UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

WILLIAM DIXON, et al.,	)	
	)	
Plaintiffs,	)	
v.	)	Civil Action No. 74-285 (TFH)
	)	
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,

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REPORT TO THE COURT

Court Monitor
Dennis R. Jones

July 21, 2004

I. Current Situation

In November 2003, the Court approved the Monitoring Plan for the period October 1, 2003 through September 30, 2004. The Monitoring Plan included three primary areas for review during this period:

A. Progress in obtaining final Court approval of performance targets for all of the various categories in the Exit Criteria and monitoring the operational implementation of each of these.

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

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

This Report provides updates on the status and/or progress in each of the above-named areas, highlights any identified barriers to progress, and makes recommendations for future actions.

The May 23, 2002 Court-approved Consent Order called for a Report twice per year. This constitutes the fourth formal monitoring Report to the Court.

II. Findings Regarding Exit Criteria

With the December 11, 2003 Federal Court approval of the Exit Criteria, there are now three major clusters within the exit criteria for ongoing review: 1) the review of DMH-developed consumer satisfaction method(s) and consumer functioning review method(s); 2) the implementation and findings of Year Two consumer services reviews for both adults and children/youth; 3) the implementation of Court-approved performance levels. This Report will identify current status as it relates to each of these three areas:

A. Consumer Satisfaction Method(s) and Consumer Functioning Review Method(s)

The Court-approved exit criteria call for the DMH to develop method(s) to assess consumer satisfaction with services and to also access consumer functioning. The exit criteria describes the role of the Court Monitor as one of review and approval of such proposed method(s) for consumer satisfaction and review of proposed functional review method(s). In both areas, the Court Monitor will also assess the degree to which the results obtained are utilized as an integral part of the DMH's overall quality improvement process.

As relates to consumer satisfaction method(s), the DMH continues with its Year One contract with the newly formed consumer organization called Consumer Action Network (CAN). The Court Monitor has reviewed the progress of this effort both with DMH staff and with CAN staff directly. The CAN staff have done considerable research in evaluating successful consumer satisfaction methodologies across the country. Five broad domains of consumer satisfaction have been selected; these include: 1) access to services; 2) quality of services; 3) participation in treatment; 4) empowerment; 5) autonomy. The first year project plan calls for the initial development of needed instruments, methodologies and sample selection. CAN is nearing the end of phase one which has entailed the design and pretest of a satisfaction tool. The next step will involve the selection of sample sizes, the degree to which stratification will be necessary (e.g. different age groups), and the specific methods for utilizing the instrument (e.g. telephone vs. in-person vs. mail). It is clear to the Court Monitor that this is a major undertaking given the scope and requisite methodologic issues involved. CAN is seeking out needed expertise on all of these concerns and has also done a good job of involving consumers directly in the design phase. The overall timeframe calls for CAN to complete its initial survey, analyze results and make recommendations for Year Two to the DMH by November 14, 2004.

The Court Monitor continues to be pleased with the overall approach that the DMH is taking on this issue and the obvious commitment that CAN brings to the task. The major concern is the enormity of the project for a newly-formed organization – particularly given the broad scope of the design instrument and the expressed desire to reach a sufficient number of consumers to achieve higher levels of statistical significance. Undoubtedly, Year One will provide major learnings that will be reflected in its November 15, 2004 report. The Court Monitor will report results in greater detail in the January 2005 Report to the Court.

In terms of the development of consumer functioning review method(s), the DMH has indicated that it is actively exploring the use of LOCUS (Level of Care Instrument for Adults) and CALOCUS (same instrument but designed for children and youth) as the approach to measuring consumer functioning. The positives expressed to the Court Monitor are that these sets of instruments are easy to use and have shown high degrees of inter-rater reliability. The DMH indicates it has had positive results from the use of the CALOCUS in its juvenile justice diversion efforts. Likewise the LOCUS has been used successfully in the reconfiguration of residential service placements and rates for adults with serious mental illness.

It is premature for the Court Monitor to make any substantive judgments on this proposed approach. Once a formal proposal is brought forward by DMH, the Court Monitor will make a detailed review and response.

As relates to both consumer satisfaction and consumer functioning method(s), it is worth underscoring the fact that the ultimate court approval is a two-step process. First is the review (and the formal approval as relates to consumer satisfaction) of the proposed method(s). Second is the demonstrated use of the results to make necessary improvements in the care delivered. Obviously this entire cycle will take time, but it is encouraging to see that the DMH has solid efforts in place to accomplish the first step.

B. Findings Regarding Year Two Consumer Service Reviews for Children/Youth

Year Two Consumer Service Reviews (CSR's) were conducted for both Children/Youth and Adults during the March-April time period of 2003. These CSR's used the same protocols as were used in Year One reviews. Also, as in Year One, the DMH provided staff to be trained by Human Systems and Outcomes (HSO) in order to provide 50% of the total reviews; the other 50% of the reviews were performed by outside HSO-contracted reviewers. This process of involving DMH authority staff has been largely successful. In spite of the additional work demands, the response from many DMH staff has been one of active engagement and enthusiasm to participate in this process. In addition, DMH provided invaluable coordinative, legal and strategic support for both reviews.

Changes for Year Two reviews involved the direct scheduling of consumers (and others to be interviewed) out of the Court Monitor's office – as opposed to doing this via the providers. The reason for this change was the concern from Year One that some consumers were missed as a result of the provider-driven process. Despite the continued challenges in finding and engaging consumers and families, the Court Monitor believes that this process of direct contact to consumers should be continued in succeeding years. The target number for reviewed cases for Year Two was 54 for both Child/Youth and Adults; this target was an increase from 36 for Year One in order to provide a more representative review of the consumer population. Both reviews drew an initial sample of 162 names from the DMH-generated list of enrolled consumers; from this list the ultimate list of persons selected was driven by several factors including: 1) the consumer being active – i.e. having received services in the past 90 days; 2) the need to ensure stratification of the sample across the

variables of age, level of need and provider agency; 3) the willingness of the individual consumer (and/or family) to participate. As will be detailed in a summary of each review below, each of these three factors played into the reality that achieving a final interview sample of 54 was a major challenge.

1. Summary of Child/Youth Findings

Out of the 2,781 Children/Youth enrolled in the DMH eCura system as of January 2003, the HSO staff randomly selected 162 names. However, as the previously mentioned stratification process was applied, there were not sufficient cases to get to the 54 target. This was largely due to the fact that the DMH eCura system continues to show a large number of cases that are not, in fact, active with a CSA. While the DMH has put in place a policy for disenrollment of inactive cases, this has not been uniformly applied by CSA's. Even for CSA's that have begun to apply this policy, the DMH, as of this Report, has not yet actually removed those persons from the eCura enrollment list. The net result of this large continued gap between enrolled and active consumers was that HSO had to pull an additional list of sampled names in order to achieve the 54 sample target. It should be noted, though, that DMH staff, the Court Monitor's assigned Review Coordinator, and HSO staff worked exceedingly hard and well to overcome the multiple barriers in this process. Interagency agreements, parental consents and logistical coordination was accomplished for 54 representative cases that were reviewed over a three-week period in March 2004.

The HSO model provides considerable quantified information across the multiple domains of a child's life (e.g. academic status, home and school placement, safety, caregiver support, etc.). These measures of how the individual children/youth are doing aggregate to an overall percentage. For the 54 cases reviewed, the aggregate child/youth measurement was 74% favorable (rating levels of 4, 5 or 6 on a six-point scale). This compares very closely to the 77% favorable rating that was achieved in the Year One reviews. The individual scales showed that 92% of children and families were in the acceptable range in terms of satisfaction with services. While this is encouraging, it stands in contrast to other scales (e.g. only 54% of cases were acceptable in terms of academic status and only 48% in terms of responsible social behavior).

The Dixon exit criteria (as relates to the CSR process) speaks to a different set of measures – namely the question of how the system is performing. These practice performance measures include and quantify, for example, issues of service coordination, availability of unique resources for each child/family, treatment implementation, etc. For this review, the aggregate measure for systems performance was 43% positive (scores of 4, 5 or 6 on the six-point scale). This score also compares to last year's systems performance score of 47%. Year Two data also support the continued fact that children/youth who are lower functioning are less likely to receive adequate systems support than those who are higher functioning.

The fact that Year One and Two scores (both as to child status and systems performance) are comparable should not be surprising. It is clear to all that the child/youth service system is still in a very formative stage in the District. The system, as noted by HSO in its Year Two Report, has considerable work to do in creating the consistent understanding and practice of resiliency concepts, child care team formation and attention to educational needs. The encouraging note is that the fundamental business practices are now in place (e.g. certification, billings, standards, etc.) for most agencies. The hope is that now the attention and focus can move to placing greater emphasis on "quality and consistency of practice."

2. Summary of Adult Findings

HSO randomly selected 162 names out of the 13,224 adult consumers who were enrolled in the DMH eCura system as of March 2004. Out of the 162 names, the intent was to review 54 cases, stratifying across age, agency, and level of care. However, the major gap in enrolled vs. active, the need to proportionally review cases across agencies, and the unwillingness of some consumers to participate all worked to make 54 cases an impossible goal. The final number reviewed was actually 41. Despite missing the target, the Court Monitor recognizes that tremendous effort was made to contact all eligible consumers. The DMH staff, the Dixon review coordinators and HSO staff worked very collaboratively and diligently to schedule and engage the 41 consumers whose cases were reviewed. It is noteworthy, for example, that three homeless consumers, randomly selected for inclusion, were located and agreed to participate. Despite the lower than planned numbers, it would appear that the sample reviewed

does in fact fairly represent a cross section of individuals and services being provided.

