

District of Columbia

UNIFORM APPLICATION
FY 2008 - STATE PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 08/20/2007 - Expires 08/31/2008

(generated on 8-30-2007 6.29.58 PM)

Center for Mental Health Services
Division of State and Community Systems Development

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane. Rockville. MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

Table of Contents

State:
District of Colum

Face Page	pg. 4
Executive Summary	pg. 5
Certifications	pg. 6
Set-Aside For Children Report	pg. 17
MOE Report	pg. 18
Council List	pg. 20
Council Composition	pg. 24
Planning Council Charge, Role and Activities	pg. 26
Public Comments on State Plan	pg. 35
Adult - Overview of State's Mental Health System	pg. 36
Adult - Summary of Areas Previously Identified by State as Needing Attention	pg. 38
Adult - New Developments and Issues	pg. 40
Adult - Legislative Initiatives and Changes	pg. 45
Adult - Description of Regional Resources	pg. 48
Adult - Description of State Agency's Leadership	pg. 50
Child - Overview of State's Mental Health System	pg. 53
Child - Summary of Areas Previously Identified by State as Needing Attention	pg. 56
Child - New Developments and Issues	pg. 59
Child - Legislative Initiatives and Changes	pg. 64
Child - Description of Regional Resources	pg. 66
Child - Description of State Agency's Leadership	pg. 68
Adult - Service System's Strengths and Weaknesses	pg. 70
Adult - Unmet Service Needs	pg. 76
Adult - Plans to Address Unmet Needs	pg. 86
Adult - Recent Significant Achievements	pg. 89
Adult - State's Vision for the Future	pg. 93
Child - Service System's Strengths and Weaknesses	pg. 96
Child - Unmet Service Needs	pg. 97
Child - Plans to Address Unmet Needs	pg. 99
Child - Recent Significant Achievements	pg. 100
Child - State's Vision for the Future	pg. 101

Planning Council Letter for the Plan	pg. 240
Appendix A (Optional)	pg. 241
Adult - Transformation Efforts and Activities in the State in Criteria 1	pg. 136
Adult - Estimate of Prevalence	pg. 138
Adult - Quantitative Targets	pg. 157
Adult - Transformation Efforts and Activities in the State in Criteria 2	pg. 158
Adult - Outreach to Homeless	pg. 159
Adult - Rural Area Services	pg. 164
Adult - Older Adults	pg. 166
Adult - Transformation Efforts and Activities in the State in Criteria 4	pg. 168
Adult - Resources for Providers	pg. 170
Adult - Emergency Service Provider Training	pg. 179
Adult - Grant Expenditure Manner	pg. 181
MHBG Transformation Expenditures Reporting Form	pg. 184
Adult - Goals Targets and Action Plans	pg. 186
Child - Establishment of System of Care	pg. 212
Child - Available Services	pg. 213
Child - Transformation Efforts and Activities in the State in Criteria 1	pg. 214
Child - Estimate of Prevalence	pg. 215
Child - Quantitative Targets	pg. 216
Child - Transformation Efforts and Activities in the State in Criteria 2	pg. 217
Child - System of Integrated Services	pg. 218
Child - Geographic Area Definition	pg. 219
Child - Transformation Efforts and Activities in the State in Criteria 3	pg. 220
Child - Outreach to Homeless	pg. 221
Child - Rural Area Services	pg. 222
Child - Transformation Efforts and Activities in the State in Criteria 4	pg. 224
Child - Resources for Providers	pg. 225
Child - Emergency Service Provider Training	pg. 226
Child - Grant Expenditure Manner	pg. 227
Child - Goals Targets and Action Plans	pg. 228

FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

 FY2008 **FY 2008-2009** **FY 2008-2010**

STATE NAME: District of Columbia

DUNS #: 014384031

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Mental Health

ORGANIZATIONAL UNIT: Office of the Director

STREET ADDRESS: 64 New York Avenue, NE 4th Floor

CITY: Washington

STATE: DC

ZIP: 20002

TELEPHONE: 202-673-2200

FAX: 202-673-7053

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Stephen T. Baron TITLE: Director

AGENCY: Department of Mental Health

ORGANIZATIONAL UNIT: Office of the Director

STREET ADDRESS: 64 New York Avenue, NE 4th Floor

CITY: Washington

STATE: DC

ZIP CODE: 20002

TELEPHONE: 202-673-2200

FAX: 202-673-7053

III. STATE FISCAL YEAR

FROM: 10/01/2007

TO: 09/30/2008

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Anne Sturtz TITLE: Deputy Director, Office of Strategic Planning, Policy & Evaluation

AGENCY: Department of Mental Health

ORGANIZATIONAL UNIT: Office of Strategic Planning, Policy & Evaluation

STREET ADDRESS: 64 New York Avenue, NE 5th Floor

CITY: Washington

STATE: DC

ZIP: 20002

TELEPHONE: 202-671-4074

FAX: 202-673-7053

EMAIL: anne.sturtz@dc.gov

District of Columbia

Executive Summary

Please respond by writing an Executive Summary of your current year's application.

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2008

I hereby certify that District of Columbia agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State¹ will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2008, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

21. The term State shall hereafter be understood to include Territories.

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")

(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.

(C) 24-hour-a-day emergency care services.

(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.

(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;

(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and

(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:

(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and

(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;

(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

- (2) A condition under subsection (a) for a Council is that:
- (A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
 - (B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

- (1) to provide inpatient services;
- (2) to make cash payments to intended recipients of health services;
- (3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
- (4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
- (5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

- (1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
 - (2) the recipients of amounts provided in the grant.
- (b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
- (c) The State will:
- (1) make copies of the reports and audits described in this section available for public inspection within the State; and
 - (2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

- (a) The State will:
- (1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
 - (B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
 - (2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
 - (3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section
- (b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

~~XXXXXX~~
Stephen T. Baron, Director

Date

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about--
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
 Office of Grants Management
 Office of the Assistant Secretary for Management and Budget
 Department of Health and Human Services
 200 Independence Avenue, S.W., Room 517-D
 Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under-

signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children’s services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children’s services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director	
APPLICANT ORGANIZATION Department of Mental Health		DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action: <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. Status of Federal Action <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____
4. Name and Address of Reporting Entity: <div style="display: flex; justify-content: space-between;"> Prime Subawardee </div> <div style="text-align: right; margin-top: 10px;"> Tier _____, if known: </div> <div style="margin-top: 20px;"> Congressional District, if known: </div>		5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, if known:
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, if applicable: _____	
8. Federal Action Number, if known:	9. Award Amount, if known: \$ _____	
10. a. Name and Address of Lobbying Entity <i>(if individual, last name, first name, MI):</i>	b. Individuals Performing Services <i>(including address if different from No. 10a.)</i> <i>(last name, first name, MI):</i>	
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____	
Federal Use Only:		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age;
- (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director	
APPLICANT ORGANIZATION Department of Mental Health		DATE SUBMITTED

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY X

Federal FY _____

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2006	Estimate/Actual FY 2007
<u>\$6429000</u>	<u>\$16059755</u>	\$

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY X

Federal FY _____

State Expenditures for Mental Health Services

Actual FY 2005	Actual FY 2006	Actual/Estimate FY 2007
<u>\$94,017,628</u>	<u>\$88,624,509</u>	\$_

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

TABLE 1.**List of Planning Council Members**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Awosika, Samuel O.	Consumers/Survivors/Ex-patients(C/S/X)	DMH/DC CSA, Office of Consumer Affairs	2016 "D" Street, NE, Apt. #2 Washington,DC 20001 PH:202 671-4189 FAX:202 671-1210	samuel.awosika@dc.gov
Blake, Mary	Consumers/Survivors/Ex-patients(C/S/X)		2515 13th Street, N.W. Apt. #410 Washington,DC 20009 PH: FAX:	
Bonds, Lorry	State Employees	Housing	1133 North Capitol Street, NE Suite 242 Washington,DC 20002 PH:202-535-2737 FAX:202-535-1102	lbonds@dchousing.org
Carter, Merita E.	State Employees	Other	825 N Capitol Street NE Suite 8116 Washington,DC 20002 PH:202-442-5640 FAX:202-442-5602	merita.carter@k12.dc.us
Daniels, Ted	State Employees	Vocational Rehabilitation	810 First Street, NE 10th Floor Washington,DC 20002 PH:202-442-8419 FAX:202-442-8742	ted.daniels@dc.gov
Ellison, Joyce	Family Members of adults with SMI		3936 Clay Place, NE Washington,DC 20019 PH:202-396-4384 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Galbis, Ricardo	Providers	Andromeda Transcultural Mental Health Center	1843 S Street, NW Washington,DC 20009 PH:202-291-4707 FAX:202-723-4560	galbisb@aol.com
Griffin, Thyra	Family Members of Children with SED		314 34th Street, NE Washington,DC 20019 PH:202-388-4720 FAX:202-388-8340	
Holliday, Bertha G.	Others(not state employees or providers)		1719 First Street, NW Washington,DC 20001 PH:202-336-6035 FAX:202-336-6040	bholliday@apa.org
Holt, Maude R.	State Employees	Medicaid	825 North Capitol Street, NE Room 4300 Washington,DC 20002 PH:202-724-7491 FAX:202-478-1397	maude.holt@dc.gov
Jackson, Laureen	Consumers/Survivors/Ex-patients(C/S/X)		4620 Hillside Road, SE Washington,DC 20019 PH:202-582-1258 FAX:	
Lesansky, Henry R.	State Employees	Criminal Justice	1923 Vermont Avenue, NW Suite N121 Washington,DC 20001 PH:202-671-2066 FAX:	henry.lesansky@dc.gov

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Massey, Peggy	State Employees	Social Services	64 New York Avenue, NE 6th Floor Washington,DC 20002 PH:202-671-4346 FAX:202-279-7014	peggy.massey@dc.gov
Reaves, Juanita	State Employees	Mental Health	64 New York Avenue, NE 4th Floor Washington,DC 20002 PH:202-673-7597 FAX:202-673-3225	juanita.reaves@dc.gov
Simpson, Senora	Family Members of Children with SED		323 Quackenbos Street, NE Washington,DC 20011 PH:202-529-2134 FAX:	ssimps2100@aol.com
Smith, Effie	Consumers/Survivors/Ex-patients(C/S/X)		461 H Street, NW #919 Washington,DC 20001 PH:202-408-1817 FAX:	esmith@can-dc.org
Smith, Lynne M.	Family Members of adults with SMI		921 French Street, NW Washington,DC 20001 PH:202-412-3999 FAX:	lynne.smith@dc.gov
Smith-Haynie, Jessica	Others(not state employees or providers)		1514 Neal Street, NE Washington,DC 20002 PH:202-397-2261 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Wheeler, Burton E.	Others(not state employees or providers)		3800 25th Street, NE Washington,DC 20018 PH:202-468-5607 FAX:202-392-1014	burton.globalbiz@gmail.com

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	19	
Consumers/Survivors/Ex-patients(C/S/X)	4	
Family Members of Children with SED	2	
Family Members of adults with SMI	2	
Vacancies(C/S/X and Family Members)	0	
Others(not state employees or providers)	3	
TOTAL C/S/X, Family Members and Others	11	57.89%
State Employees	7	
Providers	1	
Vacancies	0	
TOTAL State Employees and Providers	8	42.11%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

The individuals listed as family members of children with SED are also family members of adults with SMI but are only counted as family members of children. One individual also has a child/youth with SED.

District of Columbia

Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

reviewing plans and submitting to the State any recommendations for modification
serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,
monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.

the role of the Planning Council in improving mental health services within the State.

In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III.

During FY 2007, the District of Columbia State Mental Health Planning Council (D.C. SMHPC) continued initiatives aimed at fulfilling its local and federal mandates. The D.C. SMHPC engaged in a number of activities through its individual members and as a collective body in an effort to improve mental health services for District residents.

Plan Review and Related Activities

The D.C. SMHPC activities related to the review of the FY 2007 Community Mental Health Services Block Grant include:

- The Council's Interim Chair served as a member of the District's team and provided information on the Council's review and comments on the FY 2007 Block Grant and responded to reviewers' questions at the FY 2007 Community Mental Health Services Block Grant Regional Consultative Peer Review held in October 2006 in Philadelphia, PA. The Council was briefed on the review process and issues discussed.
- The Council's recommendations for project funding were accepted that included the funding of three non-DMH projects in FY 2007 for adult consumers with serious mental illness (consumer choice awards, training/entrepreneurship/employment in the arts, live-in Peer Support Specialist for transitional housing program), and setting aside funding for an Older Adult Initiative and Transition Age Youth Initiative.
- The Council developed an expense report and a summary of activities and accomplishments for inclusion in the District's FY 2006 Community Mental Health Services Block Grant Progress Implementation Report.
- The Council reviewed and critiqued the District's FY 2006 Community Mental Health Services Block Grant Progress Implementation Report including submission of comments to the Substance Abuse and Mental Health Services Administration (SAMHSA).
- The Council is represented on the DMH Crisis/Emergency Services Planning Work Group that began in February 2007 and reviewed the Draft Interim Report developed in July 2007.
- The Council participated in the District of Columbia Block Grant Monitoring Site Visit that occurred March 27-29, 2007. The Council's meeting with the monitors was March 28, 2007. The Council also received the Draft Mental Health Block Grant Monitoring Report for review and comment.
- In order to remain compliant with the federal mandate for the composition of planning councils, the Council conducted a Membership Survey that resulted in a new Consumer Advocate and three new Government Agency Representatives.
- Two Council members attended the SAMHSA sponsored workshop for planning councils, "Making the Mental Health System Work for Older Adults with Mental Illness," April 3-4, 2007.
- The Council reviewed the District's FY 2007 Block Grant Modification Proposal (due to a reduction in the federal program) and forwarded a letter to SAMHSA expressing concerns about the reductions over the past several years.
- The Council developed a Letter of Support for the Data Infrastructure Grant (DIG) Application.
- The Council reviewed the quarterly reports submitted by the FY 2007 Block Grant funded projects.

- The Interim Chair represented the Council at the 2007 Joint National Conference on Mental Health Block Grant and National Conference on Mental Health Statistics.
- The Department of Mental Health (DMH) is planning to fund a Consumer Wellness activity in FY 2008. On July 31, 2007 the Council sponsored a daylong Workshop on Consumer Operated Programs conducted by Jean Campbell, Ph.D. that included a networking lunch. It was well received by the consumers, providers, advocates and DMH staff who participated. The Final Report, "On Our Own Together: A Workshop on Peer-Run Service Programs," was received on August 21, 2007.
- The Council revised the project submission announcement and initiated the Request for Projects for funding consideration under the FY 2008 Block Grant. The Council reviewed and critiqued a total of 17 project proposals; 12 were submitted by consumer, family member and community-based organizations, and five (5) were submitted by DMH programs. The Council recommended funding seven (7) of the proposed projects, also continuing to fund the Council, setting aside funds for Child/Youth and Family Initiatives, and adding funds for the Older Adult and Transition Age Youth Initiatives. The DMH Director accepted all of the Council's recommendations.
- The Council planned the FY 2007 annual mental health conference.

Advocacy Role

The D.C. SMHPC continued to advocate on behalf of children/youth with serious emotional disturbances and their families, as well as adults with serious mental illness. Council members sit on boards and/or are members of organizations that address issues and concerns related to services for children/youth and their families, adult consumers, family members, individuals who are homeless, protection and advocacy issues, health care policy, and others. The D.C. SMHPC has addressed many of these concerns through its review of the Community Mental Health Services Block Grant and other DMH initiatives, and the development of public awareness and education activities through its annual mental health conference.

During FY 2007, as previously referenced under the list of activities, the Council:

- 1) participated on the DMH Crisis/Emergency Services Planning Work Group,
- 2) continued the solicitation of projects for funding consideration under the Block Grant to consumer, family member and community organizations,
- 3) participated in DMH, District and federal initiatives including the Older Adult Workshop,
- 4) participated in consumer activities,
- 5) served on DMH advisory bodies and committees,
- 6) sponsored a Workshop on Consumer Operated Programs, and
- 7) submitted a Letter of Support for the DIG Application.

Monitoring, Reviewing, and Evaluating Allocation and Adequacy of Mental Health Services

The Council fulfills its role related to participation in system planning and monitoring through member involvement on planning bodies including committees and task forces, and its review and critique of the District's State Mental Health Plan and associated activities. Members serve on the DMH Partnership Council, a child/youth coalition,

family member groups, protection and advocacy, homeless services and other advocacy organizations.

The Council members have participated in a number of DMH planning activities through various forums. These include budget planning and priority populations development activities through the DMH Partnership Council, development of housing initiatives through the Housing Task Force, review of the Court Monitor reports through the Stakeholders Coalition, conduct of the Adult and Child/Youth Community Services Reviews, plans for the new Saint Elizabeths Hospital, and attendance at the DMH Program and Budget Hearings before the District Council.

Public Education Role

During FY 2007, the SMHPC planned and will convene the Seventh Annual Judge Aubrey E. Robinson, Jr. Memorial Mental Health Conference on September 26, 2007. The theme is "Recovery Through the Ages: Trauma Informed Care." Three panels will be convened during this daylong event. They panel topics include: Trauma Knowledge Utilization Project, Service Specific Issues (gender services), and Service Integration Issues (cross agency). District Councilmembers will moderate sessions.

Consumers, family members, providers, students, advocates, and others will attend the conference. The annual mental health conference is viewed as a means of advocacy on behalf of children/youth, families and adults, as well as means of public education.

Other Council Activities

The D.C. SMHPC members have also participated in national planning initiatives. These include: 1) attending the Seventeenth Annual Conference on State Mental Health Agency Services Research, Program Evaluation, and Policy (National Association of State Mental Health Program Directors Research Institute, Inc.), and 2) attending the 2007 Joint National Conference on the Mental Health Block Grant and Mental Health Statistics.

Directions for FY 2008

During FY 2008, the D.C. SMHPC will continue to more clearly define and strengthen its role relative to system planning, monitoring and evaluation of services and resource allocation in general, and the Community Mental Health Services Block Grant initiatives and funded projects in particular. The Council will also: 1) continue to encourage consumers, family member (serving adults and/or children/youth) and community organizations to submit project proposals for funding consideration under the Block Grant, 2) build its membership including consumer advocate, family members, and various community stakeholders, 3) hold a retreat, and 4) convene the annual mental health conference.

STATE MENTAL HEALTH PLANNING COUNCIL LETTER

District of Columbia

Public Comments on State Plan

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

District of Columbia

Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

The Department of Mental Health (DMH) adult system of care includes the Mental Health Authority, Saint Elizabeths Hospital, and certified agencies (including both the publicly funded District of Columbia Community Services Agency (DCCSA) and a group of certified private non-profit mental health agencies). Saint Elizabeths Hospital includes both the forensic services of the John Howard Pavilion and the civil hospital.

DMH has entered into interagency agreements with a number of other District agencies, including the Department of Health, Medical Assistance Administration (the Medicaid agency); the Department of Health, Addiction Prevention & Recovery Administration; the Department of Human Services (homeless services), the Department of Disability Services (mental retardation and developmental disabilities and rehabilitation services); the Department of Corrections, the Child and Family Services Agency (child welfare), the Department of Youth Rehabilitation Services (juvenile justice), the Housing Authority and the Housing Finance Agency with regard to the provision of mental health services or mental health support services.

District of Columbia

Adult - Summary of Areas Previously Identified by State as Needing Attention

Adult - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

See discussion in Section II of Adult Plan. Also see discussion about current activities in Section III. Adult Plan. Subsection 1.

District of Columbia

Adult - New Developments and Issues

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

Supported Housing

- In November 2006 DMH and the D.C. Housing Authority (DCHA) entered into a memorandum of understanding for the administration of the Housing Bridge Subsidy Program. During FY 2007, DMH will transfer no more than \$5.9 million dollars to DCHA to certify and recertify DMH deemed eligible consumers for participation in the DMH Housing Subsidy Program, as well as inspect properties, enter into Housing Assistance Payment contracts with landlords, including uphold DMH negotiated contract rent, and make rental subsidy payments to landlords, and provide all related documentation.
- In March 2007 DMH and the Department of Health (DOH) Administration for HIV Policy and Programs (AHPP) entered into a memorandum of understanding to provide supported housing for individuals in recovery from mental illness with human immunodeficiency virus (HIV). AHPP transferred \$63,000 to DMH to provide housing subsidies to a minimum of seven consumers with HIV during FY 2007.
- In FY 2006 DMH transferred \$10.5 million in capital funds to the DC Housing Finance Agency (DCHFA) for housing development and expansion. In August 2006 a legal issue was raised and the execution of projects is on hold pending the opinion of the Bond Council. DMH has continued dialogue with and receive proposals from developers.

Supported Employment

- In March 2007 DMH and the Department of Human Services (DHS) Rehabilitation Services Administration (RSA) entered into a memorandum of understanding to work collaboratively to expand opportunities for supported employment services for individuals in recovery from mental illness. RSA will contribute \$100,000 to the DMH Evidence-Based Practice Supported Employment Initiative (EBPSEI). DMH will provide \$19,249 to fund 25% of the RSA Supported Employment Supervisor's time devoted to the EBPSEI.

Homeless Services

- In January 2007 DMH and the Department of Human Services (DHS) entered into a memorandum of understanding under which DHS transferred funds to DMH for the provision of mental health services to homeless residents of the DHS Homeless Services Program. DMH issued a request for proposals in March 2007. The deliverables included psychiatric, medication, and case management services in low barrier shelters in the District. The team will consist of a team leader, psychiatrist, and case workers. This service will work closely with the DMH Homeless Outreach Program. A contract has been awarded to Anchor Mental Health Services, which is part of Catholic Charities.

Forensic Services

- A draft MOU between DMH and the Department of Corrections (DOC) was completed in April 2007 to address the continuity of services and linkage of individuals with mental illness who are incarcerated in D.C. Jail. DMH receives the daily inmates admission lists that are run through the e-Cura system to identify individuals known to DMH. The names of those individuals known to DMH who are active, had a prior history with DMH, discharged and/or seen at CPEP are shared with the mental health program at the jail. Medical and psychiatric information is shared with the mental health program to ensure treatment while incarcerated. Jail liaisons from six agencies work closely with the D.C. Jail staff. Individuals with mental illness who are scheduled within the next 60 days for release are seen and services are provided to facilitate their connection to continued services upon release. Upon release, DOC's mental health provider agrees to provide inmates with a mental illness a 7 day supply of medications. DMH's CSAs have agreed to have the inmate be seen by a community psychiatrist within 7 days of their release from the jail. DMH is awaiting DOC's response to the draft.
- DMH and the Metropolitan Police Department (MPD) implemented a 90 day pilot program to collaborate services in Police Service Area (PSA) 101 with the DMH Homeless Outreach Team (HOT) and MPD. The goal is for the HOT to be available to handle calls that involve individuals with mental illness who may not be involved in criminal behavior but MPD has received a 911 call. The HOT staff would evaluate, assess and connect these persons to appropriate mental health services and free MPD officers to handle criminal calls. Some collaboration and training will be needed with Fire and Emergency Medical Services (FEMS) and the Office of Unified Commands (receive all 911 calls).

Co-Occurring Substance Abuse

- In March 2006 DMH and the Department of Health (DOH) Addiction Prevention and Recovery Administration (APRA) entered into a memorandum of understanding to provide services for persons who have both a mental illness and a substance abuse issues. In October 2006 this agreement continued as the result of the FY 2007 Budget Support Act of 2006 that mandates that DMH make available \$824,000 for substance abuse vouchers utilizing the APRA Choice in Drug Treatment Program, and \$100,000 for mental health services at the APRA Detoxification Facility.

▪ Planning Initiatives

Biennial Language Access Plan (BLAP)

The DMH 2007-2008 Biennial Language Access Plan (BLAP) was established to provide greater access and participation in public services, programs and activities for District residents with limited or no-English proficiency (LEP/NEP) that access services and information through the Department. "Access and participate" means to

be informed of, participate in, and benefit from public services, programs, and activities offered by DMH at a level equal to English proficient individuals. Removing language barriers is critical to achieving access to needed services. In accordance with Section 5(a) (2) of the Language Access Act of 2004, each Language Access Plan (LAP) shall be updated on a biennial basis or every two years. The BLAP will be reported to and is subject to the review of the Mayor and City Administrator.

