UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WILLIAM DIXON, et al.,

Plaintiffs,

v. Civil Action No. 74-285 (NHJ)

ANTHONY WILLIAMS, et al.,

Defendants.

COURT MONITOR'S NOTICE OF SUBMISSION OF REPORT

Court Monitor, Dennis R. Jones, respectfully submits the attached Report to the Court pursuant to the Court's May 23, 2002 Order requiring regular reports concerning the status of Defendants' compliance with the Plan.

Respectfully submitted,

Robert B. Duncan (Bar No. 416283)
HOGAN & HARTSON, L.L.P.
555 13th Street, N.W.
Washington, D.C. 20004
(202) 637-5758
(202) 637-5910 (fax)

Counsel for Dennis R. Jones, Court Monitor

REPORT TO THE COURT

Court Monitor
Dennis R. Jones

Dixon, et al. v. Williams
C. A. No. 74-285

January 13, 2003

I. Context

On October 23, 2002, the Court approved the Monitoring Plan for the period October 1, 2002 through September 30, 2003. The Monitoring Plan envisioned a focus during this year in three areas:

A. Development of baselines for each of the approved categories in the Court-approved Exit Criteria and the subsequent development of Court-approved performance targets for the various categories in the Exit Criteria.

B. Monitoring the development and implementation of both the administrative and services functions outlined in the Court-ordered Plan.

C. Monitoring the occurrence of events that may significantly impact the implementation of the Court-ordered Plan.

This report provides updates concerning the status and/or progress in each of these areas, highlights any identified barriers to progress, and makes recommendations for overcoming such barriers.

The Monitoring Plan called for a report to the Court twice per year. This is the first of two formal monitoring reports, with the next report scheduled for July 1, 2003.

II. Findings Regarding Exit Criteria

The Court-approved Exit Criteria tasks for this year fall into three categories: 1) the review of DMH-developed consumer satisfaction methods and consumer functioning review methods, 2) the development of baselines and required performance levels for consumer services reviews and, 3) the development of baselines, relevant benchmarks, and required performance levels for the measurement of system performance. It is anticipated that the development of consumer satisfaction methods and consumer functioning review methods will take place in the January to March 2003 timeframe. This report will speak to progress as it relates to the development of baselines for the consumer services review and the systems performance measures.

A. Consumer Services Reviews Baseline Development

Via a contract with Human Systems & Outcomes, Inc. (HSO), the initial protocols (including the developed domains, individual assessment tools for each domain, and the scoring methodology) have been developed for both Children/Youth and Adults. The initial pilot for Children/Youth was completed in late October 2002 – utilizing the developed protocols. The

pilot phase for Adults is scheduled for the first week of February 2003. Once the pilot phase is completed for both Children/Youth and Adults, the developed protocols will again be reviewed based upon the results of the pilots.

As part of the negotiations with the parties regarding the Court Monitor's 2003 budget, it was agreed that the DMH would select a minimum of 12 staff from the DMH Authority (six for Children/Youth and six for Adults) who would be trained as reviewers for the first baseline review. This constitutes approximately 50% of the total trained reviewers – the remainder of whom will be supplied by HSO. HSO, as a part of its contract with the Court Monitor, will provide necessary training for all reviewers and develop processes to ensure individual rater objectivity and inter-rater reliability. The inclusion of DMH staff as reviewers is intended not only to constrain costs but also to develop growing internal capacity within DMH to utilize and monitor the Quality Systems Review process. The pilot phase for Children/Youth included identified DMH staff as "shadowers" for the HSO reviewers. The process of shadowing will be repeated for the Adult pilot – providing firsthand experience in the entire process of conducting reviews.

Once the pilots are completed in early February 2003, the next phase is to conduct the requisite training for all reviewers (HSO reviewers and DMH reviewers) and then to conduct the actual baseline (year one) reviews. For Children/Youth, the training of reviewers and the baseline review are scheduled with HSO for March 2003. For Adults, the training and baseline review are scheduled for late April and early May 2003. The baseline samples for Children/Youth and Adults (consisting of a minimum of 36 consumers each) will be selected by the Court Monitor using a stratification model selected by the Court Monitor, in consultation with the DMH Director.

The other critical task to be accomplished before the baseline reviews is to ensure that the leadership (and line staff) of all the Core Service Agencies are clear as to the purpose, the methodology, and the logistics involved in the Consumer Services Reviews. This goal will be accomplished by meeting with the CEO's and key leadership of each CSA prior to the selection of the initial samples.

B. Baseline Development System Performance

The Exit Criteria as approved by the Court included fifteen (15) identified areas by which to measure DMH systems performance. Data relating to some of these 15 areas has historically been captured by DMH (e.g., penetration rates), but most are new measures. The DMH, per the Monitoring Plan for '03, was given the opportunity to submit proposed

baseline data on any of the 15 areas by November 15, 2002. No data was submitted by that date, but on December 23, 2002, the District submitted a request that the Court Monitor consider the use of pre-October 1, 2002, data to establish baselines in five categories. The Court Monitor is in the process of reviewing the information submitted with this request.

