2004 Report on Adult Service Consumers

Served by the District of Columbia Department of Mental Health

August 2004

Presented to the Dixon Court Monitor

by
Human Systems and Outcomes, Inc.

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Purpose and Scope of the Review

The Final Court-Ordered Plan for Dixon, et al v. Williams [March 28, 2001] required that performance measures be developed and used within a methodology for measuring service system performance. The court-ordered Exit Criteria and Method [September 21, 2001] set forth further detail for measurement requirements attendant to consumers, including:

- Consumer service reviews will be conducted using stratified samples.
- Independent teams will conduct annual reviews.
- Annual data collection on individuals will include consumer interviews, record reviews, staff interviews, caregiver interviews, and analysis of data.
- The independent teams will cover key areas of review for each consumer. For adult service consumers, these key areas include community living, health, meaningful activity, social networks, income, assessment and planning, treatment and support services, specialized services, coordination of care, and emergent/urgent response to needs.

To begin the process of meeting the requirements of these orders, a case review protocol was developed, tested, revised, and then used to create a baseline for subsequent measurement of progress. The baseline was made during the week of May 5-9, 2003, using measurements taken on a sample of 28 adult participants randomly selected for this purpose. The results of the initial review were provided to the Court Monitor in a report dated May 2003. Findings from the initial review were generally mixed, with approximately 75% of the consumers in the sample considered to have an overall acceptable status. The appraisal of the service system for these consumers was considered overall acceptable in 54% of the consumers reviewed. Due to some methodological limitations during the initial sample selection process, there was some concern on the part of the review team and the Department of Mental Health (DMH) that the actual consumers reviewed might represent only those that were most actively engaged in the system. It was concluded that the review results likely provided a more positive status of consumers receiving mental health services and the overall responsiveness of the service system in addressing their needs than would be reflected in a more fully representative sample of consumers and the range of practices.

A larger sample was drawn for the second-year review and the Dixon Court Monitor's staff facilitated the logistical preparation with support from Human Systems and Outcomes, Inc. (HSO), as well as with major strategic support from DMH staff. A larger sample was drawn to ensure representativeness of the population of consumers and to account for some mismatch between consumers listed as enrolled for services on eCura and those actually receiving services. Review activities for the second-year review were completed during April 2004. This review should be primarily considered an extension of the baseline review using a more refined sampling process. This report contains the results of the individual consumer service reviews completed during the year-two review activities. Findings pertain to the final 41 consumers included in the review.

The design of the 2004 sampling process, training of reviewers, supervision of data collection, and analysis of data were conducted by HSO, an organization with extensive experience in qualitative service review processes used in monitoring services in class action litigation situations. HSO was contracted by the Dixon Court Monitor and worked as staff to the monitor in conducting the review.

In reading this report, the reader must recognize that a large systemic change process is occurring in the Department of Mental Health that is going to take multiple years to bring individualized, highly coordinated services to each consumer served to a highly consistent and fully functional level of performance. To date, a tremendous amount of energy and effort has been expended to create the infrastructure and foundational capacities necessary to support a consistently performing, high quality service delivery system. In the stakeholder interviews this year, some provider agencies were just beginning to reach a stage of development in which practice issues and the barriers to good practice could be discussed. In other agencies, there is still a struggle to just get the foundational infrastructure and basic understanding in place. From HSO's perspective, considerable progress continues to be made and the system is just now beginning to reach the point that more focus and effort can be put into the actual development and implementation of more consistent high quality practice.

Sample Characteristics

A stratified random sample of 162 registered consumers was drawn from those registered on the Department of Mental Health eCura data system. From that number, a stratified sample of 54 consumers was obtained from the larger sample when it was determined that the consumer was or had recently been an active case and the consumer was willing to consent to participate. The criteria for inclusion in the sample were that the case is currently active (as defined by receiving services within three months of the time of the review) and is receiving a minimum of one type of service (i.e., case management, counseling, medication management, etc.). Three variables were identified as differentiating points for a stratified random sample that was drawn the week of March 15, 2004: (1) provider agency, (2) age of the consumer, and (3) consumer's level of need.

In this section, considerable detail is provided about the sampling selection and the logistical issues encountered in setting up the actual sample of consumers that were ultimately reviewed. These are provided because the challenges and issues that were encountered are instructive in regard to both the current status of infrastructure development and the implementation of the practice model specified in the Dixon exit criteria. They also reflect how complex a service delivery system is and how many details and components have to work in sync in order to achieve the best results for consumers.

Provider Agency

The DMH eCura data system shows there are a total of 13,224 consumers enrolled in DMH who either requested referral for services through the Access Help-Line or received services either now or in the past from one or more of 18 different provider agencies. These provider agencies differ substantially in the total number of consumers they serve. Ninety-six percent of the consumers enrolled in a core service agency are receiving services from one of the ten largest agencies. These agencies are: the D.C. Community Services Agency; Community Connections, Inc.; Center for Mental Health, Inc; Green Door; Anchor Mental Health; Washington Hospital; Lutheran Social Services; Woodley House; Psychotherapeutic Outreach Services; and Coates and Lane. **Display 1** provides the number of consumers currently enrolled for the ten largest core service agencies, as well as an additional agency (Psychiatric Center Chartered) that was providing services for an additional consumer randomly selected to participate in the review. The rationale for the random selection of an additional consumer was to ensure that consumers receiving services at the eight smaller provider agencies also had a chance of being included in the review.

Display 1

Total Number of Consumers Listed as Enrolled for Services in eCura by Provider Agency

Provider	Ages 18-29	Ages 30-55	Ages 56+	Totals
1. D.C. Community Services Agency	1,098	4,983	1,308	7,389
2. Community Connections, Inc.	173	945	223	1,341
3. Center for Mental Health, Inc.	342	821	78	1,241
4. Green Door	83	467	126	676
5. Anchor Mental Health	79	418	106	603
6. Washington Hospital Center	82	322	79	483
7. Lutheran Social Services	40	181	75	296
8. Psychotherapeutic Outreach Services	30	179	51	260
9. Woodley House	34	145	47	220
10. Coates and Lane	19	148	44	211

Note: There are 504 (3.816%) consumers being provided services outside of the ten largest provider agencies. Thus, one "at large" consumer is being sampled from the remaining 504 to allow for an equal chance of being selected for inclusion in the review. This consumer was receiving services from Psychiatric Center Chartered, hence, inclusion in the review.

Age of Consumer

The number of consumers receiving services at each site varies by the ages of the consumers. Three pre-determined age ranges (18-29; 30-55; 56 and older) were specified as points to stratify the sample. The sampling frame slightly over-sampled young adults (18-29) in order to more accurately assess themes and patterns of practice regarding entry into the mental health system since it is during this age that consumers typically begin accessing adult mental health services.

Consumer's Level of Need

The consumer's level of need was separated into three categories (low, medium, high). There was a brief survey completed by the provider agency for each of the consumers included in the random sample. This survey was used to collect information such as the current level of service (type of service or Global Assessment of Functioning Scale/GAF score). The breakdown for level of need is as follows:[1]

Low Need:	Basic outpatient services: GAF > 70
Medium Need:	Intensive outpatient or wraparound services: GAF 61-70
High Need:	Partial hospitalization or hospitalization placement: GAF < 60

The intent of separating the sample by level of need was to ensure a mix of level of functioning of consumers randomly selected for inclusion in the review. It should be noted that reviewers also noted the GAF level of the consumer during the review. There was some mismatch between the provider-supplied GAF score and the reviewer-noted GAF score.

Sampling Frame

Display 2 provides the final sampling frame for the 2004 adult services review. This table indicates the number of consumers randomly selected from each agency separated by age ranges

[1] GAF scores for consumers were submitted by provider agencies in the initial survey in order to stratify the initial sample according to level of need. It should be noted reviewers also provided a level of functioning rating for consumers included in the review. These findings are provided on page 13.

Due to the large number of consumers lost from the initial sample of 162 from the D.C. Community Services Agency, the actual number of consumers who could be selected for inclusion in the final sample was notably reduced. As a result, of the 108 remaining possible cases from which the final sample could be drawn, there were only 74 eligible consumers for the review, if reasonable proportionality of consumers across smaller core service agencies was to be maintained.

The Dixon Court Monitor's office staff attempted to contact all 74 eligible consumers on multiple occasions using telephone and direct contact strategies. Logistical preparation was coordinated with the 11 participating core service agencies to maximize the likelihood of consumer participation, however, consent to participate was obtained directly by the Dixon Court Monitor's office. Of the 74 targeted consumers, eight refused to participate despite repeated attempts to engage the consumers. Similarly, despite numerous efforts to contact all eligible consumers, no current contact information was known for eight additional consumers, with some purported to have moved out of the D.C. area. Of a possible 58 eligible consumers remaining, the Dixon Court Monitor's office undertook numerous steps to attempt to locate, obtain consent, and coordinate the difficult logistical processes necessary to complete a qualitative case review. A total of 41 case reviews were completed. Despite efforts to set up case reviews for the 58 eligible consumers, difficulties such as not returning messages, no longer living at last known address with no forwarding address known, lack of a telephone, or not being home during the several attempts to locate the consumer were just several of the contributing factors to the smaller-than-originally-designed sample. The 41 case reviews completed are considered the result of an exhaustive effort to maximize the possible number of review participants within the originally specified sampling frame. It is noteworthy that three homeless consumers, randomly selected for inclusion in the review, were located by the Dixon Court Monitor's staff and consented to participate.

Description of the Consumers in the Year-Two Review

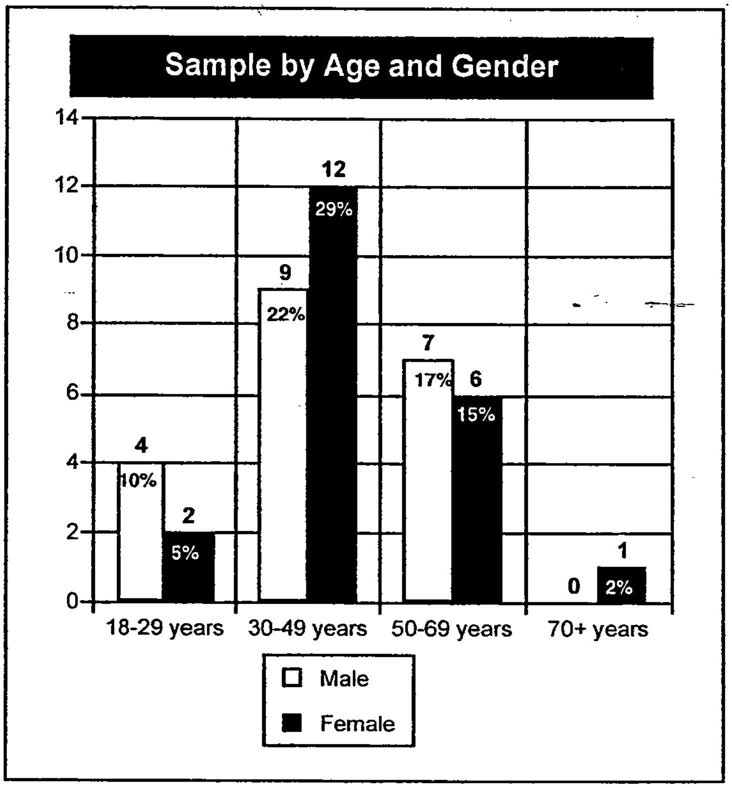
A total of 41 case reviews were completed during May 2004. These case reviews were completed over a two-week timeframe with slightly more than half (24) completed by external reviewers and the remaining cases completed by DMH staff trained to standard by HSO. Presented in this section are displays that detail the characteristics of the consumers in the second-year sample.

Age and Gender

The review sample was composed of both males and females drawn across the age spectrum served by the Department of Mental Health. **Display 4** presents the sample of 41 consumers distributed by age and gender. As shown in this display, the gender makeup of the sample was evenly distributed, with males comprising 49% of the sample and females comprising 51%.

There were six consumers ages 18-29 (15%) included in the sample. It is important to note that consumers in this age range were most likely to have either been closed, unknown, or not active cases in the original triple sample. The actual breakdown of consumers in the 18-29-year age range across the total mental health population is 15%, thus, due to the initial intent to over-sample this youngest age range, the number included in the final sample was proportional to the actual number receiving services. The majority of the case reviews completed were in the 30-49-year age range with 21 (51%), and an additional 13 (32%) were in the 50-69-year age range. Last, there was one consumer greater than age 70 included in the review.

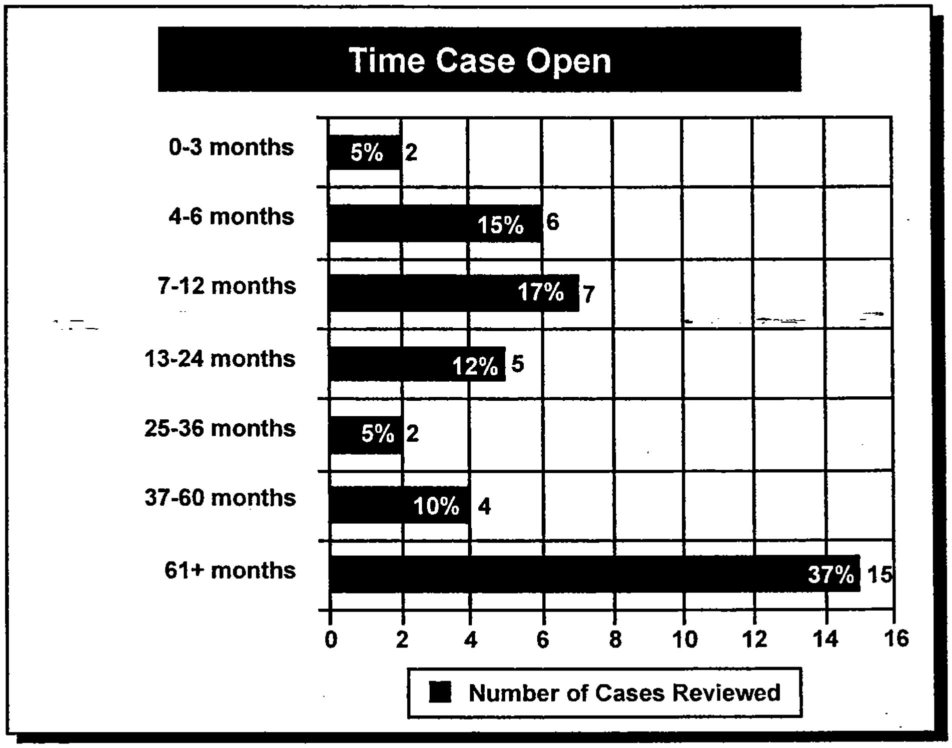
Display 4



Length of Time Served During Present Admission

All adult service consumers in the review sample were presently receiving services through DMH and being provided those services by a core service agency. As defined within the sampling parameters, a case was considered current if the consumer had been receiving any form of mental health service within the previous three months. **Display 5** presents, for these 41 adults, the length of time their cases had been open with DMH during their current, most recent admission for services. As can be seen in this display, 37% (15 consumers) of the sample had cases open for 12 months or less, 17% (seven consumers) were open for 13 to 36 months, and 47% (19 consumers) were open for more than three years.