Language services offered through DMH services and/or programs include:

- In their order of frequency, primarily Spanish, Vietnamese, Amharic, French and Chinese are the types of languages used to deliver services to DMH's LEP/NEP consumers who are receiving mental health services.
- Initially, DMH makes all effort to provide services utilizing its bilingual mental health professional staff. DMH also utilizes contracted bilingual interpreters and telephonic interpreters (especially on unanticipated emergency and walk-in cases) to facilitate the delivery of its mental health services to the LEP/NEP communities.
- In addition to reimbursement agreements with its certified Core Services Agencies (CSAs) for Medicaid related services, DMH also contracts with the following organizations to facilitate language access to its LEP/NEP consumers: ALS/Legal, Inc. and Language Doctors, Inc. to provide face-to-face interpretation services; Multicultural Community Services, Inc. for translating vital documents; and Language Line Services for telephonic interpretation services. Primarily, in the past three years, face-to-face and telephonic interpretations were made in the following languages: Amharic, Spanish, Vietnamese and Mandarin.

Expediting Access to Benefits for Individuals Who Are Homeless

Many adults who are homeless, particularly those who are chronically homeless and have mental illness and/or other disabilities, do not receive Social Security Administration (SSA) benefits. In October 2006 DMH launched D.C. SOARS (SSI/SSDI Outreach, Access and Recovery Services). The D.C. SOARS Project attempts to facilitate the acquisition of benefits for individuals who are homeless. This project is overseen by the DMH Homeless Services Director. DMH and local provider staff participated in a four day train-the-trainer program. This was followed by a two day District-wide planning session. A training for approximately 25 providers was completed as of March 2007. Three additional trainings are planned in the upcoming year to facilitate access to benefits for individuals who are homeless and are often unable to complete the application process on their own.

Crisis/Emergency Planning

The Crisis/Emergency Planning Work Group was created in February 2007 under the leadership of the Director of DMH. This diverse body includes representatives from the court, metropolitan police, emergency medical services, public and private mental health providers, homeless services providers, health, mental health and other agencies, consumers, and advocates. The charge of the group is to review the current crisis/emergency system,

other state models, and develop a comprehensive plan for the delivery of this service. It is anticipated this Plan will be developed by fall 2007.

District of Columbia

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

The DMH legislation and rulemaking activities during FY 2007 are depicted in the chart that follows:

**DEPARTMENT OF MENTAL HEALTH
LEGISLATION AND RULEMAKING ACTIVITY
FY 2007**

No.	NAME OF BILL/RULE	BILL OR RULE NUMBER	Substantive Provisions	DATE PUBLISHED	EFFECTIVE DATE
1.	Comprehensive Psychiatric Emergency Program Long Term Ground Lease Emergency Act of 2006	A16-0529	Authorizes the District to enter into a long-term ground lease with Greater Southeast Hospital for a building to operate DMH's psychiatric emergency program. Also includes definitions of comprehensive psychiatric emergency program and extended observation beds. Includes an exemption from the CON laws for community-based mental health programs licensed, certified or operated by DMH.	11/9/06	12/4/06
2.	Comprehensive Psychiatric Emergency Program Long Term Ground Lease Temporary Act of 2006	A16-0545 LT16-0298	Authorizes the District to enter into a long-term ground lease with Greater Southeast Hospital for a building to operate DMH's psychiatric emergency program. Also includes definitions of comprehensive psychiatric emergency program and extended observation beds. Includes an exemption from the CON laws for community-based mental health programs licensed, certified or operated by DMH.	11/9/06	11/14/06
3.	Comprehensive Psychiatric Emergency Program Long Term Ground Lease Emergency Amendment Act of 2007	A17-0080	Amends the Comprehensive Psychiatric Emergency Program Long Term Ground Lease Temporary Act of 2006 to repeal the provisions requiring the District to negotiate with Greater Southeast Community Hospital. All other terms and conditions remain the same	7/10/07	7/26/07
4.	Amendments to CBI rules	22A DCMR Chapter 34	DMH developed rules to amend the standards governing the provision of CBI services, to facilitate the delivery of Multi-systemic therapy and intensive in-home services.	11/10/06	11/10/06
5.	Rules to Certify Officer-Agents	22A DCMR Chapter TBD	DMH is developing rules that set forth the qualifications and training required for a clinician to serve as an officer-agent for purposes of involuntarily detaining an individual pursuant to the requirements of the District's civil commitment laws.	In draft	In draft
6.	Amendments to Grantmaking Rules	TBD	DMH is revising the rules governing mental health grants to authorize making sole source grants.	In draft	In draft
7.	Amendments to rules governing the use of restraint and seclusion	TBD	DMH is revising the rules governing the use of restraint and seclusion to reflect recent changes to the federal regulations	In draft	In draft

The Council of the District of Columbia also approved legislation authorizing pay increases for non-union staff working at DMH (this includes non-union staff working at Saint Elizabeths Hospital and the DCCSA). The legislation brings the salaries at DMH in line with the District of Columbia's salary scales and will facilitate recruiting of managers and supervisors. This legislative activity is not reflected in the table presented.

District of Columbia

Adult - Description of Regional Resources

Adult - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

Not applicable to the District of Columbia

District of Columbia

Adult - Description of State Agency's Leadership

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

The DMH has assumed a leadership role in services coordination through a number of initiatives. There has been a concerted effort to forge strong partnerships with consumer and family networks; District as well as federal agencies; public and private providers; academic and faith-based communities.

Co-Occurring Disorders

The DMH partnered with APRA to develop a comprehensive service delivery system for individuals with mental illness and co-occurring substance abuse disorder (Comprehensive, Continuous, Integrated System of Care model). National experts have provided training and technical assistance in the model's implementation to the DMH provider network and training is has also been provided by the Train-the-Trainer group. In FY 2005, DMH was awarded a 5-year Co-Occurring Disorders State Incentive Grant (COSIG) for \$3.4 million. This grant will serve as the mechanism to implement the integrated system of care model. The DMH and APRA are working closely to develop the infrastructure to improve the service system for persons with mental health and substance abuse issues through implementation of the COSIG. The DMH also participates on the Mayor's Interagency Task Force on Substance Abuse Prevention, Treatment and Control.

Supported Housing

The DMH formed partnerships with the public and private sectors and community organizations in order to implement the objectives in the Housing Business Plan. One outcome is Supportive Housing Initiative and Pilot Demonstration Program adopting best practices and other state models in order to obtain permanent housing for persons with serious mental illness. The DMH is implementing two housing related grant projects: 1) homeownership, education, and economic self-sufficiency, and 2) removal of barriers and increase homeownership for persons with mental illness and/or mental retardation and developmental disabilities, and youth aging out of the foster care system.

Supported Employment

The DMH in partnership with the Rehabilitation Services Administration (RSA) is implementing the Supported Employment Initiative. The academic and foundation partners provide technical assistance for the annual web-based training course, and evidence-based practices project. Six demonstration sites are implementing the Individual Placement and Support (IPS) model. In FY 2008, current plans would add two providers with one focusing on Transitional-Age-Youth.

Homeless Services

The DMH partnered with APRA and the Department of Human Services to operate the Sobering Station (during hypothermia season) for homeless intoxicated men and women. The DMH also initiated the "Housing First" program for adult consumers who are chronically homeless with serious mental illness. In FY 2005, the DMH Pathways to Housing project was awarded a Department of Housing and Urban Development (HUD) Chronic Inebriates Grant. The goal of this two year grant is to provide housing to 52 individuals who are chronically homeless, and addicted to alcohol. In FY 2006,

Pathways operated to ACT teams. Also in FY 2006, DMH began implementation of the outreach plan for serving children/youth and families who are homeless.

Crisis Emergency Services

In February 2007, DMH established the Crisis Emergency Services Planning Workgroup that includes representatives from the Superior Court, the Metropolitan Police Department, the Fire and Emergency Services Department, APRA, the Office of Unified Communications (911), crisis stabilization bed providers, consumers, advocates, providers and stakeholders. The purpose of the Crisis Emergency Services Planning Workgroup is to review and make recommendations for changes to the District's system for delivering psychiatric emergency services. A plan is expected to be completed in early FY 2008.

District of Columbia

Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

The establishment of the Department of Mental Health (DMH) marked a major milestone in efforts aimed at restructuring mental health services for children/youth and families in the District of Columbia. The termination of the Receivership and transition to a Court-appointed Monitor was accompanied by the development of Exit Criteria and Operational Definitions that included the assessment of the scope and efficacy of the child/youth service delivery system. Achieving satisfactory scores on the Exit Criteria measures will provide not only a baseline for quality improvement, but officially end the Court's decades-long oversight of the delivery system.

The District of Columbia has invested significant resources in the children's System of Care and important collaborations between child-serving agencies have been launched. These collaborations have now evolved into solid partnerships for real-time problem solving and next-stage planning for the evolution of the system of care. Challenges remain, but a history of small successes—implementation of MST and Multidimensional Therapeutic Foster Care—built on braided resources and collaboration means that bigger steps—such as improving accessibility and the efficacy of services and implementing wraparound—are not so daunting. The Mayor and senior city officials maintain a sharp focus on children's well being, which means that children's mental health remains a priority for the Executive and the City Council in the annual budget appropriations cycle.

The dismantling of the CINGS grant provided opportunities for D.C. agencies to build the infrastructure needed for a systems approach to service delivery and for a real partnership with the community-families, providers and community organizations such as the Family Support Collaboratives. Although the Deputy Mayor's role was not refilled by the new Mayor, the Office of the City Administrator takes a very active role in child and youth services; for example: two of the Administrator's senior analysts participate in the wraparound workgroup designing the pilot; the Administrator's office is hosting the Annie E. Casey-funded visit of Wraparound Milwaukee to D.C. in September 2007; and has assumed the Chair's role of the Interagency Steering Committee that oversees SOC development.

With carryover funds from the CINGS SOC grant, nine hundred and twenty thousand dollars (less ten percent in administrative fees) was outsourced to family and provider organizations through the Child/Youth Investment Trust. The Trust was established by Executive Order of the previous Mayor to support child-serving agencies by managing large grants and competitive procurements that often get bogged down in agency contracting bureaucracies. The Trust's staff moves dollars efficiently and has a well-run oversight mechanism with on-line vendor reporting requirements to assure that grant dollars are appropriately spent and disbursements match services performed.

Several important program initiatives were funded with these awards:

Social marketing and children's coalition:

An award to *Positive Nature*, a DMH specialty provider, supported a two-day conference for families, advocates and providers to share common interests, needs and developments

in the children's system of care. The conference was well-attended and feedback was very positive; carryover dollars will support the conference again in FY 08. In FY 08, funds will also support creation of marketing and educational materials to help families understand how to access mental health services in what is widely regarded as *a very complicated system* by families, advocates and agency staff alike.

Family organization support:

Two awards were given to family organizations to support infrastructure development and programming, such as family support activities. One of the organizations received an additional award for outreach and advocacy initiatives. In addition to stated funding objectives, DMH and its sister agencies hope that these awards, and the activities they support, help to rebuild bridges with the city's family organizations. A new family organization was formed intentionally for the purpose of applying for these grants. It obtained a fiduciary agent and secured status as a 501 C3 organization in order to qualify. The organization has developed a new birth parents support program for CFSA, produced a video for birth parents to help support them in going through the court process, and was recently informed by the State Planning Council that they would receive a grant from the FY 2008 block grant to start a children's therapeutic art program.

Family support workers, coordination and facilitation of family team meetings:

An award was given to the Health Families Thriving Communities Collaborative Council, which made subgrants to two neighborhood Collaboratives, to support paraprofessional family support workers trained in the Cornell model to provide support to families with children in the SOC. The role of these workers has been well-received by all partners in the process. In an effort to embed organization and support of these meetings in the community, the next phase of the grant will support the Collaboratives to train staff in meeting coordination and facilitation, tasks currently performed by DMH SOC staff. As Collaborative staff pick up these roles, DMH staff can be deployed to build competence in these roles in the CSA provider network.

District of Columbia

Child - Summary of Areas Previously Identified by State as Needing Attention

Child - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

Child/Youth Services

The *Dixon v. Fenty* Court Monitor conducts an annual Community Services Review (CSR) to assess overall system performance as well as performance of key domains of service including consumer functioning and consumer satisfaction. *Dixon* requires DMH to achieve an overall system performance score of 80% in both adult and child services to exit the Court Ordered Plan. The 2007 CSR revealed large gaps in the children's system of care, particularly around team formation. The child welfare agency, the Child and Family Services Agency, likewise reflects need for improvement in this domain. A number of factors contribute to the performance gap shared by the two agencies:

(1) The children's system is new and has undergone two dramatic shifts. Since 2000, all children receiving TANF Medicaid were transitioned into Medicaid Managed Care Organizations (MCO) for their mental health services. For MCO-enrolled children, DMH only provides home and community based services under the Medicaid Rehabilitation Option. All other services—counseling/therapy, medication management, diagnostic assessment, case management—are the responsibility of the MCO. This bifurcated system is confusing for families and access questions persist years after the transition. The second major shift occurred in 2005-2006, when about 2,000 children/youth in the child welfare system (carved out of the Medicaid Managed Care system) were transitioned into the public mental health system for care.

(2) These transitions occurred at a time when the children's division was insufficiently built up to manage the transition: exclusive of dedicated System of Care (DC CINGS) grant employees, there were only three FTEs in children's services and they performed RTC monitoring-related functions. With the DMH administrative infrastructure focused on paying providers there were insufficient resources to address substantive access and program needs associated with the transitions. Practice model and model fidelity issues only began to be addressed in the FY 2007 year, concurrent with the allocation of FTE resources to the children's division. This was supported largely through CFSA-transferred or CFSA-related Court-ordered appropriated dollars and redeployed CINGS resources.

(3) The number of children's providers expanded rapidly between 2004 and 2006, which led to the moratorium; there were more providers than children needing services. There was little opportunity to assess unique capabilities and provisions to assure timely access for children referred to these providers for care.

(4) Very few providers in the publicly funded mental health system are trained in the required specialty services for child welfare and juvenile justice populations. When training is provided in these services—such as functional family therapy and trauma-focused cognitive behavioral therapy—high rates of staff turnover coupled with lack of system and organizational mechanisms to sustain the intervention results in chronic service gaps.

(4) No providers in the publicly funded mental health system are currently using the evidence based family/child team model for treatment planning. This is particularly troubling, as the model has such wide utility with multi-agency involved youth and families. The model is used within the city's child welfare system prior to the initial Court disposition hearing and at placement disruptions; it is beginning to take hold within the juvenile justice system for release planning and it is the planning model within the SOC pilot for children/youth the system works to divert from institutional placement. Yet within the community provider network, resources have not yet been committed to embedding the model and thus its evidence is nonexistent. Moving this model into the community and establishing it as the practice model is key to improving child and well being in the child welfare and juvenile justice populations—the principle populations served by the publicly funded mental health system. It is anticipated that implementation of the model, over time, will significantly improve the CSR's team formation scores for both DMH and CFSA (who uses the very similar Quality Service Review [QSR]). In 2008, the children's division staff has directed resources toward training, coaching and related support to begin to embed the child/family team model in the community.

District of Columbia

Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

SAMSHA System of Care Grant.

In FY 2007, *DC CINGS* (SAMHSA System of Care grant) carryover dollars continued to support development of a functional infrastructure for effective system of care (SOC) work. A pilot SOC project began operation in the fall of 2006. Serving approximately 130 children/youth per year, family team meetings serve as the model for planning and resources family needs with a goal of meeting treatment and service needs in the community. Presently, about 50% of youth presented for placement medical pre-certification are diverted, reflecting gaps in community-based services and the fact that youth presenting now at the SOC already have deep-end treatment needs.

The 2006 Mayoral election resulted in reorganization of the Mayoral Cabinet and the reporting structure for child-serving agencies. While the new Mayor elected not to maintain a Deputy Mayor for Children and Youth, child-serving agencies report under a cluster leader in the office of the City Administration. The cluster leader is fully engaged in the system of care work and has designated senior staff to participate in ongoing workgroups on implementing wraparound services.

The largest proportion of CINGS carryover dollars (\$920,000) were moved into the community through a grant to the District's Child/Youth Investment Trust. The Trust oversees the competitive award of five subgrants for: family support and advocacy; community outreach and support; administration of flex funds; social marketing and training; family support worker training and development (to support family/child team process). Over \$200,000 was granted to two family organizations both to provide program support and to help build organizational infrastructure to that D.C. can have a strong, active family support organization working with community and agency partners to build a robust system of care that is meeting family and child needs.

Juvenile Justice.

In January of 2007, DMH withdrew its mental health clinical staff from the juvenile justice facilities run by the Department of Youth Rehabilitation Services (DYRS). Under discussion for some time, the move representing the agencies' agreement that the culture change sought by DYRS required their unitary management of personnel resources and, with implementation of the Missouri model for secured youth and a much reduced committed population, it made sense for DYRS to operate its own clinical teams. To support this initiative, DMH children's staff have worked with DYRS staff to expand opportunities to secure federal match on services at DYRS facilities and to bring DMH providers into facilities to provide services, thus supporting continuity of care and creating relational bridges that increase the likelihood that youth discharged to the community will maintain their therapeutic work with the provider.

Mayor's Partnership for Success Violence Initiative. This interagency program focuses on 50 youth with violent criminal backgrounds, presently released into the community and at risk of re-offending. The NSI Coordinator works with this initiative,

consulting with the Police Youth Division Commander and coordinating referrals for parents and families of these youth.

Child Welfare.

2007 also saw DMH written into the Amended Implementation Plan (AIP) for *LaShawn A*, the class action law suit against D.C.'s child welfare system. The AIP calls for DMH to deliver on a number of elements, including:

- 1) providing sufficient staffing for the children's services division to analyze data, provide intake and service liaison services and perform key program management functions for CFSA-involved youth;
- 2) Selecting a vendor through a competitive procurement process to implement a mobile crisis service and open crisis beds; and
- 3) Select through a competitive procurement process a network of three to five core service agencies that demonstrate capacity, capability and commitment to partner with CFSA and DMH and deliver on a set of access, quality and related service domain standards.

DMH children's services staff has taken the lead in DC's wraparound services initiative. A staff workgroup representing Child-serving Agency Directors, the City Administrator's office, the Family Court and the Medicaid Director is developing program design and implementation elements for a pilot of approximately 30 children to be launched in the spring of FY 2008. DMH has retained a consultant to work with the State Medicaid Director's office to request a waiver from the Centers for Medicare and Medicaid to optimize federal match for case management and services. Under the waiver, the pilot will be expanded to the city's full population of children/youth (including MCO enrolled children) at risk of out-of-home placement.

School-Based Mental Health.

With the D.C. City Council's push for further expansion of the SMHP, it became clear that DMH could no longer sustain a system of hiring clinicians and managing the clinical staff as internal personnel resources. In 2007, planning began for a strategic initiative to further expansion through contracting with child-serving Core Service Agencies. The utility of this model and the potential for billing for the treatment component of the SMHP model will be assessed in the FY 2008 year. Like FY 2005, 2006 and FY 2007, the FY 2008 Budget Support Act provided expansion support for the School Mental Health Program. By the end of FY 2008, the program will operate in six new schools under an outsourcing model, where a Core Service Agency selected through a competitive procurement hires the clinician and DMH retains control over the program design, staff training and development, evaluation and productivity standards. By the end of FY 2008, the program will operate in 48 public schools and public charter schools. Executive and City Council line item budget support in FY 2007 supported IT infrastructure as well as program expansion.

New line item funding for SMHP expansion in FY 2007, also included support for IT infrastructure, funding procurement and customization of a case management system that will replace the current excel spreadsheet which tracks productivity, pre- post-testing scores, satisfaction scores and scales from various screens such as depression screens. The new system supports web-based data entry, eliminating the need for the two-step manual data capture and entry process, thus reducing the likelihood for error. As well, outcomes assessed via the Ohio Mental Health Scales can now be captured on readable paper for system processing and statistical interpretation, replacing the current paper, pencil, manual entry and analysis process.

System of Care Technology Issues.

The District's Office of the Chief Technology Officer (OCTO) became interested in the SOC Project in FY 2007 and committed resources to support customization of its existing software to support a web-based case management system for children/youth in the SOC. The system will be used by staff of all the child-serving agencies, both for treatment planning and documentation of follow up, and it is intended that it will eventually link to the SPIS, so that demographic data can be pulled down into the case plan. The system is currently in its pilot stage and will move into full utilization by the early fall. Once fully operational, the new system allows action plans developed at family team meetings to be captured through the web-based system then transported to a data base which supports follow up monitoring and reporting, capturing any updates to the action plan from agency partners and community organizations providing services and supports under the treatment plan. This system will enable DMH to achieve its objective of assuring that children/youth referred to the SOC receive appropriate services and supports. As well, the ability to systematically capture and analyze data will support identification of gaps in treatment, placements and the overall system much more quickly so remedial actions can be taken.

The SOC pilot is transitioning to the next level with an agency-wide initiative to implement a wraparound pilot for a subpopulation of the SOC population of focus. A workgroup consisting of members of the City Administrator's staff, DMH children's services, CFSA, DYRS and MAA have been working since February 2007 to design the pilot program—expected to serve 25-30 children—and develop a workplan for the pilot and submission of a waiver to expand the pilot to the broader children's population that includes MCO-covered children. The Annie E. Casey Foundation is supporting the effort. Casey funded a six-member team from D.C. to make a site visit to the Santa Cruz SOC site and is bringing representatives from Milwaukee Wraparound to D.C. for a dialogue about their program. A vendor for case management and non Medicaid services and supports will be selected through a competitive procurement scheduled to be let in November 2007. Implementation is planned for April-May 2008.

Assessment of Performance Capability.

By early FY 07, DMH had reached maximum capacity for child/youth providers and attention turned instead to assessing performance capability of the network with respect

to evidence based practices and promising practices relevant to the served population and the fidelity with which those practices were implemented. Access issues were also identified and continue to be addressed on a case-by-case and system wide basis.

District of Columbia

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

See narrative in Adult Plan regarding legislative and regulatory changes affecting the District of Columbia's mental health system.

District of Columbia

Child - Description of Regional Resources

Child - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

Not applicable to the District of Columbia.

District of Columbia

Child - Description of State Agency's Leadership

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

The DMH has the key leadership role in the design and development of the District's System of Care, working with and through a network of formal and informal collaborations with D.C. child-serving agencies, children's advocates, community-based organizations that promote improved services for children and families and providers that deliver services. Focus areas for child/youth services include continued expansion of the School Mental Health Program through a contracted services model and quality improvement and competence building of the delivery system, with particular attention on core competencies for a child welfare population, including trauma assessment and treatment, intensive home and community services and behavioral coaching.

DMH continues to take a leadership role in the development of the children's system of care. Evolving out of the SOC pilot—where family team meetings have been used to bring family-centered, collaborative decision making models into planning for children with deep-end treatment needs—DMH has taken a leadership role with the child-serving agencies and the City Administrator's office to develop and implement a wraparound services pilot and to submit a waiver to CMS to seek federal match for case management and a broader service array.

DMH hosts a bi-monthly Children's Roundtable, whose members consist of children's providers, behavioral health leads of the MCOs and child-serving agency designees, with a focused purpose, which is: drill down into operational processes; eliminate barriers to services; clarifying misperceptions between and among agencies, providers and consumers; share factual information; and produce streamlined, understandable processes that mean children and families are more likely to get the services they need when they need them. Determining that detained DYRS youth could maintain Medicaid eligibility and DMH's identification of local dollar funding mechanism for team meetings and non Medicaid eligible services at DYRS are outcomes of the Roundtable's work.

In FY 2007, DMH completed its third year of the Centers for Medicare and Medicaid Services (CMS) Real Choice Systems Change grant. The grant undertook a comprehensive review of current regulations and cross-agency policy and practices and will set forth a set of specific recommendations to improve transitional support services for young adults aging out of foster care.

Under the School-Based Teen Outreach Program for Suicide (STOP Suicide) Grant, awarded to DMH in FY 2005, FY 2007 saw an additional 181 youth screened in ten public and public charter schools. Through QPR Gatekeeper Training, one hundred forty school staff members were trained on signs and symptoms of suicide. DMH has made application to SAMHSA for a one-year supplemental grant to the STOP Suicide program that would begin October 1, 2007. This grant will support concentrated suicide prevention programming at one D.C. Senior High School.

District of Columbia

Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.