The Court Monitor and Dr. Ganju (expert consultant to the Monitor) have been working collaboratively with DMH staff to ensure that there is full concurrence on the working definitions for each of the 15 areas. As of this report, it is fair to say that there is conceptual agreement, though not yet full agreement, on all fifteen; for a couple of areas (e.g., supported housing) it will likely be early January 2003 before final agreement is reached. It will then be critical to ensure that these definitions are in fact being consistently utilized, reported and aggregated through the DMH provider network. DMH has agreed to provide the Monitor with the work schedule and other relevant information for accomplishing this during January 2003.

The other key task that remains is to identify other urban jurisdictions that would serve as comparative "benchmark" cities. It will be critical to look not only at comparability in terms of demographics, but also to ensure that there is a match in terms of the definitions of the 15 areas being measured. The benchmark issues will also be discussed with the DMH Director in early January 2003, with resultant official recommendations to the parties for reaction.

III. Findings Regarding Development and Implementation of the Plan

A. Review of Certification and Functioning of Core Services Agencies (CSA's)

The Court-Monitor conducted in-person and telephone interviews with key DMH staff as well as a significant cross-section of providers, consumers, advocates and other District agencies. The interviews were focused around the development, approval, and beginning functioning of Core Service Agencies (CSA's) in the District. Of particular interest were issues of: consumer choice, availability of services, and overall systems capacity to serve children/youth and adults. Given that the entire concept of a Core Service Agency as the "clinical home" for clients is entirely new to the District, the Monitor probed the organizational impact on provider agencies and on DMH as the mental health Authority.

1. Certification as Core Service Agency

As of the filing of this report, thirteen (13) agencies have applied for and been certified as Core Service Agencies since April 1, 2002. The DMH has worked actively with interested providers

over the past 12-18 months at the pre-certification level to help agencies understand the new Mental Health Rehabilitation Services (MHRS), the required DMH certification standards, approved rates for each service, and the requisite steps in the process to enroll clients and be paid for approved claims. Agencies were encouraged to conduct self-assessments on the certification standards.

Overall, provider agencies experienced the process of certification as comprehensive, timely and instructive. The general timeframe for completing the certification review and approval cycle was 45 days.

For some provider agencies, the decision to apply as a CSA was a simple one in that the new MHRS services were the kinds of services they had historically been providing via contract with DMH. For other agencies – especially those that are smaller in size or more specialized in terms of target population or services – the decision was a much more difficult one. Agencies generally came to the conclusion that this was a way (perhaps the only way) to expand the array of services provided to existing clients as well as to serve more clients. The major dilemma for all agencies was facing a whole new set of organizational requirements.

It is important to note that every single provider agency with whom the monitor spoke indicated that the basic CSA model, clinical concepts and standards of care were "the right thing to do" for the system overall and for their individual agencies.

2. CSA Implementation Issues

By way of context, it is important to point out that the DMH has undertaken – within a very tight timeframe – the entire transformation of the community-based system in the District. This involves: a radical change in clinical services and services philosophy; an entirely new set of standards for clinical and administrative performance; shifting from a grant-based contract model to a fee-for-service model under a human services agreement; the creation of a care coordination function within DMH to support enrollment of clients and provide authorization of services; the development and implementation of a new contract management system (ECURA) to support electronic administrative, financial and clinical functions between DMH as the authority and individual providers; the development of the necessary staff at all levels to support the enrollment authorization and claims processing functions; the development of the ability

within DMH to edit claims and make payments to providers in a timely fashion; communication to providers via remittance advices on both paid and unpaid claims; development of necessary processes within DMH to be reimbursed from Medicaid for the federal portion of eligible Medicaid claims; and the provision of requisite audit support to ensure that claims are valid.

Within most state or local systems, this entire set of interrelated functions would be accomplished in a 2-3 year timeframe. The DMH is doing it in a 6-12 month timeframe. The reality is, though, that there is no choice – given that the pre-existing model for reimbursing community agencies was hopelessly flawed and had to be replaced because, among other reasons, it was inconsistent with applicable federal law. The question then – in the mind of the Court Monitor – is not does all this need to happen, but rather how can the system best work together to accomplish the multiple tasks at hand.

The implementation issues have been many – centering largely around the processes and timeframes for completing authorization plans for each consumer, submitting and approving claims pursuant to each plan, and reimbursing providers for approved claims. It is important to note that authorization plans have to be completed and approved for all of the thousands of consumers previously enrolled with each CSA as well as all new consumers. This alone is a huge task of staff training for DMH and providers.

Dominating the agenda for most providers during this period has been the question of timely payments. The DMH has experienced delays in making payments for several reasons, which have included at times such issues as building staff and provider capacity in the claims area, policy issues regarding making payments before audits are conducted, the lack of a predictable accounts payable process, and the difficulty providers have had submitting claims in the required fashion, which resulted – for a time -- in DMH staff correcting errors in billing submissions.

The net effect of all this has been a heightened level of anxiety for most providers regarding cash flow and the ability to meet current cash demands (e.g. payroll). Given all of the issues of this new system – some anticipated and some not – the DMH set up two different groups to work with providers -- a more technically oriented work group and a CEO group. The work group has been particularly effective in identifying common issues, clarifying system requirements and working through needed solutions.