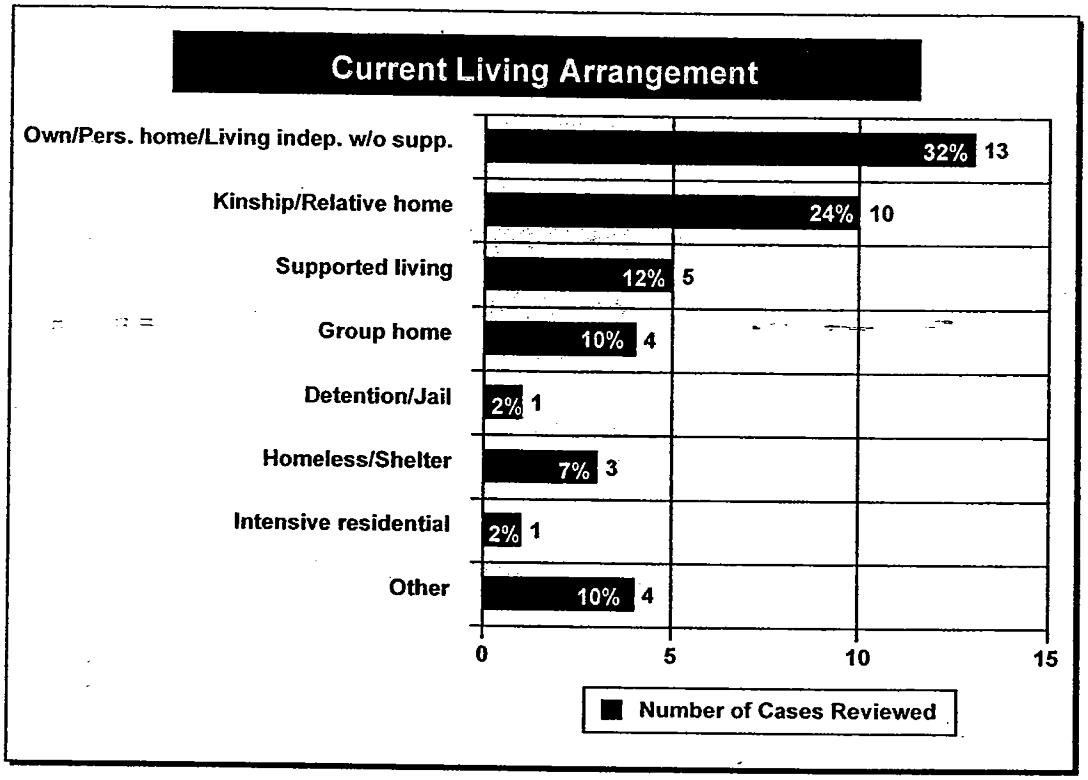
Display 5



<u>Living Settings of Sample Members</u>

Adult service consumers in the review sample were living in one of nine settings. **Display 6** shows the distribution of sample members according to their residences at the time of the review. Reviewers noted the current living arrangements of the consumers during the review. Twenty-three (56%) of the consumers were either living independently without supports or living with family. For consumers living with relatives, the degree of caretaking responsibilities by the relatives varied. Other living arrangements included supported living arrangements (five), supported independent living arrangements (four), adult group homes (four), with formal support providers including mental health programs, substance abuse/veteran's providers, and developmental disabilities programs. Also noteworthy is that one consumer was in the D.C. Metro jail and three consumers were homeless and living either on the street or in a shelter.

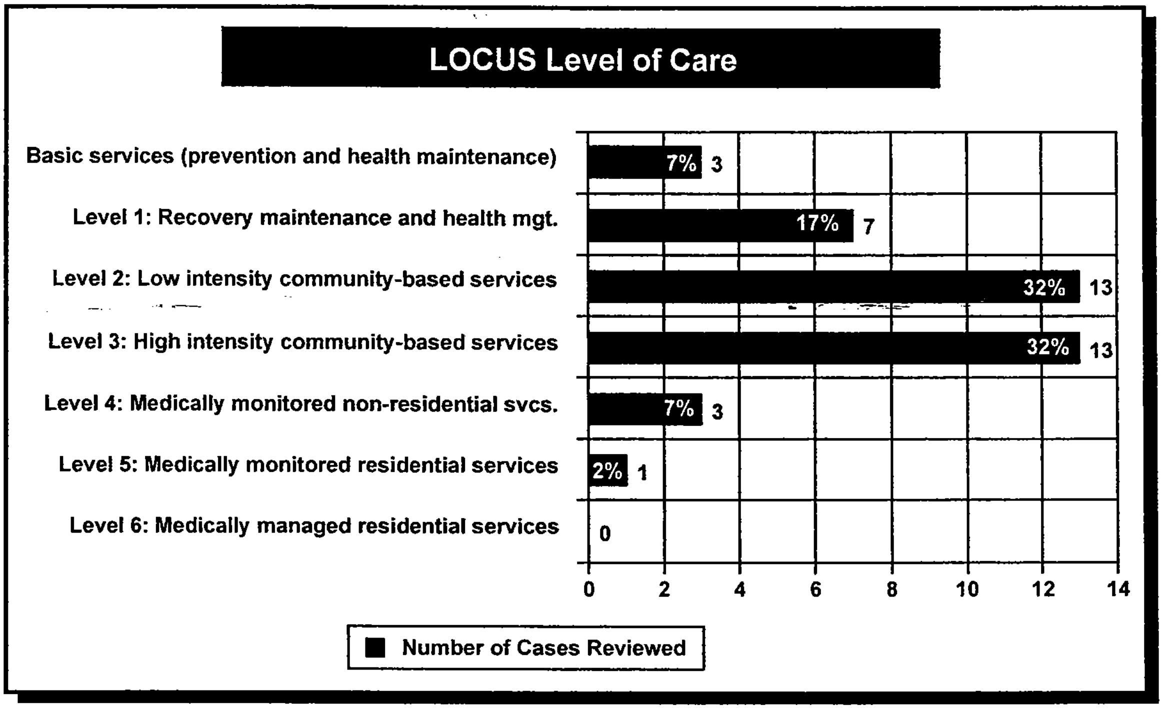
Display 6



Level of Care Provided

Consumers in the sample were classified according to the level of care being received at the time of the review. The descriptive categories used were taken from the LOCUS or Level of Care Utilization System and applied by the reviewers. **Display 7** presents the distribution of the sample according to this classification scheme. Three (7%) of the sample members were determined to be receiving basic services. Seven (17%) were receiving recovery maintenance and health management services. Thirteen (32%) of the sample members were receiving low intensity community-based services. Another 13 (32%) of the sample members were receiving high intensity community-based services. Three (7%) were receiving medically monitored non-residential services, while one (2%) was receiving medically monitored residential services. No sample members were receiving medically managed residential services. Last, the LOCUS level of one consumer was not noted by the reviewer.

Display 7



Functional Status of Sample Members

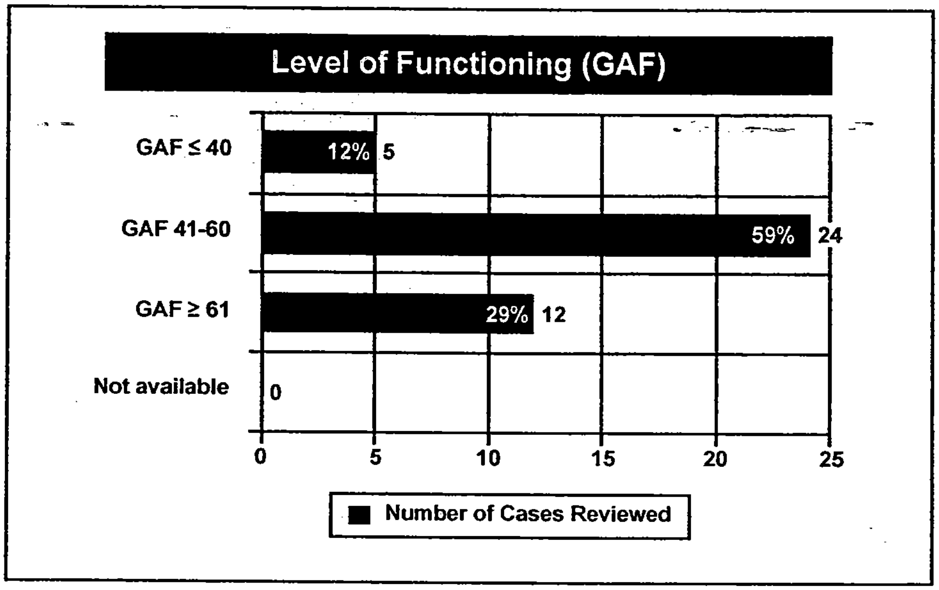
The functional status of adults in the review sample was assessed using the Global Assessment of Functioning Scale (DSM-IV, Axis V), which uses a 100-point scale. On this scale, a person in the low 1-40 range would be considered to be having significant difficulty, having substantial problems in daily functioning in normal settings, and requiring a high level of support and/or temporary treatment in alternative settings. A person in the mid-range of 41-60 would have some difficulties or symptoms in some areas but could get by with simple or occasional support in most settings. A person in the higher range of 61+ had no more than slight impairments of functioning but could be functioning well in normal daily settings. The 1-40, 41-60, and 61+ ranges were specified within the Dixon review protocol created by the local design team.[2]

Display 8 shows the distribution of the review sample across functioning levels for the 41 members. Five consumers (12%) were in the low GAF range. Twenty-four (59%) of the

[2] The GAF ranges noted in the Dixon protocol differ slightly than generally accepted GAF ranges for low, middle, or high levels of functioning. Using a more conservative approach for reviewers rating a consumer's level of functioning was determined by the District of Columbia's Dixon protocol design team.

consumers were in the middle GAF range, and 12 (29%) were considered to be in the high GAF range.

Display 8



For comparative purposes, **Display 9** indicates the level of functioning separated by age ranges of the sample. As the display indicates, younger consumers were more likely to have either low or moderate levels of functioning. In contrast, older consumers were more likely to have moderate to high levels of functioning.

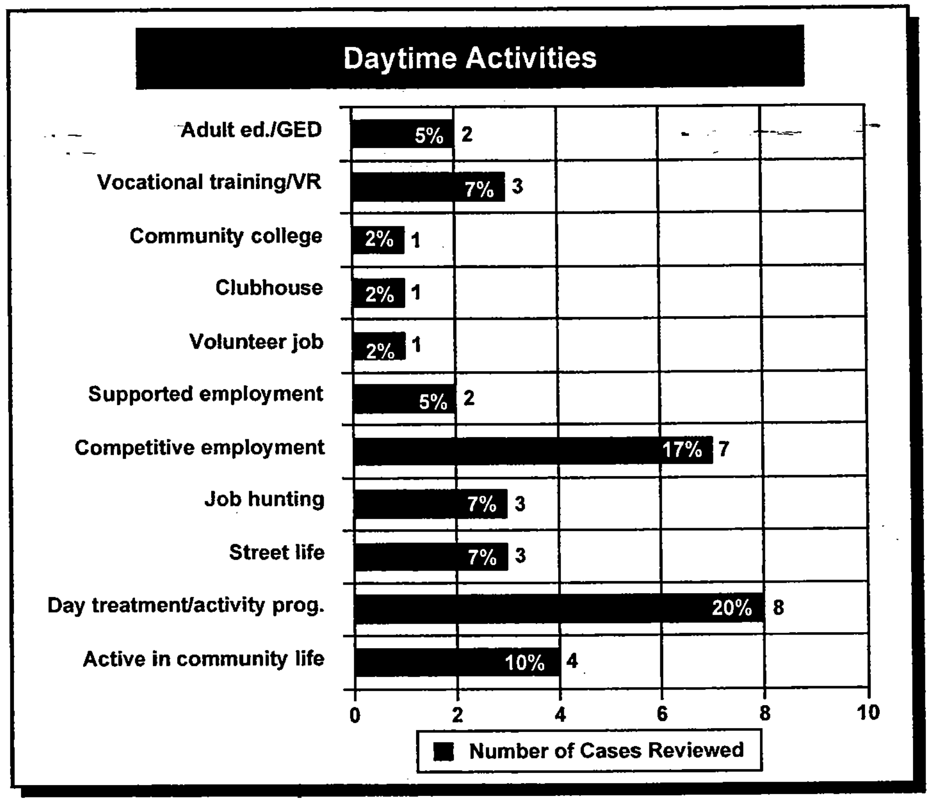
Display 9

Global Assessment of Functioning by Age Ranges				
Age Ranges	GAF <40	GAF 41-60	GAF>60	Totals
18-29	1 (16%)	4 (67%)	1 (16%)	6
30-49	3 (13%)	12 (50%)	6 (25%)	21
50-69	1 (8%)	8 (62%)	4 (31%)	13
>70			1(100%)	1
Totals	5	24	12	41

<u>Daytime Activities Reported for Sample Members</u>

Reviewers identified the major daytime activities in which sample members were participating at the time of the review. **Display 10** presents these daytime activities. The primary daytime activity categories were listed in the protocol and reviewers noted all that applied. Some consumers had more than one daytime activity noted, while this was also missing data or not applicable ratings for 13 consumers.

Display 10

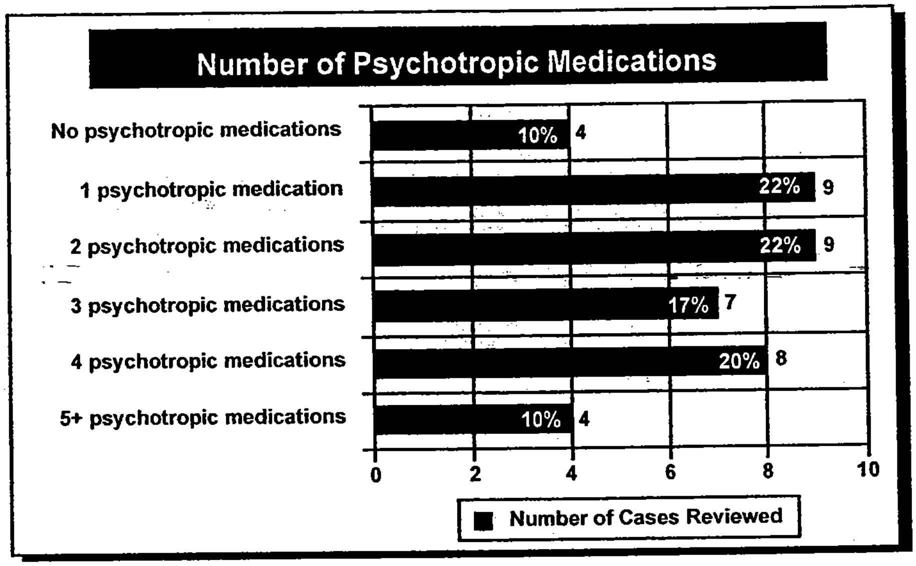


Note: Consumers whose primary daytime activity was visiting with family, friends, or neighbors were listed as active in community life.