The DMH has continued to further develop the system of care for adults. The evolution of this process has involved developing partnerships with local, federal and community-based agencies, and the introduction of evidenced-based and other best practices.

System Strengths

The DMH adult service system strengths include but are not limited to the following:

- Evidenced-Based Practices- The DMH is implementing evidenced-based practices related to supported employment, medication algorithms, integration of mental health and substance abuse services, and assertive community treatment for persons being discharged from Saint Elizabeths Hospital, being released or diverted from jails and prisons, high users of emergency services, and chronically homeless individuals.
- Supported Housing- The DMH has utilized a number of strategies in order to develop affordable housing options for consumers. These include partnerships with a housing intermediary, the D.C. Housing Authority, and the acquisition of property. The current goal is to develop, in collaboration with the D.C. Housing Finance Agency, 100 affordable housing units per year with DMH capital funds. The DMH is also implementing two grants, one addresses barriers to accessing housing and increasing homeownership for individuals with mental illness and developmental disabilities, and youth aging out of the foster care system; and the other grant is a demonstration project to promote homeownership, education, and economic independence.
- Supported Employment- The DMH has selected six (6) demonstration sites for participation in the Johnson & Johnson-Dartmouth Community Mental Health Program (evidence-based practices). As of July 2007, there were approximately 402 persons engaged in supported employment related services. It was anticipated that during FY 2007, two Supported Employment providers would be added, with one focusing on Transition-Age-Youth (TAY). There were no new providers in FY 2007. A pilot Supported Transition Employment Program was implemented with the Neighborhood Services Initiative after there were no responses to the solicitation for a TAY program. A new general provider will be added in FY 2008.
- Assertive Community Treatment (ACT)- The ACT expansion plan included adding four teams and a second team for the chronically homeless. Three teams were added in FY 2005 (general admissions, co-occurring and developmental disabilities, second homeless team). At the end of June 2006, one of the ACT providers with a team for persons with mental illness and developmental disabilities stopped providing mental health services. Also during FY 2006, a review of the ACT teams began that focused on referrals, capacity, staffing and service delivery. The review continued in FY 2007.
- Newer Generation Antipsychotic Medication- The DMH implemented the Medication Access Project (D.C .MAP) for adults with schizophrenia. The goal is that 70% of these consumers will be prescribed newer generation medications. In 2007, the Court Monitor agreed with DMH that the Department had achieved this goal. The DMH will continue to

monitor this process and is also working with the Medical Assistance Administration (MAA) to monitor prescribing practices associated with psychotropic drugs.

- Co-Occurring Disorders- The DMH, addiction and corrections systems are continuing the implementation of the Comprehensive, Continuous Integrated System of Care (CCISC) co-occurring disorders system model, including training and technical assistance in the model principles. In FY 2005, DMH was awarded a 5-year Co-Occurring Disorders State Incentive Grant (COSIG) to improve the service system for persons with mental illness and substance abuse issues for \$3.4 million. During FY 2006, the project moved forward with implementation of the objectives that include: 1) create an integrated approach to service delivery, 2) establish universal screening, integrated assessment and best treatments, 3) train mental health and substance abuse clinicians and managers for co-occurring disorder (COD) competency, 4) create financial/system incentives for improved performance, along with infrastructure and information system supports for clinicians and service programs to continually improve consumer outcomes and care, and 5) create a learning network and sustainable platform for continuous quality improvement of consumer outcomes. During the first year and a half of this project, tremendous strides have been made related to interagency collaboration among the mental health and addiction system as well as collateral systems. Two primary achievements include: 1) the Co-Occurring Clinical Competency Certificate Training (100 hours) and 2) the establishment of the Judge Aubrey Robinson Institute for Excellence in Public Behavioral Healthcare (learning network that promotes service to science and science to service model).

A promising practice related to co-occurring substance abuse disorder involves provision of mental health services at the Sobering Station (operated during hypothermia season) for intoxicated men and women who refuse a traditional shelter. From the program's inception in FY 2002 through FY 2006, approximately 1,078 different individuals came to the Sobering Station (unduplicated count per year), with about 194 entering detoxification. During 2007, the unduplicated number of persons served was 206 with 11 persons entering detoxification.

- Jail Diversion- The DMH Jail Diversion Initiative is a pre-trial program for individuals with mental health issues that have committed misdemeanor offenses and are provided services through the Options Program (post booking). During FY 2005, DMH received \$750,000 for its overall jail diversion initiative (D.C. Linkage Plus) for capacity building, development and expansion of services. In FY 2006, service expansion included: 1) screening and referral for individuals referred from D.C. Superior Court's Traffic/Community Court, and 2) funding N Street Village (21 bed facility) to provide substance treatment and housing for women pre and post arrest to prevent incarceration and/or recidivism. Also, DMH along with the Criminal Justice Coordinating Council (CJCC) became the recipient of a \$50,000 Bureau of Justice Assistance (BJA) planning grant to develop a strategic plan for persons with serious and persistent mental illness or co-occurring mental health and substance abuse disorders involved in the criminal justice system. The strategic plan will be based on the Sequential Intercept Model that envisions a system that focuses on timely and effective referrals, assessments, and treatment of individuals with mental illness involved in the criminal justice system; and has a base of

accessible services, including comprehensive therapeutic and community support services, safe and affordable housing, as well as employment opportunities. In August 2007 two forums were held to review and obtain community input for inclusion in the Draft Plan, a consumer and family member forum, and a provider and advocate forum.

- Offender Re-Entry Program-The DMH participates in this District-wide initiative for serious, violent offenders between the ages of 18-35 who are returning from the Federal Bureau of Prisons by providing assessment and referral to appropriate mental health services. DMH has a Mental Health Coordinator at the service site to provide the mental health services and accept D.C. Linkage Plus referrals from Court Services and Supervision Agency (CSOSA) and the Bureau of Prisons.
- Chronic Homelessness- The DMH is using the “Housing First” model to serve chronically homeless through the Pathways to Housing DC Assertive Community Treatment teams. Pathways of New York City is serving as a mentor for Pathways DC by providing technical assistance. Plans are underway to use the New York expertise to train all the ACT teams and help them attain fidelity to the ACT model. Pathways DC has two ACT teams to serve this population, and a policy requiring all CSAs to adopt this approach is being considered. Currently, over 100 formerly homeless individuals are housed through this program. In FY 2005, the project was awarded a two year HUD Chronic Inebriates Grant with a goal of providing housing to 36 individuals who are chronically homeless, and addicted to alcohol. Permanent status for these 36 units is included in the current HUD SuperNOFA application.
- Crisis/Emergency Services Planning Work Group- In February 2007, DMH launched this initiative to develop a plan for a centralized, community-based system for providing coordinated crisis emergency services to people requiring emergency psychiatric care. The initial workgroup included representatives from the Metropolitan Police Department (MPD), Fire and Emergency Services (FEMS), the Department of Health, Addiction Prevention and Recovery Administration, the Office of Unified Communications, the D.C. Superior Court, the two crisis bed providers, community providers, advocates and consumers. The Work Group was charged with responsibility for reviewing the current system for delivering crisis emergency services and developing a comprehensive plan for delivery of such services. A Draft Interim Report was developed in July 2007 for review and comment. The Final Report is anticipated by Fall 2007.
- Medically Compromised Consumers Planning Meeting- In June 2007, DMH initiated an interagency planning meeting to discuss issues and concerns related to an increasing number of consumers with medical needs that make it difficult to place and/or maintain them in community settings. The first meeting targeted the Department of Health’s Medical Assistance Administration and HIV/AIDS Administration, and the Department of Disability Services. The second meeting in August 2007 expanded participants to include public and private health and mental health providers, aging and advocacy agencies. The activities to date include: obtaining a summary of the Medicaid waiver programs, continuing to identify the number of consumers with medical issues, and reviewing billing

strategies under the DMH Mental Health Rehabilitation Services program. The initiative will continue in FY 2008.

- Transition Age Youth Planning Initiative- In August 2007, the DMH Divisions of Child/Youth Services and Adult Services met with the Child and Family Services Agency (CFSA) to begin a dialogue about how the two agencies could work collaboratively to more effectively plan for the service needs of youth transitioning from the child to the adult system of care. The initiative will continue in FY 2008.
- MHRS Implementation- The DMH MHRS program is an ongoing system initiative. Some of the strengths of this program include: 1) new providers have continued to seek certification, 2) providers have sought certification for a variety of service populations (i.e., adults, children/youth including those in the juvenile justice system), individuals who are homeless, members of the Latino community, persons who experience grief and loss, 3) fidelity reviews are conducted to ensure adherence to the MHRS Standards, 4) financial audits are conducted on a quarterly basis to review a sample of claims to ensure the supporting documentation is adequate, also DMH monitors providers' financial condition by requesting copies of their annual audit conducted by an independent accounting firm, 5) DMH is actively working with providers and providing them with technical assistance on ways to increase their Medicaid enrollments, and 6) DMH no longer serves as the Representative Payee; Bread for the City now provides this benefit program.

System Weaknesses

The Final Court-Ordered Plan provided the blueprint for the reformed mental health system. This new service delivery system would require a new organizational structure, service philosophy and assumptions, funding mechanisms, and infrastructure. In short, the District's mental health system has undergone a major paradigm shift.

The DMH continues to mature as a service delivery system and continues to experience growing pains. It is this evolutionary state that contributes to most of the system weaknesses, as both public and private providers learn their roles in the new system, and the infrastructure to support the system design is developed. The structure is in place and the providers are moving toward providing the services required by the new system.

Some of the system weaknesses are related to implementation of the MHRS program and other DMH initiatives. These include but are not limited to:

- Information Technology- DMH needs to improve the information system to provide greater reporting of client related data including tracking of client outcomes, and client movement across service systems (i.e., consumer's utilization of community hospitals and other services).
- Services Array- Providers have found the current services array under the MHRS program is limited in being able to provide flexible services that meet the unique needs of a given consumer.

- ACT Services- Some of the remaining concerns of the Court Monitor related to the implementation of the ACT services include: finalization of the ACT Policy, overall capacity, under-referral to ACT teams, questions of fidelity to the ACT model, and current ACT Coordinator will be leaving DMH.
- Priority Populations- DMH has found that the provider system needs to be more focused on priority populations. The results of the Annual Community Services Reviews have shown that services are equally provided to persons with the least and greatest need. Additionally, the services should reflect major initiatives (jail diversion, homelessness, school-based, in-home services for youth, services for transition age youth, housing, supported employment, ACT, etc).
- Supported Employment- DMH would like to increase the supported employment service capacity and effectiveness so that more consumers can be served. A believed barrier to service expansion is related to the current rate that does not allow providers to increase staff.
- Homeless Services- Two of the primary service issues are coordination of care among DMH providers within the adult system of care and housing availability for chronically street-bound consumers.

District of Columbia

Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

There is a correlation between the identified system weaknesses and unmet service needs and critical gaps. This is supported by information gathered from service recipients and individuals who have significant involvement with them.

Consumer Satisfaction

The Dixon Exit Criteria requires DMH to develop methods to assess consumer satisfaction with services. One source of information about unmet service needs and critical gaps is the consumer satisfaction system is being implemented under contract with a local consumer organization, Consumer Action Network (CAN). This organization conducts three different consumer satisfaction measures. These measures were all completed in 2005 and the findings were included in a February 2006 Report on Consumer/Family Member Perceptions of Mental Health Services. This Report summarizes the results of the three measures including: 1) a convenience sampling survey- targeting the level of understanding that consumers, families and staff have of the recovery model, 2) focus groups- to understand for both adults and children the current level of satisfaction with services and recommendations for improvements, and 3) a telephone satisfaction survey- a randomized survey of 1026 (complete surveys) to determine levels of satisfaction with services received.

The CAN Report identified issues related to the mental health system's strengths and weaknesses. Some of the reported weaknesses include: 1) housing- the lack of access to affordable housing that is able to meet the unique needs of consumers and meaningful choice in housing, 2) appropriate services- the inability to provide consistent individualized consumer-driven care and meaningful choices in their treatment, and 3) access to information- the lack of clear and concise information about mental health services and also other related services. The Report also included recommendations. This Report was referred to the DMH Quality Council for review and potential action steps. The Council made recommendations about the findings to the DMH Director.

Another source of information about consumer satisfaction is through the Mental Health Statistics Improvement Program (MHSIP) Surveys. During FY 2006, the DMH Office of Consumer and Family Affairs coordinated the peer administration of the MHSIP Adult and Child Surveys and the Recovery Oriented System Indicators (ROSI) Consumer Survey. The data analysis is supported by the Data Infrastructure Grant (DIG) staff.

The adult population surveyed consisted of a pool of 10,085 adults who had a record of community service with a Core Services Agency between April 1, 2005 and September 30, 2005. The rationale for this selection was that the more recently that consumers were serviced, the more accurate the contact information. Only 814 consumers responded to the MHSIP Adult Survey and 354 to the ROSI Consumer Survey. Some of the factors that contributed to the low response rate include: consumer unavailability (incorrect contact information or no means to contact, hospitalized, in jail, deceased) and other surveys being conducted within in the same timeframe. The sample of respondents constituted a convenience sample of DMH consumers. The results of the MHSIP show that there was high satisfaction across all domains. The areas for improvement include: staff returning calls (73.6%), providing consumers more information on medication side effects (77.0%), participation in deciding treatment goals (70.5%), encouraged to use consumer run programs (79.3%), get along better with family (77.6%), do better in social

situations (77.2%), do better in school and work (40.0%), housing has improved (63.9%), symptoms not bothering as much (74.1%), better able to handle things when they go wrong (79.4%), and better able to do things they want to do (76.1%).

The findings from this first administration of the ROSI, that followed the administration of the MSHIP Survey, provided additional information. The primary areas for improvement include: consumers do not believe that they have someone who honestly believes in them; they lack information and resources regarding client rights and basic human rights; they need more support in adapting recovery-oriented behavior; the need for increased resources in the areas of housing, employment, income and transportation; the need for increased staff resources related to treatment, knowledge, and access; and the opportunity to acquire mentoring relationships from other consumers.

The findings of from the FY 2006 MHSIP and ROSI surveys were presented to the Dixon Court Monitor. A consumer contractor was selected through a competitive process to conduct the FY 2007 MHSIP Survey. This process will be completed by the end of FY 2007.

Community Services Reviews

The Annual Adult Community Services Reviews (CSR) provides another data source for assessing unmet service needs and system gaps. The Year 4 (2006 CSR) included the review of 51 cases. The overall status of the consumers was at a 65% acceptable level. High scores were evident in satisfaction with services (85%), safety (73%) and living arrangements (75%). Low scores showed up in a number of measures including: social network (39%), work (32%) and recovery activities (42%).

The systems performance score, the Dixon measurement, was 69% for Year 4. While this was a significant jump from Year 3 (51%), it fell short of the performance target of 80%. The areas noted for improvement include: 1) the need to develop longer-range natural supports for consumers, 2) the need for more work development- especially for consumers under age 40, 3) the need for continued focus on services access for persons with co-occurring mental illness and substance abuse, and 4) the same issues of delayed payment and lack of "flex" funds with which to do a full recovery model.

The Year 5 (2007 CSR) adult review was completed in April 2007. The total number of cases was 55. The results indicate that 69% of the persons reviewed were in the acceptable range for overall individual status. This shows a consistent pattern with previous years (Year 4 at 65% and Year 3 at 67%). Year 5 showed continued progress on many factors impacting the person's status including safety (82% acceptable), living arrangements (78%), and overall satisfaction (90%). Other key factors though improved from prior years, did not score as well including social network (53%), education/career preparations (50%), and work (54%).

Year 5 results for systems performance was at 80%. This upward trend compares quite favorably to Year 4 (69%) and Year 3 (51%). System performance indicators in key areas also reflected a consistent upward trend including goodness-of-service fit went from 55% (Year 3) to 69% (Year 4) to 76% (Year 5). These positive improvements reflect that the larger CSAs (most notably the DC CSA) have put considerable energy into understanding and implementing a recovery-based model.

It is noted that while the 80% score technically meets the Dixon performance target, the Court Monitor is not ready to certify that the District should move to inactive monitoring. There are at least three issues that must be addressed in planning for the 2008 adult review: 1) the sample size needs to increase to provide more appropriate levels of confidence in the outcomes (the 54 sample size was agreed to as a start point while DMH was still in a developmental state), 2) there needs to be greater attention to the final sample that is reviewed (the voluntary nature of this process raises the potential that more engaged clients are more likely to participate and alternatively that persons who are marginally engaged will not) and 3) inter-rater reliability between DMH and Court Monitor consultant reviewers needs to be carefully examined (internal reviewers tend to rate higher). As noted by the Court Monitor, none of these factors should subtract from the fact that on the adult side the DMH has made consistent and measurable improvement over the past three years.

3. Priorities and Plans to Address Unmet Needs

Information Technology Issues: DMH has modified its electronic data system via providers in order to obtain data on several of the Dixon Exit Criteria measures. These enhancements (event screens) were initiated in April 2005 and were tied to service authorizations (making them mandatory in July 2005). During FY 2006 and FY 2007, data review and refinement continued. This included variables related to the Dixon Exit Criteria and system enhancements associated with provider reporting issues. In FY 2008, DMH intends to implement a dash board on-line reporting capability within component programs (Authority, Hospital and Community Services Agency). DMH is also contemplating replacing the Ecura Contract Management System in the near future.

Services Array: DMH will continue to explore strategies to support more flexibility in the crafting of services that allow for varying levels of need for consumers. A consideration for creating opportunities for more flexible and individualized services will be the potential for adding to services already provided (i.e., expanding the basic community support model might prove beneficial in this regard).

ACT Services: The following actions have been taken to address issues regarding ACT services: 1) during FY 2005 the DMH Division of Quality Improvement conducted targeted field audits of 16 certified providers that focused on ACT, Community Support, and Rehabilitation Day Services, 2) in February 2006 an ACT Coordinator was appointed, an experienced member of the Access HelpLine/Care Coordination program, 3) during FY 2006 planning for a review of the ACT teams began that continued during FY 2007 to address issues related to team capacity, referral, and performance including clinical issues, and 4) accomplishments during FY 2007 included: a single point to collect and analyze ACT data, provide information to ACT providers and provide consistent guidelines and procedures for all ACT teams, the ability to generate ACT data per the Dixon criteria, considerable education to key stakeholders including psychiatric emergency services, Saint Elizabeths Hospital staff, Mental Health Commission members, and DC Superior Court Judges (each of these are key points of referral to the ACT program). The DMH targeted 50 consumers, as a part of its Hospital Discharge Plan, who will move into an ACT program run by Pathways to Housing by August 2007.

Priority Populations Issues: During FY 2005, DMH initiated training related to priority populations to assist providers understand the DMH priority population funding and new initiatives for FY 2006. During FY 2006, the DMH Chief Clinical Officer chaired a Priority Populations Work Group that included provider representation. This body developed clinically-based, draft criteria for DMH's refinement and operationalization of its focus on Priority Populations. As part of this process, draft definitions for priority adult and child populations were developed.

Supported Employment: The DMH is increasing the hourly rate for supported employment service providers. This will allow the providers to cover their costs as well as add staff to serve more consumers. The DMH will also implement an outreach plan to disseminate information about the availability of supported employment services to consumers and clinicians to increase access to the service.

Homeless Services: The DMH Office of Homeless Services will begin to meet regularly with other DMH homeless providers, the DMH Supported Housing and Supported Employment offices in order to share information, facilitate referrals and provide coordinated care planning. Homeless Services will also work closely with Housing Office and Pathways DC to identify chronically street-bound clients in need of housing.

Consumer Satisfaction Issues: As previously noted, the Consumer Action Network (CAN) assesses consumer satisfaction using three measures (convenience sampling survey, focus groups, telephone survey). Based on implementation of these measures in FY 2005, CAN submitted a report to DMH in February 2006. The report findings suggest the need for improvements related to housing, provision of appropriate services, and access to clear and concise information. This Report was referred to the DMH Quality Council for review and potential action steps. The Quality Council reviewed the CAN Report and made a series of recommendations to the DMH Acting Director in June 2006. The Council recommended that issues related to housing should be a top priority.

MSHIP Surveys and ROSI Issues: The Dixon Court Monitor reviewed the findings from these surveys. In the July 2007 Report to the Court he states "...the DMH has finalized its 2006 annual Mental Health Statistics Improvement Program (MHSIP) consumer survey in March 2007. This survey – together with the supplemental Recovery Oriented System Indicators (ROSI) – provide a very rich set of opportunities for systemic quality improvement. However, it is unclear how this data is being communicated to providers and utilized in any discrete way to make changes. The DMH Quality Council has not met in over six months... the plan is to reactivate this group in September 2007 – with the Internal Quality Committee (IQC) serving as an Advisory Board to the Quality Council." Once the DMH Quality Council is reactivated, the findings of these surveys would be presented to them for review with recommendations for implementation made to the DMH Director.

Adult Community Services Reviews Issues: One of the most noteworthy outcomes of the Year 5 (2007 CSR) was the five-year analysis. The DMH Director and Senior Staff asked the Court Monitor and Human Systems and Outcomes, Inc. (HSO)- the consultant overseeing the CSR process- to present themes, trends, and data points over the past five years. These findings

were discussed extensively with DMH senior leaders as part of an initiative that DMH has undertaken via the Institute for Healthcare Improvement (IHI). The overall goal is to identify specific practice or system performance areas in which DMH can make a real impact. The DMH is formalizing its overall priorities for 2008 in terms of the CSR process and will be sharing these with the Court Monitor and the provider/advocacy community.

4. Summary of Recent Significant Achievements

A brief summary of significant achievements for the Adult Services Program include but is not limited to the following:

Co-Occurring Disorders

The DMH continues the collaboration with the Addiction Prevention and Recovery Administration (APRA) in implementing the Comprehensive, Continuous, Integrated System of Care (CCISC) model of care that serves as the District's guide to the best practice interventions for the provision of services to individuals with co-occurring mental illness and substance use disorders. The DMH Co-Occurring Disorders State Incentive Grant (COSIG) embraces the philosophy of this model and is the mechanism by which its basic tenets are being implemented. The progress on the COSIG through FY 2007 includes: 1) DMH and APRA have adopted provider standards for screening, integrated assessment and appropriate treatment for mental illness and substance use disorders, 2) targeted provider trainings are ongoing, 3) the first annual Leadership Training has been completed and a 100-hour Educational Certificate Program in Co-Occurring Disorders has been developed for providers with sections running through 2008, 4) a regular D.C. COSIG Newsletter is published, 5) DMH and APRA are developing a single process for provider agencies to qualify for the designation of "Co-Occurring Competent Agency," 6) interagency data sharing initiatives for care coordination and performance monitoring are ongoing, 7) clinical chart audits on co-occurring disorder indicators are ongoing in both agencies, 8) "Outcomes Informed Care", an evidence-based practice shown to improve consumer outcomes, is being tested in multiple mental health and substance abuse clinical sites with the intention to fully implement the model by 2008, 9) a series of strategic continuous quality improvement projects are underway to improve linkages, communication, coordination and collaboration among agencies and programs across the District, and 10) D.C. COSIG is creating an Institute for Quality Improvement, which will be the sustainable cross-agency platform for continuous improvement of consumer outcomes, performance tracking, benchmarking, provider performance incentives and an ongoing learning network within the District of Columbia.

Supported Housing

The DMH, along with other District agencies, public and private housing, social service organizations, the banking industry, consumers, and housing advocates is implementing key elements of the DMH Housing Business Plan. The Housing Division continues to identify and adopt best practices to obtain permanent housing for persons with serious mental illness (SMI). DMH is currently working with the Housing Finance Agency (HFA) to use capital funds to develop 100 units of affordable housing each year for as long as capital funds are available. Affordable is defined as sustainably affordable for individuals receiving SSI and paying 30-35% of their total income for housing.

Some of the accomplishments during FY 2005 and FY 2006 include: 1) developed financing strategies for over 200 new affordable housing units, 2) ongoing work with developers and landlords to identify sites for affordable housing, 3) providing housing options to over 1,000 DMH consumers, 4) accessed 85 of the 108 project-based Federal subsidies, 5) opened 32 new single room occupancy (SRO) housing units, 6) expedited the placement of over 125 indigent consumers at Saint Elizabeths Hospital into community housing, and 7) worked with over 127 licensed community residential facilities (CRFs) who provide supervised settings for over 700 individuals.