As with the child/youth reviews, the Adult reviews look at practice performance across a number of domains (e.g. safety, living arrangements, mental health status, recovery activities). These measures of how the individual consumer is doing aggregate to an overall percentage. For the 41 cases reviewed, the overall status of the consumers was at a 54% acceptable level (rating levels of 4, 5 or 6 on a six point scale). Individual scores showed that satisfaction with services and safety were the highest scores attained (77% and 78% respectively) while scores in work and recovery activities were at 35% acceptable. The mental health status/care benefits scored at 49% acceptable.

The measures of how the system is performing (the Dixon exit criteria measure) also look at multiple domains (e.g. treatment and service implementation, practical support, service coordination, and recovery plan adjustments). On these measures the DMH scored at a 39% acceptable level; this compares to a 54% acceptable rating for Year One reviews. However, because Year One had significant methodologic issues (in terms of reaching a true cross-section of consumers) Year Two should probably be considered the true baseline for adult services.

The HSO, in its respective reports to the Court Monitor on both the child/youth and adult reviews, touch on some common themes. These tend to center around the fact that clinical/services staff have a very inconsistent understanding of a systems of care model. Much of the work of the past two years throughout the system has been in bringing up basic service arrays, learning to enroll and bill in a new model, and learning to meet productivity standards in a fee-for service world. It is small wonder, then, that many staff view Individual Resiliency/ Recovery Plans more as a way to authorize payment for services than as a true basis for practice activities. It is also evident that, as the system matures, ways need to be found to incentivize workers to "practice" differently – which gets at the perceived (and perhaps real) constraints in a Medicaid-driven model of reimbursement. The Court Monitor agrees with the summary comments from HSO: "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." Discussions with DMH leadership support these conclusions. Clearly the system has a long way to go to achieve an 80% level of systems performance (versus the current levels of 43% and 39%). The issue is how to best leverage resources in order to accelerate learning and practice at the individual provider, team and clinician level. The Court Monitor and DMH agree that HSO protocols are a potentially powerful way of teaching, reinforcing and measuring how providers and clinicians are doing. The shared goal is to "internalize" this process so that practical issues are consistently being learned and applied. It appears to the Court Monitor that the DMH – at this critical juncture – needs to find committed resources at the authority level (or via contract) in order to accelerate the improvement process. These committed resources could work with individual providers throughout the year to promote consistent learnings, practice changes and provide internal measurement of how individuals and teams are performing. In order for any of this to work, individual providers (with CEO leadership) will also need to commit the requisite resources and energy to this change process. The DMH is ultimately dependent on providers embracing new and better ways of delivering services. In sum, this strategy has to be a shared one between DMH and the provider community.

C. Implementation of Court-approved Performance Levels

On December 11, 2003, the Federal Court approved a Consent Order that established exit criteria in nineteen different areas, the methodology that will be used to measure each of these nineteen and the specific performance levels required in each area. The Consent Order also requires, in order to achieve requisite consistency and reliability, that the DMH must demonstrate to the Court Monitor that the necessary policies and practices are in place and that the DMH be able to "document any methods utilized for verifying the degree to which relevant policy and practice is being followed by providers." This requirement is critical throughout, but it is especially important for those exit criteria that are based upon the front-end referrals by providers to certain services. For example, the Exit Criteria for Assertive Community Treatment (ACT) requires that 85% of persons referred for ACT services will receive them within 45 days. The ultimate reliability of this measure has three necessary preconditions – namely that the DMH has clear policy and practice on who should be referred to ACT, that providers understand these policies and are in

fact referring, and that the DMH has in place reasonable methods to assure that providers are following the policy and practice requirements.

The same issues apply in terms of data integrity. The final exit criteria are, by and large, new measures for the DMH. While they are believed to be more sensitive measures of system performance, they also are requiring the development or adaptation of the DMH information system in order to capture these new data elements.

The Court Monitor has been working with the DMH staff on all of these issues. At the Court Monitor's request, the DMH has developed an initial matrix that delineates the relevant policies, monitoring strategies, current state of data development, and the assigned DMH "lead person" on each exit criteria. The next several months for the Court Monitor will be involved in working through each of these nineteen areas. The goal is to ensure that all of these requisite elements (policy, practice, DMH practice oversight and data fidelity) are solidly in place before actual numbers on performance are reported to the Court. It is clear that some areas will be easier to measure and monitor than others, but all of them will require concerted work by the DMH and the Court Monitor. The Court Monitor is especially pleased to see the clear articulation of responsibilities for each exit criteria to DMH staff and the demonstrated commitment from DMH leadership to move forward on this major effort.

The Court Monitor also wants to report that during the current planning and budgeting cycle the DMH Director has chosen to use the nineteen exit criteria as the major focus in D.C. Council oversight hearings, 2005 Budget presentations and in the DMH's performance-based budgeting (PBB) documents. This is seen as a major developmental milestone because it clearly aligns the Department's goals (and individual managers accountability) with the ultimate goals of Dixon. While this alignment had been happening, it is now being expressed and reinforced in more explicit and compelling ways. One of the major learnings from class action suits across the country is that the ultimate success is directly dependent upon the degree to which there is a true sense of shared vision, common goals and agency priorities. Aligning external and internal expectations is a powerful step toward ultimate success; this is now clearly happening and bodes well for continued progress.

III. Findings Regarding Development and Implementation of Court-ordered Plan

A. Review of the Development and Implementation of Key Systemic Authority Functions

1. Quality Improvement and Provider Oversight

The primary authority for quality improvement and provider oversight continues to be placed in the Office of Accountability (OA). The Deputy Director for OA reports directly to the DMH Director and has direct responsibility for the major functions of certification, licensure, policy development, support, and quality improvement. All of these functions are in direct comportment to the Court-ordered Plan and the Mental Health Establishment Act of 2001. As of the time of this Report, there are 20 FTE's carrying out one or more of these functions. With the exception of the Q.I. Director position, all of the Director level and supervisory level positions are filled and in most cases have been filled by the same person since development of the OA Division in the 2001/2002 period. This consistency of leadership has allowed OA to develop increased capacity and in-depth knowledge on many fronts. This leadership from OA is evident as sensitive and potentially volatile situations occur in terms of providers. For example, in the past year there have been three provider-related instances of alleged fraud and abuse under established Federal and local rules. In each instance, OA has taken a lead role in investigating the situation, issuing corrective action plans and doing follow-up monitoring. These investigations often involve cross-agency collaboration in terms of roles and authority e.g. the Medical Assistance Administration (MAA) and the Office of the Inspector General (OIG). This is noteworthy because it is exactly the kind of "hands-on" leadership role that was envisioned for the mental health authority in the Court-ordered Plan.

This Report will briefly summarize progress within each of the four functional areas that are part of the Office of Accountability:

a. Division of Certification (DOC)

This division has the direct responsibility for certification, re-certification and oversight for all Mental Health Rehabilitation Services (MHRS) providers. Currently, there are 19 Core Service Agencies (CSA's), 4 sub-providers and 3 specialty providers. This contrasts to the July 2003 period when there were 14 CSA's and 2 specialty providers. It is even more telling that there are currently 24 MHRS applications in the pipeline, of which 20 are primarily targeted to serving children and youth. The DOC is

also processing 10 re-certification applications and monitoring 15 corrective actions pursuant to specific consumer complaints. Certification as an MHRS provider is for two years; hence the original MHRS providers are now due for re-certification. The DOC's enforcement strength with providers was augmented with the January 2004 DMH final rule approval of MHRS Provider Certification Infractions Standards. This rule gives DMH the authority to fine providers for MHRS rules violations.

The sheer volume of MHRS provider growth represents a major challenge. Each new provider requires a new set of demands for orientation, training, common understanding and eventual "going live." Given the overall goal of creating a common (and single) set of mental health providers for children and youth in the District, it is likely that this high growth in applicants will continue. This will continue to place high demands on the Division of Certification.

b. Division of Licensing (DOL).

The Division of Licensing (DOL) has likewise taken on a major challenge in its oversight role of Community Residential Facilities (CRF's) and Supported Independent Living (SIL) facilities. Both of these adult living environments have a history (prior to DMH) of very sporadic oversight, inconsistent enforcement and a lack of sufficient staff to do regular inspections. Hence, it is encouraging to see that DOL staff have in the past year: 1) conducted at least one inspection at each of the 142 CRF's it licenses; 2) investigated 41 complaints against CRF providers and substantiated 22 of these complaints (with required corrective action); 3) issued $33,450 in fines to 23 different providers. While all of this suggests there are many remaining CRF issues, it is encouraging to see that there is now a clear process of oversight in place that is consistent and has some "teeth" in it.

The DOL is also implementing the Supported Housing standards to ensure that basic facility conditions are met in the 480 Supported Independent Living (SIL) facilities in which DMH places consumers and in all other independent living situations in which a DMH

consumer receives community support or ACT services. In the event that facilities do not meet the quality checklist, the clinical team is required to assist the consumer with getting the problems fixed or assist them with moving to better housing.

A systemic problem relates to the dramatic increases in liability insurance costs for CRF providers. These cost increases alone have led to nine providers closing their facilities (and one more currently at risk). The DOL is working collaboratively with the CRF provider association and others to find creative solutions. Needless to say, this displacement of at least 60 consumers has added to the overall pressure on the DMH system to find adequate and affordable housing for consumers.

c. Division of Policy Support (DPS)

The DPS has the lead responsibility to draft needed (or revised) rules, policies and procedures for the DMH in order to meet its legislative and oversight mandates. The DMH indicates that, over the past nine months, it has issued two major rules (Provider Infractions and Consumer Grievances Procedures) and six major policies. All of these rules and policies represented gaps in the regulatory process that the DPS has taken the lead in developing drafts for DMH, provider, advocacy and general public review (in the case of rules). It is clear that while this is a small number of FTE's (three at present) it is a critical function in support of the entire DMH system.

d. Division of Quality Improvement (DQI)

The DQI is charged with the overall development and implementation of a comprehensive Quality Improvement Program. It also has had the specific responsibilities to: 1) analyze and respond to unusual incidents (UI's) throughout the system; 2) perform chart audits of providers to ensure compliance with MHRS standards and Medicaid requirements; 3) assist the chief clinical office in doing clinical and fidelity audits regarding all services, beginning with an audit of medication and somatic services; and 4) targeted audits at the request of the DMH Director.