<u>Psychiatric Medications Reported for Sample Members</u>

Persons with severe and persistent mental illness often take prescribed psychiatric medications to relieve symptoms. **Display 11** presents the number of psychiatric medications prescribed to members of the review sample. Approximately half (54%) of the sample received two or less psychotropic medications. A breakdown of the actual number of psychotropic medications taken by sample members is as follows: four persons (10%) were not prescribed medications; nine persons (22%) received one medication; nine persons (22%) received two medications; seven persons (17%) received three medications; eight persons (20%) received four medications; and four persons (10%) received five or more medications.

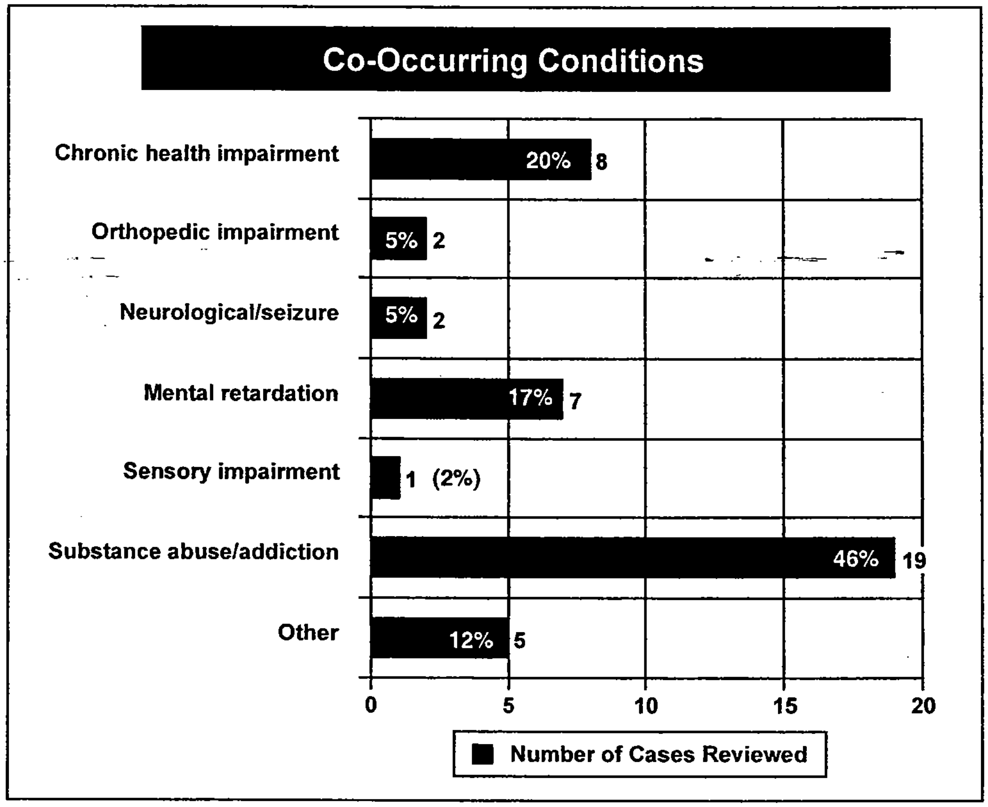
Display 11



Co-Occurring Conditions

The co-occurring conditions of consumers often present unique practice considerations for service providers. These complicate the delivery of services, as practitioners must take into account the additional challenges or complexities faced by the consumer when planning and implementing interventions. Oftentimes, co-occurring factors can be lifelong disabling conditions that require the integration of other service disciplines, such as medical or substance abuse, in the delivery of services. Reviewers indicated in their case review findings the presence of any of the following co-occurring conditions. These findings are noted in **Display 12**. The most prevalent was substance abuse/addiction, which was noted in 19 (46%) consumers. Other co-occurring conditions included mental retardation for seven consumers (17%) and chronic health impairment or medical condition (examples including, but not limited to, HIV and cardiac conditions) for eight consumers (20%). There was also a limited number of co-occurring conditions such as orthopedic or neurological impairments and sensory impairment, noted during the review. Last, it was not uncommon for a consumer to have a combination of co-occurring conditions, with substance abuse and a second factor the most likely combination.

Display 12



Quantitative Case Review Findings

Overview of the Case Review Process

Case reviews were conducted for 41 consumers during the weeks of April 19 and 26, 2004, using the *Community Services Review (CSR) Protocol,* a case-based review tool developed for this purpose. This tool was based on a recovery philosophy and a community-based approach to service provision as specified in the exit criteria of the Dixon Consent Decree. The general review questions addressed in the protocol are summarized in **Appendix A**.

Review questions were organized into three major domains. The first domain pertains to questions concerning the current status of the consumer (e.g., safety, economic security, or physical well-being). The second domain pertains to recently experienced progress or changes made (e.g., symptom reduction), as they may relate to achieving treatment goals. The third domain contained questions that focus on the performance of practice functions (e.g., engagement, teamwork, or assessment) for provided services in a recovery-oriented practice model. For each question deemed applicable in a case, the finding was rated on a 6-point scale, with a rating of 5 or 6 in the "maintenance zone," meaning the current status or performance is at a high level and should be maintained; a rating of 3 or 4 in the "refinement zone," meaning the status is at a more cautionary level; and a rating of 1 or 2 in the "improvement zone," meaning the status or performance needs immediate improvement. Oftentimes, this three-tiered rating system is described as having case review findings in the "red, yellow, or green zone." A second interpretive framework can be applied to this 6-point rating scale, in that, ratings of 1-3 are considered "unacceptable" and ratings of 4-6 are considered "acceptable." A more detailed description of each level in the 6-point rating scale can be located in **Appendix B**. It should be noted that the protocol provides item-appropriate details for rating each of the individual status and progress performance indicators also. Both the three-tiered action zone and the acceptable vs. unacceptable interpretive frameworks will be used for the following presentations of aggregate data.

Interviews

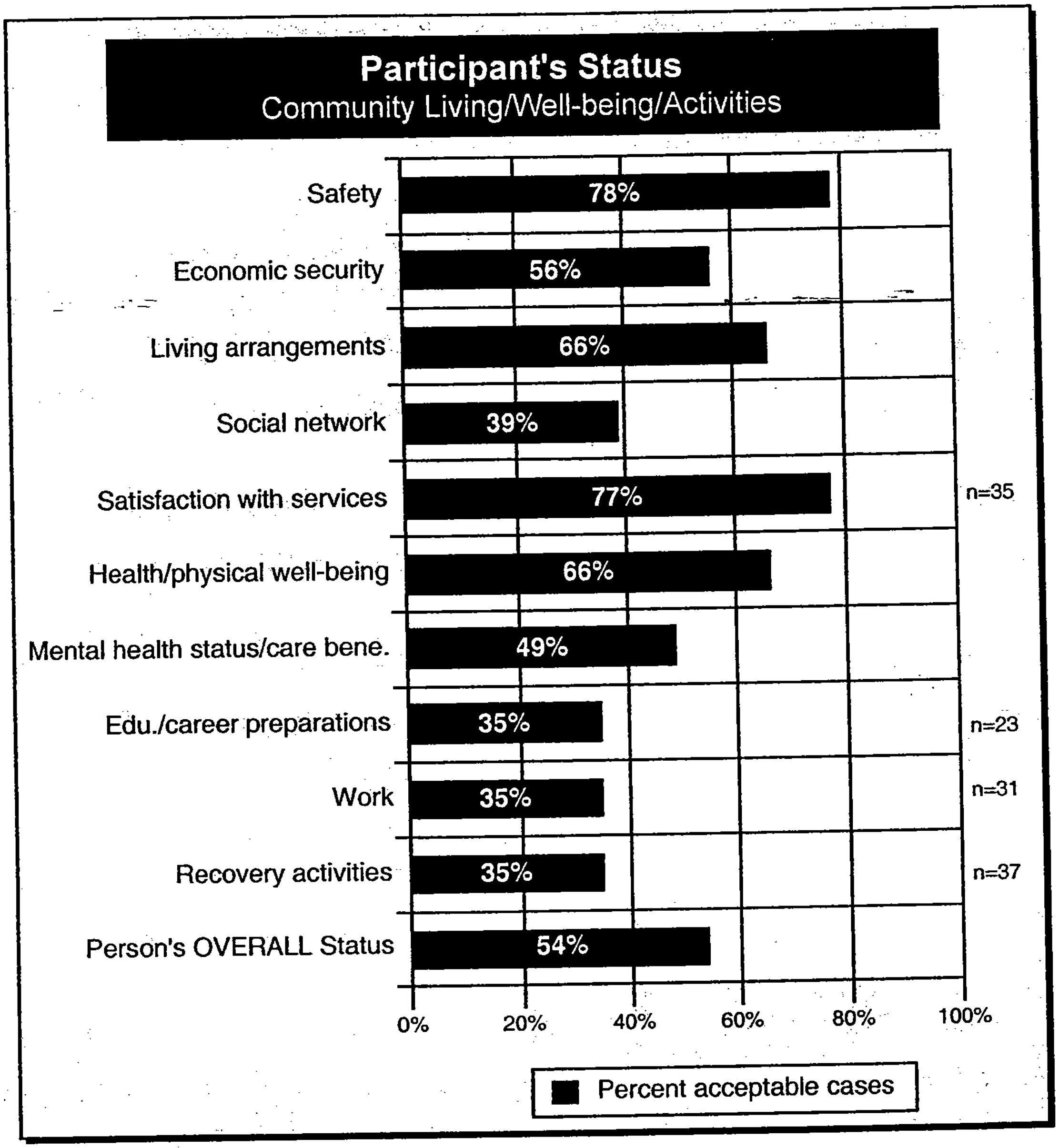
Review activities in each case included a review of plans and records as well as interviews with the consumer, any relevant caregiver, and others involved in providing services and supports. A total of 159 persons were interviewed for these 41 consumers. The number of interviews ranged from a low of two persons in one case to a high of seven persons in another case, with an average of four per case.

Consumer Status Results

Ten indicators related to the current status of the consumer were contained in the CSR protocol used by reviewers. Readers are directed to **Appendix A** for a detailed description of these ten areas examined by the reviewers. **Displays 13 and 14** present findings for each of the ten indicators. Display 13 uses a "percent acceptable" format to report the proportion of the sample members for whom the item was determined applicable and acceptable. Display 14 uses the "action zone" framework that divides the 6-point rating scale into three segments corresponding to the maintenance, refinement, and improvement zones. Findings on both displays are presented concurrently below. While these two different displays are useful in presenting findings, both displays are derived from the same set of case review findings.

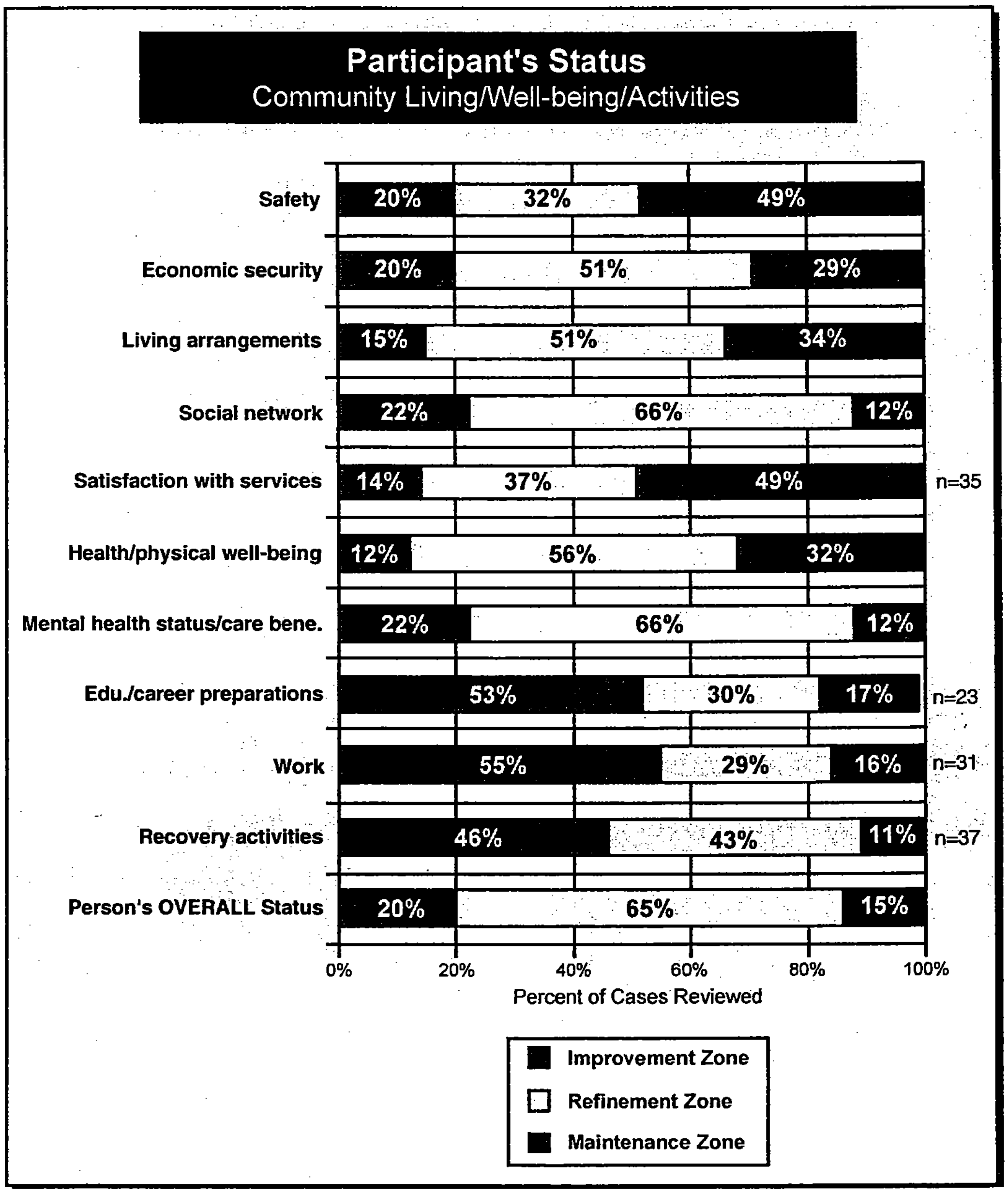
Safety. Sample members were generally safe from imminent risk of physical harm, as 78% of the consumers reviewed were given overall acceptable safety ratings by reviewers. For comparative purposes, 89% of the consumers reviewed in the 2003 review were noted as having at least minimally acceptable safety ratings. As for action zones, 49% of the consumers were rated in the maintenance zone, 32% were rated in the refinement zone, and 20% were rated in the improvement zone. The circumstances of those consumers whose imminent safety was considered needing immediate improvement included: a 22-year-old female whose recent suicide attempt resulted in emergency medical treatment (it was reported during the review that this consumer continued to have suicidal ideations); a 51-year-old male who has been a chronic IV substance user (heroin) whose current HIV status has not been assessed; a 58-year-old female with active psychosis living in a home in which the doors cannot be locked and she reports that neighbors regularly steal from her who is at risk of victimization; an unstable male with bipolar disorder who is not receiving any mental health services and whose mother recently sought court-ordered treatment; a male currently incarcerated and going through the process of detoxification from methadone without appropriate treatment and support; a 47-year-old male with depression and a history of poly-substance abuse who has interacted once with his mental health provider within the previous two years and for whom no other assessment information was available; a 49-year-old female with a history of schizophrenia who is actively abusing alcohol and cocaine and also has other significant health risks; and a 35-year-old female in which both she and her family have a lengthy history of substance abuse and are engaged in illegal drug sales activity.