During FY 2006, planning began for the MyHouse Project, a pilot project funded by the Conrad Hilton Foundation for assisting District of Columbia tenants who are consumers of mental health services in danger of losing their homes. The project uses mediation rather than traditional court proceedings to facilitate landlord/tenant communication in order to avoid potential homelessness. The project was implemented during FY 2007.

Other activities during FY 2007 included receipt of funding to house persons with mental illness and HIV/AIDS, finalization of the housing database, re-institution of the Housing Advisory Committee, Draft Housing Rules, and designation of one site to Pathways DC that has housing based subsidies already attached to facilitate the discharge of consumers from Saint Elizabeths Hospital.

Also, during FY 2007, DMH continued implementation of two housing related grants: 1) a long-term supports and housing initiative that to assist providers in the removal of barriers to accessing housing and increasing homeownership for persons with mental illness, mental retardation and/or developmental disabilities youth aging out of the foster care system, and 2) an Assets for Independence (AFI) demonstration project for mental health consumers to promote homeownership, education, and economic independence.

Supported Employment

The DMH and the Rehabilitation Services Administration (RSA), in collaboration with Dartmouth College and a grant from Johnson & Johnson Foundation, are implementing a Supported Employment Initiative. Supported employment programs have been established at six (6) sites throughout the District. During FY 2007, 402 consumers were enrolled in these programs. The profile of the persons enrolled includes 186 consumers who worked an average of 26.92 hours a week, and earned an average hourly wage of \$8.95. During FY 2008, one program will be added.

In FY 2006, a four-part Supported Employment Specialist training series was launched. The first three trainings addressed job development techniques, and providing employment services for transitional age youth, and previously incarcerated persons. In FY 2007, an Employer and Consumer Orientation Forum was held to promote supported employment services to employers as well as have them meet consumers currently searching for employment.

Also during FY 2007, a Transition Supported Employment Program was developed through an innovative collaboration between DMH's Adult Services Division and the Neighborhood

Services Initiative. The goal of the pilot program is to promote successful strategies for assisting Transition-Age-Youth, ages 18 to 24 in obtaining and maintaining employment along with support as they transition to adult life.

Other projects that the Supported Employment Program has implemented and/or supported include: the DMH Peer Recovery Specialist Initiative, Co-Occurring Disorders Focus Group Project, D.C.CSA Job Club, D.C. Recovery Initiative, Medicare Part-D Trainees, Youth Supported Employment Project, and Employment Specialists Training Initiative.

Homeless Services

The District of Columbia has developed a strategy to end homelessness in 10 years (by 2014). It involves making substantial, immediate investments to improve the existing “Continuum of Care” for homeless people while simultaneously launching long-term strategies (i.e., increase homeless prevention efforts, develop 6,000 units of affordable, supportive permanent housing for homeless and other very low-income persons, provide wraparound mainstream supportive services fully coordinated with “Continuum of Care” programs and special needs housing). This initiative uses a committee structure. The Homeless Services Program Manager participates on the sub-committee on family issues.

The DMH and APRA operate the Sobering Station (during hypothermia season) for homeless intoxicated men and women who refuse a traditional shelter. The DMH provides mental health services, staffing and supervision of the program while APRA provides the facility. Since its inception in 2002 through 2006, approximately 1,078 different men and women have visited the Sobering Station and about 194 have gone to the detoxification facility. In FY 2007, 206 different men and women were served at the Sobering Station, offering over 900 bed nights of service and at least 10 people were referred for detoxification services.

The DMH, working closely with the D.C. Housing Authority, has implemented two “Housing First” Assertive Community Treatment (ACT) teams for chronically homeless individuals. This program is modeled on the Pathways to Housing program in New York City, and is run by the same administration. It provides housing first assertive community treatment that allows chronically homeless individuals to move directly into housing, without a period of “housing readiness.” During FY 2005, the DMH Pathways to Housing Project was awarded a two year HUD Chronic Inebriates Grant that will provide housing for 52 individuals who are chronically homeless and addicted to alcohol.

During FY 2006, DMH implemented the outreach services plan for children/youth and families who are homeless. The implementation continued during FY 2007 and will continue during FY 2008.

5. Future Vision of Comprehensive Community-based Public Mental Health System

It is envisioned that the adult mental health system will reflect the mission, vision and values of DMH. In other words, DMH will provide adult consumers with access to flexible and responsive services, in a service delivery system that is recovery-based, dynamic, innovative and outcome-oriented, and holds in high esteem values that include respect, accountability, consumer

choice, quality, learning, and caring. The system will also develop, in collaboration with District and other community agencies and stakeholder groups, strategies to address the needs of unique populations including transition age youth, medically compromised consumers, and older adults.

The CSAs will assure that: a) consumers and families are provided timely and accurate information; b) consumer communication needs are addressed; c) staff are fully oriented to the service delivery system and to a wide range of consumer needs; d) services are made available for consumers with routine, urgent and emergent needs; e) consumers' rights relating to access to services, treatment planning and service delivery are fully explained and protected; f) clinical operations and treatment planning processes are consumer and family-centered and provided in a culturally competent manner; g) consumers and their families have full freedom to choose a CSA and a clinical manager; and h) safe affordable housing is found for each consumer in the most independent setting.

A number of program proposals were developed for implementation during FY 2005 that continued during FY 2006 and FY 2007 will continue during FY 2008. Some of the outcomes achieved include:

1. Shift all civil acute care to community hospitals- DMH has an agreement with Greater Southeast Hospital for a 20-bed unit to serve involuntary and uninsured patients and an agreement with Psychiatric Institute of Washington (PIW) to serve patients on an as needed basis.
2. Enhance community crisis and psychiatric emergency services- DMH has created a Crisis Emergency Services Work Group with a Draft Interim Report developed in July 2007 and disseminated for review and comment. The Final Report is expected during the Fall 2007. There are two community crisis providers, Crossing Place and Jordan House for a total of 15 residential beds.
1. Expand ACT services- teams have been added with a focus on specific client populations including forensic, mental illness and co-occurring developmental disabilities, and chronic homelessness.
2. Begin conversion of day services and development of support alternatives- a system-wide review of the utilization and implementation of Day Services was undertaken. The results of the review support the proposed changes. While the DMH continues to provide day services, the request for services is closely reviewed and monitored. Once the consumer obtains maximum rehabilitative benefit from the service, they are transitioned to lower levels of care (i.e., community support and other community-based services).

In keeping with the Exit Criteria for the Dixon Case, the adult mental health system will be able to consistently demonstrate:

1. Implementation and use of functional consumer satisfaction methods.
2. Use of consumer functioning review method(s) as part of the DMH quality

improvement.

3. Planning for and delivery of effective and sufficient consumer services.
4. High degree of system performance.

The strategic plan for DMH includes the development of a new hospital on the grounds of Saint Elizabeths. The new hospital is projected to be completed by 2009 and will have a capacity of 292 beds (175 forensic and 117 long-term). In order to prepare for the opening of the new hospital and in keeping with the DMH commitment to allow people to function in the most integrated, least restrictive environment, the Department has put forth an initiative to:

- Develop comprehensive adult services for those leaving the hospital,
- Develop appropriate incentives for providers to encourage the successful transition of consumers with serious mental illness and multiple needs,
- Provide appropriate residential and housing resources, and
- Develop system capability to respond to consumer needs with training and organizational changes.

District of Columbia

Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.

Information Technology Issues: DMH has modified its electronic data system via providers in order to obtain data on several of the Dixon Exit Criteria measures. These enhancements (event screens) were initiated in April 2005 and were tied to service authorizations (making them mandatory in July 2005). During FY 2006 and FY 2007, data review and refinement continued. This included variables related to the Dixon Exit Criteria and system enhancements associated with provider reporting issues. In FY 2008, DMH intends to implement a dash board on-line reporting capability within component programs (Authority, Hospital and Community Services Agency). DMH is also contemplating replacing the Ecura Contract Management System in the near future.

Services Array: DMH will continue to explore strategies to support more flexibility in the crafting of services that allow for varying levels of need for consumers. A consideration for creating opportunities for more flexible and individualized services will be the potential for adding to services already provided (i.e., expanding the basic community support model might prove beneficial in this regard).

ACT Services: The following actions have been taken to address issues regarding ACT services: 1) during FY 2005 the DMH Division of Quality Improvement conducted targeted field audits of 16 certified providers that focused on ACT, Community Support, and Rehabilitation Day Services, 2) in February 2006 an ACT Coordinator was appointed, an experienced member of the Access HelpLine/Care Coordination program, 3) during FY 2006 planning for a review of the ACT teams began that continued during FY 2007 to address issues related to team capacity, referral, and performance including clinical issues, and 4) accomplishments during FY 2007 included: a single point to collect and analyze ACT data, provide information to ACT providers and provide consistent guidelines and procedures for all ACT teams, the ability to generate ACT data per the Dixon criteria, considerable education to key stakeholders including psychiatric emergency services, Saint Elizabeths Hospital staff, Mental Health Commission members, and DC Superior Court Judges (each of these are key points of referral to the ACT program). The DMH targeted 50 consumers, as a part of its Hospital Discharge Plan, who will move into an ACT program run by Pathways to Housing by August 2007.

Priority Populations Issues: During FY 2005, DMH initiated training related to priority populations to assist providers understand the DMH priority population funding and new initiatives for FY 2006. During FY 2006, the DMH Chief Clinical Officer chaired a Priority Populations Work Group that included provider representation. This body developed clinically-based, draft criteria for DMH's refinement and operationalization of its focus on Priority Populations. As part of this process, draft definitions for priority adult and child populations were developed.

Supported Employment: The DMH is increasing the hourly rate for supported employment service providers. This will allow the providers to cover their costs as well as add staff to serve more consumers. The DMH will also implement an outreach plan to disseminate information about the availability of supported employment services to consumers and clinicians to increase access to the service.

Homeless Services: The DMH Office of Homeless Services will begin to meet regularly with other DMH homeless providers, the DMH Supported Housing and Supported Employment offices in order to share information, facilitate referrals and provide coordinated care planning. Homeless Services will also work closely with Housing Office and Pathways DC to identify chronically street-bound clients in need of housing.

Consumer Satisfaction Issues: As previously noted, the Consumer Action Network (CAN) assesses consumer satisfaction using three measures (convenience sampling survey, focus groups, telephone survey). Based on implementation of these measures in FY 2005, CAN submitted a report to DMH in February 2006. The report findings suggest the need for improvements related to housing, provision of appropriate services, and access to clear and concise information. This Report was referred to the DMH Quality Council for review and potential action steps. The Quality Council reviewed the CAN Report and made a series of recommendations to the DMH Acting Director in June 2006. The Council recommended that issues related to housing should be a top priority.

MSHIP Surveys and ROSI Issues: The Dixon Court Monitor reviewed the findings from these surveys. In the July 2007 Report to the Court he states "...the DMH has finalized its 2006 annual Mental Health Statistics Improvement Program (MHSIP) consumer survey in March 2007. This survey – together with the supplemental Recovery Oriented System Indicators (ROSI) – provide a very rich set of opportunities for systemic quality improvement. However, it is unclear how this data is being communicated to providers and utilized in any discrete way to make changes. The DMH Quality Council has not met in over six months... the plan is to reactivate this group in September 2007 – with the Internal Quality Committee (IQC) serving as an Advisory Board to the Quality Council." Once the DMH Quality Council is reactivated, the findings of these surveys would be presented to them for review with recommendations for implementation made to the DMH Director.

Adult Community Services Reviews Issues: One of the most noteworthy outcomes of the Year 5 (2007 CSR) was the five-year analysis. The DMH Director and Senior Staff asked the Court Monitor and Human Systems and Outcomes, Inc. (HSO)- the consultant overseeing the CSR process- to present themes, trends, and data points over the past five years. These findings were discussed extensively with DMH senior leaders as part of an initiative that DMH has undertaken via the Institute for Healthcare Improvement (IHI). The overall goal is to identify specific practice or system performance areas in which DMH can make a real impact. The DMH is formalizing its overall priorities for 2008 in terms of the CSR process and will be sharing these with the Court Monitor and the provider/advocacy community.

District of Columbia

Adult - Recent Significant Achievements

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

A brief summary of significant achievements for the Adult Services Program include but is not limited to the following:

Co-Occurring Disorders

The DMH continues the collaboration with the Addiction Prevention and Recovery Administration (APRA) in implementing the Comprehensive, Continuous, Integrated System of Care (CCISC) model of care that serves as the District's guide to the best practice interventions for the provision of services to individuals with co-occurring mental illness and substance use disorders. The DMH Co-Occurring Disorders State Incentive Grant (COSIG) embraces the philosophy of this model and is the mechanism by which its basic tenets are being implemented. The progress on the COSIG through FY 2007 includes: 1) DMH and APRA have adopted provider standards for screening, integrated assessment and appropriate treatment for mental illness and substance use disorders, 2) targeted provider trainings are ongoing, 3) the first annual Leadership Training has been completed and a 100-hour Educational Certificate Program in Co-Occurring Disorders has been developed for providers with sections running through 2008, 4) a regular D.C. COSIG Newsletter is published, 5) DMH and APRA are developing a single process for provider agencies to qualify for the designation of "Co-Occurring Competent Agency," 6) interagency data sharing initiatives for care coordination and performance monitoring are ongoing, 7) clinical chart audits on co-occurring disorder indicators are ongoing in both agencies, 8) "Outcomes Informed Care", an evidence-based practice shown to improve consumer outcomes, is being tested in multiple mental health and substance abuse clinical sites with the intention to fully implement the model by 2008, 9) a series of strategic continuous quality improvement projects are underway to improve linkages, communication, coordination and collaboration among agencies and programs across the District, and 10) D.C. COSIG is creating an Institute for Quality Improvement, which will be the sustainable cross-agency platform for continuous improvement of consumer outcomes, performance tracking, benchmarking, provider performance incentives and an ongoing learning network within the District of Columbia.

Supported Housing

The DMH, along with other District agencies, public and private housing, social service organizations, the banking industry, consumers, and housing advocates is implementing key elements of the DMH Housing Business Plan. The Housing Division continues to identify and adopt best practices to obtain permanent housing for persons with serious mental illness (SMI). DMH is currently working with the Housing Finance Agency (HFA) to use capital funds to develop 100 units of affordable housing each year for as long as capital funds are available. Affordable is defined as sustainably affordable for individuals receiving SSI and paying 30-35% of their total income for housing.

Some of the accomplishments during FY 2005 and FY 2006 include: 1) developed financing strategies for over 200 new affordable housing units, 2) ongoing work with developers and landlords to identify sites for affordable housing, 3) providing housing options to over 1,000 DMH consumers, 4) accessed 85 of the 108 project-based Federal subsidies, 5) opened 32 new single room occupancy (SRO) housing units, 6) expedited the placement of over 125 indigent

consumers at Saint Elizabeths Hospital into community housing, and 7) worked with over 127 licensed community residential facilities (CRFs) who provide supervised settings for over 700 individuals.

During FY 2006, planning began for the MyHouse Project, a pilot project funded by the Conrad Hilton Foundation for assisting District of Columbia tenants who are consumers of mental health services in danger of losing their homes. The project uses mediation rather than traditional court proceedings to facilitate landlord/tenant communication in order to avoid potential homelessness. The project was implemented during FY 2007.

Other activities during FY 2007 included receipt of funding to house persons with mental illness and HIV/AIDS, finalization of the housing database, re-institution of the Housing Advisory Committee, Draft Housing Rules, and designation of one site to Pathways DC that has housing based subsidies already attached to facilitate the discharge of consumers from Saint Elizabeths Hospital.

Also, during FY 2007, DMH continued implementation of two housing related grants: 1) a long-term supports and housing initiative that to assist providers in the removal of barriers to accessing housing and increasing homeownership for persons with mental illness, mental retardation and/or developmental disabilities youth aging out of the foster care system, and 2) an Assets for Independence (AFI) demonstration project for mental health consumers to promote homeownership, education, and economic independence.

Supported Employment

The DMH and the Rehabilitation Services Administration (RSA), in collaboration with Dartmouth College and a grant from Johnson & Johnson Foundation, are implementing a Supported Employment Initiative. Supported employment programs have been established at six (6) sites throughout the District. During FY 2007, 402 consumers were enrolled in these programs. The profile of the persons enrolled includes 186 consumers who worked an average of 26.92 hours a week, and earned an average hourly wage of \$8.95. During FY 2008, one program will be added.

In FY 2006, a four-part Supported Employment Specialist training series was launched. The first three trainings addressed job development techniques, and providing employment services for transitional age youth, and previously incarcerated persons. In FY 2007, an Employer and Consumer Orientation Forum was held to promote supported employment services to employers as well as have them meet consumers currently searching for employment.

Also during FY 2007, a Transition Supported Employment Program was developed through an innovative collaboration between DMH's Adult Services Division and the Neighborhood Services Initiative. The goal of the pilot program is to promote successful strategies for assisting Transition-Age-Youth, ages 18 to 24 in obtaining and maintaining employment along with support as they transition to adult life.

Other projects that the Supported Employment Program has implemented and/or supported include: the DMH Peer Recovery Specialist Initiative, Co-Occurring Disorders Focus Group Project, D.C.CSA Job Club, D.C. Recovery Initiative, Medicare Part-D Trainees, Youth Supported Employment Project, and Employment Specialists Training Initiative.

Homeless Services

The District of Columbia has developed a strategy to end homelessness in 10 years (by 2014). It involves making substantial, immediate investments to improve the existing “Continuum of Care” for homeless people while simultaneously launching long-term strategies (i.e., increase homeless prevention efforts, develop 6,000 units of affordable, supportive permanent housing for homeless and other very low-income persons, provide wraparound mainstream supportive services fully coordinated with “Continuum of Care” programs and special needs housing). This initiative uses a committee structure. The Homeless Services Program Manager participates on the sub-committee on family issues.

The DMH and APRA operate the Sobering Station (during hypothermia season) for homeless intoxicated men and women who refuse a traditional shelter. The DMH provides mental health services, staffing and supervision of the program while APRA provides the facility. Since its inception in 2002 through 2006, approximately 1,078 different men and women have visited the Sobering Station and about 194 have gone to the detoxification facility. In FY 2007, 206 different men and women were served at the Sobering Station, offering over 900 bed nights of service and at least 10 people were referred for detoxification services.

The DMH, working closely with the D.C. Housing Authority, has implemented two “Housing First” Assertive Community Treatment (ACT) teams for chronically homeless individuals. This program is modeled on the Pathways to Housing program in New York City, and is run by the same administration. It provides housing first assertive community treatment that allows chronically homeless individuals to move directly into housing, without a period of “housing readiness.” During FY 2005, the DMH Pathways to Housing Project was awarded a two year HUD Chronic Inebriates Grant that will provide housing for 52 individuals who are chronically homeless and addicted to alcohol.

During FY 2006, DMH implemented the outreach services plan for children/youth and families who are homeless. The implementation continued during FY 2007 and will continue during FY 2008.

District of Columbia

Adult - State's Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

It is envisioned that the adult mental health system will reflect the mission, vision and values of DMH. In other words, DMH will provide adult consumers with access to flexible and responsive services, in a service delivery system that is recovery-based, dynamic, innovative and outcome-oriented, and holds in high esteem values that include respect, accountability, consumer choice, quality, learning, and caring. The system will also develop, in collaboration with District and other community agencies and stakeholder groups, strategies to address the needs of unique populations including transition age youth, medically compromised consumers, and older adults.

The CSAs will assure that: a) consumers and families are provided timely and accurate information; b) consumer communication needs are addressed; c) staff are fully oriented to the service delivery system and to a wide range of consumer needs; d) services are made available for consumers with routine, urgent and emergent needs; e) consumers' rights relating to access to services, treatment planning and service delivery are fully explained and protected; f) clinical operations and treatment planning processes are consumer and family-centered and provided in a culturally competent manner; g) consumers and their families have full freedom to choose a CSA and a clinical manager; and h) safe affordable housing is found for each consumer in the most independent setting.

A number of program proposals were developed for implementation during FY 2005 that continued during FY 2006 and FY 2007 will continue during FY 2008. Some of the outcomes achieved include:

1. Shift all civil acute care to community hospitals- DMH has an agreement with Greater Southeast Hospital for a 20-bed unit to serve involuntary and uninsured patients and an agreement with Psychiatric Institute of Washington (PIW) to serve patients on an as needed basis.
2. Enhance community crisis and psychiatric emergency services- DMH has created a Crisis Emergency Services Work Group with a Draft Interim Report developed in July 2007 and disseminated for review and comment. The Final Report is expected during the Fall 2007. There are two community crisis providers, Crossing Place and Jordan House for a total of 15 residential beds.
3. Expand ACT services- teams have been added with a focus on specific client populations including forensic, mental illness and co-occurring developmental disabilities, and chronic homelessness.
4. Begin conversion of day services and development of support alternatives- a system-wide review of the utilization and implementation of Day Services was undertaken. The results of the review support the proposed changes. While the DMH continues to provide day services, the request for services is closely reviewed and monitored. Once the consumer obtains maximum rehabilitative benefit from the service, they are transitioned to lower levels of care (i.e., community support and other community-based services).

In keeping with the Exit Criteria for the Dixon Case, the adult mental health system will be able to consistently demonstrate:

1. Implementation and use of functional consumer satisfaction methods.
2. Use of consumer functioning review method(s) as part of the DMH quality improvement.
3. Planning for and delivery of effective and sufficient consumer services.
4. High degree of system performance.

The strategic plan for DMH includes the development of a new hospital on the grounds of Saint Elizabeths. The new hospital is projected to be completed by 2009 and will have a capacity of 292 beds (175 forensic and 117 long-term). In order to prepare for the opening of the new hospital and in keeping with the DMH commitment to allow people to function in the most integrated, least restrictive environment, the Department has put forth an initiative to:

- Develop comprehensive adult services for those leaving the hospital,
- Develop appropriate incentives for providers to encourage the successful transition of consumers with serious mental illness and multiple needs,
- Provide appropriate residential and housing resources, and
- Develop system capability to respond to consumer needs with training and organizational changes.

District of Columbia

Child - Service System's Strengths and Weaknesses

Child - A discussion of the strengths and weaknesses of the service system.

District of Columbia

Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

See response in section II,

District of Columbia

Child - Plans to Address Unmet Needs

Child - A statement of the State's priorities and plans to address unmet needs.

District of Columbia

Child - Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

District of Columbia

Child - State's Vision for the Future

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

District of Columbia

Adult - Establishment of System of Care

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

The Adult Community Service system is comprised of the Mental Health Authority, Saint Elizabeths Hospital, and certified agencies (including both the publicly funded District of Columbia Community Services Agency (DC CSA) and a group of certified private non-profit mental health agencies). Saint Elizabeths Hospital includes both the forensic services of the John Howard Pavilion and the civil hospital. What is being described in the FY 2008 State Mental Health Plan is the community-based organizational structure, as it exists today. Emphasis in the current plan will be on objectives to be carried out within the Mental Health Authority as they pertain to system development.

1. The Authority

The Mental Health Authority supports the overall administrative mission of the Department of Mental Health (DMH), and encompasses the global functions necessary to support the entire system. The Authority is responsible for establishing priorities and strategic initiatives for DMH, as well as coordinating fiscal services, accountability functions, information systems, and service planning and policy development.

In addition, the Authority acts as an agent of the Medicaid Assistance Administration (MAA) in receiving and adjudicating claims for services provided. It assumes the responsibility for reimbursing providers for services rendered, and reconciles with Medicaid for the Federal Funds Portion (FFP) of those claims for services provided to Medicaid-eligible consumers.

The Authority also functions as a regulatory body through which certification will be sought by any provider seeking to provide Mental Health Rehabilitation Services (MHRS). The MHRS program encompasses nine services (four are classified as core services and five as specialty services) provided by DMH-certified community-based providers.

The DMH has developed an Access HelpLine that provides 24-hour, 7-day a week access for persons in need of mental health services. Administered as part of the Care Coordination function, this program handles routine requests for services and those requiring both urgent and emergency services. The Access HelpLine provides functions such as enrollment in appropriate DMH services, as well as prior authorization and continuing stay authorization. All these actions are based on consumer choice.

The Comprehensive Psychiatric Emergency Program (CPEP), which provides services to adults experiencing psychiatric emergencies, was placed under Care Coordination in FY 2005. The CPEP was formerly under DC CSA.