The DMH has also created a claims manual that details all of the functions in the enrollment, claiming and payments process. It also lays out a specific timeframe for processing and paying claims each month. This claims manual is still in draft form, but DMH staff indicate that it will be finalized in early January 2003. An example of the technical issues to be resolved is the need for user-friendly remittance advices. Currently, each remittance advice (regarding an individual consumer service) is printed on a separate page – creating literally volumes of pages for each provider. This is an Information Systems issue that the DMH is working with its vendor to fix in the near future.

All in all, given the magnitude of the tasks and the truncated timelines, the CSA development has moved as far as one could reasonably expect. The DMH staff assigned to work through Authority issues are viewed as responsive (even when overloaded with issues) and committed to successful resolution of all issues. As of the time of this report, the payment issues are being aggressively pursued; the DMH has indicated it will develop a payment schedule for each provider on current accounts payable. This should help, in that the major complaint from providers is the lack of predictability of payments – creating tremendous pressure regarding cash flow, expanded lines of credit, etc.

Overarching all of the short-term stressors is the need to develop business planning capacity within each provider agency and for the system overall. The shift to a fee-for-service payment mechanism is a mammoth change for agencies that have operated in a grant mode. Fee-for-service requires a careful examination of productivity expectations for staff. Provider agencies are at varying levels of organizational readiness to embrace this new model. Experience suggests that it is critical to have a more comprehensive integration of clinical expectations, administrative supports (e.g. information systems, record keeping systems, internal utilization management systems), financial systems (billing, collecting, forecasting) and human resources systems (recruiting, hiring and training of staff).

The DMH has responded to this issue by contracting with the National Council for Community Behavioral Healthcare to provide individualized consultation for provider agencies. The small teams of consultants would work with each provider to develop an action plan of 3-5 priority goals based upon the agency assessment. This consultation process has begun. Hopefully, DMH can work out the issues necessary to make this consultation a reality for all CSA's. This process will also provide feedback and consultation to DMH

as to ways to improve the Authority functions to support the evolving MHRS/CSA system.

It should be noted that the Court Monitor will be formally evaluating in the next report to the Court the Authority's capacity as it relates to quality improvement and provider oversight. The multiple developmental issues as relates to CSA's will likely re-emerge as part of that review.

3. Continuity of Care

On July 25, 2002, the DMH issued a final continuity of care policy, the intent of which is to ensure clear responsibilities between CSA's and all other providers of mental health services and supports to DMH consumers. This policy establishes practice guidelines, which include, for example, the requirement that all consumers who are in an acute care facility (including St. Elizabeths) must be enrolled in a CSA, and the CSA must have regular face-to-face contact with the consumer.

This is an extremely important step forward policy-wise, because for the first time, almost all of the civilly committed consumers at St. Elizabeths have a "clinical" home. The literature is replete with the obvious fact that if a consumer is in a facility like St. Elizabeths, they are much more likely to stay in that facility or not get connected to community services upon discharge unless a community agency (CSA in this case) is actively involved in planning for their community treatment while they are in the hospital.

In addition to the policy, DMH has also taken the lead in beginning what are called "flow" meetings at St. Elizabeths. The purpose of these meetings is to bring DMH staff, CSA staff and St. Elizabeths staff together around a specific long-term client. The goal is to look at specific client issues (strengths and challenges) with an eye to creating the kind of hospital plan and community services plan that will maximize effectiveness. These "flow" meetings have been well received – serving to enhance communication among agencies and look at real life barriers to community placement.

Overall, the perception is that the continuity of care policy has been widely accepted and is being supported on all sides. The Court Monitor views this as a very important positive development in support of the fundamental concept of a CSA as the "clinical home" for all consumers.

4. Consumer Choice

One of the key elements of the new community-based model is the mandate for consumer choice. The concept of choice has many issues within it (e.g. degree of information available, personal services history, availability of needed services, etc.) The DMH compiled, at the Monitor's request, a snapshot of some 1,341 records of consumers who have contacted the DMH Access Help-line and subsequently selected a CSA.

The aggregated data indicated that the major reason for CSA selection was accessibility. Fully 58% of consumers indicated that either location or transportation was the major reason for CSA selection. The second cluster of reasons (17%) were for provider-specific reasons, either previous knowledge of the provider or specific characteristics of the provider (e.g. language spoken and ethnicity of staff). Only 8% of the respondents identified treatment specialties as the dominant reasons for CSA selection.

While it is not surprising that basic accessibility is a major issue, it would seem desirable that over time, other issues (e.g. specific CSA services available) would become a more prominent reason for selection. The whole issue of choice will need to be tracked over time, with an eye to developing a system that provides true choices (e.g. more than one provider available) and that provides consumer-friendly information on the front-end. The DMH's commitment to fundamental choices for consumers is a powerful one. This is an area for ongoing discussion and collaboration among DMH, providers, and the consumer advocacy community.

5. Overall Systems Capacity

One of the key questions regarding the certification process is this: is the new DMH system – overall – growing capacity for children/youth and adults? To measure this trend, the DMH staff and the Court Monitor agreed that it would be helpful to establish a baseline of persons served as of July 2002, and then to track the number of persons served for future periods in relation to this baseline.