Display 13



Economic Security. This area of review focused on: (1) whether the person is receiving entitled economic benefits; (2) whether income and economic supports are sufficient to cover basic living requirements; and (3) whether the person's economic security is sufficient for maintaining stability and effective life planning. Slightly more than half (56%) of the consumers included in the review were noted to have at least minimally acceptable economic security. For comparative purposes, 75% of the consumers reviewed in the 2003 review were noted as being at least minimally acceptable. Of those consumers in the year-two review, 29% were in the maintenance zone, 51% were in the refinement zone, and 20% were in the improvement zone. Of the 12 consumers in the green zone, all had moderate (41-60) to high (61+) GAF levels and were likely to be participating in either competitive or supported employment. If the consumers were not working, then they were receiving a sufficient array of benefits and supports through multiple sources (e.g., veteran's benefits, SSI, food stamps, housing assistance). Those consumers noted as needing immediate improvement typically either had no source of income or were not receiving a sufficient array of benefits and supports to meet their day-to-day needs.

Display 14



Living Arrangements. This review area probed whether the consumer was living in a home of choice with supports, if needed, that would allow the consumer to safely and successfully pursue recovery. Two-thirds (66%) of the consumers were noted to have at least minimally adequate living arrangements. Of those reviewed, 34% were in the maintenance zone, 51% were in the refinement zone, and 15% were in the improvement zone.

Social Network. This indicator examined whether a consumer was connected to a natural support network of family, friends, and peers, consistent with the person's choices. Achieving and maintaining a social network may depend on whether the person is provided peer support and community activities and whether the person has opportunities to interact outside of the core service agency. Slightly more than a third of the sample (39%) was noted to have at least a minimally acceptable social network. Of those consumers included in the review, 12% were in the maintenance zone, 66% were in the refinement zone, and 22% were in the improvement zone.

Satisfaction with Services. This indicator involved asking the consumer the extent to which he/she was satisfied with the treatment, support services, respect, and recovery progress that was presently being experienced. A majority (77%) of the 35 consumers responding expressed having at least minimally acceptable levels of satisfaction with services. Satisfaction was rated in the maintenance zone for 49% of those responding, in the refinement zone for 37%, and in the improvement zone for 14%.

Health/Physical Well-Being. This status indicator assessed the general physical health of the consumer, in that, the focus of inquiry includes whether the person has basic physical health needs met and if the person has sufficient access to needed health care services. Of those consumers included in the review, two-thirds (66%) of sample members were found to have at least minimally acceptable physical health status. Physical health was noted to be in the maintenance zone for 32% of the consumers, in the refinement zone for 56% of the consumers, and in the improvement zone for 12% of the consumers.

Mental Health Status. Is the person's mental health status currently adequate or improving? If symptoms are present, does the person have access to mental health services that are sufficient to reduce symptoms and improve the person's daily functioning? Is the person benefiting from mental health care received? These were the questions explored in this area by reviewers. Findings indicate that mental health status among persons reviewed was determined to be minimally adequate or better for approximately half (49%) of the sample members. For comparative purposes, 68% of the consumers were considered to have at least a minimally acceptable mental health status in the first-year review. Mental health status was found to be in the maintenance zone for 12%, in the refinement zone for 66%, and in the improvement zone for 22% of the persons reviewed. Consumers considered needing improvement included: the aforementioned 49-year-old female with schizophrenia and a co-occurring substance abuse disorder arrested within the previous week for substance possession; the aforementioned female with bipolar disorder who was treated within the previous week for attempted suicide; the aforementioned recently incarcerated male with post-traumatic stress disorder who was going through the process of detoxification from chronic substance abuse; the aforementioned male with bipolar disorder who had active psychotic symptoms and was not receiving sufficient mental health services resulting in his biological mother seeking court-ordered treatment; the aforementioned male having major depressive disorder who also had a history of chronic IV substance use; and a 46-year-old male with schizophrenia who had been hospitalized recently after an interruption in his medication. An interesting trend is that five of the nine consumers receiving ratings of needing improvement for mental health status also had a safety rating of needing improvement.

<u>Education/Career Preparation</u>. Based on the person's needs and interests, is this adult actively engaged in educational activities (e.g., adult basic education/GED preparation, post-secondary education) or a vocational training program? This was the central concern in this review area. This review was deemed applicable to 23 (56%) of the 41 sample members. The indicator was deemed not applicable if the consumer was retired and/or did not have aspirations or goals to pursue education or training opportunities. Among those consumers, 35% were found to be receiving an adequate level of education and career preparation. This finding is also consistent with the first-year review ratings. Education and career preparation was rated in the maintenance zone for 17% of the sample, in the refinement zone for 30%, and in the improvement zone for

53%. The status was poor in this area for more than half of those for whom this area was deemed applicable.

Work. Based on the person's needs and interests, is the person actively engaged in employment (e.g., competitive, supported, or transitional)? If not, does the person have access to productive activities? This review area was deemed applicable for 31 (76%) of the 41 persons in the sample. This indicator was deemed not applicable if the consumer was retired and/or lacked aspirations or goals to pursue employment or voluntary opportunities. Work activities and opportunities were found to be minimally acceptable for 35% of the sample members for whom the review area was deemed applicable. This finding is somewhat lower than the 50% considered acceptable in the first-year review. Work was found to be in the maintenance zone for 16%, in the refinement zone for 29%, and in the improvement zone for 55% of the applicable sample members. The education/career preparation and work status indicators had the greatest proportion of sample members receiving ratings of needing immediate improvement, thus, highlighting a specific area of practice needing additional growth.

Recovery Activities. Consistent with the person's needs and preferences, did the person actively engage in activities necessary to improve capabilities, competencies, coping, self-management, social integration, and recovery? This review area was deemed applicable for 37 (90%) of the 41 persons in the sample. This review indicator was deemed not applicable if the consumer chooses not to pursue recovery opportunities at the time of the review. Engagement in recovery activities was found to be minimally adequate or better for 35% of the sample members for whom the review was deemed applicable. This finding is notably lower than the 60% of the first-year sample found to be at least minimally acceptable. Engagement in recovery activities was rated in the maintenance zone for 11%, in the refinement zone for 43%, and in the improvement zone for 46% of the sample members. As with education and work, the rate of acceptable participation and opportunity was found to be substantially inadequate for many persons in the sample. Thus, access to and participation in meaningful recovery activities remains a challenge for many adults.

Overall Status of Adult Consumers. The protocol provides a scoring rubric for combining ratings values across the items deemed applicable to the adult service consumers being reviewed to produce an "overall status rating." Applying this rubric resulted in the determination that approximately half (54%) of the adult consumers reviewed had at least a minimally acceptable overall status (rating levels 4, 5, and 6). For comparative purposes, 75% of the first-year sample were determined to have at least a minimally adequate overall status, however, the discrepancy between the first and second years has largely been attributed to methodological limitations of the first-year review. The findings from the current (April 2004) review are considered to be a fair and representative result for a baseline measurement across status indicators.

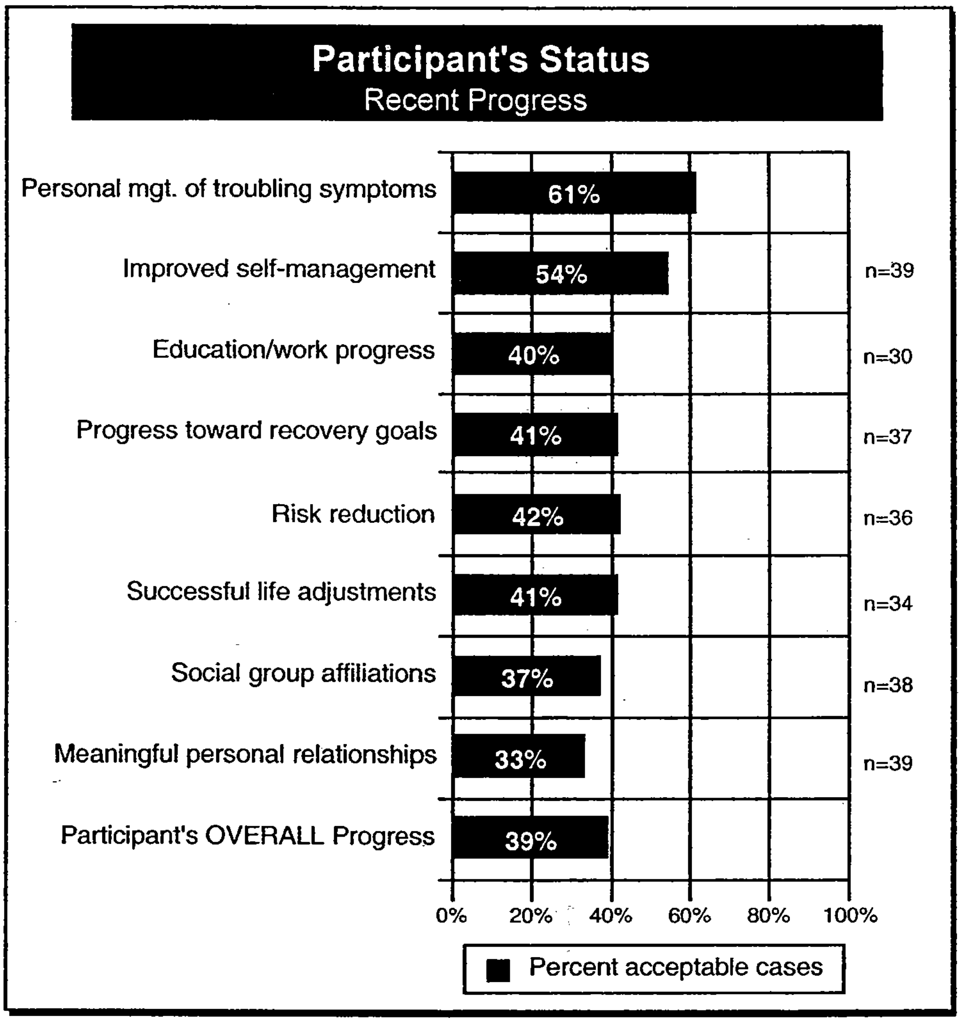
Recent Progress Patterns Showing Change Over Time

The CSR protocol provided eight indicators that enabled reviewers to examine recent progress noted for the sample members reviewed. The focus was placed on changes occurring over the past six months or since admission if less than six months. Descriptions of these eight indicators can be found in **Appendix A**.

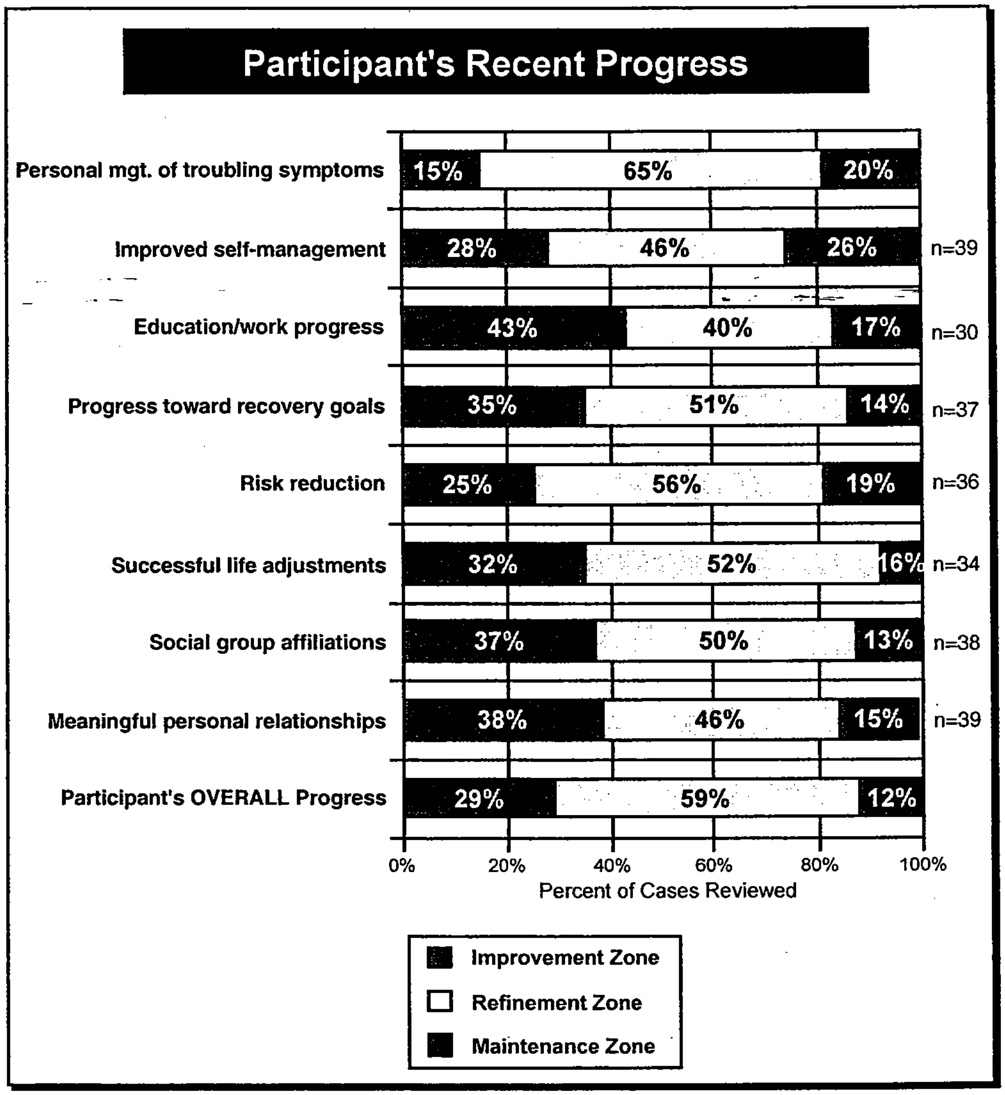
Displays 15 and 16 present findings for the progress indicators for the review sample. It should be noted that indicators could be deemed not applicable in certain cases, based on specific case circumstances. Progress findings on both displays are summarized concurrently as follows.