The District originally engaged KPMG to do an overall assessment of DMH's administration of its MHRS system. The August 2006 Report detailed numerous ways for DMH to improve its MHRS programs. Many of these initiatives are underway. To assist DMH with some of its priority objectives, DMH contracted with KPMG again in early 2007 to provide help in four areas: 1) project management of MHRS improvement initiatives, 2) support for Medicaid-denied claims recovery, 3) movement of Medicaid claims payment to MAA, and 4) development of an Administrative Services Organization (ASO) request for proposal. It is noted that the transition of Medicaid payment to MAA

will occur on October 1, 2007. Also, a request for information regarding the ASO went to potential contractors on July 17, 2007.

2. Core Services Agencies

In August 2007, 54 agencies were certified as providers of DMH MHRS services: 36 Core Services Agencies (CSAs) including a DMH-operated CSA, 18 Specialty Providers, and 16 Sub-Provider agencies. Only the CSA total is an unduplicated count, as a CSA can also be a Specialty and/or Sub-Provider. DMH will continually review community needs and provider capacity as the MHRS program is implemented.

The public and private non-profit providers serve as the backbone of the District's comprehensive, community-based system for providing services to persons with serious mental illness. The objective of a CSA is to create a clinical home for each person receiving DMH services, ensuring a single point of accountability for service delivery. The CSA model ensures that each person has an Individualized Recovery Plan (IRP) that clearly identifies the treatment goal and the services necessary to achieve these goals. This plan and service model is focused on a strengths and rehabilitative approach to each consumer's recovery.

D.C. Community Services Agency- The largest of the DMH-certified CSAs is the publicly funded D.C. Community Services Agency (DC CSA), which has been certified as a CSA and Specialty provider. A variety of services are provided to adults in recovery from serious mental illness. In addition to over a dozen community support teams and three assertive community treatment teams, some services address special population needs such as older adults, and individuals from multi-lingual and multi-ethnic communities. The DC CSA major accomplishments include the development of a number of protocols (i.e., for forensic populations, acute and long-term care of consumers residing in Saint Elizabeths Hospital, intake at all adult program sites); increased daily attendance at the dually diagnosed day services program; and increased staffing at the mental retardation/developmental disabilities/hearing impaired program.

Older Adult Services- DMH older adult consumers who are outpatients receive MHRS and other services necessary for living in the community through both a specialized geriatric program at one DC CSA service center and integration of geriatric services into Community Services at another site, and the services teams of the other CSAs. The consumers are supported through community support services in their own homes or may be placed in community residential facilities (CRFs), nursing homes, or with their immediate guardian.

The DC State Mental Health Planning Council set aside funds in the FY 2007 Block Grant to develop an Older Adult Initiative and recommended additional FY 2008 Block Grant funds for this initiative. The Council will work with DMH to develop a plan of action for implementation during FY 2008.

Transition Age Youth Services- DMH and the Child and Family Services Agency (CFSA) began a dialogue in August 2007 about youth and young adults with mental health issues transitioning from the child/youth to the adult mental health system. It was noted that the transition has primarily focused on placement issues and not program issues, and that the emphasis should be on both. The next steps will involve CFSA providing data about transition age youth, and developing short-term and long-term solutions based on service need. These activities will continue during FY 2008.

The DC State Mental Health Planning Council set aside funds in the FY 2007 Block Grant to develop a Transition Age Youth Initiative and recommended additional FY 2008 Block Grant funds for this initiative. The Council will work with DMH to develop a plan of action for implementation during FY 2008.

Multicultural Services- The DC CSA Multicultural Community Support Program (MCSP) provides a range of mental health services for the ethnic, cultural, and linguistic minority communities in the District. The MCSP also provides language translation including document development for limited and non-English proficient individuals, and developments data on the city's diverse ethnic populations.

The DMH developed the Biennial Language Access Plan for 2007-2008. The purpose of the plan is to establish and provide greater access and participation in public services, programs and activities for District residents with limited or no-English proficiency that access services and information through DMH). "Access and participate" means to be informed of, participate in, and benefit from public services, programs, and activities offered by DMH at a level equal to English proficient individuals. The removal of language barriers is critical to achieving access to needed services. In accordance with Section 5(a) (2) of the Language Access Act of 2004, each Language Access Plan (LAP) shall be updated on a biennial basis or every two years. The BLAP will be reported to and is subject to the review of the Mayor and City Administrator.

3. Saint Elizabeths Hospital

Adults requiring treatment in a 24-hour inpatient setting may receive services at Saint Elizabeths Hospital. The three primary programs at Saint Elizabeths are Acute Care, Continuing Care, and Forensic Services. The Acute Care Program currently consists of 92 certified beds (4 units); one unit for all admissions, most of which are stabilized within 14 days; and one unit for patients who require treatment beyond 14 days for stabilization. The Continuing Care Program has 128 beds and provides ongoing psychiatric treatment to a variety of populations, including geriatric, hearing impaired, behavior management, and psychosocial. In keeping with the recovery-based model of care, the Hospital has established an environment of care that allows patients to leave their units during the day and receive the majority of treatment at a "treatment mall," and two ward-based geri-malls. This concept promotes community reintegration and assures that all patients are involved in active treatment. The treatment mall provides specialized programming for Geriatrics, Dual Diagnoses, Cognitive Remediation, Cognitive Impairment, Psychosocial Rehabilitation, and Acute Care.

The Forensic Services Inpatient Program has 225 beds, as well as an outpatient department that provides treatment and/or monitoring for approximately 105 insanity acquittees on court ordered conditional release in the community. The Forensic inpatient program provides a full range of mental health services to pre and post-trial consumers committed by the Criminal Divisions of the District of Columbia and Federal Courts. The courts control admission to and discharge from the Forensic Program. Services to forensic inpatients include evaluations of competency to stand trial and criminal responsibility; treatment of defendants in need of hospitalization to restore them to competency before trial; treatment of those adjudicated incompetent and unlikely to regain competency in the foreseeable future while awaiting civil commitment; treatment of consumers found Not Guilty By Reason of Insanity (NGBRI) and committed for inpatient treatment until released by the court.

The Forensic Legal Services Branch provides community-based pre-trial, pre-sentencing, and post-sentencing evaluation and assessment services to individuals residing in the community or at correctional facilities referred by the criminal courts and the District of Columbia's probation and parole authority. The Legal Services Branch also operates field offices in the District of Columbia Courthouse that provide same day competency screenings for both defendants who are detained and on bond.

Plans are underway to build a new inpatient facility that will include forensic and civil patients.

District of Columbia

Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing services;
Educational services;
Substance abuse services;
Medical and dental services;
Support services;
Services provided by local school systems under the Individuals with Disabilities Education Act;
Case management services;
Services for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities leading to reduction of hospitalization.

Mental Health and Rehabilitation Services

The DMH has developed and is implementing a comprehensive set of service standards through the Mental Health Rehabilitation Services (MHRS) program. This program consists of four core services (diagnostic/assessment, medication/somatic treatment, counseling, and community support) and five specialty services (crisis/emergency, rehabilitation, intensive day treatment, community-based intervention, and assertive community treatment). A DMH-certified Core Services Agency (CSA) or Sub-Provider provides the core services while a DMH-certified Specialty Provider offers the specialty services.

As of August 2007, approximately 8,212 consumers over the age of 18 had received at least one billable service from the DMH MHRS program. This included 2,552 consumers in the DC CSA.

The CSAs serve as the consumers' clinical home and are responsible for the coordination of the consumers care across services and provider agencies. The Individual Recovery Plan (IRP) is a key to the development of mutually agreeable treatment and rehabilitative goals and objectives, and to coordinate the care of multiple providers who often participate in the consumer's care plan. Representatives of each service being provided and the CSAs clinical manager and qualified practitioner, consumer and others that the consumer would like to be a part of the treatment planning process are involved. The IRPs and Integrated Service System Plans (ISSPs), which are the authorization requests for services to the DMH Authority flow from the treatment objectives that are completed every 90 days or whenever there is a change in the consumer's course of care.

The DMH Provider Relations Division continues to provide technical assistance and communication linkage on both clinical and financial issues, as well as troubleshooting of problems for the provider network. This Division also convenes separate monthly meetings for the providers' Chief Operating Officers and Chief Financial Officers (CEOs/CFOs), the Clinical Directors, and the User Group.

During FY 2005, the DMH Division of Quality Improvement (DQI) conducted targeted fidelity audits of 16 certified providers that focused on ACT, Community Support, and Rehabilitation Day Services. These audits use the MHRS standards as the basis for review with required corrective action plans for any noted deficiencies. The DQI staff also assisted the Medicaid agency in conducting Medicaid compliance audits for 11 community service providers with DQI providing the actual staff to do the onsite reviews.

In December 2005, the DQI assumed the primary responsibility for auditing claims of certified providers. The function was previously performed by the DMH internal auditor. The claims audit function involves an onsite audit of each new provider and then desk audits of provider claims on a quarterly basis. Audit results (together with any corrective action) are given to individual providers and appropriate DMH staff.

In FY 2006, DMH began a review of the audit process. An attempt is being made to identify all of the audits being conducted (management, MHRS, claims, CRFs, etc.) to determine the most feasible data collection and scheduling process.

Also during FY 2006, the DQI implemented a formal mortality review of consumer deaths. Once a death notice is received from a provider, they have 45 days to complete a full mortality review on the deceased consumer. There are follow-up procedures to ensure receipt of this information. Once the information is received, it is reviewed by the DQI Director then forwarded to the Office of the Chief Clinical Officer for review and appropriate follow-up action. The DMH is in the process of developing a reporting format and reporting frequency.

The Quality Council composed of the Quality Improvement Directors of each provider agency and Saint Elizabeths Hospital began meeting monthly in February 2005. The Council has formed two subcommittees – one on outcomes and one on utilization system-wide. Each subcommittee meets monthly and the full Council meets quarterly. The Outcomes Subcommittee has included in its priorities the task of reviewing the DMH Satisfaction Survey and comparing the results with other internal agency reviews to note similarities or dissimilarities.

In December 2006 a new Director of the Office of Accountability was hired. Six initiatives were identified with targeted progress for each by the end of FY 2007. These include: 1) build interactive data bases for all key OA functions (licensure, certification, major unusual incidents (MUIs), complaints, investigations, audits, and corrective action plans); 2) revise the claims-auditing process and protocols; 3) ensure adequate training for OA staff.; 4) create quality improvement infrastructure – both internally (for DMH-run entities) and for the overall system (the Quality Improvement Director position has been filled that was vacant for over two years and the Internal Quality Committee (IQC) has begun meeting and the plan is to reconstitute the overall Quality Improvement Council by September 2007); 5) build a small but effective Investigative Unit within OA; and 6) develop a comprehensive work plan for FY 2008.

Employment Services

The Mental Health Block Grant funds have been instrumental in advancing the DMH Supported Employment Initiative. These funds have been blended with grant funds from the Johnson & Johnson-Dartmouth Community Mental Health Program, appropriated funds from the DMH budget and appropriated funds from the Rehabilitation Services Administration (RSA) to promote developments in the implementation of supported employment as an evidence-based practice.

In December 2002, DMH selected three agencies (Community Connections, Deaf-REACH, and Northwestern Human Services Midlantic) to serve as demonstration sites for the implementation of the Individual Placement and Support (IPS) model. The latter agency no longer provides services as part of the provider network. Other agencies have been added to the Supported Employment Initiative bringing the total to six (Green Door, Anchor Mental Health Association, Psychiatric Center Chartered, and DC CSA).

Each site is responsible for adherence to the principles of the IPS model: zero rejection of any consumer who desires work; job selection based on the consumer's preferences; integrated work setting with a salary of at least minimum wage; rapid job search; time unlimited supports and integration of employment goals and staff within the overall treatment team process. Each site

submits quarterly outcome data and an annual evaluation is conducted using the Supported Employment Fidelity Scale. Annual evaluations are scheduled with Deborah Becker, a prominent researcher in this field who works at Dartmouth University's Psychiatric Research Center.

During the summer of 2004, Annual Evaluations were conducted at the six sites by the DMH Employment Specialist and Dr. Ernest Quimby (a project consultant), with consultation from Deborah Becker at Dartmouth University's Psychiatric Research Center. In FY 2005, site evaluations were conducted at all sites during the months of July and August by the DMH Employment Specialist.

Employment Specialists from the six sites continue to attend monthly meetings, which began in 2004, to discuss service delivery issues, client employment successes and staff training needs. In addition Supported Employment Program Managers continue to attend bi-monthly meetings to discuss program development issues, successes and sustainability. The DMH Employment Specialist facilitates both meetings.

In March 2005, the monthly outcome tracking process was implemented to monitor the provision of supported employment services and referrals and has been a useful tool in developing a supported employment database. Also, the monthly tracking is a component of DMH efforts to comply with the Dixon Exit Criteria measure to provide employment services within 120 days of referral.

Dr. Ernest Quimby, Professor of Sociology/Anthropology at Howard University has played an important role in the DMH supported employment activities as a consultant since the inception of the Supported Employment Evidence-Based Practice Initiative in 2002. Dr. Quimby has conducted interviews with consumers receiving supported employment services at the six sites. His consultative work with DMH is a commitment made by DMH to the Johnson & Johnson-Dartmouth Community Mental Health Program. Block Grant funds were used to support Dr. Quimby's research activities in FY 2004 and 2005.

In the Spring and Summer of 2005, FY 2004 Block Grant funds were used to develop a youth employment program at Eliot Junior High School. Fifteen (15) students completed the program that consisted of discussion, research and presentations. Each student was required to present an employment project. Professionals also presented career-related information on fields such as video production and architecture. Students were very motivated by the program and received a stipend for their participation. During FY 2005, the Child/Youth Supported Employment Project was renamed the Youth Supported Employment Program and implemented at Ron Brown Middle School. A summer employment component was added to the curriculum. The DMH partnered with the Department of Employment Services (DOES), Summer Youth Employment Program, so that students in the program could obtain summer jobs in their careers of interest, which they identified during the school year. Twelve (12) students completed the Youth Supported Employment Program and eight obtained summer jobs. Students earned \$5.15 an hour and worked 20 hours a week. They held a variety of jobs such as Recreation Aide, Administrative Clerk, Paralegal Aide, and Teacher's Aide. Four students were unable to obtain summer jobs due to various personal and academic reasons.

In FY 2005, Dr. Quimby assisted in the implementation of a six-month focus group initiative examining the effects of co-occurring disorders on job retention among clients working in the community. This short-term project involved clients employed through the six sites, who were dealing with alcohol and drug abuse issues. They were invited to participate in focus groups to discuss strategies for maintaining employment and avoiding alcohol and drug use once they began to earn money. Job retention strategies identified through the focus groups were shared with employment staff from the six sites, as well as all DMH approved providers.

The Peer Recovery Specialist Training Initiative trained a total of 33 consumers to provide peer-to-peer support and mentoring from FY 2004 through FY 2005. Consumers who completed the training were assisted in locating internships with DMH approved programs. Consumers also received a \$1,200.00 stipend for participating in the internship. The day-to-day operation of the Peer Recovery Specialist Training Initiative was transferred to the DMH Office of Consumer and Family Affairs at the end of FY 2005.

The DC CSA Job Club continued in FY 2005. Consumers transitioning from the CSA's Work Adjustment Training Program met on a monthly basis. Thirty-five (35) consumers learned to write resumes and present themselves in job interviews. Five (5) to seven (7) consumers participated in the club each month. The Job Club has become an ongoing part of the CSA's Supported Employment Program.

During FY 2006, DMH continued the implementation of the Supported Employment Initiative, which is designed to increase provider service capacity and improve employment outcomes for individuals with serious mental illness. As a related aspect of this goal, DMH will continue to examine the feasibility of creating a Medicaid waiver for Supported Employment. Research was gathered and background information obtained from other state agencies during FY 2005. The DMH is working to create a feasibility plan regarding creation of a waiver, including costs involved and the interagency collaboration required. Other efforts to increase service capacity involve adding new supported employment service providers. The DMH allocated funding in FY 2006 for two additional providers- one would provide supported employment services to adults and the other would provide services to Transitional-Age-Youth. These projects were to be implemented in FY 2007 but did not forward. It is anticipated that a rate increase will be implemented along with the recruitment for a new supported employment adult provider at the beginning of FY 2008.

With regard to the Transition-Age-Youth Supported Employment Program, when a provider could not be identified, DMH implemented a pilot program in FY 2007 in collaboration with the Neighborhood Services Initiative (NSI). This transitional employment training program involved 20 participants age 18-24 in the designated new communities of the District (Park Chester/Barry Farms and Lincoln Heights/Richardson Dwellings). The participants were encouraged to select a career and obtain a job in their chosen profession. They became involved in career training, job training, employment, and education completion and advancement. The participants also participated in a bi-monthly workshop that emphasized progressive employment skills. NSI also provided case management to all participants.

The supported employment data that is collected for each program site captures: 1) the number of consumers enrolled, 2) the number of consumers working, 3) the average number of hours worked per week, and 4) the average hourly wage. This information is reported in the table that follows.

FY 2006 and FY2007 Supported Employment Consumer Outcome Data for the Individual Placement and Support (IPS) Model Six Program Sites:

Supported Employment Providers	Number of Consumers Enrolled		Number of Consumers Working		Average Number of Hours Worked Per Week		Average Hourly Wage	
	FY 06	FY 07	FY 06	FY 07	FY 06	FY 07	FY 06	FY 07
Anchor	63	75	31	32	28.0	27.0	\$9.37	\$9.50
Community Connections	50	67	16	30	27.0	25.0	\$8.43	\$9.20
Psych. Center Chartered	50	50	29	39	37.0	37.6	\$8.88	\$8.90
Green Door	68	78	43	52	28.6	27.9	\$10.11	\$10.09
Deaf Reach	37	24	4	11	22.5	24.0	\$7.50	\$8.00
DC CSA	130	108	41	22	33.0	20.0	\$8.65	\$8.00
Total	398	402	164	186	29.35	26.92	\$8.82	\$8.95

Also during FY 2006, two supported employment trainings were held as part of a four-part training initiative for Employment Specialists. The first training, which covered job development techniques, was attended by 18 Managers and Employment Specialists from the six sites. The second training focused on providing employment services for Transition-Age-Youth, and was attended by 25 Managers, Employment Specialists and Youth Advocates from the DMH School Mental Health Program. A third training focused on providing employment services to previously incarcerated persons and was held at the end of FY 2006.

During FY 2008, DMH will continue to focus on building service capacity. The DMH is increasing the supported employment hourly rate from \$45 to \$65. This will allow current and future services providers to cover the costs associated with providing supported employment services as well as add more staff to serve more consumers. The DMH will also implement an outreach plan to disseminate information about the availability of supported employment services to consumers and clinicians to increase access to the service. This will include ongoing supported employment training targeted to clinicians and consumers. The training will help to educate clinicians that consumers can work and how to link consumers to supported employment services. The consumer training will help consumers understand the service, that they can work, and how to request the service.

Also during FY 2008, DMH will continue to work with all service providers to help them develop and provide supported employment services that are programmatically effective and financially efficient. The DMH will also try to continue to maintain the Dixon Exit Criteria measure to provide supported employment services to 70% of the persons referred within 120 days of referral.

Housing Services

In order to respond to the needs of consumers as well as to federal and local policies and judicial directives, DMH developed a three-year Housing Business Plan (2000) that signaled the beginning of a major shift in policy related to the provision of housing and services. Initially, the Plan (now updated annually) called for the production of 850 new permanent supported housing units. In 2003, the Plan incorporated new finance strategies, the best practice “Housing First” approach to serving persons who are chronically homeless, and an emphasis on formalizing relationships with local housing partners. Creating public and private partnerships has significantly strengthened the DMH capacity to accelerate affordable housing production utilizing creative leveraging strategies that maximize the Department’s capital funding.

Mission

The Department has engaged in a systematic approach to fulfill the mission articulated in the Housing Business Plan, that is, to help solve (in partnership with public and private entities, and consumer advocates), the affordable housing crisis for District residents who experience serious mental illness. The Housing Business Plan establishes clear policies, goals, and specific finance strategies for achieving the Department’s commitment to this mission. These goals include financing the development of safe, decent and sustainable affordable housing options, maximizing consumer choice in housing and residential support services; and providing more accessible and individualized support services in the consumers own home.

Goal

The DMH ongoing goal is the development of 100 new sustainable affordable housing units each year.

Need

The lack of safe decent and affordable housing options for people with mental illness has reached a crisis level. Many consumers are extremely poor and live on an SSI income of \$623 per month, if they have any income. The frustrated voices of consumers, staff and family members echo loudly as they seek recovery, healing and a home. The quality of life is significantly impacted when the road to recovery is defined partially by sleeping in the streets. Mental health gains can often be minimized by a continuous cycle of homelessness.

There are not enough resources, at this time to house all of the consumers in need. Approximately 500 consumers have been referred and others are yet to be referred for subsidized housing. The greatest priority housing needs and the majority of persons referred for DMH housing subsidies include:

- Persons who are homeless and live on the street or in shelters or other places not fit for human habitation,

- Persons no longer in need of care at Saint Elizabeths Hospital,
- Persons being released from institutions (jail/prison, other hospitals/court ordered for housing),
- Persons living in 24-hour supervised group homes who no longer need this level of care
- Persons living in substandard, overcrowded housing; rent burdened, and
- Persons being evicted because they cannot afford to pay for housing.

There are growing consumer needs for supported housing among certain target populations. New initiatives are being developed to respond to consumers who are transitioning or aging out of the foster care system and those being released from jails. In addition, there are consumers whose medical conditions impact housing. These medical conditions include diabetes, high blood pressure, heart disease, stroke, chronic bronchitis, emphysema, cancer, kidney disease, liver disease, arthritis, seizure disorders, mobility issues, including wheelchair bound, paraplegic, hepatitis, HIV/AIDS, dual diagnoses of mental illness and substance abuse and/or mental retardation and developmental disabilities, vision impairments/blindness, incontinence and a host of others. Each of these conditions often requires mental health and primary health services and ongoing illness management.

Supported Housing Program

- The shift from a focus on traditional supervised residential group home services to a priority on supported housing is an extraordinary mental health systems change initiative for both DMH and local landlords and developers. While there will continue to be a need for clinically focused supervised community residential settings, the greatest system commitment of resources is for the production of new, permanent, affordable housing. The focus is on the provision of housing in the most integrated settings possible in the community.
- The Supportive Housing Program Initiative is designed to expand safe, quality, permanent and affordable housing options for people with serious mental illness.
- The initiative grew out of an assessment of local resources by the Corporation for Supportive Housing and reviews of “best practices” in supportive housing in other jurisdictions.
- The mission of the Supportive Housing Initiative is to expand the type and the amount of affordable housing by strengthening the partnerships with public and private agencies, including the D.C. Housing Authority, D.C. Housing Finance Agency, and the Department of Housing and Community Development.

DMH Housing Array

1. **Permanent Scattered Sites** - A variety of types of tenant-based and project-based housing is utilized. The tenant-based housing subsidy funding is linked to the individual and follows the individual should they relocate. The project-based subsidy is attached to a specific housing location and remains at the location if the consumer relocates. These include apartments, Single Room Occupancy (SRO) units, and single-family homes. Over 300 local landlords lease their properties to DMH consumers.
 - **Permanent Locally Subsidized Housing** - The majority of DMH housing resources are directed toward permanent housing for mental health consumers. DMH's locally funded "bridge" housing subsidy program assists consumers who pay 30% of their income for rent until a Federal voucher is obtained or self-sufficiency is achieved. Funding from the Mental Health Block Grant (housing subsidy) and the PATH Grant (one time security deposits and eviction prevention) supports the housing initiative.
 - **Permanent Federally Subsidized Housing** - HUD vouchers for DMH consumers include: Shelter Plus Care; Partnerships for Affordable Housing; DMH Set Aside; Mainstream Housing for People with Disabilities; and Housing Choice Vouchers-Pathways.
2. **DMH "Capital Infusion" Program (200 units/ 100 per year)** - The DMH capital fund, is utilized for the production of new permanent, affordable housing. Approximately \$12 million will be leveraged in FY 2008. Over 100 housing developers participate in the capital program. The properties remain in use for DMH consumers for 25 years.
3. **Contracted Community Facilities/ 24-hour supervision** - The houses are licensed by the DMH Office and Accountability, Division of Licensure.
4. **Non- Contracted Community Facilities/ 24-hour supervision** - The operators for this category of homes does not receive funds from DMH.