DMH data indicate that as of July 31, 2002 there were a total of 6088 consumers enrolled through all of the CSA's that were certified as of that time. This included 5589 adults and 499 children/youth. As of December 19, 2002 (the most recent statistical report) there were a total of 8425 consumers enrolled including 1154 children/youth and 7275 adults. This represents an

overall growth of 38% during this period and a 131% increase in the number of children/youth being served through the new system. It is recognized that as new CSA's have come on line, they bring existing clients to the new system; hence one must use caution in stating that all of this is true growth in terms of services. Nevertheless, the task is to measure the capacity of this new DMH system to enroll and provide services, so in this light it is highly encouraging to see capacity growing this dramatically — especially for children/youth.

The DMH also tracks on a current basis the percentage of enrolled consumers who have a currently approved authorization plan. This authorization plan must be submitted by the individual CSA initially (for new clients), and then every 90 days thereafter. It is of concern to note that as of December 19, 2002 there were four CSA's whose authorization percentages (compared to total enrollees) was less than 30%. It is unclear to the Monitor as to the reasons for this gap, but it will need to be one of the areas for follow-up review. At the broadest level, it is an indication that developmental efforts between DMH and the evolving CSA's will need to be ongoing in the months to come.

B. Review of Systemic Development Efforts in Key Areas

The Court Monitor – pursuant to the Court-ordered Plan – looked at current development efforts in the areas of housing, supported employment, assertive community treatment, services to youth in natural settings (e.g. schools), and capacity for children/youth to live in own home or surrogate home. The Court Monitor explored each of these areas with designated DMH staff and with other key informants outside of DMH who have been actively involved in these systems development issues.

1. Housing

The DMH has taken on a leadership role in interagency efforts to increase the amounts and types of affordable housing available to persons with serious mental illness. These renewed efforts began in April 2002, with the report of the Corporation for Supportive Housing (CSH). The CSH is a national organization that has worked with many state and local entities to create a more dynamic housing strategy for persons with mental illness. The CSH had several recommendations that centered around the need to use DMH capital expenditures for housing as a way of leveraging other public sources of housing dollars, and strengthening the partnership between DMH and other housing entities in the District (e.g. the D.C. Housing Authority).

As a direct result of the CSH recommendations, the DMH has undertaken multiple initiatives including:

- The development of an annual housing business plan that emphasizes the need for creating more supportive housing options for consumers and that seeks to involve all interested stakeholders (including other D.C. agencies that are involved in housing development or support). This annual plan has not yet been finalized, but appears to be on track toward a final first draft.

- The release of a Notice of Funds Available (NOFA) to provide up to $2.0M of local and federal funds to provide bridge rental subsidy amounts to approximately 450 consumers with serious and persistent mental illness. The rental subsidy effort is already in place, but DMH staff believe that this new NOFA should serve approximately 100 additional consumers over the current level (450 versus 350). As of this report, there are two organizations that have responded to the NOFA. DMH intends to make a final decision by January 1, 2003.

- The creation, with the support of the Mayor's office, of an interagency Memorandum of Understanding (MOU) between and among DMH and other Housing entities in the district. The purpose of this MOU, with a designated work group to support it, is to develop innovative housing finance and development models using bonding authority, grant programs, housing subsidies and technical assistance from the respective agencies. As a direct off shoot of this interagency effort, the D.C. Housing Finance Authority has orally committed to a $10.M bonding program, which if completed, would allow lower interest rates and directed projects for local developers. This initiative could be key to the development of smaller and scattered site supportive housing units. It is also the intent of this interagency group to put in place a "one-stop" housing application – thus reducing duplication and frustration for interested agencies and developers.

Altogether, the creation of a new housing philosophy targeted toward supportive housing (as opposed to congregate/group living)

is encouraging; as is the strong beginning of an interagency partnership to support this new direction.

The question of measurable overall housing capacity for persons with serious mental illness remains. It will be important to establish a clear baseline – tracking all of the different kinds of housing/residential options as well as total persons served at a given point. DMH staff have expressed interest and willingness to work with the Monitor in creating an integrated tracking/data collection tool so as to measure overall housing capacity as well as the shift in housing/residential options over time.

2. Supported Employment

Historically, the lack of a supported employment initiative has been one of the glaring programmatic gaps in the District's mental health system. The DMH has taken a major step in closing this historic gap.

The DMH began this supportive employment initiative via an interagency conference in 2001 that featured national experts in supported employment for persons with serious mental illness. The conference was presented by faculty at Virginia Commonwealth University (VCU) – one of the recognized leaders in this area. VCU has stayed involved since the conference and has assisted in the collection of baseline data from the local mental health agencies that have been providing employment services under contract with DMH. This survey indicated as a baseline (April-June 2002) that only 133 DMH consumers were involved in supported competitive employment. The large majority of employment efforts (and dollars) were focused on Transitional Employment and Sheltered Employment. While it is recognized by this author and others that there is a role for Transitional Employment in the array, it is equally clear from the research that supported competitive employment is the preferred option for most consumers.

The Dartmouth Research and Training Center (DRTC) began providing consultation to DMH, at DMH's initiative, on evidence-based practices for adults with serious mental illness last year. DMH was added to a four state, seven-site demonstration project funded by the Johnson & Johnson foundation on the effectiveness of supported employment. As a result, DMH is currently conducting three supported employment projects in the District.