Progress in Symptom Reduction and Management. The focus of this review was placed on the extent to which troublesome symptoms of mental illness were being reduced, coped with, and personally managed by the individual. Reducing symptoms of mental illness is usually a goal of treatment for adults receiving mental health services. Recent progress in symptom reduction and management was found to be at least minimally adequate for nearly two-thirds (61%) of sample members reviewed. Symptom reduction and management was determined to be in the maintenance zone for 20% of the sample members, in the refinement zone for another 65%, and in the improvement zone for another 15%. Although the consumer status indicator for mental health noted 49% of the sample having adequate ratings, it is promising to note the progress towards symptom reduction and management was acceptable for approximately two-thirds of the sample. These findings were consistent with first-year review results in which 64% of the sample were noted as having at least minimally adequate progress in personal management of troubling symptoms. Of those cases rated in the improvement zone, there were several cases in which the consumers briefly participated in a substance abuse treatment milieu, however, these services were not sufficient in addressing underlying mental health needs. For example, "...[The consumer stated] dissatisfaction seemed to arise out of what she considered an inappropriate focus on her addiction problems instead of addressing her issues of abuse and trauma." Other consumer circumstances included persons having active psychoses and/or delusions at the time of the review, as well as one consumer who had recently attempted suicide.

Display 15



Display 16



Progress in Self-Management. The extent to which a person was making progress in key life areas, including self-management in the community, was the focus of review in this indicator. Improvements in self-management were found to be minimally adequate in approximately half (54%) of the cases reviewed. Of the cases reviewed, 26% were rated in the maintenance zone, 46% were rated in the refinement zone, and 28% were rated in the improvement zone. It should be noted that this indicator applied to 39 of the 41 individuals included in the sample. This review indicator was deemed not applicable if the consumer was not expected to improve due to conditions such as being in an end-of-life stage. These findings were somewhat less than first-year review results, in which 68% of the cases reviewed were noted to have at least minimally acceptable progress in self-management.

Education/Work Progress. The focus of this indicator was on the extent to which a person was making progress toward educational program completion or making progress in getting and keeping a job. This review was deemed applicable to 30 of the 41 persons in the review sample. Education or work progress was found to be minimally adequate or better in 40% of the applicable cases. Of the 30 applicable cases, 17% were rated in the maintenance zone, 40% were rated in the refinement zone, and 43% were rated in the improvement zone. These findings were somewhat less than first-year review results, in which 56% of the cases reviewed were noted to have at least minimally acceptable progress toward education and work goals. Of the five consumers in which education/work progress was rated acceptable, primary daytime activities include competitive employment (three) or participating in work preparation activities (community college and vocational rehabilitation). Following is a positive case example that was rated in the maintenance zone, more clearly illustrating this indicator. This 40-year-old female recently completed a core service provider's day treatment program for her depressive disorder and substance dependence. One component of the program included a focus on employment and the consumer is currently working for an area public transportation company. One of the goals of her Individualized Recovery Plan (IRP) included a focus on reducing job-related anxiety and she continues to meet with the career counselor from the agency on a monthly basis as a component of her after-care activities. However, the consumer did state that although she felt like she was an active participant in the construction of her treatment plan, she would have liked to be a part of the center's staffings since they were discussing her treatment.

Review findings noted little emphasis placed on education/work progress activities in the actual provision of treatment and services, despite these areas often noted in the IRP. It is noteworthy that no consumers participating in supportive employment rated in the maintenance zone for this indicator. Several consumers noted a desire to find employment in some environment, but services that they had received did not typically address this domain.

Progress Toward Recovery Goals. To what degree is the person making progress toward attainment of personally selected recovery goals in the person's IRP? This review indicator was deemed applicable in 37 of the 41 cases in the sample. This indicator was deemed not applicable if the consumer chooses not to pursue recovery goals or is in an end-of-life stage. Recovery progress was found to be at least minimally adequate in 41% of the applicable cases. Recovery progress was rated in the maintenance zone for 14% of the applicable cases, in the refinement zone for 51% of the applicable cases, and in the improvement zone for 35% of the applicable cases. These findings were somewhat less than first-year review results, in which 59% of the cases reviewed were noted to have at least minimally acceptable progress towards recovery goals.

Risk Reduction. To what extent is reduction of risks of harm, addiction, or use of coercive techniques being accomplished for this person? This indicator was deemed applicable in 36 of the 41 cases in the review sample. Risk reduction was found to be at least minimally acceptable for 42% of the applicable cases. Risk reduction was rated in the maintenance zone for 19% of the applicable cases, in the refinement zone for 56% of the applicable cases, and in the improvement zone for 25% of the applicable cases. These findings were somewhat less than first-year review results, in which 62% of the cases reviewed were noted to have at least minimally acceptable progress towards risk reduction.

Successful Life Adjustments. Consistent with the person's life goals, to what extent is the person making successful transitions and life adjustments between settings, service providers, levels of care, and from dependency to personal control and direction of one's life? This review indicator was deemed applicable to 34 of the 41 cases in the sample. Successful life adjustments were found to be at least minimally acceptable for 41% of the applicable cases. Successful life adjustments were rated in the maintenance zone for 16% of the applicable cases, in the refinement zone for 52% of the applicable cases, and in the improvement zone for 32% of the applicable cases. These findings were somewhat less than first-year review results, in which 69% of the cases reviewed were noted to have at least minimally acceptable progress towards successful life adjustments.

Improved Social Group Affiliation. To what degree is the person increasing his/her social affiliation among a variety of social groups (outside of his/her immediate social group), consistent with IRP goals? This indicator was deemed applicable in 38 of the 41 cases. Reviewers found progress in social group affiliation at least minimally adequate in 37% of the applicable cases. Progress in social group affiliation was rated in the maintenance zone for 13%, in the refinement zone for 50%, and in the improvement zone for 37% of the applicable cases. These findings were somewhat less than first-year review results, in which 58% of the cases reviewed were noted to have at least minimally acceptable progress towards improved social group affiliation.

Improved Meaningful Personal Relationships. To what degree is the person improving meaningful personal relationships with peers, friends, and community members, consistent with the person's preferences? This indicator was deemed applicable in 39 of the 41 cases in the sample. This indicator was deemed not applicable if the consumer was unable or unwilling to participate in social integration opportunities. Progress toward improved meaningful relationships was found to be at least minimally adequate or better in 33% of the applicable cases reviewed. Progress on this indicator was rated in the maintenance zone for 15% of the applicable cases, in the refinement zone for 46%, and in the improvement zone for 38%. These findings were somewhat less than first-year review results, in which 58% of the cases reviewed were noted to have at least minimally acceptable progress towards improved meaningful personal relationships.

Overall Progress Pattern. To what extent are persons in the sample making overall progress on applicable indicators in their cases? Reviewers provided a holistic impression of overall progress in each case based on those progress indicators deemed applicable in the case. The overall progress pattern was found to be at least minimally acceptable in 39% of the cases in the sample. Overall progress was rated in the maintenance zone for 12% of the cases, in the refinement zone for 59%, and in the improvement zone for 29%.

Although both the overall progress pattern (first-year ratings of at least 61% minimally acceptable) and the individual progress indicators are somewhat less than the first-year review results, this is attributed to a more representative sample of consumers receiving services than the sample in the first-year review and, when combined with the first-year data, represents an adequate baseline. A number of individual case examples were shared by review team members during the debriefing activities that illustrated effective delivery of recovery-oriented practice provided through consumer-driven individual service teams. To increase the consistency of these good practices, additional supports and strategies through ongoing mentoring and coaching, supervision, and quality assurance mechanisms must be implemented.

Case-Level Performance of Practice Functions

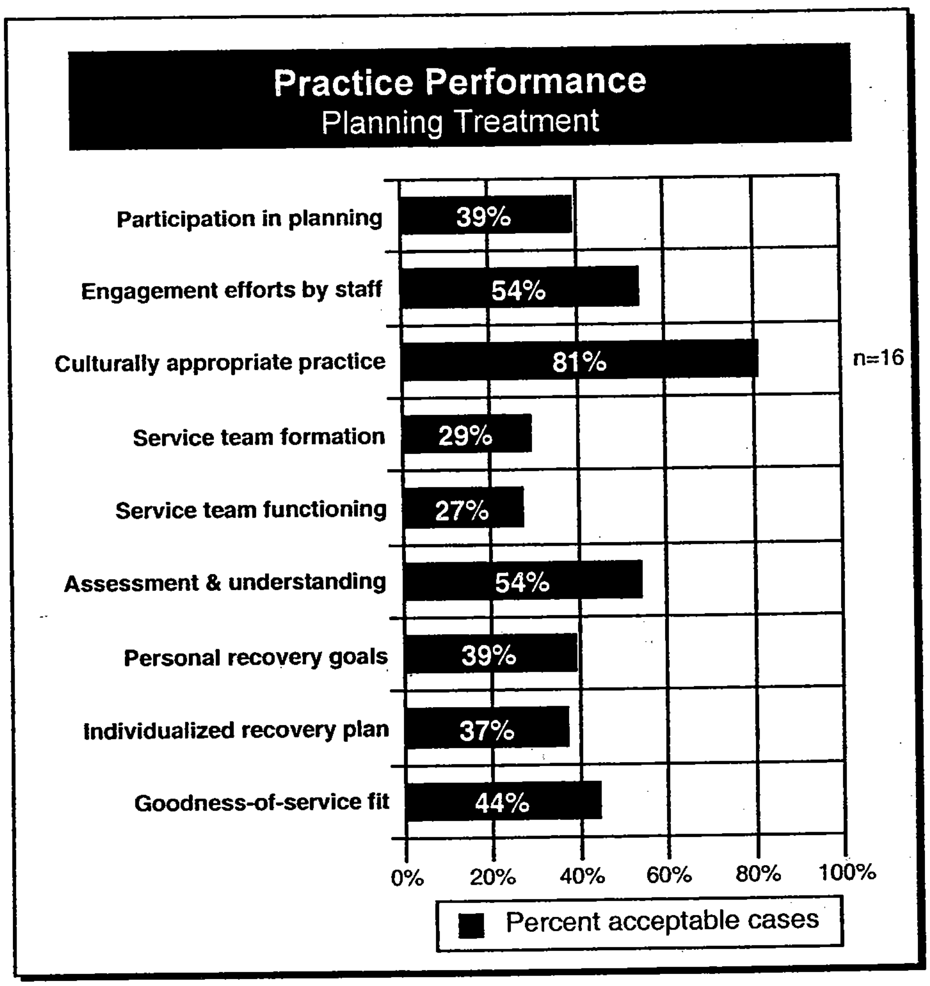
The CSR protocol contained 17 indicators of practice performance that were applied to the service situations observed for members of the review sample. See **Appendix A** for further information about the questions probed through these indicators. For organizational purposes, the 17 indicators were divided into two sets. The first set—"planning treatment," containing eight indicators—focused on engagement, understanding the situation, setting directions, making plans, and organizing a good mix of services. Findings for these eight indicators are presented in **Displays 17 and 18**. The second set—"providing and managing treatment," containing eight indicators—focused on resources, implementation, special procedures and supports, service coordination, and tracking and adjustment. **Displays 19 and 20** present findings for the second set of indicators.

The first set of performance indicators describes important functions and aspects of daily frontline practice conducted with 41 persons. Findings for these indicators are presented in the two displays and summarized concurrently below.

Engagement/Participation of the Person. The adult consumer and his/her selected supporters should be active participants in making decisions and plans about services. Service staff should make greater outreach and engagement efforts. Achieving active participation depends on the relationships formed and sustained over the course of the treatment process. Consumer participation in practice was at least minimally acceptable in 39% of the cases reviewed, while engagement efforts by frontline practitioners was at least minimally acceptable in 54% of the cases reviewed. Consumer participation in service planning was in the maintenance zone for 17% of the cases, in the refinement zone for 44% of the cases, and in the improvement zone for

39% of the cases. Similarly, engagement efforts by frontline practitioners were found to be in the maintenance zone for 24% of the cases. Engagement was found to be in the refinement zone for 49% of the cases and in the improvement zone for 27% of the cases. These findings are somewhat consistent with first-year review results and again illustrate one of the primary conclusions of that review: there does not appear to be a consumer-focused, strengths-based, recovery-oriented practice model operating consistently within the District of Columbia. Although some individual cases were noted in which the practice expectations were being implemented with sufficient diligence of effort, additional gains must be made in the engagement and participation of consumers through the provision of recovery-oriented services in order to meet the exit criteria of the Dixon Consent Decree.