The charts below list the supported housing and residential services that is currently available.

Supported Housing and Residential Programs

Supported Housing Programs	Number of Units
DMH Bridge Rental Subsidy Program <ul style="list-style-type: none"> Tenant and Project-based bridge subsidy program Consumer pays 30% to 35% of income for rent Includes homeless, DC Linkage Program/Options /Jail Diversion, S.E.H., Long Term Supports Grant, domestic violence, older adults, transition age youth, families, dually diagnosed, rent burdened Must be registered with DC Housing Authority 	660
Supported Independent Living (SIL) Contract <ul style="list-style-type: none"> Includes Mental Health Rehabilitation Services (MHRS) as needed and documented in the Individual Recovery Plan (IRP); also monthly onsite visits and monitoring required by CSA - Green Door (70); Coates & Lane (35); Comm. Conn. (240); Woodley House (55); Deaf Reach (15) and Anchor (41) 	461
HUD Shelter Plus Care <ul style="list-style-type: none"> Permanent housing subsidy program Targets homeless, dual diagnoses of mental illness, substance and/or HIV/AIDS 	130
HUD Mainstream Housing for People with Disabilities <ul style="list-style-type: none"> Individual pays 30% of income for rent 	40
HUD/DCHA Housing Choice Voucher Program - DMH Set-Aside <ul style="list-style-type: none"> Individual pays 30% of income for rent 	50
Partnerships for Affordable Housing - Project-based HCVP HUD/DCHA	130
Housing Choice Vouchers - Pathways/ Homeless Outreach to Housing First	75
HIV/AIDS Administration (HAA) and DMH MOU	7
HUD Chronic Inebriates Grant - Pathways to Housing	52
TOTAL SUPPORTED HOUSING	1605

Residential Service Homes for DMH Consumers

Community Residential Facilities (CRFs) (6 to 8 beds per house)	Total Beds
DMH Contract Residential Beds DMH residential contract providers: Careco (43), Community Connections (81), Coates and Lane (25), Deaf Reach (11), and Life Stride (63)	223
DMH Transitional Facilities Woodley House/Valenti Woodley House/Pilot	15 8
Independent CRF Residential - Non contract (Licensed by DMH)*	436

Crisis Stabilization Beds <ul style="list-style-type: none"> • Crossing Place (Woodley) 8 beds • Jordan House (SOME) 7 beds 	15
TOTAL RESIDENTIAL	697

*Information Source for residential: DMH Office of Accountability, Division of Licensure 8/21/07
Housing Statistical Update

Highlights of Some Major Recent Accomplishments

Some of the accomplishments during FY 2005 and FY 2006 include: 1) developed financing strategies for over 200 new affordable housing units, 2) ongoing work with developers and landlords to identify sites for affordable housing, 3) providing housing options to over 1,000 DMH consumers, 4) accessed additional project-based Federal subsidies, 5) opened 32 new single room occupancy (SRO) housing units, 6) expedited the placement of over 125 indigent consumers at Saint Elizabeths Hospital into community housing, and 7) worked with over 127 licensed community residential facilities (CRFs) who provide supervised settings for over 700 individuals.

During FY 2006, planning began for the MyHouse Project, a pilot project funded by the Conrad Hilton Foundation for assisting District of Columbia tenants who are consumers of mental health services in danger of losing their homes. The project uses mediation rather than traditional court proceedings to facilitate landlord/tenant communication in order to avoid potential homelessness. The project was implemented during FY 2007.

Other activities during FY 2007 included receipt of funding to house persons with mental illness and HIV/AIDS, finalization of the housing database, re-institution of the Housing Advisory Committee, Draft Housing Rules, and designation of one site to Pathways DC that has housing based subsidies already attached to facilitate the discharge of consumers from Saint Elizabeths Hospital. Through the HUD SuperNOFA grant process under the Continuum of Care, DMH placed number one in the new programs category and received 20 new Shelter Plus Care Program subsidies.

Housing Working Group and Housing Advisory Committee

The DMH formed two separate partnership groups to assist with implementing the housing production objectives and to provide continuous planning and monitoring of the Housing Business Plan. These are: 1) a Working Group consisting primarily of representatives from the public agencies to provide technical expertise on specific aspects of the development process, such as site selection, loan review and capital funding; and 2) an Advisory Committee representing consumers and other mental health advocacy groups, and housing and support service providers to provide policy input, and assist in developing additional goals and strategies based on their experience with DMH customers.

The scope of the Annual Housing Business Plan is focused on the Department's activities relative to the goals laid out in the initial Housing Plan, that is, to transform the housing delivery

system to a recovery-based approach that promotes greater choice, and self-determination among its consumers through the provision of permanent supportive housing. Along with its partners, DMH can achieve the objectives that will fulfill the vision articulated by the Housing Plan.

Housing Related Grants

During FY 2004, DMH was awarded two housing related grants. The Assets for Independence (AFI) demonstration project to establish an Independent Development Account (IDA) program targeting mental health consumers with a particular emphasis on alleviating poverty through the promotion of homeownership. Through the use of matching deposits and supportive services, DMH will help low-income mental health consumers to acquire both the capital and the skills that they need to set goals for the future, integrate themselves into the mainstream economy, and achieve economic self-sufficiency. In order to achieve the project goal, DMH has established four strategic objectives: 1) increase the number of project participants who are homeowners, 2) increase the number of project participants who acquire post-secondary education, 3) increase the number of project participants who create or expand a micro-enterprise, and 4) enhance the capacity of the national AFI program to support mental health consumers. The DMH has identified the non-public funding match. Therefore, the plan is to begin implementation now that the match has been identified.

The second grant is designed to address the need to improve access and coordination of long-term supportive services with affordable housing for persons with mental illness, mental retardation and developmental disabilities (MI/MRDD). This project brings together government agencies that address the needs of this population and service provider organizations responsible for housing, to remove barriers to accessing housing and to increase homeownership for these targeted population through an improved infrastructure. The grant effort concentrates on the following tangible results: 1) an integrated and streamlined process for applying for Medicaid funded long-term supports and housing choice options; 2) a mechanism is being established to pay for transition needs (i.e., rental deposits, furniture, bedding, etc.) of individuals moving out of an Intermediate Care Facility for Mental Retardation (ICF-MR) to community housing; 3) a process has been developed that provides individuals with disabilities access to housing of their choice, to include both individual and collaborative relationship housing options; 4) a Section 1115 Research and Demonstration Project Medicaid waiver will be created to eliminate barriers that prevent individuals sharing a home from pooling long-term supports; and 5) a new infrastructure is being developed comprised of the District agencies that will facilitate implementation of housing options for persons with disabilities who can receive information and support in the process of purchasing their own home. A Housing Advisory Group was established comprised of consumers, advocates, housing representations, Medical Assistance Administration and other stakeholders. The Advisory Group meets monthly to develop the infrastructure for long-term supports and housing.

In FY 2008-2009, DMH, in concert with its partners, will seek to meet the following major objectives:

1. Continue to finance the development of 100 new housing units each year.
2. Continue to work with the new housing intermediary structure for more cost-effective use of DMH capital funds.
3. Implement the “Housing First” approach through Pathways D.C. for 75 DMH consumers. This approach is being expanded.
4. Try to reach the Dixon Performance Target to provide housing related services to 70% of persons referred within 45 days of a referral.
5. Continue to implement the two grants that enable mental health consumers including those with mental retardation and developmental disabilities acquire affordable housing.
6. Implement the new FY 2008 Shelter Plus Care grant.

Health Services

The DMH MHRS standards require that the health status of the consumers of DMH services be screened at least every 90 days as part of the assessment process that is part of the Individual Recovery Plan (IRP). It is the responsibility of the assigned Core Services Agency (CSA) clinical manager to assure that the health issues are followed up.

As a result of increasingly more consumers with medical conditions that make it difficult to place and/or maintain them in community settings, in June 2007 DMH hosted a small interagency meeting with the Department of Health (Medicaid, HIV/AIDS) to begin a dialogue about how to collectively address this issue. In August 2007, the meeting grew into an expanded meeting of public and private health and mental health providers, advocates, and District agencies including disability services, and aging. Some of the activities include: 1) obtaining a summary of Medicaid waivers, 2) documenting the numbers of consumers and medical needs, and 3) identifying the billing opportunities under the Mental Health Rehabilitation Services (MHRS) program to bill for Medication/Somatic. A third meeting of what has become the Medically Compromised Consumers Planning Group will be held in September 2007. This activity will continue in FY 2008.

Medical and Dental

Documentation of annual physicals is also a MHRS requirement. Health services are available through medical and dental services clinics provided through Saint Elizabeths Hospital and medical services provided by the DC CSA, as well as the District’s community health system.

The DMH currently provides free medical as well as psychiatric medications to those individuals who do not have Medicaid or other means to purchase them. The Department’s goal is to increase the number of consumers enrolled in the D.C. Health Care program and other medical resources. A resource guide was developed and disseminated that includes information on how to assist those consumers who do not have Medicaid in accessing health insurance through the D.C. Health Care program. The focus has been on coordinating services through other health

care providers while concentrating on providing care to consumers difficult to connect to other medical services (i.e., geriatric and undocumented consumers).

Medication Services

The DMH is continuing the implementation of the District of Columbia Medication Access Project (D.C.MAP) that provides algorithms (guidelines and procedures) for psychiatrists treating consumers with schizophrenia. This program is modeled after the highly successful Texas Medication Algorithm Program (TMAP), developed by the Texas Department of Mental Health and Retardation in collaboration with Texas universities. Algorithms help facilitate clinical decision-making by providing physicians with current information on the newest psychotropic medications and research data, as well as specific treatment sequences with tactical recommendations. It is expected that the employment of such treatment guidelines to treat individuals with serious mental illness may bring about a decrease in the use of crisis/hospital services and the number of clinical visits. This will also increase overall efficiency of consumer care while providing accountability for scarce resources.

The D.C.MAP has been implemented throughout the District system of care and Saint Elizabeths Hospital. Algorithms for schizophrenia and depression have been distributed. The D.C.MAP has a consumer/family education component that is very helpful for consumers in understanding the nature of their illnesses, use of medications, reasons to continue medications, and self-assessment. Easy to understand, consumer educational materials have been developed in English and Spanish.

Prescribing Practices: The DMH is working with the Medical Assistance Administration (MAA) and their contractor (Comprehensive Neuro-Sciences) to analyze medical point of sell data by examining poly-pharmacies and dosage of all psychotropics. Beginning in FY 2005, a plan was initiated for prescribers whose practices fall outside of practice guidelines, whereby educational letters would be forwarded to have them review their prescribing practices. The plan continued through FY 2007.

In FY 2007, there was agreement between the Court Monitor and DMH that the Department met the Dixon Exit Criteria to increase the number of adults with schizophrenia who receive the new generation antipsychotic medications to 70%.

DMH is expected to continue to monitor this performance measure in FY 2008.

Educational Services

DMH Training Institute

The Final Court Ordered Plan (March 2001) required the establishment of a Department Training Institute. Initially, the main focus of the DMH Training Institute was educating the stakeholder community of providers, consumers, family members, advocates and citizens about the new system reform under the Medicaid Rehabilitation Option (MRO) and the new Mental Health Rehabilitation Services (MHRS). The DMH Training Institute has evolved into a primary mental health workforce development training and community education medium for District

agencies, human services providers, consumers, family members, and community residents. The Institute's Fall and Spring training series provide a wealth of information on a range of topics (i.e., mental health diagnoses, consumer populations (child/youth, adults, older adults), consumer choice, consumer leadership skill building, family member issues, recovery model, MHRS training, service delivery models and settings, co-occurring disorders, cultural competency, evidence-based practices, privacy issues (HIPAA), workforce development issues). The training program is developed in partnership with consumer, family member, community, academic, professional, federal and local government agencies. An important feature of the DMH Training Institute is the award of continuing education units (CEUs) for several disciplines.

Office of Consumer and Family Affairs (OCFA)

The OCFA has focused on educating consumers on community resources so that they do not depend totally on DMH for services that are available in the community. This education has included services such as assistance with utilities, food banks, rehabilitation services for those consumers who want employment options and other essential needs of consumers living in the community. The OCFA also educates consumers on the grievance system and continues to educate about their rights and the remedies available to them if they feel that their rights have been violated. The OCFA has also continued to coordinate the DMH Recovery Initiative. In FY 2005, two forums were held, one focused on compelling consumer self reports about their journey to recovery, and the other presented the Wellness Recovery Action Plan (WRAP). The FY 2006 forum addressed employment issues. The OCFA has also planned and coordinated a seminar for consumers, case managers, and families on the new Medicare Part D Prescription Drug Program including establishing a hotline at DMH to answer questions. Some of the OCFA activities for FY 2006 and FY 2007 include sponsoring a Peer Recovery Specialist training initiative, employing consumers at the DMH Authority some of whom have been hired including at the DC CSA, sponsoring WRAP training that allowed some consumers to become official WRAP Facilitators, and providing consumer rights training to consumers, providers, DMH staff and community organizations. The OCFA will continue its consumer oriented initiatives in FY 2008.

D.C. Community Services Agency (DC CSA)

The DC CSA now has two consumer education programs. One of the programs is a Computer Training Center. The other program is a Life Long Learning Center (literacy and remedial educational instruction including preparation for the General Equivalency Diploma/GED).

General Educational Services

Educational services are also available in the Washington, D.C. community. These services address the individual needs of consumers with various disabilities. There is a full range of educational opportunities, from basic literacy through the GED and college.

Mental Health Training for Providers of Emergency Services

In addition to providing training for consumers and a variety of mental health stakeholders and the public, DMH is committed to training others who impact consumers. The DMH has partnered with the Metropolitan Police Department (MPD) to provide training to new police recruits and other officers on mental health issues including dealing with mental health consumers. Additionally, DMH has offered a variety of other specialized trainings such as hostage negotiation. The DMH also trains other agency staff on issues related to homelessness, hypothermia, and mental illness. These staff include providers of emergency services. The DMH also conducts training for its own staff to become officer agents (a person who can file an FD-12/ involuntary application for psychiatric assessment). This training focuses on legal, clinical and ethical issues.

In February 2007, DMH established a Crisis/Emergency Services Planning Work Group that had broad participation from MPD, Fire and Emergency Medical Services (F/EMS), the courts, crisis providers, consumers, family members, homeless providers, public and private mental health providers, and advocates. An Interim Report was disseminated in July 2007. A Final Report is expected to be developed by Fall 2007.

The DMH Training Institute developed a Crisis Restraint Training series during the third quarter of FY 2007 that will be implemented in the fourth quarter of FY 2007 (September 2007). The participants will include Comprehensive Psychiatric Emergency Program (CPEP) staff, Saint Elizabeths Hospital staff, and District Core Services Agency crisis staff.

Substance Abuse Services

The DMH continues its collaboration with the Addiction Prevention and Recovery Administration (APRA) in implementing the Comprehensive, Continuous, Integrated System of Care (CCISC) model of care for the provision of services to individuals with co-occurring mental illness and substance use disorders. With the award of the Co-Occurring Disorders State Incentive Grant (COSIG) during FY 2005, DMH and APRA will be able to accelerate the steps already underway to: 1) establish an integrated approach to service delivery for persons with co-occurring mental illness and substance use disorders, 2) screen all individuals who present for treatment in partner agencies for the presence of co-occurring disorders, 3) provide integrated clinical assessments for all individuals who screen positive for both mental health and substance abuse disorders, 4) treat people with co-occurring conditions with the most appropriate interventions and recovery supports consistent with current science and best practices, 5) create the financial incentives, programmatic infrastructure and information system supports so that clinicians and service programs will continue to improve screening, assessment, treatment, and recovery support for people with co-occurring conditions, and 6) build a learning network for continuous quality improvement.

The progress during FY 2006 on the COSIG includes: 1) DMH and APRA have adopted provider standards for screening, integrated assessment and appropriate treatment for mental

illness and substance use disorders, 2) targeted provider trainings are ongoing, 3) the first annual Leadership Training has been completed and a 100-hour Educational Certificate Program in Co-Occurring Disorders has been developed for providers with sections running through 2008, 4) a regular D.C. COSIG Newsletter is published, 5) DMH and APRA are developing a single process for provider agencies to qualify for the designation of “Co-Occurring Competent Agency,” 6) interagency data sharing initiatives for care coordination and performance monitoring are ongoing, 7) clinical chart audits on co-occurring disorder indicators are ongoing in both agencies, 8) “Outcomes Informed Care”, an evidence-based practice shown to improve consumer outcomes, is being tested in multiple mental health and substance abuse clinical sites with the intention to fully implement the model by 2008, 9) a series of strategic continuous quality improvement projects are underway to improve linkages, communication, coordination and collaboration among agencies and programs across the District, and 10) D.C. COSIG is creating an Institute for Quality Improvement, which will be the sustainable cross-agency platform for continuous improvement of consumer outcomes, performance tracking, benchmarking, provider performance incentives and an ongoing learning network within the District of Columbia.

In March 2006, DMH and APRA entered into a Memorandum of Understanding (MOU) to provide services for persons who have both a mental illness and a substance abuse issue. The agreement requires DMH to provide funds to APRA for substance abuse vouchers utilizing the APRA Choice in Drug Treatment Program, and funds for mental health services at the APRA Detoxification Facility. The MOU continued in FY 2007.

Services for Persons with Other Co-occurring Disorders

The DMH recognizes that there are many other different possibilities of co-occurring disorders (i.e., mental illness/mental retardation, mental illness/HIVAIDS, mental illness/hearing impairment, etc.). This section will address mental illness/mental retardation.

Mental Illness/Mental Retardation Services

The DC CSA operates a program for individuals with mental illness/mental retardation/developmental disabilities/hearing impaired program. It provides diagnosis and evaluation, psychiatric treatment, behavior management, community outreach, drug therapy, medication management and other services.

During FY 2005, DMH and the Mental Retardation and Development Disabilities Administration (MRDDA) entered into a Memorandum of Understanding (MOU) to try to improve the health-related outcomes of persons with mental retardation who have a mental health related disorder or who have mental health problems. Specifically, the MOU focused on establishing effective interventions and enhancing the delivery of mental health services in the District for this targeted population. The MOU continued into FY 2006. Initially, DMH and MRDDA planned and conducted training sessions that outlined to providers the skills necessary to provide mental health services to individuals who are dually diagnosed with mental illness and mental retardation/developmental disabilities. The activities have included: establishment of a Joint Project Review Committee (JPRC) and Joint Dispute Resolution Committee (JDRC),

selection of two Core Services Agencies to participate in the pilot project, and the award of two ACT teams for persons dually diagnosed (MRDD/MI). At the end of June 2006, one of the ACT providers stopped providing mental health services leaving one ACT team. Also, by the end of FY 2006, there were 64 individuals in the pilot project.

While an effective cross agency tracking system was working in FY 2005 and FY 2006, due to significant staff and organizational changes in MRDDA the pilot project was adversely impacted. The former MRDDA is now the Department of Disability Services (DDS). The DDS have met with Saint Elizabeths Hospital staff to discuss discharge planning for individuals leaving the hospital who also have a diagnosis of mental retardation. The DDS and DMH Authority staff have met to discuss service planning and options for this population including the pilot project. In August 2007, there were approximately 56 consumers in the pilot program.

In FY 2006 and FY 2007, DMH also continued working on a grant project that includes individuals in both the DMH and DDS systems to assist providers in the removal of barriers to accessing housing and increasing homeownership for this population, as well as youth aging out of the foster care system.

Case Management Services

The DMH strives to create an effective, welcoming, community support/case management system that is based on the consumer strengths and choices, promotes recovery through the attainment of individualized goals to help the consumer develop the skills to live the best possible quality of life, and provides aggressive outreach to maintain consumers in the community. The DMH case management is provided to consumers in a number of ways by both DMH practitioners and private providers and is based on the individual consumer's treatment needs as determined through the individualized recovery planning process where attainable, mutually agreeable goals and objectives are developed. Each consumer is assigned a clinical manager (case manager) and qualified practitioner to coordinate consumer care, often across multiple provider agencies and to provide rehabilitation services, treatment and supports. At a minimum of every 90 days the consumer's clinical manager is responsible for assessing with the consumer each of the consumer's major life domains and assess which areas of need are to be worked on for the next time period.

The following values and principles guide the DMH in achieving this goal of effective case management:

- Consumers are provided choice in choosing their Core Services Agency, Clinical Manager, and type of housing.
- Consumers can expect to be provided empathetic, hopeful, rehabilitative services that develop measurable skills to promote successful independent living.
- Clinical Managers maintain continuous responsibility for their client until the consumer chooses another Clinical Manager or recovers; responsibility continues even when the consumer is hospitalized, in a residential setting, or incarcerated.

- The DMH is committed to expanding the scope of community-based services.
- The DMH provides a comprehensive and effective continuum of assessment and treatment and assures movement within service settings so that the most appropriate, least restrictive setting is utilized when available.
- All DMH consumers have the right to access high quality care in a timely manner.
- The DMH facilitates the integration of a full range of services that is available to each consumer and meets the mental health needs of each consumer.
- The case manager is supported by regular supervision, both administratively and clinically, from managers and/or senior clinicians. The DMH provides on-the-job training and course work to supplement the basic qualifications of the case manager.
- Services will be provided in the least restrictive, most appropriate setting.
- Clinical Managers and providers strictly respect the confidentiality and privacy rights in all treatment planning and provision of services. Complete adherence to all confidentiality mandates pursuant to local and federal regulations will be maintained at all times.

Activities to Reduce Hospitalizations

The DMH is engaged in a number of activities that will lead to a reduction in hospitalization.

Crisis Stabilization

The Department has expanded crisis/emergency services. Each CSA must have an on-call system for crises and provide a crisis plan for each consumer in their Individual Recovery Plan (IRP) or Individual Service Specific Plan (ISSP). The DC CSA is certified to provide crisis/emergency services that include mobile and on-site crisis assessment and stabilization services 24 hours a day, seven days a week and serve as a central point of entry into DMH for non-DMH consumers experiencing crises, especially those requiring hospitalization. The Access HelpLine also receives referrals for crisis services.

During FY 2005, DMH implemented a proposal for psychiatric emergency and crisis services that included: 1) expansion of mobile crisis teams, 2) expansion of extended observation units, 3) expansion of crisis residential capacity, and 4) expansion of ACT services. Some of the activities and outcomes achieved through FY 2007 include: the creation of a Crisis/Emergency Services Planning Work Group; the establishment of 15 crisis beds (eight at Jordan House and seven at Crossing Place); and the development of ACT teams for service populations including forensic, dually diagnosed with mental illness and mental retardation and/or developmental disability, and chronically homeless.

With regard to the Crisis/Emergency Services Planning Work Group, the DMH Director chairs this body that has met on a biweekly basis since February 2007. It is composed of law enforcement, medical and other emergency services, the courts, local mental health and other providers, consumers, family members, and advocates. The work group has undertaken a thorough analysis of current internal gaps and interviewed other jurisdictions with comprehensive crisis/emergency systems. The overall components of a crisis/emergency system have been identified. These include (at a minimum): a 24/7 crisis/emergency services hotline, mobile crisis services, crisis observation beds, and crisis/respite beds. All of these services will need to be carefully planned with law enforcement so as to ensure clear understanding of roles and the appropriate diversion of people into the mental health system. A Draft Interim Report was circulated to the work group in July 2007. It is anticipated that a Final Plan inclusive of the organizational structure and funding strategies will be circulated by Fall 2007.

Reducing Reliance Upon Hospitalization

The DMH has made and will continue to make strenuous efforts to reduce the reliance on hospitalization at Saint Elizabeths Hospital. The development of the MHRS system of care and other adult services development initiatives described previously are all targeted to enhance the adult service system and reduce the number of patients residing at Saint Elizabeths. These efforts result from a commitment to provide individualized services and supports in the most integrated setting possible. The development of community-based alternatives to hospitalization is required as well in *Dixon v. Fenty*, the longstanding federal court case concerning mental health treatment in the District. Although the court-ordered Receivership has ended and the court- monitoring phase of the settlement is in progress, the Exit Criteria of this case and mission of DMH is to substantially reduce the number of beds at the hospital. During FY 2005 and FY 2006, the Saint Elizabeths Hospital census ranged between approximately 412- 431 (average is 200-225 on the civil side and 206-212 for forensic). The hospital is in the process of being reduced to accommodate a 292 bed new facility projected to open by 2009.