As a second initiative, the DMH has taken steps to reorganize and hopefully redirect the Work Adjustment Training Program (WATP) that has for many years been housed, funded and located at St. Elizabeths. The WATP has historically provided part time employment to over 220 clients. The majority of these clients (118) actually live in the community and travel to their jobs at St. Elizabeths. The DMH has transferred the majority of dollars and responsibility for this program to the D.C. Public CSA as of October 1, 2002. In addition to fixing the responsibility for community-based consumers with the CSA, the longer-term goal is to transition this program to a true supported employment model.

Thirdly, the DMH has developed with VCU and Dartmouth a core-training curriculum for employment specialists, which will be offered to 30 different individuals from the certified CSA's, the D. C. Mental Retardation and Developmental Disabilities Administration (MRDDA) and individual consumers. This is a model web-based training package that selected individuals can do on their own. Upon the satisfactory completion of the six lessons, individuals will be eligible for certification as Employment Specialists.

Despite the low baseline of activity in supported employment, the DMH is providing strong leadership in developing a viable program. As in other areas, it will be critical to maintain efforts (and targeted dollar resources). Likewise, it will be important for DMH and the Monitor to develop information system capacity to track progress over time.

3. Assertive Community Treatment

Assertive Community Treatment (ACT) services are included as one of the specialty services within the overall MHRS approved array. The MHRS manual delineates the requirements for ACT, which include the necessity to have a clearly identified ACT Team, limited caseload sizes (given the intensity of services required) and 24/7 availability of staff. These requirements are consistent with national ACT standards. ACT also requires prior approval from DMH care coordinators.

The DMH currently supports six (6) ACT Teams, four at the D.C. Public CSA and one each at Northwestern and Psychiatric Outreach. These ACT Teams are largely the transition from what once were called MCOTS. The MCOTS did not as previously structured have a very high level of conformity to ACT standards.

In review of the current ACT teams, there appear to be multiple developmental issues still at play. First, the existing ACT Teams need training and coaching in understanding and implementing a full-blown ACT model. The DMH has engaged an ACT consultant to work with the existing teams in providing on site coaching.

Second, there appear to be systemic barriers in identifying and referring those individuals who need ACT services to developed ACT Teams. It would appear from conversations with providers, advocates and DMH staff that the large majority of persons with serious and persistent mental illness (SPMI) are being served via community support and/or other services that are more readily available in most CSA's.

National data is clear that not all consumers (even those identified as SPMI) need the intensity of ACT services. However, for persons at highest risk (e.g., homeless and persons leaving St. Elizabeths) ACT services should be a priority consideration.

The Monitor believes that it will be critical — if ACT services are to find their rightful place in the overall mix — for the DMH to address these barriers. Planning efforts should include a careful look at broader education regarding ACT, systematic identification of potential ACT clients, the needed development of new ACT Teams and the removal of barriers for referral to existing ACT Teams.

4. School-based Services

The DMH has taken significant steps in the development of a viable school-based mental health initiative. Prior to the Transitional Receivership, the Department had applied for and gotten federal funding to provide onsite mental health services in ten (10) charter schools. The federal grant for these 10 schools ran out in September 2002, but the DMH has picked up the cost of maintaining this initiative. In addition, the DMH has developed and begun to implement another major school-based model in the Springarn cluster of DC public schools. This second initiative, at present, involves fourteen (14) additional schools. The DMH has been hiring staff for the Springarn cluster since early 2002 and is presently almost fully staffed with school-based mental health professionals (psychologists, social workers and mental health specialists). In total, the DMH is now involved in 24 different schools (10 charter and 14 Springarn) with a total staff

complement (not counting supervisors) of 26 mental health professionals.

Much of the developmental work is currently in progress. DMH staff, together with staff from DC Public Schools (DCPS), have taken an approach to referrals for mental health services through the already existing DCPS policy of Teacher Assistance Teams (TAT). This mechanism is at different stages of development in each school.

A major focus during the fall of 2002 has been to provide training to all targeted schools regarding the appropriate use of the TAT process. This training has been well received and has been a strong collaborative effort between DMH and DCPS staff.

As of the writing of this report, DMH staff report that a handful of the Springarn cluster schools (3-4) are pretty well developed in terms of referrals and working relationships. The remainder are works in progress. As of November 2002, DMH staff served 108 children/youth in the Springarn school-based initiative, and 780 children/youth in the overall school-based initiative. It should be noted that DMH is spending approximately $2 million in local funds to support this entire initiative (line staff plus supervisors/administrators). A future step should be to explore the appropriate utilization of MHRS services to support the school initiative.

It is clear that DMH and DCPS are committed to the school-based model. It is also clear that considerable work remains at the individual school level in working out roles, referral processes, etc. DMH has also developed a plan with DCPS for expanding services into the fourteen (14) identified Transformation Schools (schools that have been targeted for major reform). DMH leadership indicates that there is budgetary commitment for this latest expansion.

5. Capacity for Children/Youth to Live in Own Home or Surrogate Home

As a part of a multi-pronged effort to develop true systems of care models for DC children/youth and families, the DMH has taken the lead in developing and implementing two interagency service development models.