This multitude of tasks was further complicated by the loss of the Q.I. Director in September 2003. A new Q.I. Director was finally hired and begins in August 2004. The primary focus of the Q.I. staff in the past year has had to be on responding to UI's and doing MHRS compliance reviews. The QI staff have assisted the DMH Internal Auditor in conducting Medicaid Compliance reviews. The compliance reviews are conducted prior to DMH approving claims that are submitted to the Medical Assistance Administration (MAA) and also to do retrospective reviews. The unusual incident responsibility remains and appears to be growing in volume. FY 2004 has seen more UI's through the first six months (1,266) than all of FY 2003. The reason for this increase appears to be that DMH issued a revised policy in July, 2003, that required providers to report all UI's, not just major ones. The DQI is working hard to differentiate the major UI's from the others and to identify trends or systemic concerns.

The DQI began its fidelity audits in March 2004 – starting with MHRS standards as relates to medication-somatic treatment, assessments, counseling and psychotherapy, and community support services. Other standards will be phased in over time.

The broader task of refining and implementing the DMH's Quality Improvement Program Plan (approved in January 2003) will likely be one of the tasks for the new Q.I. Director. As noted in the July 2003 Report to the Court, the implementation of a more comprehensive Q.I. Plan is a multi-year process. The OA leadership has indicated its intent to move forward, for example, with the Quality Council that is articulated in the Q.I. Plan.

Overall, the Court Monitor is pleased with the growing depth and breadth of the Office of Accountability. While it remains organizationally separate (to protect its inherent oversight role) it has worked in a collaborative mode – both within the DMH and with the provider/advocacy community – to develop and enforce consistent oversight. The first two years has been largely consumed with basic development issues

e.g. rules, enforcement, documentation, etc. The next phase will be more focused on reviewing the quality of care provided e.g. MHRS fidelity audits. The DMH, through the OA Office, has spent considerable time in developing the protocols for these audits and in training staff. The tasks and requisite skills for OA staff will shift. The whole issue of DMH being able to insure provider compliance with program policies and standards has been highlighted with the court approval of the exit criteria. Undoubtedly the Office of Accountability will be a key ingredient in this DMH effort.

2. Consumer and Family Affairs

The Office of Consumer and Family Affairs has gone through major restructuring (in terms of its role) in the past year. The OCFA has taken on several major responsibilities, including: 1) the responsibility for the implementation of the new grievance systems within DMH (which will be discussed in III.A 3); 2) the oversight of the consumer satisfaction initiative (which was reviewed in II. A); and 3) the monitoring and tracking responsibility for Periodic Psychiatric Examinations (PPE). The PPE responsibilities involve some 461 committed consumers (as of April 2004); the revised D.C. commitment laws and DMH policy require a patient review every 90 days (a standard which DMH staff indicate has not been monitored nor met). The OCFA Director developed an action group in order to establish clear reporting procedures, data control systems and improved communication with the appropriate staff from CSA's and St. Elizabeths. Among the early on tasks was to ensure that the list of committed consumers was in fact accurate – an issue that the Office of the Inspector General (OIG) had called into question from its reviews. OCFA staff (in conjunction with the DMH chief clinical officer) have put forward a request for a new and upgraded electronic database that will provide expanded, timely and accurate reporting on all committed patients. As of the time of this Report, this whole effort is still in process. The OIG's office will continue to track this issue until it is successfully resolved. It is evident to the Court Monitor that OCFA staff are working diligently to ensure that patient rights are protected and that the commitment statutes are actively enforced.

The OCFA has become the central "nerve center" for a number of consumer-related issues. For example, the OCFA Director has gotten directly involved in the planned phase-out of the Work

Adjustment Program at St. Elizabeths. Consumers were concerned that this work program was being ended without a viable alternative. The OCFA Director – in joining this issue – has been helpful in negotiating timeline extensions so as to develop a clear transitional "jobs plan" for each of the 50 impacted consumers. This is an example of the impact that a consumer office can have within a larger mental health organization – namely the ability to advocate for consumers from the "inside" of the system. As in this case, the ultimate goal remained the same (i.e. better jobs for consumers) but the process of getting there was directly impacted.

The OFCA – with its new Director just finishing Year One – has clearly taken on major responsibilities within DMH. It is clear to the Court Monitor that the past year has been one of major challenge for all – with the expected growing pains along the way. It is hoped that the next year will bring a greater sense of stability and increased ability for this small office to navigate the internal DMH structure (e.g. clarity in the OCFA budget).

3. Enforcement of Consumer Rights

The Mental Health Reform Act of 2001 required the DMH to put in place a number of consumer protection policies or rules – including information privacy, durable power of attorney, informed consent for administration of medications, policies regarding seclusion and restraint, and consumer grievance rules. All of these protections have been put in place and are being actively utilized. The Consumer Grievance Procedure rule was published in final form in October 2003 after a lengthy process of review and comment. As outlined in the July 2003 Report to the Court, these rules provide for "a comprehensive approach to consumer rights and protections." One of the key elements in this rule is the requirement that each local mental health provider establish (within 180 days of the effective date of the rule) its own written consumer rights policy, which DMH must then approve in order for the provider to be certified. The thrust of the rule is that consumers have a full, fair, and timely process to resolve grievances at the local level. Failing resolution at the local level, consumers can then appeal to the DMH, which has formalized a hearing process that allows consumers to either pursue a hearing pathway (with final opinion by the DMH Director) or a mediated solution (with the Hearing Officer functioning as a trained mediator). The DMH to date has seven fully trained Hearing Officers.

Another key element of the rule is the mandated establishment of one or more peer advocacy programs that are independent of all mental health providers. The peer advocacy program selected by the consumer functions to support and advise consumers throughout the entire grievance process. The DMH has formally contracted with the Consumer Action Network (CAN) to do peer advocacy. CAN has been actively involved in providing information and training to both consumers and providers about its role and about the process overall. While the whole process is still very new, it would appear that consumers are beginning to utilize CAN – with over 200 consumer contacts to-date.

The DMH has relied heavily throughout this entire development and early implementation phase on the contractual work of Advanced Dispute Resolution Systems (ADRS). This small local organization has been instrumental in the overall design, rule development, training of hearing officers, and consultation with local service providers to develop their own grievance policies and plans. ADRS has also been instrumental in creating the database that will provide for ongoing analysis and tracking of the program overall. The DMH has had to reduce its reliance on ADRS due to the constraints of its contract for this year. Going forward, there remains a concern both within DMH and outside that the internal capacity (e.g. training, database development and report management, and provider support and review) is not sufficiently developed at this point in time and thus there will likely be need for some continued outside consultation.

As of the time of this Report, OCFA has reviewed the grievance plans of 37 agencies (CSA's, sub-providers and specialty providers) and has approved 15 of those plans. DMH staff are still in the process of reviewing all others and providing feedback to providers as to needed changes. The OCFA, through its Grievance Manager, is tracking this whole process very actively and working well with identified Grievance Managers at the local level. It should also be noted that the formal DMH hearing process is working, with some ten reviews having been conducted. Early reports are that this process has worked well for consumers – providing the kind of respectful and empowering process that was envisioned.

All in all, the Court Monitor continues to be very pleased with the development and beginning implementation of the Grievance Procedures rule. It is undoubtedly one of the most comprehensive programs of its kind in the country. It is also at a

key stage of development – with considerable work still to be done at the local level and at the authority level (in terms of building the database and providing oversight and support to local CSA's). There is also the longer-term issue of being able to aggregate and utilize grievance data as an inherent systems improvement tool for senior management. Given the early development of this process, the Court Monitor should continue to review continued development in succeeding Reports to the Court.

A matter integrally related to consumer protection is the legislative status of the Ervin Act. The required amendments to the Ervin Act (originally passed by Congress in 1964) were a critical component of the Court-ordered Plan. The District of Columbia's Mental Health Civil Commitment Act of 2002 (D.C. Law 14-283) was enacted on January 22, 2003, sent to Congress on February 10, 2003, and became law on April 4, 2003, following the 30-day Congressional review period. The law was responsive to the Court Monitor's original concerns about the critical need to modernize the civil commitment statutes, for example, the original Ervin Act provided for indeterminate commitments (whereas the new law provides for a maximum of one year commitment without due process for recommitment). The new statute also makes it possible for private hospitals to provide emergency inpatient psychiatric care – which is a critical element as regards the Court-ordered Plan for St. Elizabeths to become a tertiary care Hospital and local hospitals to provide acute care.

The legislative problem is that several of the key provisions of the amended Act require affirmative Congressional approval before they can take effect. Unfortunately, it is now into the second Congressional session without affirmative action by Congress. In recent months, a bill to accomplish this has been introduced in the House of Representatives by Rep. Tom Davis, Chair of the Government Reform Committee. As of this Report, H.R. 4302 has passed out of committee with a favorable recommendation to the full House. The Congressional Budget Office (CBO) is doing the requisite fiscal impact before the bill moves for House passage. H.R. 4302 adopts verbatim the language in the D.C. Act. It would appear that the Congressional desire is to move this bill through the House before it gets introduced in the Senate. It is unclear at this point who will sponsor the Senate bill, which committee it will be assigned to, and how quickly it will move to final approval.