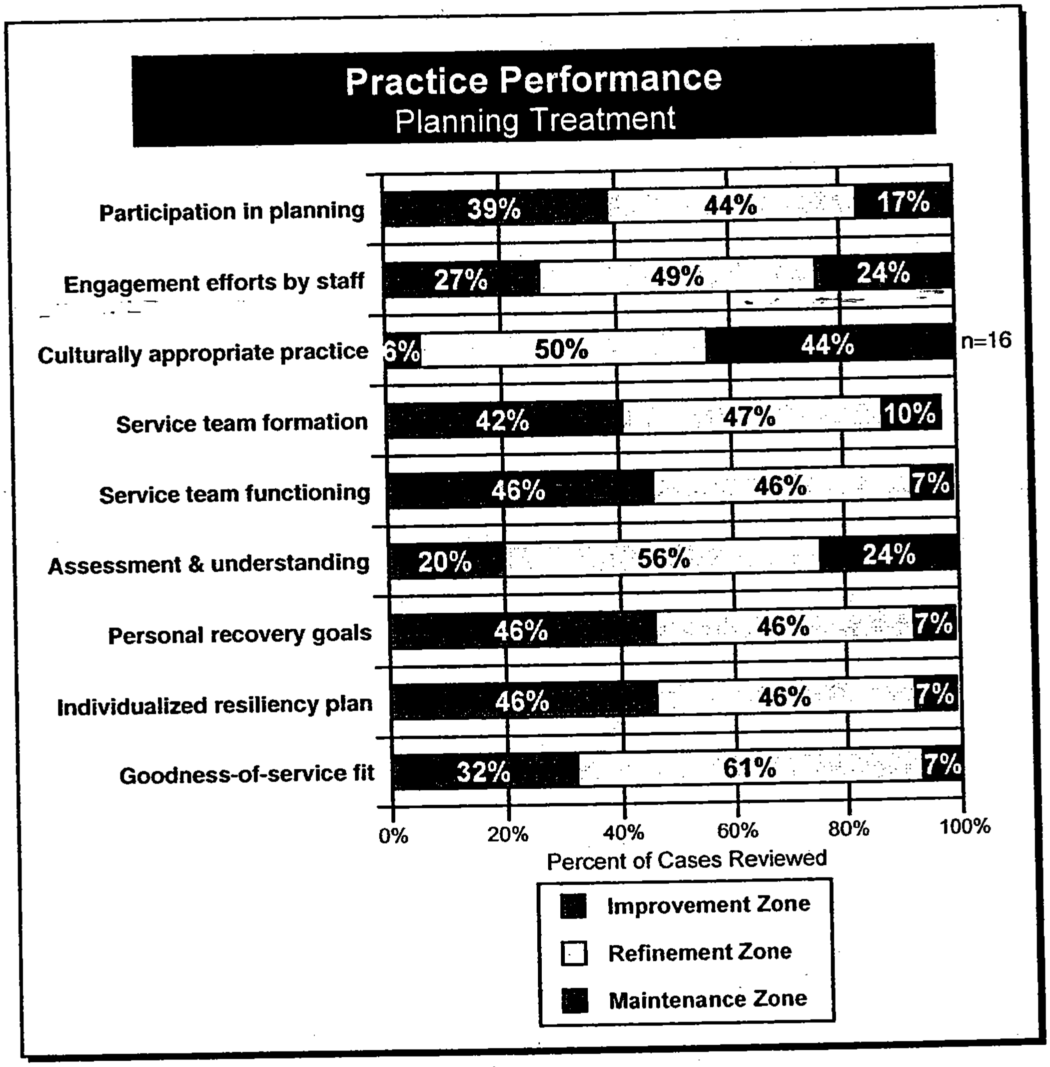
Display 17



<u>Culturally Appropriate Practice</u>. Significant cultural issues should be recognized and addressed in practice through special accommodations and supports used to adapt or augment basic functions of practice (e.g., engagement, assessment, and planning). This expectation is applicable when there are cultural differences between the persons providing and receiving services. This indicator was deemed applicable for 16 of the 41 sample members. Reviewers found that practice was culturally appropriate in 81% of the cases to which this indicator applied. Culturally competent practice was found to be in the maintenance zone for 44% of these cases, in the refinement zone for 50% of these cases, and in the improvement zone for 6% of these cases. These findings are similar to first-year review results, in which 73% of the cases were at least minimally acceptable for this indicator. Practitioners appear to be meeting the expectation of providing services in a culturally appropriate manner consistently, and this specific area of practice delivery is considered a strength in the provision of mental health services within the district.

<u>Service Team Formation</u>. Each adult consumer served should have a service team involving the person, informal supports, and service providers. There is no fixed formula for team composition, but the team should be the "right people" for the person and include those who are active service providers in the consumer's life. It is not uncommon for a consumer's individual service team to include the participation of other family members, both mental health and other agency case managers, therapists, psychiatrists, medical providers, or parole officers. Service team formation was found to be at least minimally adequate for 29% of the adults reviewed. Service team formation was found to be in the maintenance zone for 10% of these cases, in the refinement zone for 47% of these cases, and in the improvement zone for 42% of these cases.

Display 18



Several contributing factors were noted in the case review findings that are continuing to challenge the service system's ability to construct appropriate service teams to meet the needs of individual consumers. Stakeholders report that their understanding of current billing policies impede participating in a consumer's individual service team meetings as all team members are not allowed to claim participation in the team meetings, or activities relating to the team meetings, as billable hours. Likewise, basic case management services, such as transportation or advocacy assistance, were also reported as not being billable time. It should be noted, however, that DMH considers the billing structure adequate to cover appropriately provided, individually oriented recovery activities. Review findings also suggest that regularly scheduled clinical staff meetings within the core service agencies are often interpreted as a consumer's individual team meetings, however, these meetings do not typically include the consumer, and despite discussion of the consumer's IRP, participants may include clinicians who are not actively working with the consumer. This more traditional "medical treatment team model" approach is not congruent with the recovery-model operating principles in providing individually oriented services developed by a team of persons who are actively working with the consumer and, when appropriate, the family.

Although case review findings indicate that IRPs were being updated at 90-day intervals, this often occurred in concert with just the case manager and not in the context of an individual service team meeting.

Service Team Functioning. The service team should function as a unified team in planning services. The actions of the service team should reflect a coherent pattern of teamwork and collaborative problem solving that achieves results benefiting the adult service consumer. Service team functioning was found to be at least minimally adequate for 27% of the persons reviewed. Service team functioning was found to be in the maintenance zone for 7% of the cases, in the refinement zone for 46% of the cases, and in the improvement zone for 46% of the cases. As noted with service team formation, service team functioning remains an area requiring significant attention in practice development.

Assessment and Understanding. A functional assessment involves not only the collection and assembly of information about a person but also the development of a "big picture view" and deep understanding of the person's situation, circumstances, and preferences. The knowledge gained through ongoing functional assessments, when shared across service team members, enables those providing services to ensure that the appropriate combination and sequence of supports and interventions are implemented to maximize progress and success for the person. Assessment and understanding of the person were found to be at least minimally adequate in 54% of the adult service consumers reviewed. Functional assessment was found to be in the maintenance zone for 24% of the cases, in the refinement zone for 56% of the cases, and in the improvement zone for 20% of the cases. These findings are somewhat less than first-year results, in which 71% of the cases were noted to have at least minimally acceptable assessments.

Personal Recovery Goals. Do the personal recovery goals used for service planning reflect the person's life situation, interests, and career aspirations? If met, will these goals lead to the person managing successfully at home, at work, and in the community, with supports and services as necessary? Personal recovery goals of the person being served enable practitioners to look ahead to where they hope the person will be in the next 3-5 years so that goals can be reached and transitions accomplished. The long-term success of the person depends on a meaningful, long-term, strategic vision that creates a pathway that guides services, enabling the person to achieve important life outcomes. Without personal recovery goals to guide planning, service providers tend to focus on the present episode (reduce a behavior problem or change a placement) rather than planning strategies and providing services for reaching critical long-term goals.

Personal recovery goals were found to be at least minimally adequate in 39% of the cases reviewed. Personal recovery goals were found to be in the maintenance zone for 7% of the cases, in the refinement zone for 46%, and in the improvement zone for 46%.

Individualized Recovery Plan. The IRP should set forth strategies and services across providers that are directed at achieving the personal recovery goals set for the person. The IRP should build on personal recovery and strengths, providing interventions and supports that help the person succeed at home and work. More than a mere service authorization document, the IRP should actually drive practice and service provision in a case. The IRP was found to be at least minimally adequate for 37% of the persons reviewed. The IRP was found to be in the maintenance zone for 7% of the cases, in the refinement zone for another 46%, and in the improvement zone for another 46%. The development and use of the IRP in actual case practice is an area that continues to require further attention.

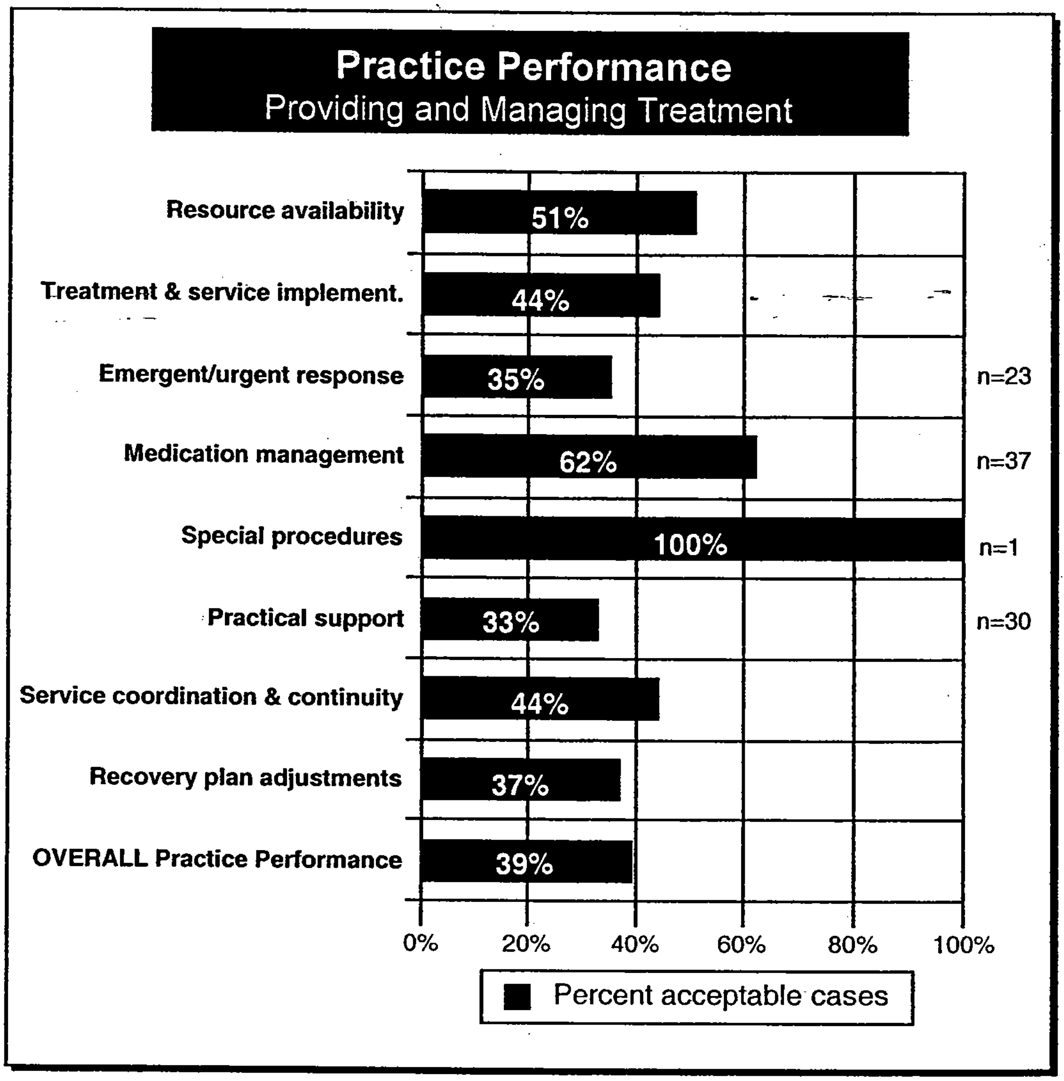
Goodness-of-Service Fit. The therapeutic, rehabilitative, and supportive services should be assembled into a coherent mix that has a "logical fit" to meet the presenting needs of the consumer. This "fit" of services should maximize positive results and benefits while minimizing conflicting strategies and hardships imposed. The goodness-of-service fit was found to be at least minimally adequate for 44% of the persons reviewed. The service fit was found to be in the maintenance zone for 7% of the cases reviewed, in the refinement zone for 61% of the cases reviewed, and in the improvement zone for 32% of the cases reviewed.

The second set of performance indicators covers important functions related to the provision and management of treatment and support services to persons receiving services. Findings for these indicators are presented in the next two displays and summarized concurrently below.

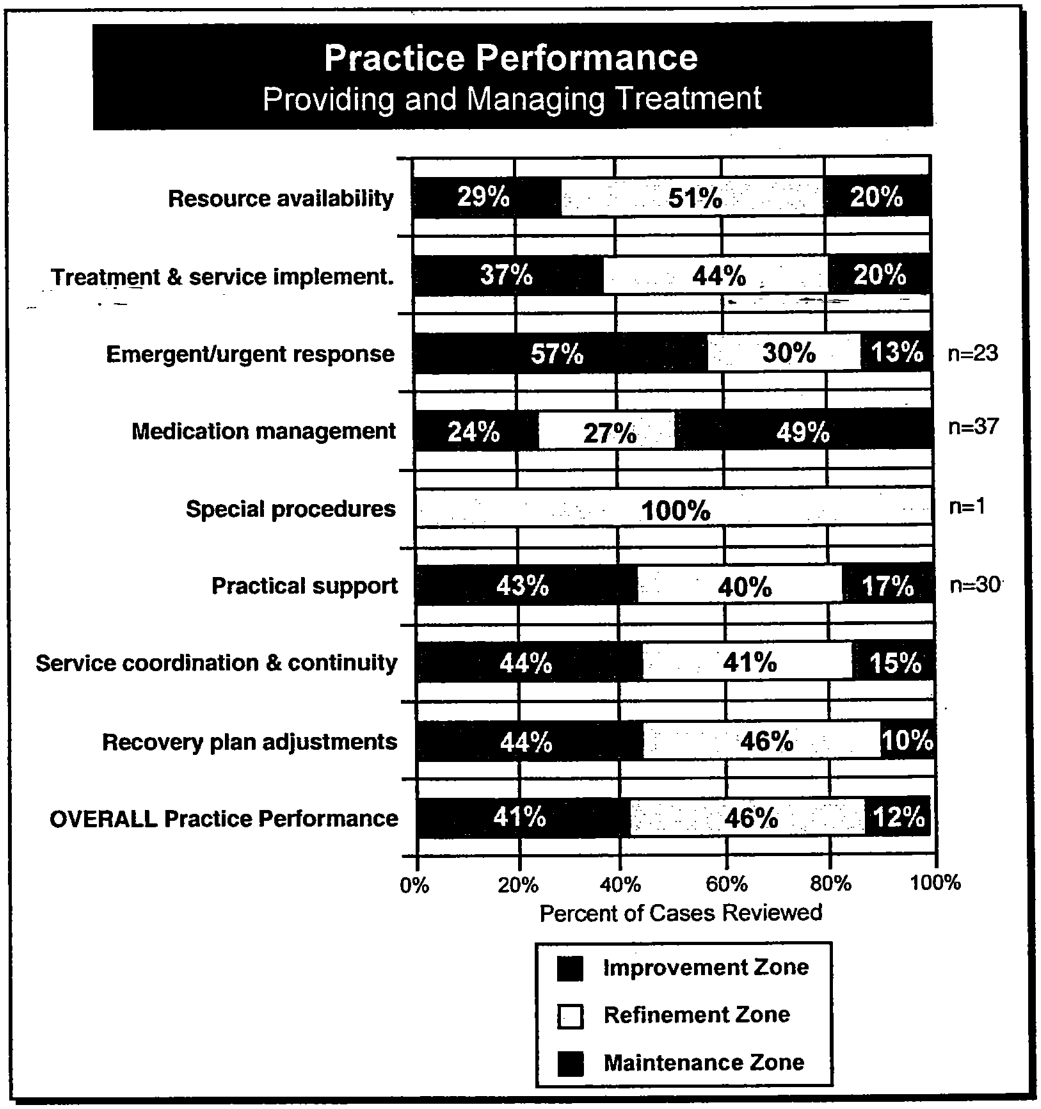
Resource Availability. Are the supports, services, and resources necessary to meet the needs addressed in the IRP available for use by the person, supporter, and service team? Does the service team identify any needed but unavailable resources with efforts being made to secure these resources? Resource availability was found to be at least minimally adequate for 51% of the sample members. Resource availability was rated in the maintenance zone for 20%, in the refinement zone for 51%, and in the improvement zone for 29% of the sample. These findings are somewhat less than the first-year results, in which resource availability was at least minimally acceptable for 64% of last year's sample.