The first, a Multi-Agency Planning Team (MAPT) process, is being operationalized in three agency settings (DMH, YSA and

CFSA), and has replaced the old Residential Placement Unit (RPU) process. The goal is to avoid unnecessary utilization of costly residential placements whenever possible by aggressively developing alternative community-based services and supports.

The MAPT, which operates as the frontline operational area for the Mayor's subcouncil on Intra-governmental Youth Investment Collaborative, has been a true cross agency forum for the multiple governmental entities involved in or placing children into residential care. The MAPT began officially in November 2002, with three different teams meeting per week. The team meetings include family members for children who are at risk of residential placement, as well as family advocates, who can lend a peer perspective to consumer families.

The early results of this new process are very encouraging. Of the 43 children/youth presented to the MAPT Teams, only 3 have been recommended for residential placement. DMH officials estimate that in the old RPU model, 90-95% of children/youth were subsequently placed in residential care.

It should be noted that the MAPT process is a part of a broad-based initiative for DMH called CINGS (Children Inspired Now Gain Strength). The DMH was recently awarded an $8 million (over 6 years) federal grant to assist in the development of a viable community-based systems of care for children and youth with serious emotional disturbance. The MAPT initiative is a critical first step in that process. It is the Court Monitor's belief that the strong interagency support for this process — plus the active involvement of family members — will provide a stable structure upon which to build.

It is the Monitor's view that a critical next step is to build at the service coordination and service delivery level the kind of intensive services that high risk children/youth need in order to avoid institutional settings. The DMH staff are highly encouraged to continue looking at extant models in other urban settings. There are major issues of care coordination, cross-agency service planning teams, pooling (or braiding) of funds, development of nontraditional services (e.g., mentoring) and ongoing systemic accountability for outcomes and costs.

The second systems reform effort for children/youth is a result of a $2 million grant from the D.C. Juvenile Justice Advisory Group (JJAG). The official announcement of these funds was recently made. The intent is to develop a diversion program with intensive

community-based wrap-around services for 75 youth who are at risk of entering the juvenile justice system. This particular initiative is part of an overall effort to collaborate more effectively with the juvenile justice agencies in the district. The DMH is also intending to provide training for the Metropolitan Police "youth officers" who do the front-end processing of delinquent youth and also to place mental health clinicians in the First Precinct for the purpose of doing screening on all youth who are apprehended by MPD. These screenings should promote, whenever possible, the appropriate referral for mental health and/or substance abuse services for youth. These efforts are very encouraging and will need continued support in their development.

C. Review of Access and Crisis Response

The "front door" to the new system was envisioned in the Court-ordered Plan as an Access and Crisis Response System, including a 24 hour, 7 day a week telephone hotline to do triage, dispatch mobile crisis teams as indicated and coordinate information and access to certified CSA's.

1. Access Helpline

The DMH Access Helpline has been operational on a 24-hour per day basis since February 2002 and with clinician coverage 24 hours per day since May 2002. Total staffing for this unit has grown from seven (7) initially to seventeen (17) at present. The DMH tracks wait times for calls to be answered: November data indicate an average wait time of 12 seconds or less. The volume of calls has steadily increased from a low of 2394 calls in July 2002 to a high of 3742 calls in October; the October spike being directly attributed to the random sniper shootings in the D.C. area. The average number of calls per month for July-November 2002 is 3030.

It is important to distinguish the kinds of calls received on the two numbers maintained by DMH — one for providers and the other for the general public. DMH tracks the kinds of calls received. Currently about 4% of the calls are true crisis calls involving a threat of harm, 15% for enrollment of active DMH consumers, 35% for supportive counseling, 18% for information and referral and 18% from providers needing assistance. The Access Helpline also functions (since August 2002) as the care coordinator unit for DMH. In this role, they provide prior authorizations to St. Elizabeths, utilizing developed practice guidelines for acute inpatient treatment and the DMH policy on continuity of care. At

this point, referrals to St. Elizabeths can come from the DMH operated Comprehensive Psychiatric Emergency Program (CPEP), CSA's or from local emergency rooms. The care coordinators work to ensure that clinical criteria are met prior to admission and that each person admitted to St. Elizabeths selects or is given a CSA to serve them in discharge to ongoing community services.

As the central triage and intake point into the system, the Access Helpline has processed over 7200 enrollments of consumers to MHRS and CSA's, and provided prior authorization for 523 St. Elizabeths admissions.

Feedback was obtained from a variety of persons (consumers, providers, advocates and other DC agencies) as to the responsiveness and efficacy of this new unit. In general, comments were very positive. The initial startup period was rocky in that volume significantly exceeded staff capacity — resulting in delays and lost calls. However, as the unit has become more fully staffed, people have experienced the unit as generally being timely, informed, professional and responsive. One person — in evaluating the Access Helpline — said it has been "an increasingly positive experience." The Helpline at the leadership level has gotten especially positive comments in terms of responsiveness and a collaborative problem-solving approach.