The DMH staff are very attuned to the critical need to move this bill and are working with Congressional staff to make it happen. Unfortunately, this issue has not been sufficiently high on the District's legislative agenda to get the attention it requires. It is dismaying that – two and a half years after the Mental Health Civil Commitment Act – there is still no final resolution on this core legislative issue. The Court Monitor will continue to track this issue closely in the months ahead and will report back formally to the Court in the January 2005 Report.

B. Review of Systems of Care Development and Specific Systemic Efforts

1. Review of Adult Systems of Care Development and Specific Adult Systemic Efforts

a. Overall Philosophy and Organizational Efforts to Develop Adult Systems of Care

It continues to be evident that the DMH is committed to a systems of care model for adults as was envisioned in the Court-ordered Plan. The Court-ordered Plan speaks to the need for DMH to play "the key leadership role in the design and development of an overall systems of care model" and to create approaches that "stress strong cross-agency partnerships, a shared responsibility for ultimate outcomes, mobile/on-site responses by mental health professionals, …and the mixing and matching of funding streams to support an overall services plan." As will be evident throughout the specific service development areas, the DMH has embraced this philosophy. The July 2003 Report noted two major barriers in terms of moving this philosophy to consistent practice. The first was simply the amount of energy required in the early stages to put basic enrollment and payment systems in place. As will be detailed in other parts of this Report, those issues – at least for established providers – are largely stabilized. This then should free up both the Authority and individual providers to focus on building true recovery-based service systems for persons with serious mental illness. The second barrier spoken to in the July 2003 Report to the Court was the multiple changes in leadership within Delivery Systems Management – the program arm of the DMH. The Court Monitor is encouraged to see that the DMH Director – in restructuring the Department – has created a position as Associate Deputy Director for the

Office of Policy and Program. This position – which has been filled by a very seasoned and knowledgeable person – will have broad authority within the DMH; this will include both the child/youth and adult divisions, provider relations, forensics, human resources, fiscal policy, the training institute and organizational development. This position creates the real potential to forge a more unified strategy across service systems and to develop increased confidence with the advocacy and provider community about the direction and stability of DMH initiatives.

The following sections (III. b-d) will provide updates on three major systemic efforts that are critical if an overall systems of care model is to work. These efforts should also be read in connection with III. F (Mental Health and Drug and Alcohol Services) and IV C and D (update on crisis services and acute care beds) in order to get a full picture of the evolving systems of care implementation.

b. Housing Capability

The DMH is intensifying and targeting its efforts to implement the April 2002 Report from the Corporation for Supported Housing (CSH). The CSH report made numerous recommendations that were all intended to increase the leveraging capacity of DMH capital dollars and build on the existing partnerships between DMH and other public and private housing-related organizations in the District. While DMH continues to support a restructured Residential Treatment Program (which currently supports a capacity of 1,040 persons), the real emphasis is to create additional supported housing options. DMH indicates that it currently supports (as of April 2004) 878 persons through a combination of Bridge Subsidy Housing programs (time-limited) and permanent subsidy housing programs. In addition, there are 482 persons receiving Supported Independent Living (SIL) services through seven (7) different service providers.

Despite these various efforts, the demand for housing services and supports is exceedingly high. DMH estimates that it currently has 400 consumers who have been referred for housing services – of which nearly half have been in the past 6-8 months. In addition, the budget for one of the bridge subsidy programs has been reduced by $500,000, which will mean a loss of 67 housing support slots. This

program also can no longer support any flexible or discretionary expenditures (e.g. furniture or bridge loans to consumers ready to leave St. Elizabeths). The DMH has taken steps to prioritize housing subsidies – with first preference given to St. Elizabeths discharges, consumers being evicted from shelters and consumers being referred from a CRF to a Supported Housing model.

A major positive development is that the D.C. Housing Authority (DCHA) has committed to DMH 1000 housing vouchers under the HUD annual contribution contract. In addition, because of the effective interagency work that has been done, DCHA will support up to 150 Housing Choice Vouchers for the DMH Housing First initiative. This initiative is targeted to persons with dual diagnosis serious mental illness and substance abuse and who are chronically homeless. All told, DMH estimates that the DCHA partnership will add over 1,200 additional housing vouchers for DMH consumers. These vouchers should all be available by the end of calendar year 2004 – with the majority available within the next 60 days.

On the Housing development front, DMH continues to employ multiple initiatives. DMH has $5.5 million included in its 2004 capital budget for Housing development. However, the DMH is having to enforce with developers a new policy that will require that any new housing stock developed with DMH capital dollars must ensure that new units are sustainable at the consumer contribution level of 30% of SSI income. 30% is the Federal standard for both the Shelter Plus Care program and the Housing Choice Voucher (Section 8) program. The DMH continues to work actively with its Housing Intermediary (Cornerstone) which has made commitments to deliver 27 new Housing units by the end of 2004 – which will house 64 consumers. In addition, the partnership with the D.C. Housing Finance Agency (DCHFA) continues to be strong, with DCHFA committing to set aside targeted dollars in bonding authority for DMH scattered site multi-family housing units.

It would certainly appear that DMH efforts in adding to the diversity and total number of supported housing options is beginning to pay off. The next 6-12 months should see major growth in overall supported Housing capacity. These efforts should better position DMH to meet the exit

criterion that is specifically tied to supported housing (i.e. 70% of persons referred for supported housing served within 45 days). As this process unfolds, it is encouraging that DMH is also taking a critical look at the overall level of care needs for persons currently in housing. This, coupled with its leveraging strategy on financing, should help to ensure that housing resources are used to maximal advantage. Historically, the mental health system has relied very heavily on congregate housing models. Hence, it is encouraging to see the DMH shift in both policy and funding emphasis toward supportive housing models. These efforts will hopefully continue and intensify over the next year.

c. Supported Employment

Since the time of the July 2003 Report to the Court, the DMH has moved beyond the original three demonstration sites to now include seven agencies. As a part of the evidence-based practice (EBP) initiative, Dartmouth (a national center for the support of EBP initiatives) continues to be involved via monthly teleconference calls with the program directors of each of the seven agencies. In addition, DMH staff meet monthly with the providers to review relevant issues. The most recent concern is the impending closure of Northwestern Human Services – one of the CSA's and one of the seven SEP providers. It appears that one of the other SEP sites (Green Door) can and will pick up the SEP clients who have been served via Northwestern. As the overall transfer of mental health services occurs (with Northwestern closing in June 2004) there will likely be additional demand for supported employment which will need to be assessed.

Overall, the DMH indicates that there are 222 consumers enrolled in one of the seven (now six) supported employment programs. Out of these 222 consumers, 64 are actually working at an overall average hourly rate of $9.05/hour. The model of Individual Placement and Support (IPS) is still the model that DMH is promoting – which continues to require changes at the pre-existing vocational sites.

The DMH staff person who developed the SEP and began its implementation has left the agency – requiring the Adult Services Director to temporarily fill this leadership gap. A

new and very experienced person has been selected for this position and is beginning to take hold.

The Court Monitor's assessment is that this program will need strong and continued leadership at the DMH Authority for years to come. While there is no indication of current demand for these services, it would certainly appear that this is a very underdeveloped service (222 out of over 13,000 currently enrolled DMH consumers). Given that this is still a newly developed model, it will take work to educate both providers and consumers as to the efficacy of this supported approach. This is also an area in which the Court Monitor will look closely at relevant DMH policy and provider compliance as a way to ensure that those consumers who need supported employment are in fact being referred. The Court-approved Exit Criteria for this element requires that 70% of persons who are referred for supported employment will be served within 120 days.

d. Assertive Community Treatment (ACT) Services

The Court Monitor has – in each Report to the Court – expressed concern about ACT services as relates both to the quality (fidelity) and the overall quantity of ACT services available. The DMH leadership – through the new Office of Policy and Programs (OPP) – continues to work on both of these major issues. Noteworthy developments include:

- Both of the major ACT providers (the Public CSA and Psychotherapeutic Outreach Services) have undergone leadership changes that should positively impact ACT services. Psychotherapeutic (POS) will be adding an ACT Team to replace the loss of one from the closure of Northwestern. There appears to be a strong commitment to expand and monitor ACT services – with increased emphasis on ensuring continuity of care and using the LOCUS to determine functioning levels. Likewise at the Public Core (PCSA), the Adult Services Director has restructured the ACT Teams so as to provide adequate staffing; this has resulted in moving from four ACT Teams to three. The PCSA has utilized the ACT fidelity scale to assess current performance and will make changes accordingly.

- The DMH has renewed the contract with Fran Register Joyner, an experienced consultant whose contract had been pending for several months. The DMH leadership indicates that this consultant will continue to play a key role in the training, consultation and oversight of the ACT Teams. The DMH indicates that the ACT changes are measurable and will be followed up by the ACT consultant within the next 60 days. The ACT consultant will also work with DMH leadership in the development of an ACT policy within the next 90 days.

- In late January 2004, the Pathways to Housing ACT Team began to operate. As noted elsewhere in this Report, this very specialized team will focus on persons with serious mental illness, substance abuse problems and long-term homelessness. The goal is to grow the caseload from its current level of approximately 10 to a maximum of 65-75.

- The restructured Office of Policy and Programs (OPP) also includes the permanent appointment of the Adult Services Director. The OPP Director indicates that the responsibility for ACT services will fall directly to the Adult Services Director. The Adult Services Director is charged – among other tasks – with working directly with the DMH Access Helpline Director to monitor the referral process to ACT, the overall program compliance and the ongoing concern about systems capacity.