To accomplish this reduction in census, the DMH Office of Programs and Policy has been focusing on working with the community provider network and the hospital on a weekly basis to facilitate discharge planning, assist with resource utilization and development towards placing consumers in the least restrictive setting that best meets their individual needs. The plan and process includes developing services and resources for individuals with special needs such as the hearing impaired or persons with physical disabilities. Also the process engages community providers in transition planning and efforts to promote continuity between the hospital and community.

The DMH has shown progress in implementing its Discharge Plan. The original target list was 108 patients who had been at SEH for over 30 days. The goal was to outplace 55-65 persons by July 2007. By mid June 2007, eighty (80) persons had been discharged from SEH. Seventy-two (72) were discharged into community settings and eight (8) into nursing homes. The DMH Project Team Leader for this effort has worked intensively with staff at the Authority, SEH and CSAs. While the target numbers have been exceeded, the census at SEH has not changed appreciably because patients from the acute units at SEH are moving into the longer-stay units.

Hence, the focus is now being broadened to look both at new admissions (less than 30 days) and those who have been there over 30 days.

Saint Elizabeths Hospital (SEH)

The hospital is now a separate organization within DMH and operates under its own Chief Executive Officer. Clinical Managers interface with hospital staff in order to assure continuity of care and to reduce the number and length of stay for acute hospitalizations. The CSAs are responsible for coordinating consumers' return to the community and are mandated to work closely with the consumer, SEH, and other community treatment teams to minimize the length of hospitalization. Implementation of an agreement with community hospitals to take involuntary patients has begun.

In May 2006 the Department of Justice (DOJ) issued a report regarding operation and other conditions at SEH. In response to the Settlement Agreement approved by the Court in June 2007, a Reform Plan was developed. It delineates specific actions, responsible person, target date and current status in each of the following areas: integrated treatment planning, mental health assessments, discharge planning and community integration, specialized treatment services, protection from harm, incident management, quality improvement, environmental conditions, training, staffing, and equipment/ infrastructure/IT needs.

Forensic Services

The SEH still has major responsibility for adult forensic services, however there are a number of special initiatives that the community is exploring that would enable that population to return to the community sooner and provide the additional support to assure a successful transition for the consumer and provide safeguards for the community. One of those initiatives includes consideration of moving the outpatient follow-up services for insanity acquittees on court ordered conditional release from the hospital to Core Services Agencies instead of it being a component of the hospital. This multi-year initiative will require extensive discussions with criminal justice stakeholders and legislative change.

In FY 2006, The DMH Authority, SEH and the public CSA collaborated with the Court, United States Attorney's Office for the District of Columbia, the defense bar, and the Court Services and Offender Supervision Agency (CSOSA) to implement the *Incompetent Defendants Criminal Commitment Act of 2004* which became law on May 25, 2005. The statute permits defendants adjudicated incompetent to stand trial in D.C. Superior Court to be treated and restored to competency while in the community unless the Court finds that an inpatient setting is necessary to provide appropriate treatment or the defendant is unlikely to comply with an order for outpatient treatment. Outpatient treatment, competency restoration and evaluation are a collaborative effort of the clinical staff from the public CSA and Forensic Legal Services clinical staff. DMH in collaboration with SEH, the Court and other criminal justice stakeholders continues to explore ways to enhance outpatient competency restoration services so that treatment and evaluation outside of a hospital setting will be a viable alternative for an increasing number of defendants.

The forensic mental health consumer population presents with unique challenges and needs that have given rise to a number of first-time collaborations with various criminal justice agencies in the effort to ensure access and service linkage. Within the context of this overall effort, the DMH continues working toward the following:

- Development of a coordinated response model and a diversion initiative between DMH and Metropolitan Police Department;
- Collaboration with criminal justice agencies to improve identification of service needs to aid in diversion of mental health consumers;
- Coordination with criminal justice agencies to align processes for collaborative program development, consumer access, linkage and coordinated communication between agencies;
- Collaboration between the Office of Justice Programs/Department of Justice and the Mayor's Office and with criminal justice agencies to ensure identification of needs and service linkages for previously incarcerated persons returning to the community from prison and jail;
- Development of a forensic training initiative that supports knowledge and skill-building for community providers, in service of consumers involved in the criminal justice system returning/residing in the community; and
- Development of plan and implementation to move individuals from the forensic setting to the community as appropriate.

The DMH has also adopted a diversion from incarceration initiative, Options Program, which is designed to stabilize, provide community support and housing services to pre-trial defendants charged with misdemeanors and nonviolent felonies. The DMH received an additional \$750,000 to support jail diversion during FY 2005 to facilitate capacity building and expansion of services. In FY 2006, DMH along with the Criminal Justice Coordinating Council (CJCC) became the recipient of a \$50,000 Bureau of Justice Assistance (BJA) planning grant to develop a strategic plan for persons with serious and persistent mental illness or co-occurring mental health and substance abuse disorders involved in the criminal justice system. The Saint Elizabeths Hospital, through its Forensic Division, provides inpatient services for consumers entering the DMH system who are in need of inpatient care and involved with the Court's Criminal Division.

Other Support Services

The DMH provides an array of rehabilitative and support services directed toward enabling adults with serious mental illness to live in the least restrictive community setting, as independently and self-sufficiently as possible. Large-scale training has been provided to staff to shift to a strengths-based recovery model of treatment and rehabilitative services. Working with consumers on their areas of choice and reaching mutually agreeable goals is seen as paramount

in receiving good outcomes. The Individual Recovery Plan (IRP) assessment and treatment planning process requires that the life domains of individuals such as the need for housing, meaningful activities such as work or education, interpersonal relationships, socialization, medical/health needs and mental health services and supports are assessed. Rehabilitative services are provided directly by DMH staff and through contractual arrangement with private providers.

While DMH has integrated rehabilitation services and activities throughout its MHRS system of care, the development of evidence-based practices for services and supports in the areas of supported employment and supported housing has been a major focus. This is in keeping with the many formal and informal discussions with DMH stakeholders especially the consumers, who when asked state that their most common goal is to have a job and a decent, safe affordable place to live.

The services provided by the DMH Office of Consumer and Family Affairs may also be considered support services. These include but are not limited to: 1) educating consumers on their rights and exercising choice, 2) overseeing the implementation of the grievance review process, including contract monitor for the Independent Peer Advocacy service, 2) tracking, monitoring and ensuring that periodic psychiatric examinations are automatically conducted for committed consumers every 90 days from the date of the prior examination, or if a recent commitment, 90 days from the date of the commitment order; 4) launching a Certified Peer Recovery Specialist program, 5) launching the Recovery DC Initiative, and 6) planning and conducting a job fair for mental health consumers.

Some of the major activities initiated by the OCFA through FY 2007 include:

- Employment – The DMH has successfully employed over 20 consumers in short and longer term contract employment assignments in various offices at the Authority. Several of these persons have gone on to obtain full time permanent employment at DMH or the DC CSA.
- Consumer Choice – The OCFA has worked closely with other DMH offices to ensure that consumers are successfully transitioned out of closing programs. The OCFA has been present to ensure that consumers receive adequate information and individual assistance to make an informed choice about a new provider.
- Consumer Advocacy – The OCFA actively assisted in the creation of a Patient Advisory Council at the John Howard forensic facility at SEH. Consumers from each unit participate on this Council and a consumer is elected to chair the meeting. The goal is to openly communicate with Administrative staff on issues of both patient rights and patient responsibilities.
- Wellness Recovery Action Plan (WRAP) – The OCFA has continued its leadership role in promoting WRAP. In addition to ongoing groups at John Howard, OCFA contracted with the Copeland center to provide a 3-day introduction to WRAP for 16 consumers. Fourteen (14) of these consumers went on to additional training and are now official

WRAP facilitators trained by the Copeland Center. The future goal is to train 20 WRAP facilitators per year with dedicated funding to achieve this support.

- Consumer Rights Training – The OCFA continues to provide consumer rights training to consumers, providers, DMH staff and community organizations. For example, over 200 Community Residential Facility (CRF) staff and owners were recently trained.

Evidence-Based Practices

The DMH is implementing a number of evidenced-based practices (EBPs) and promising practices, (i.e., supported housing, supported employment, medication algorithms, integration of mental health and substance abuse services, and assertive community treatment) for persons being released from Saint Elizabeths Hospital, from jails and prisons, persons who are high users of emergency services, and chronically homeless individuals. The table that follows briefly summarizes these initiatives.

EBPs/Emerging Best Practices	Activities	Partners	Issues/Solutions
Supported Housing	Working with public and private partners on permanent housing for persons with SMI. Trying to reach Dixon Exit Criteria target that 70% of persons referred receive housing services within 45 days of a referral. Administering two federal grants for homeownership including financial literacy.	Housing Authority (DCHA), Housing Finance Agency (DCHFA), Department of Housing and Community Development (DCHCD), Manna Inc, Community Partnership for the Prevention of Homelessness	Finding safe, decent and affordable housing for consumers with extremely low incomes. Continue the rental subsidy program to bridge the gap between consumer financial resources (primarily entitlements) and housing costs.
Supported Employment	Implementing the Individual Placement and Support (IPS) model at six agencies. Trying to maintain the Dixon Exit Criteria target that 70% of persons referred receive services within 120 days of a referral.	Rehabilitation Services Administration (RSA), Dartmouth Psychiatric Research Center, ISP providers (i.e., Green Door, Anchor Mental Health, Community Connections, Psychiatric Center Chartered, Deaf-Reach, D.C. Community Services Agency/ DC CSA)	A service access issue has been raised, namely does everyone who wants the service receive it. DMH will increase the daily rate and bring a new provider on-board to increase capacity. An outreach plan will be implemented directed at providers and consumers. DMH will explore developing a Medicaid waiver for supported employment to bring in federal funds along with local dollars.

EBPs/Emerging Best Practices	Activities	Partners	Issues/Solutions
Assertive Community Treatment (ACT)	Collecting and analyzing data, providing information to ACT teams, and providing consistent procedures across teams, and educating referral sources and stakeholders about service. Trying to reach Dixon Exit Criteria target that 85% of persons referred receive services within 45 days of a referral.	Psychotherapeutic Outreach Services, Pathways to Housing, DC CSA, Family Preservation Services, Inc.	Assigned ACT Coordinator within Access HelpLine/ Care Coordination to work with teams; conducted a review of ACT teams to address capacity and clinical issues.
Medication Algorithms	Implementing D.C. MAP (provision of newer generation antipsychotic medications to adults with schizophrenia). Reached the Dixon Exit Criteria target that 70% of persons with schizophrenia receive these medications.	Saint Elizabeths Hospital and provider network	DMH is working with the Medical Assistance Administration (MAA) to analyze medical point of sell data by examining poly-pharmacies and dosage of all psychotropics. Educational letters are sent to have prescribers review their practices.
Integrated MH/SA Services	Implementing a comprehensive, integrated systems model for persons with mental illness and co-occurring substance abuse disorder via a Co-Occurring Disorders State Incentive Grant (COSIG).	Department of Health (DOH)/Addiction Prevention and Recovery Administration (APRA)	The COSIG is the mechanism by which the integrated model for individuals with mental health and substance abuse issues is being implemented.
Jail Diversion	DMH jail diversion program called D.C. Linkage Plus, provides pre- and post-booking continuity of care services for individuals with mental illness connected to the criminal justice system; screening and referral for individuals referred from traffic court; and funds substance treatment and housing for women referred pre and post arrest for services.	DMH Options Program at Community Connections, D.C. Superior Court, Supervision Unit of D.C. Court with Pre-trial Services and Traffic/Community Court, Central Detention Facility (jail), N Street Village Recovery House	In March 2005 a MOU was initiated between D.C. Pre-trial Services (PSA), Court Services and Offender Supervision Agency (CSOSA) and DMH to ensure full integration of systems so that service delivery is completely seamless. In late FY 2005, D.C. Linkage Plus was launched as the umbrella program for the DMH jail diversion services. In FY 2006 DMH and Criminal Justice Coordinating Council awarded a Bureau of Justice Assistance Grant to develop an overall strategic plan for persons with serious mental illness

EBPs/Emerging Best Practices	Activities	Partners	Issues/Solutions
			or co-occurring conditions who are involved with the criminal justice system. This plan will be built on the Sequential Intercept approach. The goal is to have this plan completed by September 2007.
Offender Re-Entry Program	DMH participates in the District's community re-entry program for serious, violent offenders between the ages of 18-35 who are returning from the Federal Bureau of Prisons. It is estimated that approximately 2500 will return each year. DC conducted pilot program (FY 2004-FY 2006) for 400 previously incarcerated persons. DMH provides assessment and referral to appropriate mental health services.	Court and D.C. multi-agency venture	Mayor hired a Director of the D.C. Ex-Offender Re-entry Initiative to oversee the program. DMH hired a Mental Health Specialist to help fulfill its role related to this program.

Criminal Justice Diversion

In FY 2001, the Options Program (post-booking) was developed through collaboration between the Public Defender Services, Office of the Corrections Trustee, Pre-trial Services, and DMH in coordination with the District of Columbia Superior Court. The DMH continues the Options Program through Community Connections, a provider agency. The mission of the Options Program is to service the needs of pre-trial defendants with mental illness by promoting pre-trial release of appropriate defendants to community-based case management and treatment; ensuring the defendant's return to court, and providing for the public safety. The DMH has staff assigned to the Central Detention Facility (jail) to provide linkage and other support services to detainees with mental illness.

During FY 2005, DMH received \$750,000 for its Jail Diversion Initiative to facilitate capacity building development and expansion of services. In FY 2006, DMH created D.C. Linkage Plus to serve as the umbrella program for all jail diversion and related initiatives. The FY 2006 activities include: 1) target \$1.5 million toward expanding D.C. Linkage Plus; 2) provide pre-booking and post-booking continuity of care services for individuals with mental illness connected to the criminal justice system; 3) provide screening and referral for services for individuals with mental illness referred from the D.C. Superior Court's Traffic/Community

Court; 4) fund N Street Village Recovery House, a 21 bed facility, to provide substance treatment and housing for women with mental illness referred pre- and post-arrest for services in order to prevent incarceration and/or recidivism; and 5) work closely with the criminal justice agencies to communicate and develop a stronger and improved working relationship.

The DMH also began providing outpatient competency restoration treatment to individuals referred from D.C. Superior Court. The services are provided in conjunction with D.C. Community Services Agency and Saint Elizabeths Hospital Forensic Legal Services Branch. The development of this service decreases the utilization of inpatient beds and provides the service in the least restrictive environment.

In FY 2006, DMH along with the Criminal Justice Coordinating Council (CJCC) became the recipient of a \$50,000 Bureau of Justice Assistance (BJA) planning grant to develop a strategic plan for persons with serious and persistent mental illness or co-occurring mental health and substance abuse disorders involved in the criminal justice system. The implementation of the grant continued through FY 2007. The strategic plan will be based on the Intercept Model that envisions a system that focuses on timely and effective referrals, assessments, and treatment of individuals with mental illness involved in the criminal justice system. The system would also have a base of accessible services, including comprehensive therapeutic and community support services, and safe and affordable housing as well as employment opportunities. In August 2007, community forums were held (one for consumers and family members and one for providers and advocates) to review and discuss elements of the plan and receive feedback. It is anticipated that the final strategic plan will be developed in September 2007.

During FY 2008, DMH plans to initiate a pilot Court Urgent Care Clinic (CUCC) to be based at the DC Superior Courthouse, DC Misdemeanor and Traffic Community Court. The CUCC will be specifically targeted at persons who pass through the Misdemeanor and Traffic Community Court who are identified as being in need of mental health services. This court-based Urgent Care Clinic will identify, assess, support and develop relationship with those in need of mental health services. This may include persons who are dually diagnosed with a substance abuse problem, have serious physical health issues, are seniors, Veterans, or others who come from a variety of backgrounds. The goal of the pilot program would be to establish a well-run, organized and accountable Clinic over a nine month period and to determine the eventual need and scope of the fully functioning CUCC.

Offender Re-Entry Initiative

Serious and violent offenders between the ages of 18-35 are being re-integrated back into the community, who are returning from the Federal Bureau of Prisons. The District conducted a pilot program (FY 2004-FY 2006) for approximately 400 previously incarcerated persons. This multi-agency venture offered a one-stop re-entry program (single center) where employment, social services, and life needs were provided in a collaborative and comprehensive manner. The agency partners (employment, human services, health, mental health, motor vehicle, parks and recreation, child and family services) assigned staff to the Assessment Center. The DMH role included assignment of a full-time staff person to the Assessment Center providing mental health screenings, linkage to Core Services Agencies (CSAs), and follow-up/monitoring to ensure that

individuals are engaged and are receiving the services that are needed. This was a grant funded activity that ended in June 2006.

The project has continued and this Re-Entry One Stop Center is now known as Project Empowerment Plus. The DMH has a Mental Health Coordinator on location to provide the mental health services and accept D.C. Linkage Plus referrals from Court Services and Supervision Agency (CSOSA) and the Bureau of Prisons.

Annual Adult Community Services Reviews

The Final Court-Ordered Plan required that performance measures be developed and used within a methodology for measuring service system performance. The Annual Community Services Reviews for adults and children fulfill this mandate.

The Annual Adult Community Services Review (CSR) was completed during a two week period in April 2007. The total number of cases was 55, with approximately half of the reviews done by DMH staff and half by Human Systems and Outcomes, Inc. (HSO) reviewers. HSO is a consultant group engaged by the Court Monitor.

The Year 5 (2007) results indicate that 69% of the persons reviewed were in the acceptable range for overall individual status. This shows a consistent pattern with previous years. Year 4 (2006) was at 65% acceptable and Year 3 (2004) was at 67% acceptable. Year 5 (2007) shows continued progress on many factors impacting the person's status, e.g. safety (82% acceptable), living arrangements (78%), and overall satisfaction (90%). Other key factors while improved from prior years did not score as well, e.g. social network (53%) education/career preparations (50%), and work (54%).

The Year 5 (2007) results for systems performance was at 80%. This compares very favorably to Year 4 (2006) which was 69% and Year 3 (2005) at 51%. System performance indicators in key areas also reflected a consistent upward trend, e.g. goodness-of-service fit went from 55% (Year 3) to 69% (Year 4) to 76% (Year 5). These positive improvements reflect that the larger CSAs (most notably the DC CSA) have put considerable energy into understanding and implementing a recovery-based model.

It should be noted that while the 80% score technically meets the Dixon performance target, the Court Monitor is not ready to certify that the District should move to inactive monitoring. There are at least three issues that must be addressed in planning for the 2008 adult review: 1) the sample size needs to increase to provide more appropriate levels of confidence in the outcomes (the 54 sample size was agreed to as a starting point while the DMH was still in a developmental state), 2) there needs to be greater attention to the final sample that is reviewed (the voluntary nature of this process raises the potential that more engaged clients are more likely to participate and alternatively that persons who are marginally engaged will not), 3) inter-rater reliability between DMH and HSO reviewers needs to be carefully examined (internal reviewers tend to rate higher). As noted by the Court Monitor, none of these factors should subtract from the fact that on the adult side the DMH has made consistent and measurable improvement over the past three years.

One of the most noteworthy outcomes of the 2007 review was the five year analysis. The DMH Director and Senior Staff asked the Court Monitor and HSO to present themes, trends, and data points over the past five years. These findings were discussed extensively with senior leaders as part of an initiative that DMH has undertaken via the Institute for Healthcare Improvement (IHI). The overall goal is to identify specific practice or system performance areas in which DMH can make a real impact. The DMH is formalizing its overall priorities for 2008 related to the Annual Community Service Reviews and will share them with the Court Monitor and the provider/advocacy community.

District of Columbia

Adult - Transformation Efforts and Activities in the State in Criteria 1

Adult - Describes mental health transformation efforts and activities in the State in Criteria 1, providing reference to specific goals of the NFC Report to which they relate.

DMH is engaged in the following transformation efforts and activities with respect to Criteria 1.

Goal 2: Improve Access to Evidence Based Practices which relates to NFC Goal 5.2

Increase access to ACT services and ensure that services are delivered in fidelity to the model.

Increase access to Supported Employment services and ensure that services are delivered in fidelity to the model.

Increase access to Supported Housing services.

Maintain and improve availability of newer generation antipsychotic medications to adults with schizophrenia.

District of Columbia

Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

Definition of Serious Mental illness

Prior to FY 2002, the Department of Mental Health (DMH) defined serious mental illness as follows:

- Extended or repeated psychiatric hospitalization, or
- Multiple episodes or intensive outpatient care (i.e., day program services, emergency services), or
- Poor reasoning and/or perceived likelihood of injury to self or others. (The likelihood of actual danger need not necessarily be physical or involve violence. Likelihood of injury includes situations wherein the person inadvertently places himself/herself in a position of danger or harm to self or others), or
- Remission periods reflecting only partial rather than full recovery and return to the community, or
- Daily functioning that demonstrates persistent problems in a general life area (i.e., self-care, cognitive, emotional, social, economic, vocational/educational, residential and/or recreational).

Further, the DMH clinically defined a person who is seriously mentally ill according to diagnostic classification. He or she was a person who:

- Has a diagnosis on Axis I or II as contained in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV),
- Has or had a DSM Axis V Global Assessment Function Scale (GAF) of 50 or less, and
- Will need to be in treatment indefinitely because the GAF is likely to remain less than 51 if not in treatment.

The definitions were operationalized as follows:

- A DSM-IV 295 or 296 diagnosis (schizophrenia or major affective disorder);
- Extended psychiatric hospitalization of 90 days or more in a one year period of time;
- Two or more hospitalizations within a year; and
- Danger of injury to self or others.

At the time, these definitions were consistent with the orders in Dixon vs. Williams and its civil commitment law. As the District's mental health system has continued to evolve, a review of the definition of serious mental illness was undertaken. A new definition of serious mental illness is captured in Chapter 12, Title 22A, DCMR. Persons with serious mental illness are:

Individuals age 22 or over who currently have, or at any time during the prior year have had, a diagnosable mental, behavioral or emotional disorder (including those of biological etiology) that:

- Is or was of sufficient duration to meet diagnostic criteria specified within DSM-IV or the ICD-9-CM equivalent (and subsequent revisions), except for DSM-IV “V” codes;
- Is not a substance abuse disorder or a developmental disorder, unless co-occurring with another diagnosable mental illness; and
- Results, resulted in, or will without treatment or other support services result in a functional impairment that substantially interferes with or limits one or more major life activities, including basic daily living skills, instrumental living skills, and functioning in social, family and vocational or educational contexts.

In FY 2003, implementation began on a Level of Care Utilization System (LOCUS), for adults, to support the clinical operationalization of the new definition. The LOCUS has proven easy to use and has shown a high degree of inter-rater reliability. The DMH has used this instrument successfully in the reconfiguration of residential service placements and rates for adults with serious mental illness.

During FY 2005, DMH began to fine tune developmental activities related to establishing priority populations and priority services. Draft adult and child priority populations were developed. For adults, the profile includes persons who:

- Have a serious mental illness
- Are involved in the criminal justice system
- Have been recently discharged or diverted from an inpatient stay
- Are homeless or at risk of homelessness
- Have been dually diagnosed as having substance abuse disorder and/ or mental retardation/developmental disability

Priority services would be considered those services that: 1) that assist consumers in their recovery or building resiliency, and 2) help consumers stabilize; reduce psychiatric or behavioral symptoms that could lead to incarceration, homelessness, institutionalization or continually chaotic lives. These include:

- Assertive Community Treatment
- Jail/Residential Treatment Diversion Services
- Mobile Crisis
- Crisis Emergency
- Supported Employment
- Community-based Intervention

The DMH conducted orientation sessions with MHRs providers on the priority populations and priority services during the fourth quarter of FY 2005.

During FY 2006, the DMH Chief Clinical Officer chaired a Priority Populations Work Group that included provider representation. This body developed clinically-based, draft

criteria for DMH's refinement and operationalization of its focus on Priority Populations. As part of this process, draft definitions for priority adult and child populations were developed. The Adult priority population is defined as follows:

1202 PERSONS WITH SERIOUS MENTAL ILLNESS

1202.1. Persons with serious mental illness are:

- (a) District of Columbia residents;
- (b) Who are over the age of 18 (or over the age of 21 if in special education, MRDDA, or in foster care);
- (c) Have at any time in the last year received a DSM Axis I diagnosis or the diagnosis of Borderline Personality Disorder;
- (d) Have either a:
 - (1) documented significant treatment history as defined in §1202.2; or
 - (2) coexisting condition or circumstance as defined by §1202.6.