Treatment Implementation. Intervention strategies, supports, and services set forth in the person's IRP should be implemented with sufficient intensity and consistency to achieve the goals and results expected. Implementation should be timely and competent. Treatment implementation was found to be at least minimally adequate for 44% of the sample members reviewed. Implementation was found to be in the good to optimal range (maintenance zone) for 20% of the cases. Implementation was found to be in the refinement zone for 44% of the cases and in the improvement zone for 37% of the cases. These findings are somewhat less than the first-year results, in which treatment implementation was at least minimally acceptable for 64% of last year's sample.

Display 19


Practice Performance
Providing and Managing Treatment
Resource availability
51%
Treatment & service implement.
44%
Emergent/urgent response
35%
n=23
Medication management
62%
n=37
Special procedures
100%
n=1
Practical support
33%
n=30
Service coordination & continuity
44%
Recovery plan adjustments
37%
OVERALL Practice Performance
39%
0%
20%
40%
60%
80%
100%
Percent acceptable cases

Display 20



Emergent/Urgent Response. Persons served should have timely access to and provision of effective services to stabilize or resolve emergent or episodic problems of an urgent nature. Not all persons served need such services. Indeed, only 23 persons served within the sample of 41 needed and used these services in the recent past. Emergency and urgent service provision was found to be at least minimally adequate for 35% of the persons in the sample who needed and used such services. Emergency and urgent service provision was found to be in the maintenance zone for 13% of these cases, in the refinement zone for 30% of these cases, and in the improvement zone for 57% of these cases. These findings are consistent with the first-year review findings and indicate that emergency and urgent service provision continue to be areas in which significant improvements are needed to benefit service consumers. The following is a case example that highlights diligent work completed to address the emergent needs of an 18-year-old male who began accessing publicly provided mental health services (and other social service supports) for the first time within three months of the review. This case example also highlights the positive outcomes individual service teams can produce when they are functioning adequately and focus on providing traditional case management services to address the individual needs of the consumer.

> "...It is important to note that [the consumer] has only been receiving mental health services from a core service agency for the previous 2 and 1/2 months. Prior to enrollment, all mental health services had been covered through his parent's health insurance and he was accessing private providers. Numerous steps have had to be taken to ensure care for [the consumer] since he left home to live in an area shelter. Since that time, his case manager has assisted him in accessing interim disability payments and obtaining D.C. alliance for health coverage. Staff at the shelter, as well as his case worker, advocated to get [the consumer] placed into his current group home, despite initially being informed of a wait list over six months long. He has received an initial psychiatric consult, has met with an RN twice, and has had prior medication re-authorized until the new psychiatric evaluation/recommendations could be incorporated into his case plan. [The consumer] has quickly adapted to his new setting and is making several friends. When his roommate attempted suicide, with [the consumer] finding him, staff from both the provider agency and group home responded quickly and adequately. There has also been a team meeting at the group home that included the consumer's parents. Although this meeting was not identified as an IRP team meeting, all participants noted it being helpful, and they are planning on meeting again. The case manager is in regular contact with both [the consumer] and the group home staff, and has had numerous contacts with the consumer at his home residence.

Medication Management. Use of psychotropic medications should be necessary, safe, and effective, when used. The person taking such medications should be screened and treated for any side effects. Medication use should reflect state-of-the-art medications and practices. Medication use should be coordinated with other treatment modalities and with treatment for any co-occurring conditions (e.g., seizures, diabetes, or asthma). Thirty-seven of the 41 persons served in the sample were taking psychotropic medications. Medication management was found to be at least minimally adequate for 62% of the persons in the review sample who took medications. Medication management was found to be in the maintenance zone for 49% of these cases, in the refinement zone for 27% of these cases, and in the improvement zone for 24% of these cases.

Special Procedures. If emergency seclusion or restraint is used for a person, each use should be: (1) done only in an emergency, (2) done after less restrictive alternatives were found insufficient or impractical, (3) ordered by a trained and authorized professional, (4) accomplished with proper techniques that were safely and respectfully performed by trained staff, (5) effective in preventing harm, and (6) properly supervised during use and evaluated afterward. This review indicator was deemed applicable in only one case in the review sample and although it was considered at least minimally acceptable, some refinement in its usage was also suggested.

Practical Support. Is the array of in-home and community-based supports provided to the person sufficient [in design, intensity, and dependability] to meet the person's preferences and do they assist him or her achieve recovery goals? Are practical supports effective during life change adjustments and in maintaining the person in his/her home, job, and community? Where applicable, are individually assigned staff (job coach, crisis worker, skills trainer) receiving the education and supports necessary to maintain an appropriate relationship with the person? This indicator was deemed applicable in 30 of the 41 cases in the review sample. This indicator was deemed not applicable if neither the consumer nor home provider needs or receives supports at this time. Practical support was found to be at least minimally adequate for 33% of the cases. Practical support was found to be in the maintenance zone for 17% of the applicable cases, in the refinement zone for 40% of the applicable cases, and in the improvement zone for 43% of the applicable cases.

Service Coordination and Continuity. There should be a single point of coordination, accountability, and continuity of services for the person. IRP-specified treatment and support services should be well coordinated across service settings, providers, funding agencies, and levels of care for this person. Service coordination was found to be at least minimally adequate for 44% of the cases. Service coordination was found to be in the maintenance zone for 15% of the cases, in the refinement zone for 41%, and in the improvement zone for 44%. These results are consistent with last year's sample.

Recovery Plan Adjustments. Is the service coordinator using monitoring activities to follow the person's progress, changing conditions, consistency and effectiveness of supports, and results achieved? The service coordinator and team should be tracking the person's treatment progress, stressors and supports, and results. The team should communicate frequently to discuss treatment fidelity, barriers, and progress. IRP services and strategies should be adjusted in response to progress made, changing needs, problems solved, and experience gained to create a self-correcting treatment process for the person. Tracking and adjustment was found to be at least minimally adequate for 37% of the persons reviewed. Tracking and adjustment was found to be in the maintenance zone for 10% of the cases reviewed, in the refinement zone for 46% of the cases reviewed, and in the improvement zone for 44% of the cases reviewed. These results are somewhat consistent with last year's review findings.

Overall Practice Performance. The protocol provides a scoring rubric for combining ratings values across the items deemed applicable to the person being reviewed to produce an "overall practice performance rating." Applying this rubric resulted in the determination that overall practice performance was rated as adequate (rating levels 4, 5, and 6) in 39% of the cases reviewed. Of the cases reviewed, 12% were rated in the maintenance zone, 46% were rated in the refinement zone, and 41% were rated in the improvement zone.

Case Review Outcome Categories

Members of the case review sample can be classified and assigned to one of four categories that summarize review outcomes. Sample members having overall status ratings in the 4, 5, and 6 levels are considered to have a "favorable status." Likewise, those having overall practice performance ratings of 4, 5, and 6 are considered to have "acceptable system performance" at the time of the review. Those having overall status ratings less than 4 had "unfavorable status" and those having overall practice performance ratings less than 4 had "unacceptable system performance." These categories are used to create the two-fold table shown in **Display 21**.

Display 21 reveals that 13 of the 41 consumers (32%) fell into outcome category 1. Outcome 1 is the desired situation for all adults receiving services, in which the consumer is faring well and the service system is responding adequately in accordance with their needs. Three of the consumers (7%) in the sample fell into outcome category 2. Outcome 2 includes those consumers whose needs are so complex that despite the diligence of appropriate response of the service system, the consumers continue to have a poor status. Nine consumers (22%) fell into outcome category 3. Outcome 3 contains those sample members whose status was favorable but experienced less than acceptable service system performance. Some persons are resilient and may have excellent supports provided by family, friends, or others whose efforts are contributing to the person's favorable status. But, current service system performance may be limited, inconsistent, or seriously inadequate at this time. Sixteen cases (39%) fell into review outcome category 4. Outcome 4 is the most unfavorable combination because the person's status is unfavorable and system performance is inadequate.

This display shows that service system performance was acceptable for 39% of the sample members. It is the experience of HSO, who has been the court-appointed monitor in class action litigations similar to the Dixon Consent Decree, that service systems, when they have achieved a high level of organizational development and practice refinement, are capable of achieving greater than 90% acceptable system performance results as reflected in consumer review findings.

Display 21

Case Review Outcome Categories

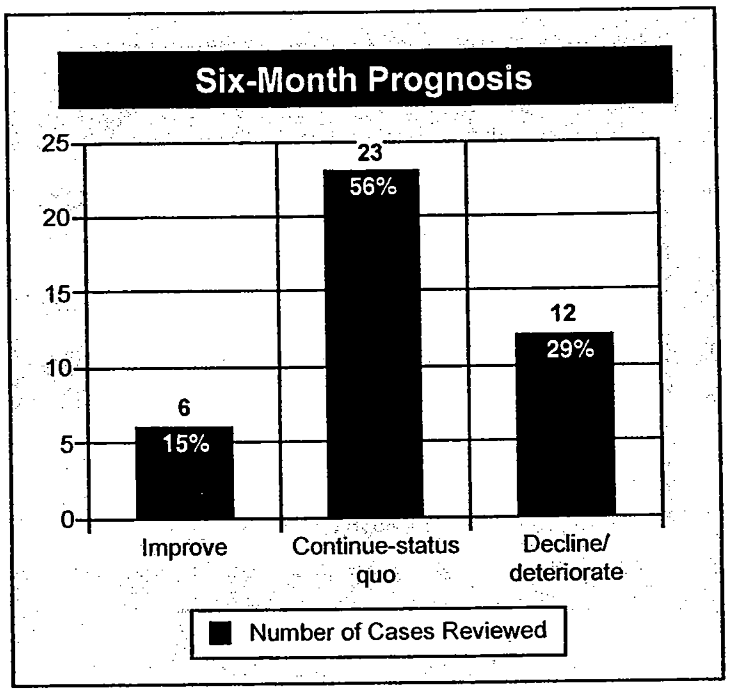
Status of the Participant in Individual Cases

Acceptability of Service System Performance in Individual Cases	Favorable Status	Unfavorable Status	
Acceptable System Performance	**Outcome 1:** Good status for the participant, ongoing services acceptable. **32% (13 cases)**	**Outcome 2:** Poor status for the participant, ongoing services minimally acceptable but limited in reach or efficacy. **7% (3 cases)**	**39%**
Unacceptable System Performance	**Outcome 3:** Good status for the participant, ongoing services mixed or unacceptable. **22% (9 cases)**	**Outcome 4:** Poor status for the participant, ongoing services unacceptable. **39% (16 cases)**	**61%**
	54%	**46%**	

Six-Month Prognosis

Reviewers made a six-month prognosis for each member of the sample. Formulation of the six-month prognosis was based on current overall status, known events forthcoming in the next six months, and the current overall practice performance observed in the case. **Display 22** presents the six-month prognosis offered by reviewers. Six consumers (15%) in the sample were expected to achieve improved status, 23 (56%) were expected to remain status quo, and 12 (29%) were expected to decline or experience deterioration of circumstances over the next six months.

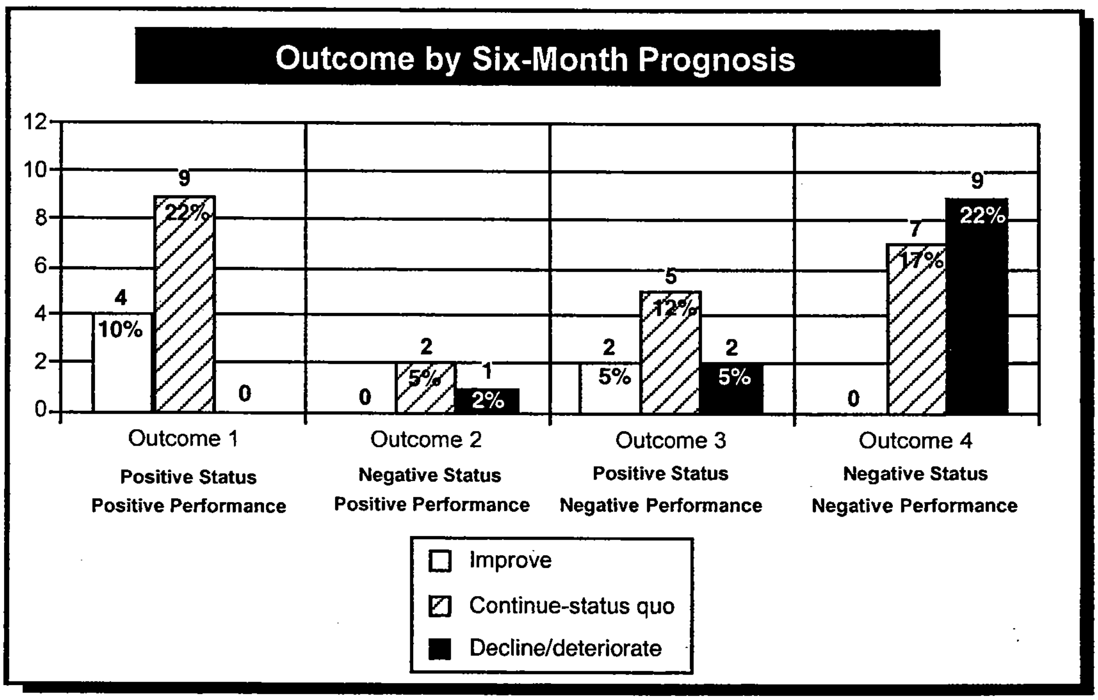
Display 22



Review Outcome and Prognosis

For members of the review sample, **Display 23** reveals the relationship between the person's outcome category and the person's six-month prognosis. All persons categorized in review outcome 1 (i.e., favorable status and acceptable system performance) were predicted to continue status quo (22%) or to improve status (10%). It is noteworthy that there were no consumers in outcome category 1 who were perceived to be in a state of decline within the next six months. Those persons in outcome 2 were expected to either remain status quo or decline. Mixed prognoses were found for those sample members in outcome 3 (i.e., favorable status but unacceptable system performance). In outcome category 3, 5% were expected to improve, 12% were predicted to remain about the same, and 5% were expected to decline over the next six months. Persons found in outcome 4 (i.e., unfavorable status and unacceptable service system performance) tended to have poor near-term predictions. Seven consumers (17%) in outcome 4 were predicted to remain status quo in the next six months and nine consumers (22%) were predicted to decline. There were no consumers in outcome 4 with a favorable prognosis of improvement in the near future.