- As a part of the overall acute care strategy, the DMH has recently committed to adding four new ACT Teams in '05. While it is likely that one of these will be an additional Pathways ACT Team, the DMH will solicit new or existing providers to apply. The stated overall goal is to double the current ACT capacity.

As relates to ACT, the Court Monitor is pleased with the leadership decisions and changes that have occurred – both at the Authority level and at the CSA level. It is hoped that these changes will provide a consistency of direction and oversight that will be visible at the ACT service level. The reengagement of the ACT consultant

is also seen as a positive sign as is the recent commitment to double overall ACT capacity. As with other areas, the focus on this issue by the Court Monitor will begin to shift to the actual performance under the Exit Criteria mandate (i.e. 85% of persons referred for ACT services will receive them within 45 days). This data-driven focus will start with the review of the to-be-developed DMH policy on ACT and then the methods to determine its actual implementation. The Court Monitor continues to be concerned that this is an underdeveloped service component (with approximately 500 consumers in ACT) but the real answer will be forthcoming as clear policy and practice are measured.

2. Review of Child/Youth Systems of Care Development and Specific Child/Youth Systemic Efforts

   a. Overall Philosophy and Organizational Efforts to Develop Child/Youth Systems of Care

   The DMH has been a very visible and energetic leader in the District in developing systems of care for children and youth. The fact that Child/Youth services started at such a low level has made this leadership all the more impressive and imperative. The $8 million Federal grant that DMH received in 2002 is named Children Inspired Now Gain Strength (D.C. CINGS); it very concretely embodies the DMH's commitment to a system of care philosophy in all of its efforts. The stated overarching goal is "to overcome existing procedural policy and structural barriers – thereby creating a true systems of care for District children and families."

   The specific areas of development in III.B 2 (b-d) will describe current progress and barriers in that overall goal.

   b. School-Based Services

   DMH continues – through its Authority-based staff – to provide mental health services in 28 D.C. schools. DMH staff indicate that from September 2003 through April 2004, 495 students were formally referred to the School Mental Health Program (SMHP) and an additional 1,634 were seen on a "walk-in" basis without a formal referral. The mental health

clinicians who work in schools provide a range of direct clinical services (individual, group and family therapies) as well as providing teacher consultations, staff development and classroom observations in support of staff. It is noteworthy that – as a direct result of these on-site interventions – 21 different students were referred for psychiatric hospitalizations and 218 crisis responses were performed.

The overall program has grown significantly from its inception in 2001 to the present. In an effort to stabilize and strengthen existing efforts, the decision was made not to expand into any additional schools in the 2004/2005 Budget year.

One of the areas in which school-based staff have been involved is as a part of the DMH response to several violent deaths of school students. These high-profile incidents have generated considerable community outcry and media attention. The DMH staff (including school-based staff) have provided valuable on-site intervention with students, families and school staff. As a related effort, the SMHP staff have been involved in the ongoing development of the D.C. Children's Grief and Loss Network. This is a true community partnership of providers, universities, District government agencies and community members whose goal is to expand the array of supports for grieving students and families. The school mental health staff conducted a very successful conference on grief and loss in December 2003, and will be doing additional training for school staff during the summer of 2004.

Another innovative program has been the pilot youth supported employment program at Eliot Junior High. Some 16 students have participated in this effort which – with the incentive of a small stipend – provides "real world" opportunity to hear about different careers, complete mock job applications, learn interviewing skills, and research one potential career of interest. This program is a good example of the kinds of proactive and prevention-oriented collaborations that can grow out of community-based models.

The Court Monitor continues to be pleased with the diversity and quality of the school-based initiative. Strong DMH leadership has allowed this program to gain increased visibility and credibility with the D.C. Public Schools. The major concern continues to be that this program cannot grow without additional budgetary support. The DMH continues to pursue alternative funding options, including a Federal Grant to create

a new Center For Support Services tied to DCPS. The DMH also is reviewing alternative approaches to use Medicaid dollars to support at least some of its school-based efforts. These funding strategies will be key to enable this excellent program to expand into additional D.C. schools.

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

As part of its system of care approach, the DMH has – through its Child/Youth Services Division (CYSD) – continued to develop multiple initiatives that are directly tied to the goal of being able to support children in their own homes or in surrogate homes. The following summarizes developments in these areas over the past year:

- The Multi-Agency Planning Team (MAPT) continues its process of assessing youth who are at risk of out-of-home placements. Three diverse teams continue to provide these reviews. Since the beginning of the MAPT process, some 603 cases have been reviewed. Of that number, 460 (76%) have been referred to community-based services and 143 (24%) to residential treatment. This 76% diversion contrasts markedly with the previous Residential Review Committee (RRC) which only diverted 5%-10% of assessed children/youth. In order to monitor progress, the DMH has begun a process of using family liaisons to do follow-ups on each family three weeks after the initial MAPT review. One of the major current developments related to MAPT is the implementation of the Harmony Information System, a software data system that will allow all of the referring District agencies to know the current status of children/youth and the degree to which the desired results of the care plan are being achieved. The DMH is planning to use the Federal grant to fund three new positions tied to the MAPT/Harmony process. These positions will provide more intensive monitoring/follow-up on individual children/youth and the development of a quality improvement process. The DMH anticipates having this Harmony System up and running by July 2004; the additional staff will hopefully be hired and on board by the fall of 2004. This system should be

responsive to one of the expressed concerns – namely the ability to know what happens to children/youth who are diverted (individually and in the aggregate) and to use this information to make needed system changes.

- During the past year, the Deputy Mayor's office has established a Juvenile Justice Reform Task Force. This Task Force is charged with developing – as part of an overall Juvenile Justice vision – a multi-year and multi-agency plan. The recent appointment of a Special Master for the Juvenile Justice system (as part of the Jerry M. case) will add additional leverage to this effort. As a result of this new focus, the previous funding to DMH for the Alternative Pathways program has not been renewed ($1.6 million). As a result, the DMH is attempting to fund some of the major initiatives from the '04 Local Funds – namely the Assessment Center and Youth Empowerment Services (YES). It appears that the Assessment Center will not be negatively impacted; in fact the Assessment Team will have additional staff added as a part of the Foster Care initiative (which will be discussed below). However, the YES program has had to reduce staff and curtail operations as relates to the mental health screenings that were occurring at the MPD's Juvenile Processing Center (JPC). The DMH indicates that the '05 budget should fully fund all of the key Alternative Pathways initiatives; the D.C. Council has added $1.25m to the DMH budget to make these restorations possible.

- The Acute Care agreement with Children's National Medical Center (CNMC) continues to evolve. The DMH now provides onsite mental health staff at CNMC seven days per week from 4:00pm to midnight. The overall working relationship continues to be strong. The numbers of children seen on a monthly basis ranges between 150-200 and a typical month. The inpatient agreements with Riverside and PIW remain in place. DMH tracks all admissions to these Hospitals, for purposes of notifying CSA's to provide post discharge care.

- At the direction of the Mental Health Care Subcouncil, a Residential Treatment interagency group has been created. This group is moving to implement a process that will greatly standardize oversight, contracting, and funding for all Residential Treatment Centers (RTC's) in the District. The plan was for DMH to be the centralized point of certification and monitoring for all RTC's through its Office of Accountability. Another vital component will be that children in RTC's (irrespective of the referring agency) will be enrolled in one of the DMH certified CSA's as their "clinical home." This lack of CSA enrollment has been detailed in previous Reports to the Court as a major gap. The plan also calls for the transfer of funding for all RTC's to the DMH budget, creating the ability to utilize available MHRS funding instead of just local dollars. A detailed financial analysis has been completed, which provides a baseline from which to measure future efforts. The Court Monitor is very pleased to see this additional major effort to oversee both a consistent clinical pathway for children/youth and a financial strategy that utilizes available Medicaid funding.

- The DMH has continued to actively involve youth and families in all aspects of planning and implementation. The DMH won two national awards for its social marketing efforts. One was a first place award for the development of a compact disc presentation on how the Youth Advisory Group helped to train members of the MPD and the other was a second place award on how family members were trained to become part of the MAPT clinical review teams.

- The DMH, in conjunction with the Child and Family Services Agency (CFSA), has received from Congress $3.9 million in new funding that will greatly increase the availability of mental health services for abused and neglected children. The DMH is actively engaged on multiple fronts to develop new or expanded services for this population. The plans for these funds include: a) the expansion of the existing assessment center that was begun as part of the Alternative Pathways

initiative; b) the provision of training and technical assistance to increase the capacity of new MHRS providers; c) the funding of new or existing providers to deliver targeted Multi-System Therapy (MST) intensive home and community-based services, and mobile response and stabilization services. The DMH has recently sent out Notices of Funding Availability (NOFA) for these initiatives. Successful applicants understand the one-time possibility for these funds and will be required to develop the ability to transition to MHRS billing over the longer term. While the ongoing Congressional support for these enhanced services is not yet clear, the District is hopeful that recent negotiations will lead to some continued funding in Year 2.

As part of this Foster Care initiative, current CFSA-contracted mental health providers are now required to become certified through DMH under the MHRS program. This will be another major step in the direction of creating a single and coherent mental health system for children and youth.

All in all, the DMH has taken major strides in the development of a systems of care model. The Foster Care initiative will bring DMH and CFSA systems together in new and profound ways. While all of these efforts are – in and of themselves – just parts of the larger puzzle, it appears to the Court Monitor that many of the major components are now beginning to be integrated into a more coherent whole. DMH leadership has been – and will continue to be – a vital component of these reform efforts.

