who utilized Same Day Appointments increased from 8 to 55 or 129%. The table below demonstrates in increasing utilization of Same Day Appointments.

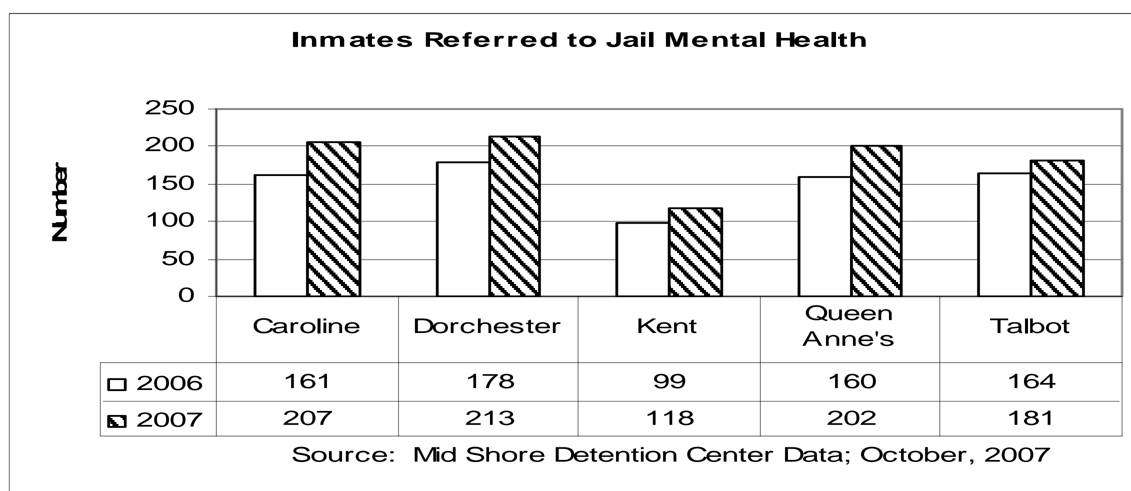


	Child 0-13	Adolescent 14-17	TAY 18-22	Adult 23-64	Geriatric 65 up	Total
FY 05	0	1	1	6	0	8
FY 06	1	3	2	15	3	24
FY 07	6	7	4	35	3	55

Source: Provider Agency, Contract Monitoring Data

- For consumers who utilized inpatient mental health services in an acute facility, a general decline in inpatient numbers is noted across the most recent five years. In 2007, 244 individuals were served in an acute facility.

- In 2006, a total of 762 inmates in Detention Centers serving the mid-shore region were referred to Jail Mental Health with the total increasing to 921 in 2007. Caroline County had the greatest increase at 29%. At least 97% of those receiving jail mental health services were assessed with a history of substance abuse. The total number of inmates for the mid-shore region who were released with aftercare rose by 22% to 146 in 2007. With the growing inmate population/need and limited state resources, supplemental county funding is likely to be the only opportunity to avoid interruption of services in future years.



	Caroline	Dorchester	Kent	Queen Anne's	Talbot
2006	161	178	99	160	164
2007	207	213	118	202	181

- For the mid-shore region, the total number of inpatient admissions at the state hospital in Dorchester County has fluctuated from a high number of 138 in FY 2004 to a low number of 99 in FY 2006. Meanwhile, the number of individuals counted as Forensic (those who are inpatient on court order in a criminal matter), have generally increased from 44 in FY03 to 55 in FY07.

- The number of individuals who are referred to Residential Rehabilitation Programs (RRP) and who meet the requirements for being Not Criminally Responsible (NCR) has significantly increased. From FY03 to FY06, the total referrals increased from five (5) to forty-one (41); while those meeting NCR requirements during the same time period rose from two (2) to twenty-two (22). In FY06, RRP placement wait time increased to 120 days for the general population, and 134 for those who were NCR.

- Total suicide deaths for all five counties reached 17 in FY03, increased to 26 in FY04, and dropped back to 17 in FY05.

- Cost factors include the number of Medicaid enrollees and eligibility, the penetration rate, the average cost per consumer, and the comparison of residential placement verses hospital