2. Mobile Teams for Children/Youth and Adults

The DMH currently has two certified mobile crisis agencies for children/youth (one at CPEP and one via contract with Hillcrest Children's Center). For adults, the mobile crisis capacity is done entirely through the mobile crisis efforts at CPEP. The CPEP was reorganized in May 2002, such that there are no longer separate and distinct mobile teams for Children/Youth and Adults. The CPEP staff decide on a case-by-case basis as to the need for mobile team intervention. One of the broad decision points for doing mobile (versus site-based) is that if an individual is more likely to be managed in a community setting, then a mobile team response would be more likely. If, on the other hand, an inpatient admission appears possible, that individual would more likely be brought to CPEP.

CPEP staff indicate that they are averaging approximately 80 mobile visits per month. This includes adults and children/youth. Adults run over 90% of total mobile visits.

CPEP employs some 37 staff, including 5 psychiatrists and 10 RN's. Staff (most) are cross-trained so as to be able to deal effectively with both adults and children/youth.

3. Site-based Psychiatric Emergency Services

As of October 1, 2002, DMH began a contract with the emergency room at Children's Hospital to do all site-based psychiatric emergency assessments for children/youth. As of this date, CPEP ceased providing this service for children/youth. The anticipation — based on historical utilization — was that the volume of assessments at Children's would go up approximately 10%. In fact, for the month of October 2002, volumes went up over 40%. As a result, the additional staff added via the DMH contract ($125,000 for the first 6 months) have struggled to keep up with the unexpected demand. Children's Hospital staff indicate that Children's has mobilized resources to meet this crisis, but have agreed with DMH that the existing contract needs to be re-evaluated on a going forward basis. The reasons for this spike are unclear. One of the speculations is that Children's Hospital — with its strong reputation as a quality provider — is simply a much more attractive place for children and families to be assessed than was CPEP.

The adult site-based services are provided entirely by CPEP. The number of CPEP visits averages between 400 and 500 per month, with the 2:00 p.m.-10:00 p.m. timeframe having the heaviest volume. CPEP continues to be the place where law enforcement brings involuntary detainees for evaluations and potential inpatient admission. CPEP recommends 140-150 inpatient admissions per month, with over 80% of admissions going to St. Elizabeths and the remainder to local private hospitals.

General feedback from law enforcement, consumers and advocates is that CPEP has improved its operational efficiency and consumer sensitivity and overall level of professionalism and responsiveness.

The major remaining issues are the location and poor condition of the building in which CPEP is housed and the inability to provide coordinated medical evaluation and triage for consumers. Both of these argue for the continued need to pursue a better model. The DMH continues to look at alternative sites. The preferred model should be in a setting that supports medical triage, quick access to medical treatment, and an adequate professional-looking location. The Court Monitor will continue to track the DMH's efforts in this regard.

4. Development and Utilization of Crisis Residential/Respite Beds
The DMH has developed a two level model for short-term residential beds. The first is a residential step down/transitional bed service. The basic goal of this model is to provide a safe, accessible and supervised residential setting to allow consumers to move more rapidly from an inpatient unit or a homeless shelter. This model provides basic care level staff on a 24-hour basis with the assumption that all professional services (including nursing and medical services) would be provided by the CSA in which the consumer is enrolled. Currently, the DMH is contracting with Woodley House to provide eight transitional beds with a presumed length of stay of no more than 14 days.

The second model is a residential crisis service that is intended to provide more intensive services (including medication management, nursing and psychiatric services, etc.) for a time-limited period (7-14 days). This model would provide for some consumers an alternative to inpatient admission or a reduced length of stay in inpatient. Unfortunately, at this point, there are no crisis residential beds being operated in the District. The previous 15-bed unit was closed in July 2002. The DMH has clearly identified the need to contract for at least one crisis residential unit as well as provide expansion of the mobile units. However, as of the date of the submission of this report, contracts have not been issued, although DMH is in active negotiations with several potential providers. DMH indicates that it has identified funding for these services. It would appear to the Court Monitor that the lack of crisis residential beds is limiting options in the acute care area, thus forcing admissions to inpatient settings that could be avoided or shortened. It is also putting pressure on the existing eight-bed step down unit to take individuals they are not set up to handle.

IV. Review of Significant Events that Could Impact the Court-Ordered Plan

The Court-approved Monitoring Plan contemplated that certain events would occur that were of sufficient impact on the system that they could directly (or indirectly) impede the implementation of the Court-ordered Plan. The Court Monitor believes there are two events during this period that warrant review; namely the 2003 DMH budget as it is currently before Congress and the DMH plan to restructure its workforce. While these two issues are at certain levels interrelated, they also have unique drivers and thus will be discussed separately.

A. 2003 Budget

The DMH budget for 2003 constitutes a $10 million reduction in spending from the 2002 budget. District officials have informed the Court Monitor

that a management decision has been made to realign staffing priorities to conform with requirements of the Court-ordered Plan as part of the DMH Director's realignment of the agency.

The Court Monitor has reviewed the overall plan for achieving the $10 million reductions. In general (and approximate) terms, the plan will reduce pharmaceutical costs by $4 million, fixed costs (utilities) at St. Elizabeths by $2 million and personnel costs by $4 million. The Court Monitor has been informed that the pharmaceutical reductions can be achieved via operational efficiencies and curtailing expenses for items and individuals that are not the direct charge of DMH. The utilities savings at St. Elizabeths will be the direct result of consolidation onto the east campus. The personnel savings are planned as the result of multiple personnel initiatives to include the reduction of up to 235 positions currently on the DMH staffing table. These are positions that are deemed by DMH to be "not essential to the fundamental health and safety" of clinical services. This "reduction in force "is part of an overall restructuring which is detailed below.