C. Review of DMH Progress in Maximizing Funds

The Court-ordered Plan spoke to the need to develop both the clinical/program capacity (via MHRSA federally approved services) and the administrative infrastructure to maximize Federal revenue. The overall goal of this mandate is to utilize Medicaid as a source of payment for needed services whenever and wherever possible; the result of this effort, then, is that local funds can be used to pay the

Federal match (30%) and to pay for those services that are not eligible for Federal Financial Participation (FFP).

The DMH has, since the July 2003 Report to the Court, demonstrated progress on several fronts. One of the major issues over the past two years has been the timeliness of claims payments. The DMH multi-year progression shows that the percentage of claims processed within 30 days has gone from 37 % (2002) to 69% (2003) to 82% (2004 year to date). The reasons for this dramatic improvement are many, but in general have to do with refinements in Information Systems, improved provider understanding, and improvements in DMH approval and processing of claims through the system. If you look at claims processed within 60 days, the percentage for 2004 jumps to 95%. The 5% gap represents claims that have been denied or are having to be reworked (and hence delayed from payment). While claims payment does not in and of itself represent maximization of Federal funds, it is a good enough proxy for the fact the overall system of providing approved consumer-based Medicaid-eligible services and paying providers in a timely way is now solidly in place. It is also reflective of the system's growth and maturity that overall MHRS warranted claims have grown from $5.6 million (in 2002) to a projected level in excess of $40 million for 2004.

One of the other major developments in the past year has been the DMH initiative to bill for approved MHRS services that are provided to consumers residing in DMH licensed and contracted residential treatment settings. Historically these clinical/support services have been bundled into the residential rates paid to providers and hence have been entirely out of local funds. This separation of rates between residential and MHRS services is being implemented in two phases in order to allow providers to adapt. The DMH estimates that the savings (in terms of local tax dollars) will be approximately $6 million for 2004. These local tax dollar reductions can then be more appropriately directed to provide local match and support other mandatory services that are not Medicaid reimbursable.

One of the issues that will require effort is the working relationship with MAA (Medicaid Administration). While the overall delegated authority model between MAA (as the single state agency) and DMH, the inner workings of this contractual agreement are not fully on course. For example, the MAA, without discussion with DMH, assumed that many of the claimed reimbursements due DMH were stated on an hourly basis and processed payments at a quarter hour basis. Since DMH had in fact already submitted these at a quarter hour basis, the claims reimbursement to DMH was only 25% of what

was due. While these correct payments are being resolved, they speak to the need for a better interagency understanding in the months ahead.

All in all, DMH appears to have made substantive progress in terms of maximizing Federal revenue. Additional gains will be made, for example, as the residential unbundling is fully implemented and as the PCSA continues to improve productivity. But, viewed from its start point of only two years ago, one has to give major credit to the DMH's ability to ratchet up to a level of approximately $40 million in community services in just two years.

The Court-ordered exit criterion for revenue maximization assumes that approximately 70% of persons within the overall community system are Medicaid eligible and that FFP likewise occurs at a 70% level (hence the 49% overall collection threshold). Future Reports to the Court will detail progress on this specific criterion, but it would appear from the review of reports for the past six months that DMH is solidly on course.

D. Review of DMH's Role as a Provider

The Court-ordered Plan articulated a clear role for St. Elizabeths as one of providing tertiary care (on the civil side) with the evolving CSA's being primary and local acute care hospitals being secondary for persons needing acute hospitalization. The role of the single public CSA was one of necessity at the time the Plan was written; there was simply not sufficient capacity to meet the value and array of community-based needs.

The July 2003 Report to the Court detailed progress (and obstacles) in carrying out the basic elements of the Plan. This Report will provide updates on all major elements:

1. Role of St. Elizabeths

St. Elizabeths has continued to provide multiple functions for the District on both the forensic and civil side. St. Elizabeths has continued – until recently – to be the primary source of admissions for adults who are involuntary or who do not have a source of payment. The recent utility crises at St Elizabeths have resulted in temporary outages to both electrical systems and one of the boilers that heats water for patient care buildings. While temporary fixes have been made, it is apparent that the age and depleted condition of these utility systems will cause continued disruptions in basic electrical supply – affecting both the heating and cooling systems. As a

result, the DMH has put in place a concerted effort to assess and redirect to alternative sites consumers who are presenting to CPEP for evaluation. Of the 140 consumers seen at CPEP during a recent two and a half week period, only six were admitted to St. Elizabeths. The remainder were admitted to community hospitals, admitted to a crisis residential program, referred for detox or released back to a community-based program. Senior DMH leadership are monitoring CPEP cases on a daily basis. One of the outcomes is to ensure that enrolled consumers are in fact getting from CSA's the required level of followup and community outreach. The DMH is developing a Memorandum of Understanding for use with community hospitals to allow the admission of involuntary patients. The DMH plans to continue this effort at very careful screening prior to any civil admission to St. Elizabeths – with either the DMH's Chief Clinical Officer or the CCO for the Public CSA needing to personally approve any admissions.

While this crisis approach may not be the desired state, it has had the effect of engaging acute care hospitals and community agencies in helping to find clinically appropriate alternatives. It may well help to focus and concretize planning for more formal acute care arrangements – which will be discussed in II. D 3 below. The impact on St. Elizabeths should be significant, given that it has averaged over 100 admissions per month historically; these recent efforts to redirect should result in acute admissions more in the range of 15-25 per month. The net result should be the ability to reduce significantly the number of acute care and acute care step down beds, which has been approximately a total of 100 beds.

In terms of overall accountability for performance, the Court Monitor was provided a draft performance contract between the DMH Director and the CEO/Director of St. Elizabeths. This FY 2004 performance agreement is similar in format to those between the DMH Director and other top management personnel. It spells out some 13 different performance requirements for the year – with specific quantifiable measures in each area. In order to achieve acceptable ratings, the St. Elizabeths CEO must meet at least 70% of the outlined expectations; 80% or above is recognized as "exceeded expectations." Future reviews will suggest how this accountability tool is used to achieve desired performance. In a broad sense, however, it does appear that the DMH has worked to create a model of delegated authority and accountability as outlined in the Court-ordered Plan. The

major systems issues in terms of the role of St. Elizabeths still remain – namely the completion of a rebuilt Hospital and the successful implementation of acute care contracts with local hospitals.

2. Planning for New/Consolidated Hospital

The DMH has continued its planning and design efforts toward the construction of a new/consolidated Hospital at St. Elizabeths. The DMH is moving toward the final planning stages of the pre-construction phase. The DMH has had a seemingly endless array of reviews and approvals along the way – including environmental impact, the Commission on Fine Arts, certificate of need, and zoning reviews to name the major ones. The second certificate of need hearing was held in mid June; assuming approval on this, the final major hurdle will be the second zoning hearing in either July or September 2004. The net effect of all these mandated reviews and hearings is that the estimated beginning construction date is now early 2005 with completion and occupancy in mid-late 2007 – which is about a year later than was estimated by DMH per the July 2003 Report to the Court.

The basic design and planning for the new Hospital remains – with a total of 292 newly constructed beds (including 178 forensic beds and 114 civil beds). The Court Monitor has reviewed the basic design of the new buildup and continues to be positively impressed with the basic design principles – which seek to maximize patients' access to outdoor space and provide a treatment mall which is distinct from the patients' living areas.

The other remaining hurdle is the issue of how the new Hospital will be financed. At the time of this Report, there is still discussion as to the preferred method(s) for financing. It should be noted that on May 6, 2004, the Mayor sent a letter to the Court Monitor affirming his personal support for this new construction and committing to an updated construction financing proposal in the near term.

The Court Monitor is pleased with the new Hospital design and with the DMH's persistence throughout this process. The multiple reviews are apparently unavoidable, but have had the effect of delaying timelines for construction and ultimate occupancy. All of these delays stand in the face of the incredibly deteriorated physical plant at St. Elizabeths and the

fact that the DMH is having to spend literally millions of dollars to provide temporary fixes for electricity generation and other basic utility needs. The Court Monitor will continue to track progress on this major effort – with the hope and expectation that final planning approvals and an approved financing package will be completed in the next several months.

3. Review of Progress on Use of Local Hospitals for Acute Care Inpatient Services

The Court-ordered Plan and both the second and third Reports to the Court spoke to the need for DMH to establish agreements/contracts with local acute care hospitals. The Court-ordered Plan spoke to the critical need for this objective given that "general hospitals can be reimbursed for Medicaid-eligible psychiatric admissions and will very likely be less stigmatizing, and more likely to result in integrated healthcare and shorter lengths of stay (based on nationwide statistics) than emergency admissions to St. Elizabeths have been."

The DMH, in response to this mandate, has very recently put together an Acute Care Options Paper. The purpose of the Options Paper is to outline three different possibilities as to how the DMH might proceed on this issue. The first option would be a Community-wide Purchasing Plan. This option would allow for DMH to purchase acute inpatient services from any hospital provider in the District. The basic financial arrangement would be that participating hospitals would bill Medicaid or other third parties when available. DMH would pay only for indigent consumers. The hospitals would also be liable for the costs of general medical care and would be required to work closely with DMH on issues of prior authorization and continuity of care. Hospitals would be required to accept both voluntary and involuntary consumers.

The second option would be generally similar to option one in terms of obligations and financial requirements. The difference is that option two would involve an Acute Care Network – a consortium of Hospitals that contract with DMH as a single entity on behalf of its participating providers. Depending on the size of the network, the DMH might purchase a "reserve" number of beds in order to ensure timely admissions.

The third option would be to contract with a single general hospital to manage all of the acute care needs. The DMH estimates the need for adults at up to 55 beds, which would need to be dedicated for this agreement. Under option three, the DMH would pay for operating costs, after third party payments are accounted for and medical costs are excluded. DMH would need to work with this single provider to ensure that all physical plant requirements are adequately met.