waiting. The number of Medicaid enrolled individuals from the mid-shore increased by 13.2% from FY 2002 to FY 2005. In FY 2007, the number of Medicaid eligible individuals from the mid-shore totaled 24,812. The Medicaid penetration rate is the portion of the population served out of the total Medicaid eligible. For Maryland, the average rate during the past five years has fluctuated between 11 and 14%. Across the mid-shore, the rate is on the high end, averaging 14.9% in FY07. Cost per consumer for public mental health services are calculated by dividing the total number of consumers into the cost for the total number of services. Costs per consumer have remained the same for Maryland, yet have declined by 21% for the mid-shore area. There is a difference of $1403 in average cost between Maryland at $4,936 and the mid-shore region at $3,533. The mid-shore's average cost per consumer is 28% less than Maryland's. The cost of Residential Rehabilitation Programs across the past four fiscal years was compared on the mid-shore to the cost of hospital stays while waiting for an opening in a Residential Rehabilitation Program. There is a marked difference in cost allocation with Residential services representing a much lower cost. The cost per day per consumer in FY06 for RRP was $112.95, while the inpatient cost at the Upper Shore Community Mental Health Center was $564.00 and the inpatient cost at the Eastern Shore Hospital Center was $636.00. The increasing and disproportionate costs for hospital waiting are attributed to the lack of community-based resources to meet standards of release.

- Mental health outreach and public engagement was achieved in several ways to include 23 public events, annual anti-stigma presentations attracting an average of 91 attendees, engagement of 12 consumers in FY07 through ongoing Consumer Council meetings, and engagement of 48 providers through Provider Council meetings. Mid-Shore Mental Health System staff emphasize that consumers can affect change in the public mental health system and this could be saving grace for a strengthened system getting. They add that a cultural shift in providers to support greater consumer involvement will lead to a more welcoming attitude with consumers and their families.

- A review of other needs assessments conducted on the federal, state, and local levels revealed a noteworthy number of conclusions stating the need for additional mental health providers and professionals, mental health funding, services for adolescents, and support addressing economic stressors such as affordable housing. Cultural competence and outreach to the Hispanic population received several mentions, as well as addressing substance abuse, returning war veterans, and stigma associated with mental disorders.

- The six provider and consumer focus groups recognized the strengths of the public mental health system as being the dedication of clinicians, the collaborative network, and greater public awareness. Priority challenges were identified as the need for additional public funding, shortage of professionals, and the lack of specific resources. When asked about solutions, focus group members suggested increased funding, mobile treatment, increasing fees for service, strengthening advocacy, and pooling resources.

- Twenty providers participated in the key informant interviews conducted by Chesapeake Helps. The strengths of the public mental health system were identified as dedicated providers, good working relationships, collaboration, and increased public awareness.

Priority challenges were not enough providers, transportation, and lack of funding. Top strategies suggested were various funding ideas (increase fee for service, bring back public mental health, increase government funds), reducing stigma, staff recruitment to address shortages, and public education.

There are 34 provider agencies or individuals representing 14 different types of public mental health services. The table below features the quantity and location, by county, of these services on the mid-shore.

Public Mental Health Service Type	#	Car	Dor	Kent	QA	Tal	Notes
Acute (Emergency) Hospitals	3		1	1		1	General hospitals
Acute (Inpatient) Hospitals	2		2				Includes Potomac Ridge
Case Management	1	✓	✓	✓	✓	✓	Serves multiple areas
Certified Professional Counselor	2				1	1	Licensed mental health professional
Co-Occurring (Substance) Disorder	4		3	1			With dual licensure
Crisis Beds	0	**Service Not Available**					
Crisis Respite (Urgent Unplanned Stay)	0	**Service Not Available**					
Crisis Response (24/7)	0	**Service Not Available**					
Federal Health Center	1					1	Federally funded
Mobile Treatment	0	**Service Not Available**					
Outpatient Mental Health Center	14	2	5	2	2	3	10 Psychiatrist/54 Therapists
Physicians	2		2				Private Practice w/ MA
Psychiatric Rehabilitation	8	1	2	1	2	2	Also Supported Employment
Psychologist	1					1	1 person serves mid-shore
Residential Rehabilitation Program	2	✓	✓	✓	✓	✓	Serves multiple areas
Residential Treatment Center	1		1				For youth only
School Based Mental Health	5	1	1	1	1	1	Different for each county
Social Workers	7	2	2	2		1	Independent
State Hospital Facility	2		1	1			Eastern and Upper Shore

= Quantity; Car=Caroline County, Dor=Dorchester County; QA = Queen Anne's County, Tal=Talbot County

The above chart represents a visual perspective on the depth and breadth of the Mid-Shore region's continuum of care for public mental health. Clear gaps in crisis services are visible and the notes above regarding the dramatic utilization explosion in the Same Day Appointment service line detail only the need that we have successfully met using this stop-gap measure.

The other critical gap is rapidly forming with regard to jail mental health delivery in our region's detention centers. Currently, the degree of attention that an inmate can expect during their stay may only be described as 'management' because of the resource limits faced by the provider. True therapeutic care would cost far more than the CSA can afford, and while we have had some success convincing county government to underwrite an increasing portion of the cost, the extra dollars have risen only to meet inflationary pressure – not to match ever-increasing demand.