B. DMH Restructuring

The DMH has publicly presented a restructuring plan that is intended to align/realign the agency to comport with the community-centered thrust of the Court-Ordered Plan. The DMH has undertaken a process to evaluate each position in the organization. The planned net result of this endeavor is that: 1) up to 235 positions will be eliminated, including Public Health Officers in positions that are no longer considered hard to fill; 2) some existing positions will be assigned new job functions, with incumbents in positions that do not change more than 50% being provided necessary training to take on new duties, and incumbents in positions that change more than 50% needing to reapply; 3) the restructuring will result in approximately 75 new positions in targeted growth areas; and 4) retirement and early-out options have been made available. The number of employees who exercise these options will obviously impact the final number of actual people who lose jobs.

The DMH laid out this overall plan on November 18, 2002. However, the actual individuals who will be impacted will not be known until at least January 10, 2003.

The Court Monitor has been assured by both the DMH Director and the Mayor's Office that the $10 million budget reduction and the planned reduction in force will in not negatively impact compliance with the Court-ordered Plan. In fact, DMH contends that the restructuring will accelerate and focus priorities to implement the Court-ordered Plan.

There is no way at this point in time for the Court Monitor to fully evaluate the impact of the restructuring. Hence, it would seem prudent that both the 2003 budget reductions and the restructuring be formally reviewed by the Court Monitor as they occur and the analysis be included in the July 1, 2003 report to the Court.

V. Recommendations

The following recommendations are made based upon the findings in this report:

A. As it relates to the 15 systems performance measures, it is critical that DMH develop a work plan to ensure the timely development of definitions, operational definitions, information systems to collect the data and needed provider training. It will be key that the DMH assign the necessary leadership and prioritization for these tasks. The Monitor will review and comment on the work plan.

B. The DMH should continue its detailed review as to the causes for the major gap for some CSA's between enrolled clients and authorized plans. This issue – along with other developmental CSA issues (e.g. timely payment) – will require ongoing and concerted work by DMH in partnership with the CSA's. It is critical that there be continued forums for open communication and problem-solving on the multiple developmental issues still at hand.

C. The DMH should carefully review any and all barriers as identified in this report that appear to be causing significant underutilization of ACT services. Unless addressed, there is concern that ACT teams will not be readily available to the high-risk consumers who need this intensive model.

D. The MAPT model for assessment and diversion of high-risk children appears to be working very well. However, as children are diverted, it will be critical to create the kind of care coordination models to serve these children, youth and families. The Court Monitor is very concerned about the capacity within the existing CSA network to serve this highest-risk population. It is recommended that DMH staff continue to look at already existing models across the country. The review will hopefully build on the strong interagency partnership that has already developed. Critical issues include: care coordination, alignment/integration of funding streams, full family inclusion, and measurement of systemic outcomes.

E. DMH should continue to pursue alternative sites for CPEP. The existing location and model are not suitable and do not comport to the intent of the Court-ordered Plan.

F. The DMH should move as quickly as possible to develop needed crisis residential beds in the District. The Court Monitor will evaluate in the spring of 2003 the impact of DMH plans to contract for at least one crisis residential unit and add mobile crisis capacity.

G. The DMH should develop both a process and a format for measuring key data in a consistent manner. These key data would include, for example, overall system capacity, housing (by type), supported employment, residential placements, ACT services, etc. The Court Monitor's intent is to create both an early baseline and a quarterly snapshot of key data that can be trended over time. Hopefully, this same data would be useful to DMH leadership as well as providers and the wider community. The Monitor will review and comment on the adequacy of the reporting format.

H. The Court Monitor should closely evaluate the impact of both the $10 million budget reduction for 2003 and the DMH restructuring initiative. This evaluation should be then shared with the parties and included in the July 1, 2003 report to the Court.

CERTIFICATE OF SERVICE

I hereby certify that copies of the foregoing COURT MONITOR'S NOTICE OF SUBMISSION OF REPORT and the COURT MONITOR'S REPORT were served by first class mail, postage prepaid, this 14th day of January, 2003 upon:

Peter J. Nickles
Covington & Burling
1201 Pennsylvania Ave, N.W.
Washington, D.C. 20004-2401

Ira A. Burnim
Bazelon Center For Mental Health Law
1101 15th Street, N.W., Suite 1212
Washington, D.C. 20005-5002

Grace M. Lopes
Special Counsel to the Mayor for
Receiverships and Institutional Reform
Litigation
Executive Officer of the Mayor
District Of Columbia Government
One Judiciary Square
441 4th Street, N.W., Suite 1120
Washington, D.C. 20002

Janet L. Maher
Deputy Corporation Counsel
Office of the Corporation Counsel
441 4th Street, N.W., Room 4N29
Washington, D.C. 20001

Virginia M. Vander Jagt
Sidley Austin Brown & Wood, LLP
1501 K Street, N.W.
Washington, D.C. 20005