The DMH options document indicates an openness to develop any of these three options – dependent upon the response from the local hospital themselves. The DMH has had multiple discussions with individual hospitals but has also worked closely with the D.C. Hospital Association in developing an overall approach. DMH leadership has indicated that it plans to implement the new acute care model on November 1, 2004 – or if option three is selected – as soon as possible given any physical plant modifications that will be required.

The Court Monitor is pleased with the concrete proposal that is now in full play. Clearly all of the options will have pros and cons – but any of the models could work. Like most new arrangements, it will take concerted effort by DMH and willing hospitals to work through all the details. The Court Monitor wants to communicate a true sense of urgency on this issue. It is critical that this major step be taken now; the sense of urgency draws not only from the need to comply with the Court-ordered Plan but also from the utility crises at St. Elizabeths.

4. Management and Role of the DMH-operated CSA

The DMH continues to operate a single CSA, the so-called "Public Core" (PCSA). This management entity in reality includes multiple functions within the overall scope of its $45.3 million FY 2004 Budget. Over $18 million of the total is allocated to functions that are above and beyond the scope of MHRS-approved services; these include e.g. pharmacy services, services to youth at Oakhill, medical services, and specialized non-MHRS services in crisis, homeless, and children/youth. Without question these are critical systems support functions but they should be viewed as distinct for purposes of looking at the PCSA as a part of the overall CSA community system.

The PCSA has continued its efforts to create a viable and accountable CSA. One of the major accomplishments of the past year has been the planning and implementation of a new Information Systems. Historically, the PCSA has not had any electronic I.S. capability. At this point the PCSA is billing electronically and is able to produce financial management reports on all of its MHRS-generated services. The PCSA in the past year has also seen major improvements in: a) billing capacity; b) overall financial management; c) restructuring of adult services; d) creation of new and modern facilities for youth and adults (with the opening of the U Street facility); e) the recent focus on continuity of care/discharge planning in relation to PCSA consumers at St. Elizabeths; f) the downsizing and restructuring of medical and pharmacy services; g) the continued upgrading and development of responsive crisis services and; h) the restructuring of ACT services. All of these efforts should be viewed as substantive and critical – given the enormous challenge that has existed in creating a "culture of accountability" in and through the PCSA.

Major systemic issues remain. Perhaps the most glaring continues to be that the PCSA cost structure far surpasses its current ability to generate matching revenue. Despite a growing emphasis on staff productivity, the 2004 gross revenue projections for MHRS services will likely not exceed $15 million. This compares to a cost structure for these same services of $24.7 million. This potential $15 million in gross revenue compares to $13.39 million for FY 2003 and with fewer (31) clinical FTE's for the current year. Thus the trend lines are in the right direction but the "break-even" gap remains very large (with approximately a $9 million difference between costs and gross revenue for FY 2004). The PCSA is well aware of these issues and has developed an overall pro forma for staff productivity which shows that aggregate staff productivity needs to be in the range of 60% (billable hours as a percentage of total hours paid) in order to achieve break-even. This compares to current productivity of less than 30%. Hence the challenge is huge – particularly given the sizable number of staff whose productivity is still below 20%.

The issues of financial viability beg the larger question of the going-forward role of the PCSA. These issues were outlined in the July 2003 Report to the Court and still remain. It is clear to all that the PCSA continues to provide a critical "safety net" function for the system – providing services that are critical to the overall running of a responsive public system. It is also

clear that the PCSA continues to be a major player in terms of the overall capacity of the community system. Per DMH eCura data, the PCSA represents 51% of total consumers enrolled in the community system. Hence the ongoing DMH authority challenge is to keep pressure on the PCSA to be accountable and maximally productive. At the same time, the DMH is faced with the mandate to manage fixed local funds in a manner that achieves their highest payoff. The overall strategy that the DMH has undertaken is to "unbundle" the multiple functions that have been lumped together in the PCSA and to develop potentially different strategies for different functions. An immediate example of this is the recent proposal to create a mobile crisis response team from the current CPEP (see IV. C. for full discussion of this proposal.) This approach to crisis services will take time to implement but – in addition to creating a more responsive crisis system – should have the effect of placing a major systems function outside of the direct responsibility of the PCSA. This should hopefully allow for increased focus on the multiple clinical, programmatic and financial issues that will remain. The DMH has indicated that the next major PCSA area for review – once the crisis component is done – will be that of children/youth.

The Court Monitor is very supportive of this overall organizational approach if it can achieve the desired goals of improving consumer-responsive services within a clear accountability framework. The longer-term role of the PCSA remains uncertain, but it is clear that it will be a more circumscribed role. As such, the role issues (and the incremental strategies to get there) should become clearer as time goes on. Even with an incremental approach, the DMH will have multiple challenges in dealing with these transitions (e.g. personnel issues, transition issues, etc.). Nevertheless, it is critical that the next phase of systems reform tackle these underlying concerns as originally mandated in the Court-ordered Plan. The Court Monitor will continue to track all of these developments in the months ahead. In addition to the larger unbundling strategy, it will also be critical that the DMH Director and the PCSA Director have clearly articulated performance goals for FY 2005. These expectations can then be translated into concrete goals for PCSA management staff and individual clinicians. It is not clear, for example, what the repercussions are in the current situation for non-performance in meeting productivity targets. It is also clear that continued organizational support will be critical in improving the quality

and consistency of clinical care e.g. the need for a clinical records system.

E. Review of Role and Functioning of the Partnership Council

The July 2003 Report to the Court indicated that the initial Partnership Council was not functioning as an "active advisory body" as was envisioned in the Court-ordered Plan. Despite multiple efforts, the Partnership Council suffered from poor attendance, confusion as to its role, and regularly unproductive interactions with DMH staff. In the fall of 2003, the DMH Director decided to restructure the Partnership Council as a way of providing new membership and clearer focus. The new 21-member Council has been meeting on a monthly basis since October 2003. From a review of the minutes and discussion with both DMH staff and Council member leadership, several things are apparent: 1.) Attendance – as compared to the previous Council – is much improved; 2.) The role of the Council has been focused on "big picture" issues – e.g. budget-related issues, new (or revised) major program initiatives, and routine reports that show overall systems performance in key areas (e.g. MHRS reports, financial data and consumer satisfaction results); 3.) The format and tenor of the meetings has become much more positive and productive. Council members now view the restructured Partnership Council as a forum in which useful information is shared, advice on key policy issues is sought, and thoughtful discussion on tough issues can and does occur. The DMH Director should be commended for taking the lead in this overall restructuring of the Partnership Council. The Court Monitor now has good reason to believe that this new structure is solidly on track and that it is now functioning as an "active advisory body, providing advice and direction on key policy issues."

F. Review of Integration of Mental Health and Drug and Alcohol Services

The Court-ordered Plan called for a Mayoral-endorsed initiative that would evaluate the need for changes in policies, programs and organizational structures in order to better meet the needs of persons with co-occurring disorders (mental illness and alcohol or other drug abuse). The District has continued the efforts which began in July 2002 between the leadership of DMH and the Addiction Prevention and Rehabilitation Agency (APRA). This cross-agency effort to better serve persons with co-occurring disorders (with estimates of over 20,000 persons in the District alone) was given a major boost in April 2003 with the signing of an interagency "charter and consensus" agreement. This document articulates the new and shared agreements between DMH and APRA – both in support of a new philosophy for

the treatment of co-occurring disorders but also as an agency commitment to achieve broadening and deepening "dual diagnosis capability" within each service delivery system. The DMH followed up on this charter and consensus agreement with a specific policy on September 22, 2003, that requires each Core Service Agency (CSA) and all other DMH providers (including St. Elizabeths Hospital) to develop the ability to meet at least minimal standards of dual diagnosis capability. Each agency is required to develop an "agency specific action plan outlining measureable changes at the agency level, the program level, the clinical practice level, and the clinician competency level to move toward dual diagnosis capability." In addition, providers are required to participate in "system-wide training and technical assistance" as a tool toward implementation of the agency action plan.

The DMH has continued to contract with two national experts (Drs. Minkoff and Cline) who are providing consultation in developing overall leadership and direction as well as providing hands-on training to some of the individual providers. The agency has adopted a "train the trainer" model – with a minimum of 40 persons who have been identified as trainees across the DMH and APRA systems. Some of the early-on trainers have themselves begun to do training in their home agencies. There are only five CSA's at this point that do not have identified trainers.

Several recent developments have added further positive energy. First, APRA has a new Director, who has exhibited a much higher level of support and leadership in this whole effort. Secondly, in recent months, there has been a new focus in the area of co-occurring disorders among children and youth. National experience indicates that this model is equally relevant for this population group and the same basic developmental needs exist (i.e. the need to develop the requisite infrastructure in every agency to carry out a multi-year dual diagnosis capability plan).

Beyond cross-agency efforts to build clinical and programmatic competence, DMH has continued with the Pathways to Housing Project that was begun in 2003. While the 2003 Federal SAMHSA Grant was not funded, DMH has moved ahead with this initiative anyway, using local funds. The target population is persons who are chronically homeless and both seriously mentally ill (SMI) and have substance abuse problems. This initiative is targeted directly toward one of the 15 systems performance measures in the Court-approved Exit Criteria. The DMH has committed $350,000 in local funds for FY 2004 and an additional $700,000 for FY 2005. The Pathways to Housing organization, which is based in New York City, will seek to become an approved CSA or specialty provider – with a target of

serving 65-75 persons in Year One – both chronically homeless ("street homeless") and dually diagnosed seriously mentally ill/substance abuse. The Pathways team will function as a new Assertive Community Treatment (ACT) team for this very high-risk population – utilizing Housing Choice vouchers provided by the D.C. Public Housing Authority and bridge vouchers provided by the Community Partnership for the Homeless. The DMH has received strong support in this effort from the Community Partnership and the Mayor's Office; it should be noted, for example, that the pathways initiative was highlighted in the Mayor's recent public plan to end homelessness. Hence the overall goal remains – which is to provide for this historically unreached population an integrated services model that responds concurrently to the array of mental health, substance abuse and health care services, as well as providing immediate access to independent and stable housing.