Display 23



Additional Themes and Patterns Noted from Case Review Findings

Several examples of effective and creative casework were noted in the cases reviewed, however, such levels of services were not being provided with sufficient consistency.

- Throughout the review, community support workers and Assertive Community Treatment (ACT) team members stated a desire to provide services in a more community-based and consumer-collaborative format. Similarly, community support workers and ACT team members stated that they were excited about the case review process, as it was perceived to be an effective means of focusing on actual frontline conditions. Likewise, several requests were made to provide specific feedback based on the case review findings.

- Many consumers demonstrated a high degree of personal resiliency. Oftentimes, consumers were also relying on supportive family members or friends to assist in meeting day-to-day needs.

- Consumers reported having a good relationship with their community support workers and ACT team providers and that their workers were able to provide the resources or assistance that was responsive to their needs.

- There was increasing awareness across frontline practitioners of the expectation to provide consumer-focused, recovery-oriented services. Practitioners appear to be gaining awareness of new job responsibilities such as providing case management services, advocating for consumer's needs, and engaging consumers in their homes or other neutral locations, rather than the traditional clinic setting.

- The implementation of a recovery-based model does not appear to be consistently occurring across the frontline. Although many practitioners reported that an individual consumer-focused practice model was being espoused as the expectation in practice by the management of their organization, current management emphasis on compliance with policies and procedural expectations (such as billing expectations) impedes the provision of services according to this practice model. There is some question as to whether the business model, as they understand it, actually supports and facilitates the consistent quality implementation of the practice model.

- Services did not appear to be consistently coordinated across multiple service providers. Similarly, there appeared to be some misunderstanding regarding the utilization of individually constructed teams as purveyors of services for consumers. Oftentimes, a consumer's individual team meetings were perceived to be the regularly scheduled intra-agency clinical staffing meetings. These meetings did not typically include the consumer, and as such, the IRP was not the primary factor driving case practice.

- Service planning was oftentimes described as crisis management, in that, services were crafted in response to emergencies as they arose from consumer to consumer. Practitioners report not being able to sufficiently plan for the long term with consumers due to factors such as staff turnover, large caseloads, resistant or non-motivated consumers, and lack of engaged, long-term relationships with consumers.

- Consumers reported a high degree of satisfaction with the services they had been receiving, despite a number of these individual cases receiving unacceptable system performance ratings. As such, consumers do not appear to be fully aware of the practice expectations of the service system.

- Services appear to be focused primarily on mental health symptoms and are not focused on improving activities of daily living, such as employment, housing, or social/interpersonal affiliation needs. Many consumers rely upon family members or friends in order to meet basic economic needs. Housing and employment were noted in both case reviews and focus groups as areas needing further resource development.

- Current supervision of frontline practitioners' case practice appears more focused on meeting the requirements to obtain licensure credentials and does not appear to be providing the coaching, mentoring, and modeling needed to support the use of a recovery-oriented practice model guiding day-to-day practice decisions. Similarly, already-licensed practitioners receive limited practice supervision and, as such, are not provided with ongoing modeling and mentoring opportunities to emphasize the provision of services according to the newly implemented DMH practice expectations.

Themes and Patterns Noted in Stakeholder Interviews

During the week of April 26, Dr. Ivor Groves met independently with core service agencies staff (both administrative/managerial and frontline practitioners), consumers, advocates, and other related stakeholders in a series of focus group interviews. Many of the focus groups were held at the service agency sites. Content of these discussions varied according to participants within the group, but typically focused on barriers to implementing the recovery practice model and other systemic factors impacting the consistency of effective practice and delivery of services.

- Practitioners noted a long-standing need for a sufficient array of housing, employment, and transportation resources. Waiting lists for housing were described as lasting between 6-12 months, if the consumer was even determined to be eligible to receive assistance. Employment opportunities were described as limited, and vocational preparation was described as both limited and underpowered to prepare consumers for real day-to-day jobs. Last, despite a well-developed public transportation system within the district, practitioners reported that many consumers are not capable of using or need more coaching and support to use the Metro or MetroBus services due to physical, cognitive, or emotional/behavioral limitations.

- The providers' perception of current billing policies was that they seemed to require a lot of frontline staff time on activities that might not be billable providing recovery-based services in accordance with the recovery practice principles. Services such as participating in independent team meetings, case management assistance and advocacy, and transportation were several examples listed as non-billable hours. Examples provided by stakeholders of typical daily work tasks that cannot be claimed as billable time included spending lengthy periods of time attempting to locate consumers or waiting during appointments. The emphasis and necessity of each direct service staff person spending time in billable activities sets the priority for where time is spent even though other activities need to be completed to achieve consistent implementation of the recovery practice model.

- Frontline practitioners reported having personal safety concerns in some neighborhoods when attempting to engage consumers in their home environments, which can be neighborhoods having high rates of crime. These workers, due to personal safety reasons, are hesitant to engage consumers in their homes during evening hours. It is not uncommon for workers to bring along a co-worker when going out to meet consumers, however, time spent by the co-worker is not considered billable time.

- Staff at the D.C. Community Services Agency reported that current caseload levels were well above recommended levels, with some staff reporting having between 40-50 consumers assigned to their care. Furthermore, these staff perceived the D.C. Community Services Agency as having to work with more challenging cases, as the D.C. Community Services Agency is reported to be perceived as being the final "safety net" for consumers, as it is perceived by D.C. Community Services Agency staff that smaller core service agency providers have more latitude in enrolling consumers for services. As such, D.C. Community Services Agency staff perceive their caseloads as containing a larger proportion of high-need, high-risk cases. Despite request, actual caseload data could not be obtained to corroborate this perception.

- Both consumers and practitioners noted that consumers are more engaged in the service delivery process and perceive having more choices available in the structuring and delivery of services.

- Stakeholders are optimistic about the progress being made in reforming the mental health system to becoming more consumer- and recovery-focused. Despite the ongoing efforts, consumers, community leaders, and stakeholders want to "see change now" and do not fully recognize the amount of time and energy needed to achieve more demonstrable consistency in practice and better results for consumers.

- Stakeholders are excited that they are beginning to see frontline staff internalize expectations of practice. There still exists variability in both the ability and the degree to which these internalizations have taken hold. Similarly, there was limited discussion of some outstanding resistance to the change process still existing.

- Core service agency staff reported being unsure about current discharge policies. A specific question includes when a consumer can be removed from "active" status. Current policy was described as requiring a qualified professional to verify that the consumer is no longer at risk to self or others. As such, practitioners are hesitant to discharge due to liability reasons.

- Stakeholders reported needing greater access to flexible funding to allow for the delivery of unique and individual services. This resource was described as very limited.

- Stakeholders reported that the previous year has seen much emphasis placed on building adequate infrastructural supports (i.e., computer systems) that will allow for more effective practice in the future.

- The Department of Mental Health is generally perceived as being more helpful and responsive to needs than in the past.

- Stakeholders reported reduction in the number of consumers entering hospitalizations or partial hospitalization placements. Data to corroborate were not obtained.

- Stakeholders reported a significant reduction in the number of consumers participating in long-term "day programs," which were generally perceived as not geared towards meeting the individual recovery needs of the consumer. Data to corroborate were not obtained.

- Stakeholders reported being excited about the review process utilized by the Dixon Court Monitor for reviewing the status of consumers and the adequacy of the service system. Stakeholders requested having additional opportunities to receive direct feedback on review findings.

- Stakeholders reported insufficient access to ACT teams and noted that community support workers are often required to perform identical services as ACT teams in order to meet the individual needs of the consumer, despite having higher caseloads.

Recommendations

The findings from the review were debriefed with review team members in order to identify themes and patterns emerging out of the sample that was reviewed. Following the debriefing, the review team offered the following list of recommendations to address the emergent themes and patterns noted from the case reviews.

There continues to be inconsistent mastery of the basic craft knowledge necessary to provide mental health services in accordance with the recovery model practice principles. Factors to which this was attributed include ongoing turnover of staff at core service agencies other than the D.C. Community Services Agency and inconsistent and, oftentimes, limited supervision of practice for experienced and licensed clinicians. Although the Department of Mental Health and subsequent core service agencies have recently completed several training initiatives, review team participants and stakeholders suggested that providing ongoing coaching, mentoring, and modeling of basic practice at the micro (or frontline) level may be a more effective strategy. One suggestion included using the Community Services Review in a small scale and targeted manner for ongoing training purposes. This may include further developing additional reviewers at the core service agency level and providing regular opportunities to shadow CSRs. Also suggested was to begin providing direct feedback to clinicians and supervisors regarding the individual cases completed during the CSR.

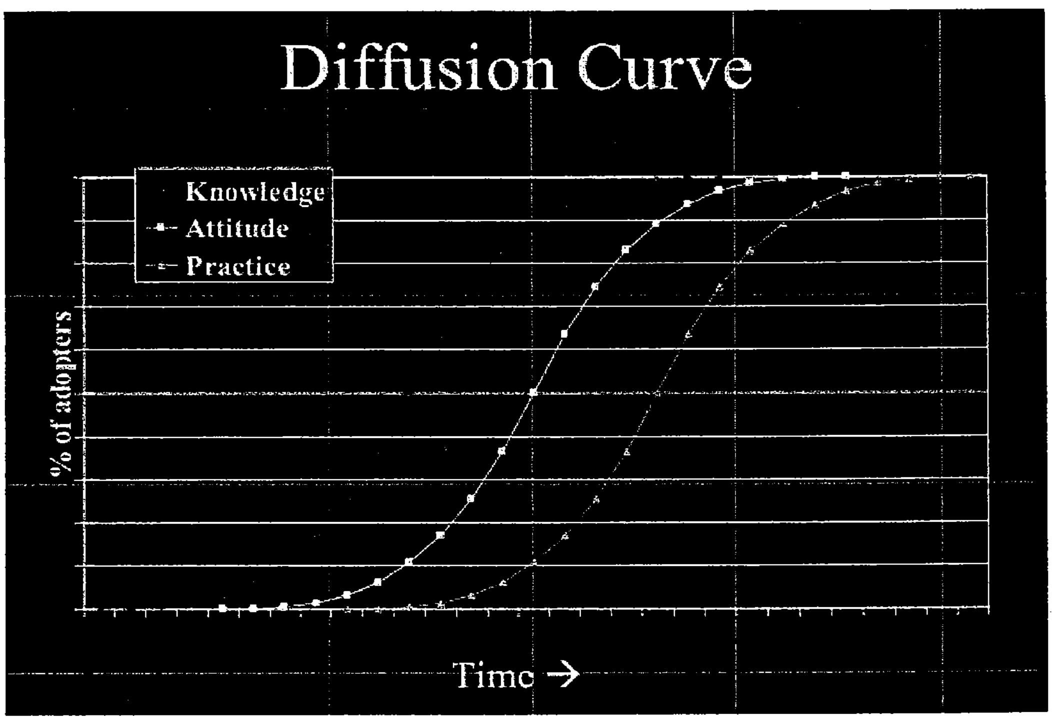
Current emphasis on producing billable hours and Medicaid billing codes determining allowable billable hours may be impeding the utilization of multidisciplinary individualized service teams. Review participants and stakeholders indicated that although the practice expectations specify that the utilization of individualized service teams is to be the basis of Individualized Recovery Planning, emphasis is primarily placed on generating sufficient billable hours. Furthermore, policies may discourage the use of a team meeting format as review participants and stakeholders indicated only one team meeting participant may actually claim available dollars for this service. Similarly, frontline practitioners often do not appear to fully understand the breadth of activities and scope of activities/interventions/strategies that comprise community support services (such as providing case management functions). It is critical that the providers and the department carefully review the current framework for billable services to determine whether the difficulty is the understanding of how to implement the current structure in a manner that supports the practice expectations or whether the billing framework needs to be refined to more fully support the agreed-on practice models.

The Individualized Recovery Plan is used more as a mechanism to authorize payment for services and is not perceived to be the basis for practice activities. Case review findings show the inconsistent utilization of consumer-driven individualized service teams. Teams are often lacking in needed composition and typically do not include practitioners beyond the service agency. In some instances, individuals adhered to a more clinical team meeting and medical model approach, in that, participants included clinical supervisors and other practitioners not actively providing services to consumers. Although IRPs are typically updated at 90-day intervals according to current policy and standards, these updates are not regularly utilized as an opportunity to reconvene the individual team, and there were limited examples of the team convening on an as-needed basis outside the expectation of the regularly held IRP updates.

Individual service teams are often limited in composition and frequently do not function according to practice principles. Some examples of adequately constructed and appropriately functioning individualized service teams were seen in the review findings, but as the quantitative findings indicate, this is occurring for less than half of the consumers reviewed. Oftentimes, the provision of services and other practice activities occurred more in response to crises rather than as a function of an appropriately crafted IRP through a functional individualized service team. There is little multi-agency participation in these teams.

Recognition of the change process over time. The Department of Mental Health continues to make progress in developing a high quality mental health system. The stakeholder interviews were revealing in that they show that the performance expectations for core service agencies are better understood and that providers are just getting to the developmental stage that will allow them to place more emphasis on the quality and consistency of practice. Examples of strong quality practice provided in accordance with expectations of Dixon were observed in some of the cases that were reviewed. When one considers the developmental milestones that a system must achieve to create the basic structure and foundation to support high quality consistent delivery of services, DMH is about on schedule for this stage of system reform. The focus of effort now needs to include more coaching, mentoring, and training of practitioners. It also needs to continue to engage and refine practices with the practice partners, such as substance abuse, probations, developmental disability services, veteran's affairs, vocational rehabilitation, and medical providers.

Display 24



Display 24 shows the stages of organizational development and the dissemination of new practices. Many of the core service agencies have moved through the knowledge and attitude stages and are beginning to actually improve practice. One exception to this progress is the D.C. Community Services Agency. Due to its size, history, and manpower challenges, it needs increased supports and interventions to assist it to make the necessary changes. It also provides

services in some of the most challenging communities in the district and needs additional support to effectively perform in these complex and complicated service delivery arenas. The D.C. Community Services Agency is a critical component because it services the largest proportion of clients in the district.

Final Considerations

DMH must be acknowledged for the progress that has been made and must be encouraged to work with its community partners to continue to refine the service delivery system.

1. DMH needs to continue to work on completing the infrastructure build out and to trouble shoot and refine some of the remaining problem areas. At this point, DMH and core service agencies should work together to develop strategies to address the areas identified as possible barriers to implementing the full practice model described in the Dixon exit criteria.

2. A specific plan of mentoring, coaching, and training should be developed in conjunction with providers to place priority and emphasis on the consistent provision of high quality services in accordance with the principles specified in the Dixon exit criteria.

3. Consideration should be given to modifying the Dixon Court Monitor's reviews for the next year or two to get more training and development benefits from the review process. This might include small-scale reviews in core service agencies for the purposes of training and practice development. Data from these reviews could still be aggregated to show the status of consumers and for appraising system performance and practice.

Appendix A