It should also be noted that the DMH continues to support via DMH funds the Sobering Station, which provides specialized detox beds during the winter months at the APRA Detoxification Center. The DMH (through the Public CSA) also provides a specialized mental health/addictions team at the APRA location on First Street. While both of these initiatives will continue to evolve as the system grows, they are concrete examples of the ongoing collaboration between DMH and APRA.

In overall review of the mental health/substance abuse efforts, the Court Monitor continues to be positively impressed with both the general philosophy and the incremental steps that are being taken to serve this co-occurring population. Without question, the development of true dual diagnosis competency throughout the system is a multi-year endeavor. As such, it will take sustained leadership and support by both DMH and APRA.

G. Review of FY 2004 Budget and Status of FY 2005 Budget

As reflected in the January 30, 2004 Report to the Court, the DMH budget for FY 2004 included a base operating budget of $194.8 million, $21.7 million in a special reserve for potential Medicaid shortfall and an additional $2 million reserve to cover Court-mandated expenses. The major issue raised by the Court Monitor throughout this process has been one of timely access to these reserve accounts – in order to provide total spending at or near the $218.5 million level. The Office of the Chief Financial Officer (OCFO) has provided assurances throughout that there would be support at the full budget level. All indications to date are that the OCFO has been true to its word; for example, the OCFO was willing to do manual overrides for the $21.7

million in advance of the formal District Council approval. These overrides in the early second quarter came at a critical time in terms of payments to providers.

Despite all of these efforts, however, the net effect of having large dollars in reserve accounts is that the DMH (and the OCFO) has to go through repeatedly (and seemingly redundant) steps in order to access funds. Providers are also directly impacted by this process, in that contracts must be redone mid-year in order to reflect the reprogramming that occurs. All of this leads to a lack of predictability for a system that very much needs a sense of stability if it is going to continue on its upward path.

The other remaining reserve issue is the $2 million reserve that was tied to the Court-ordered requirements. The Court Monitor was assured that the DMH would have access to these funds based upon demonstrated need and would not have to go through yet another reprogramming to spend these dollars. It is likely that this $2 million reserve access will be settled in the final quarter of the 2004 fiscal year (July – September 2004).

As to FY 2005, the Budget request by DMH was $220 million – essentially a flat line request from the total 2004 Budget of $218.5 million. The 2005 Budget has had strong support from Mayor Williams throughout the process to date. There are, at present, two major issues that are still outstanding. First, the District Council – its Budget deliberations – reduced the Department's fixed costs which are controlled by the Office of Property Management and primarily related to unpredicatable utility expenses for St. Elizabeths by $2.7 million. If these costs go over the amount allocated, DMH would be forced to dip into their operating expenses to cover the costs. This jeopardizes DMH's ability to meet their program and personnel obligations. The DMH, while it is concerned about this issue, has been assured that the OCFO's office will work very closely with DMH to ensure that all necessary dollars are found to cover the legitimate fixed costs.

The second – and larger – issue is that the District Council voted to place $11 million of DMH's community contract dollars into a contingency fund. The presumption is that DMH would have access to these funds, but it is not clear what the conditions for access will be. At the time of this Report, this 2005 Budget process is still in a state of discussion and negotiation between the Mayor's office and the Council.

The Court Monitor is very concerned that this $11 million might function like past reserve funds, which as noted above, have had the

effect of multiple contracts for providers, redundant work for DMH, and a general lack of predictability for solid planning. The system has now matured and stabilized to a point that contingency funds based upon Medicaid billings seems both unnecessary and counterproductive. The key issue will be the language regarding access, which the Court Monitor has not been able to obtain. Needless to say, the Court Monitor will track this issue carefully in the months ahead to ensure that adequate and timely access to funds will be in place for 2005.

IV. Follow-up on Previously Identified Recommendations

The discussion on Assertive Community Treatment (ACT) and Acute Care Beds has been reviewed previously in this Report. The remaining three areas that warrant additional review are: a) the working relationship with CSA's; b) development of crisis residential beds and; c) the location and functioning of crisis services (CPEP). Each of these areas has had recommendation(s) in prior Reports to the Court.

A. Relationship with Core Service Agencies (CSA's)

The January 2004 Report to the Court identified multiple issues in the evolving development of CSA's. The DMH has addressed many of these identified areas with the following as the most notable examples:

- The DMH has filled the leadership position of Director for the Office of Policy and Programs. This senior position has been filled by a very qualified and experienced person. She has brought a sense of openness, collegiality and focus to the many tasks at hand. For example, the meetings with CSA's that were previously separate (one for CEO's and one for CFO's) have been combined. This has helped to create consistency and accuracy of information shared. In addition to the Director of Office of Policy and Programs, the DMH has also recently added an Associate Deputy Director for O.P.P., who will also have major policy responsibility – especially in the areas of child/youth services.

    - The DMH, as noted earlier in this Report, has made major strides in the timeliness and shared understanding of the claims payment system. As new providers are added, intensive efforts are made to assist via the Provider Relations staff.

- The DMH has re-engaged the National Council for Community Behavioral Healthcare to do an assessment and consultation for new CSA's that will be seeking certification as part of the Foster Care initiative. The NCCBH consultants are very familiar with the D.C. system and should be very instrumental in helping to move this major initiative forward. The DMH actively included providers in the residential rate changes. While these changes were difficult for some providers, providers were actively engaged in understanding the policy issues and advising on implementation strategies.

- The DMH took steps with one CSA to enforce regulatory and legal issues – resulting in the decision by this CSA to stop doing business in the District. While this kind of result is painful for all, it does send a clear signal that CSA's must meet core standards in order to do business in the District.

Overall, the working relationship with CSA's has improved. This growing climate of mutual trust and respect will be critical to the next stages of organizational development.

B. Development of Crisis Residential Beds

It appears that DMH has finally come to terms with a local provider who will deliver eight beds for adults needing crisis residential care. It is anticipated that this needed service will begin in mid-late summer of 2004. The DMH has set aside $300,000 in budget support out of 2004 funds.
This crisis residential model will be staffed around the clock so as to handle psychiatric emergencies that do not need inpatient acute care but do need intensive intervention and support. The goal is to divert admissions that are currently going to St. Elizabeths or other acute care hospitals. The authorization for use of these beds will come via the Access Helpline at DMH. It is anticipated that 14 days will be the maximum length of stay for individual consumers.

Once this program is in place as a full crisis residential model, it will assist the DMH in evaluating the use of crisis beds at Woodley House – which currently operates eight beds that are staffed at a less intensive level. The open question is whether the Woodley House beds should remain as transitional or become crisis residential. The Access Helpline will hopefully be able to track need and capacity in order to determine future development. In any event, the Court Monitor is pleased to see that this program is finally going to happen.

C. Crisis Services

The issue of crisis services has had discussion in previous Reports to the Court – with the strong recommendation that DMH find an alternative site for CPEP and/or an alternative model for providing crisis service – i.e. providing services in a mobile fashion. The DMH has had considerable discussion about this issue and has already moved to create an additional mobile crisis team for children and youth (via the NOFA that is currently out to potential providers). This second child/youth mobile team should begin by late summer 2004. The DMH has also signaled – as part of the acute care options discussion – its intent to make major changes in the adult crisis model in the upcoming year. The stated intent is to move to a mobile crisis model as the primary mode of crisis intervention. For local hospitals, this would mean that mobile crisis teams would come to the Hospital Emergency Department on a 24/7 basis to assist with the intervention, disposition and potential transportation of identified consumers who need crisis mental health services. This model would then replace the current model for CPEP.

There are many issues which remain prior to implementing this major change. At the time of this Report, it is not yet clear how DMH will proceed on the specifics of this plan. Issues surround: a) the process and standards by which to select the provider of this new model; b) the intersect between this planning and the new acute care development; c) the need to develop extended observation beds (up to 72 hours) for persons needing stabilization but not inpatient admission and; d) a clear transition plan that is communicated broadly to providers, law enforcement, and the general community.

The Court Monitor recognizes the magnitude of the changes that are being contemplated in the whole acute care/crisis arena. These efforts will take major commitment on the part of DMH leadership – which is already stretched on many other fronts. Nevertheless, as noted in this Report, now is the time to move on these issues and it would certainly appear that the success of the acute care model will require major changes to the existing crisis program. Hence, the Court Monitor is very supportive of the recent pronouncements and commitment to make these changes (acute care and crisis) early in the 2005 fiscal year.

V. Recommendations

Based on the findings in this Report, the Court Monitor makes the following recommendations:

A. The DMH should develop a clear plan for ways in which to promote accelerated understanding, practice and internal measurement of the CSR systems of care model. Ideally said plan would include specific responsibility at the Authority level for these functions. This plan should be discussed with the Court Monitor to establish agreed upon connectivity between these efforts and the HSO review process.

B. This Report has identified several major Court-ordered Plan requirements that are each very time-sensitive. These include: 1) Congressional passage of the Ervin Act; 2) the resolution of FY 2005 Budget issues; 3) the active implementation of both the acute care plan and the crisis plan. The Court Monitor requests that the DMH provide monthly written updates on the progress of these efforts.

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 TO THE COURT were served by first class mail, postage prepaid, this 22nd day of July, 2004 upon:

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