1202.2 A significant treatment history is defined as any one or combination of the following:

- (a) Current residence in or discharge from an inpatient psychiatric facility, or community or correctional inpatient mental health service where the admission(s) totaled twenty (20) or more days within the past two (2) years;
- (b) Five (5) or more face-to-face contacts with mobile crisis or emergency services within the past two (2) years; or
- (c) A history characterized by the previous or current treatment of symptoms that was unsuccessful at achieving control or remission of symptoms even with intensive and/or repeated exposure, the result of which was limited success in symptom control even for short periods of time outside of structured settings

1202.3 A coexisting condition or circumstance is defined as:

- (a) Release from criminal detention within the last year; or
- (b) Court ordered to treatment; or

- (c) A risk of harm certified by a qualified practitioner to be serious to extreme as evidenced by symptoms as severe or more severe than any one or combination of the following:
 - (1) Current suicidal/homicidal ideation with expressed intentions and/or a past history of carrying out such behavior;
 - (2) A history of chronic impulsive suicidal or homicidal behavior;
 - (3) A recent pattern of excessive substance use resulting in disinhibition and clearly harmful behaviors with little or no ability to abstain from use; or
 - (4) A clear compromise of ability to adequately care for oneself or to be adequately aware of the surrounding environment.

It was envisioned that an expanded work group, including clinicians and administrators with financial and data expertise would use the clinical criteria to frame how *Priority Populations* would be operationalized. This process will be revisited during FY 2008.

Description of Estimation Methodology

The District of Columbia originally developed prevalence estimates in the early 1990s. These prevalence estimates were based on Epidemiological Catchment Area (ECA) data, and assumed that sociodemographic characteristics in most areas have a general consistent relationship to psychiatric disorder as measured in the ECA study. Indirect estimation was employed to project six-month prevalence rates of mental illness for adult residents in the District.

In brief, a multivariate estimation model was developed which was based on a cross classification of five categorical variables drawn from the 1990 Decennial Census for the District. These variables, which have a demonstrated empirical relationship to mental illness, include age, race/ethnicity, gender, marital status and high school graduation. Through logical regression analysis, estimates of the prevalence of mental illness by diagnostic category were generated and subsequently applied to local demographic data.

This procedure yielded a total six-month prevalence rate (expressed as a percentage) of 21.61 for any Diagnostic Interview Schedule (DIS) disorder, which translates into a total of 105,900 cases. In other words, during any six-month period, one of every five people ages 18 and older in the District suffers from a diagnosable mental disorder. This rate is slightly higher than that of the U.S. adult population in general which is estimated at 19.5 (Regier, et al 1984). Since the publication of these data, changes have occurred in the

District's population and a more precise estimation of prevalence was published by the Center for Mental Health Services in the Federal Register March 29, 1997, Vol. 62, No. 60 pp. 14928-14932.

In FY 1999, DMH contracted with the University of Texas, Department of Psychiatry and Behavioral Sciences to provide prevalence estimates and service analyses for the District. The analyses were made available at the beginning of FY 2000. Highlights from the prevalence estimate document and the application of the prevalence estimates to program planning were presented to DMH managers by the authors of the District's prevalence estimates analyses.

The prevalence estimates are derived from an indirect estimation technique, which utilized the 1990-1992 National Co-morbidity Survey (NCS) to estimate the prevalence of mental illness in the District's population.

An assumption that underlies indirect estimation is that demographic characteristics have a consistent general relationship with psychiatric disorder. For the District, there were seven demographic variables, which were used to develop the estimation model. The demographic variables used were age, sex, race and ethnicity, marital status, education, poverty, and residential setting. Prevalence estimates across these demographic variables are provided for persons with serious mental illness and persons with serious and persistent mental illness.

The definition of these terms incorporated definitions, which evolved out of the NCS and the Center for Mental Health Services published definitions. Persons with serious and persistent mental illness (SPMI) include the 12-month prevalence of non-affective psychosis or mania; lifetime prevalence of non-affective psychosis or mania if accompanied by evidence that the individual would have been symptomatic if it were not for treatment (use of medication or any professional treatment in the past 12 months); or 12-month prevalence of either major depression or panic disorder with evidence of severity indicated either by hospitalization or use of major psychotropic medications. This definition is less restrictive than past definitions of severe mental illness and chronic mental illness.

The definition of serious mental illness (SMI) includes all individuals meeting the SPMI definition; individuals with a 12-month DSM-IV mental disorder and either planned or attempted suicide at some time during the past 12 months, persons with a 12-month DSM-IV that substantially interferes with vocational capacity, and persons with a DSM-IV disorder who had serious interpersonal difficulty demonstrated by: lack of marriage, intimate relationships, confiding relationships or affiliative interactions more frequent than once a month; or (b) reported lack of intimacy, ability to confide, and sense of being cared for or supported in all social relationships.

Publications in the Federal Register provide estimates for states. These include Estimation Methodology for Adults with Serious Mental Illness, Federal Register March 28, 1997 (Volume 62, Number 60) and Estimation Methodology for Adults with Serious

Mental Illness, Federal Register: June 24,1999 (Volume 64, Number 121). Overall these documents estimate that 2.6% of the U.S. population has SPMI and 5.4% have SMI. This contrasts with the NCS estimate of 23.9% of the U.S. population has at least one DSM-IV mental disorder during a 12-month period. The Center for Mental Health Services estimates for SMI and SPMI adults in the U.S. did not provide estimates below the county level nor did the estimates use demographics since 1990. The District's prevalence estimate addressed these issues.

In 1999, the University of Texas conducted a study of mental health need and services in the District of Columbia. The findings were reported in the FY 2003 State Mental Health Plan. The 2003 edition of the project provides a set of estimates of the need for mental health services for the District's population for 1990 and 1995 through 2000. These estimates are based on the NCS and related surveys and are projected to the District based on data from the U. S. Census. An analysis of services relative to the estimated need for 1997 and 1998 was also provided. It is hoped that the service comparisons can be updated in the near future.

As in previous studies, it is noted that the estimated rates of need for mental health services appear to be relatively high compared to the country overall, particularly due to the high levels of poverty in the District's population.

The estimates of **Serious Mental Illness** are:

6.43% (32267 cases) for 1990,
5.81% (23020 cases) for 1999 (projected),
6.10% (27889 cases) for 2000 (from the Decennial Census).

For the household population, excluding those in institutions in group quarters, the estimates are:

5.20% for 1990,
5.04 for 1999 (projected), and
5.68 for 2000 (based on the decennial census).

The estimates for **Severe and Persistent Mental Illness** for the total adult population including those institutionalized or in group quarters are:

2.81% (14104 cases) for 1990,
2.60% (10308 cases) for 1999, and
2.73% (12472 cases) for 2000.

For the household population only, the estimates are:

2.27% (10489 cases) for 1990,
2.26% (8304 cases) for 1999, and
2.53% (10772 cases) for 2000 based on the new census.

The original estimates of need for mental health services for 2000 is broken out by age, gender, ethnicity, marital status, education, poverty level, and residence in the tables at the end of this criterion.

Based on discussions with the Court Monitor and an external panel of experts, DMH modified its penetration goals to 3% for adults and 2% for adults with serious mental illness with reporting in FY 2005.

Profile of Consumers Currently Served by the Public Mental Health System

As of August 2007, there were approximately 8,212 adult consumers who had received at least one service from the DMH MHRS program. The data on services by age, gender, and race/ethnicity (Basic Tables 2A and 2B) will be developed at the end of FY 2007 (September 30, 2007) to allow for a full year of data. This data will be reported in the District of Columbia FY 2007 Progress Implementation Report (submitted to SAMHSA on December 1, 2007).

At the beginning of FY 2003, the DMH MIS changed to a claims processing system (e-Cura). As DMH transitioned to the new MIS, challenges were experienced in both data gathering and reporting. The DMH has been working to correct issues that contribute to the reporting difficulties.

On April 1, 2005, DMH launched a tool to capture data related to the Dixon Exit Criteria measures. This quarterly data event screen, however, was not fully implemented until July 1, 2005; when it became attached to the service Authorization Plan. The data for this mandatory reporting event screen is completed every 90 days in conjunction with the 90-day Consumer Review. The implementation of this reporting process is gradual and a sufficient number of these quarterly events are needed to obtain a representative data sample. The DMH reported the data that was available for the last quarter of FY 2005 in the FY 2005 Progress Implementation Report submitted to SAMHSA.

A more detail profile of adult consumers served is being developed. The changes that occur in the adult consumer profiles will largely be dependent on the profile information that is developed as part of the Data Infrastructure Grant. The District of Columbia is going into a sixth year of developing strategies for ensuring enhancements to the information system and implementing the enhancements within the requirements of Federal grants and HIPAA requirements and federal information system standards.

The status of information system enhancements and the needs for information system enhancements for the District of Columbia mental health system is captured in the table that appears follows.

DIG Table	Report Data	Enhancements/Reporting
Table 1. Profile of the State Population by Diagnosis	Yes	DMH supplies data for federal reporting. Data are captured by

		information system.
Table 2. Profile of Clients Served, All Programs by Age, Gender and Race/Ethnicity	Yes	Data elements modified in e-Cura and data are reported for federal purposes.
Table 3 A. Profile of Clients Served in Community Mental Health Settings by Homeless Status	Yes	Operational Definition was developed. Homeless data are currently being reported.
Table 3B. Profile of Clients Served in State Psychiatric Hospitals and Other Inpatient Settings	Yes	The Hospital legacy system currently stores these data, which are being reported for federal purposes. New system is being planned.
Table 4. Profile of Adult Clients by Employment Status	Yes	Capturing data every 90 days on persons served in the community mental health setting and employment status over past 90 days
Table 5. Profile of Clients by Type of Funding Support (Medicaid/Non-Medicaid)	Yes	Modifications of information system were required. Incorporation of reporting capacity in new systems achieved.
Table 6. Profile of Client Turnover	Yes	Modification of information system was required and incorporation of capacity in new systems achieved.
Table 7. Profile of State Mental Health Agency Service Expenditures and Sources of Funding	Yes	Analyses conducted of Mental Health Authority data. Data reported for federal purposes.
Table 8. Profile of Community Mental Health Block Grant Expenditures for Non-Direct Service Activities	Yes	Analyses conducted of contract, procurement and budget data. Data reported for federal purposes.
Table 9. Public Mental Health Service System Inventory Checklist	Yes	Analyses are conducted of mental health data and report data.
Table 10. Profile of Agencies Receiving Block Grant Funds Directly from the State Mental Health Authority	Yes	Conduct analyses of Block Grant data and Report Data Years 1-3
Table 11. Summary Profile of Client Evaluation of Care	Yes	Conduct MHSIP survey yearly and provide analyses for report
Developmental Tables		
Table 12. State Mental Health Agency Profile	Yes	Conduct analyses of mental health data, which are currently reported for federal purposes.
Table 14. Profile of Clients Served with Serious Mental Illness and Serious Emotional Disturbance, All Programs by Age, Gender, and Race/Ethnicity	Yes	Reviewed operational definitions and implemented data collection requirements. Data are reported for federal purposes.
Table 15. Profile of Clients' Living Situation in Institutional and Non-Institutional Settings	Yes	Reviewed operational definitions and implemented data collection requirements. Data are reported for federal purposes.

Table 16. Profile of Clients with Serious Mental Illness and Clients with Serious Emotional Disturbance receiving Evidenced-based Services (Supported Housing, Supported Employment, Assertive Community Treatment-Adults, and Therapeutic Foster Care-Children)	Yes	Reviewed operational definitions and implemented data collection requirements. Data are reported for federal project purposes.
Table 17. Profile of Adult Clients with Serious Emotional Disturbance receiving Evidenced-Based Services of Family Psycho education, Integrated Treatment for Co-occurring Disorders and Illness Management and Recovery Skills	Yes	Reviewed operational definitions, extracted data and currently reporting data for federal project purposes.
Table 18. Profile of Adults with Schizophrenia receiving New Generation Medications	Yes	Reviewed operational definitions and implemented data collection requirements. Data are reported for federal project purposes.
Table 19. Summary Profile of Client Outcomes for Children with Increased Level of School Attendance, Children who have had Contact with the Juvenile Justice System, and Adults who have had Contact with the Criminal Justice System	Partial	Reviewed operational definitions, assessed methodology for data collection, and modified information systems to capture data. Data collection process needs to be validated. Data are used with caveats.
Table 20. Rate of Readmission to State Psychiatric Hospitals within 30 Days and 180 days	Partial	Reviewed operational definition and modified DMH information systems. Working with private hospitals to collect data from their systems.

Mental Health Transformational Activities

During FY 2008, the DIG Tables will be reviewed for the purposes of assessing the collection of data from stand alone “independent” data bases that need to be incorporated into the major information systems (e.g. e-Cura). An assessment will be undertaken to understand what currently exists and for what purposes. This activity will facilitate an increase to accessing data within the DMH.

Another major activity that will be undertaken in FY 2008 will be to initiate linking the DMH mental health authority, D.C. Core Service Agency and St. Elizabeths systems. Another major undertaking will be training on using data for planning and report purposes. Training will be provided to the State Mental Health Planning Council, DMH staff, providers, consumers and family members.

The enhancements to the information system that will be required for the next three years will greatly impact the collection and reporting of data within the District's mental health system. A critical task over the next three years will be to link the data systems that are evolving in the three major components of the DMH. The Saint Elizabeths Hospital is installing a new information system and the Community Services Agency has installed a new system named Anasazi. These projects will require ensuring commonality of operational definitions and data collection for populations served and special needs populations in particular.

Special Needs Populations

A number of special needs populations have been identified. These include individuals with mental illness and a co-occurring substance abuse disorder, homeless, and involved with the criminal justice system.

Co-occurring Disorders: The DMH and the addiction services administration are continuing their efforts to adopt a comprehensive, system of care model in the District for co-occurring disorders treatment. It involves improving and maintaining the accessibility, availability and quality of services and supports for persons with mental illness and co-occurring substance abuse disorder. With regard to consumers with co-occurring disorders, a qualitative measure was reported to the Mayor's office beginning in FY 2003. In FY 2004, a quantitative measure was introduced that involved increasing the number of on-site contacts at the Alpha Center (addiction clinic where mental health staff are co-located). During FY 2005, DMH received a Co-Occurring State Incentive Grant (COSIG) that has become the mechanism by which to implement the integrated service delivery systems model.

Chronic Homelessness: In FY 2003/2004, DMH introduced the "Housing-First" program for chronically homeless individuals to the District. The project replicates the Pathways to Housing (PTH) program in New York City and houses and supports chronically homeless, dually diagnosed men and women living on the streets and in emergency shelters. In FY 2005, a second ACT team was established to serve this population. In the past, the DMH has reported the number of service contacts for adults with a mental illness who are homeless, primarily from the D.C.CSA Homeless Outreach Program. In FY 2004, the DMH Authority began a reporting process that involved obtaining data from the provider network, while simultaneously trying to resolve data issues that have prohibited reporting through the Contract Management System.

In FY 2005, DMH began reporting on Dixon Performance Target for homeless services. It requires the engagement of a 150 adults with a serious mental illness who are homeless. In FY 2006, a data metric was developed for this measure. The metric will be validated during FY 2008.

Criminal Justice Involvement: As part of the federally funded State Indicator Project, several states participated in a pilot to link mental health and corrections databases. The

District's State Indicator Project, realizing that the city was not at that stage, sought to operationally define involvement in the criminal justice system for the D.C. mental health consumer. The District's pilot project was conducted between December 2001 and July 2002. Data were collected on 72 consumers from the two regional community mental health centers. The intake interview asked whether the consumer was a defendant, witness, or a victim in a criminal proceeding. Unfortunately, at six-month follow-up, only five individuals remained in the mental health system. The majority had dropped out of treatment. Future initiatives to address this population should include but not be limited to data system enhancements to identify individual service needs and intensive follow-up to keep individuals engaged in the service delivery process.

The DMH has continued the Options Program (post-booking), diversion from incarceration initiative, aimed at stabilizing and providing community support and housing services to pre-trial defendants charged with misdemeanors and nonviolent felonies. The Options Program at Community Connections provides housing for up to five (5) men and five (5) women at any given time. In FY 2005, DMH received \$750,000 for its overall Jail Diversion Initiative to facilitate capacity building development and expansion of services. In FY 2006, DMH created D.C. Linkage Plus to serve as the umbrella program for all jail diversion and related initiatives. The DMH jail diversion services include: 1) pre-booking and post-booking continuity of care services for individuals with mental illness connected to the criminal justice system; 2) screening and referral for services for individuals with mental illness referred from the D.C. Superior Court's Traffic/Community Court; 3) funding N Street Village, a 21 bed facility, to provide substance treatment and housing for women with mental illness referred pre- and post-arrest for services in order to prevent incarceration and/or recidivism; and 4) providing outpatient competency restoration treatment to individuals referred from D.C. Superior Court. Also in FY 2006, DMH (along with the Criminal Justice Coordination Council) received a \$50,000 Bureau of Justice Assistance Grant to develop an overall strategic plan for persons with serious mental illness or co-occurring conditions who are involved with the criminal justice system. This plan will be built on the Sequential Intercept approach. A Draft Report on the Plan was circulated in August 2007 for review and forums were held for consumers and providers and advocates to discuss the report. The Final Report is expected by end of September 2007.

The DMH continues to provide training for new recruits and other officers at the Metropolitan Police Department (MPD). The DMH had envisioned enhanced data capture efforts during FY 2003 to begin quantitative data analysis and reporting on all three populations (co-occurring disorders, homeless services, criminal justice involvement). However, due to challenges associated with data gathering and the MIS, DMH experienced delays in data capture and reporting on these and other variables. In FY 2005, a tool was implemented to capture some of this data.

Criterion 2: FY 2008 Goals, Targets and Action Plans

Goal 1: Improve Access to Community-based Mental Health Services

As previously noted, improved access to services data, as reported in Basic Tables 2A and 2B (services by age, gender, and race/ethnicity), will be developed after the end of FY 2007 (September 30, 2007) and reported in the FY 2007 Progress Implementation Report. The assumption is that by increasing access to services for adults and adults with SMI this increase would also be reflected across age, gender, and race/ethnicity groups.

The targets reported here are related to the Dixon Performance Targets for adults and adults with SMI receiving mental health services.

Targets:

1. Increase the number of adults receiving mental health services by 3% of the District Census (2004) for adults.
2. Increase the number of adults with SMI receiving mental health services by 2% of the District Census (2004) for adults.

Action Plans:

The implementation of the DMH MHRS program is ongoing. The DMH will continue: 1) service linkage and referral activities through its Access HelpLine/Care Coordination Division, 2) review of certification of providers as Core Services Agencies (CSAs), Specialty and Sub-providers, 3) provision of and/or arrangement for technical assistance in both infrastructure development and provision of MHRS, 4) engagement of key CSA staff in information exchange and discussion meetings (i.e., chief executive officers (CEOs), chief financial officers (CFOs), clinical directors, and information technology users), 5) provision of assistance related to provider reconciliation of claims submission and claims payment, 6) try to meet the Dixon Performance Target to increase the number of adults receiving mental health services by 3% of the District Census (2004) for adults, and 7) try to meet the Dixon Performance Target to increase the number of adults with SMI receiving mental health services by 2% of the District Census (2004) for adults.

The DMH will also be involved in the development of long-term strategies and processes related to: 1) data collection and reporting to meet Federal requirements, 2) capture and report on the 20 URS Tables and Developmental Measures, 3) develop a data warehouse for DMH, and 4) establish and complete the process of linking data information systems within the DMH provider network.

**DISTRICT OF COLUMBIA
 FY 2008 STATE PLANNING AND MONITORING
 MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

Goal 1: Improve Access to Community-based Mental Health Services

NOM: Increased Access to Services

Population: Adults with Mental Illness in the District of Columbia

Criterion 2: Mental Health System Data Epidemiology

Related to Transformation: Yes No

Indicator 1: Number of adults receiving MHRS

Target: Increase the number of adults receiving MHRS in FY 2008 by 3% of the District Census (2004) for adults

Numerator: Number of adults receiving MHRS in FY 2008

Denominator: Number of adults based on District Census (2004)

Sources of Information: Contract Management System

NOM Table:

Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target
NOM	2%	2%	2.10%	3%
Numerator	8,715	8,715	9,307	
Denominator	443,976	443,976	443,976	

Note: The Dixon Performance Target is 3%. Data for FY 2005 and FY 2006 are based on the Court Monitor's July 2006 Report (4/05-3/06), showing a penetration rate of 2%. The July 2007 Report (4/06-3/07) shows a rate of 2.10%. The FY 2008 target remains 3%.

DISTRICT OF COLUMBIA
FY 2008 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)

Goal 1: Improve Access to Community-based Mental Health Services

NOM: Increased Access to Services

Population: Adults with Mental Illness in the District of Columbia

Criterion 2: Mental Health System Data Epidemiology

Related to Transformation: ___ Yes xx No

Indicator 2: Number of adults with SMI receiving MHRS

Target: Increase the number of adults with SMI receiving MHRS in FY 2008 by 2% of the District Census (2004) for adults

Numerator: Number of adults with SMI receiving MHRS in FY 2008

Denominator: Number of adults based on District Census (2004)

Sources of Information: Contract Management System

NOM Table:

Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target
NOM	2%	2%	1.80%	2%
Numerator	7,213	7,213	7,989	
Denominator	443,976	443,976	443,976	

Note: The Dixon Performance Target is 2%. Data for FY 2005 and FY 2006 are based on the Court Monitor's July 2006 Report (4/05-3/06), showing a penetration rate of 2%. The July 2007 Report (4/06-3/07) shows a rate of 1.80%. The FY 2008 target remains 2%.

**Estimates of Need for Mental Health Services
for Washington DC, Total for 2000
using Serious Mental Illness (wsmi01) for Adults**

Estimates of Need for Mental Health Services for Washington DC, Total for 2000 using Serious Mental Illness (wsmi01) for Adults									
	Total Population (HH., Inst. & Group)			Household Population			Households <100% poverty		
Total Pop	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
All ages	36855	572059	6.44	33001	539955	6.11	11260	109732	10.26
Youth age 0-17 (*SED)									
Youth	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Youth total	8963	114992	7.79	8773	113428	7.73	3604	36042	10.00
Adults age 18 and older									
Adult total	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Adult total	27892	457067	6.10	24229	426527	5.68	7655	73689	10.39
Age	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
18-24	6479	72637	8.92	4520	54446	8.30	2102	17748	11.84
25-34	5432	101762	5.34	5131	99523	5.16	1378	14606	9.43
35-44	6218	87677	7.09	5884	85134	6.91	1784	13583	13.13
45-54	3776	75310	5.01	3606	72624	4.97	948	10266	9.23
55-59	1334	27803	4.80	1280	27165	4.71	352	3585	9.82
60-64	1038	21980	4.72	999	21552	4.64	268	3061	8.74
65+	3615	69898	5.17	2809	66082	4.25	825	10840	7.61
Gender	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Male	9899	211446	4.68	8415	195653	4.30	2370	29966	7.91
Female	17993	245621	7.33	15813	230874	6.85	5285	43723	12.09
Ethnicity	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent

White-NH	7637	14870 7	5.14	5975	13391 9	4.46	1137	11780	9.65
Black-NH	1702 3	25991 4	6.55	1532 4	24728 4	6.20	5613	53058	10.58
Asian-NH	981	13863	7.07	777	12033	6.46	256	2607	9.81
Native-NH	57	1057	5.39	28	664	4.16	9	119	7.95
Hispanic	2194	33525	6.55	2125	32627	6.51	641	6126	10.46
Marital status	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Married	5565	14324 2	3.88	4684	13438 6	3.49	707	10352	6.83
Sep/Wid/Div	8682	10228 3	8.49	7809	98269	7.95	2565	20374	12.59
Single	1364 5	21154 2	6.45	1173 6	19387 2	6.05	4384	42963	10.20
Education	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Grades 00-11	8996	10227 9	8.80	7985	96815	8.25	3595	28471	12.63
HS graduate	1285 7	19236 3	6.68	1036 2	17004 3	6.09	3144	32136	9.78
College grad	6038	16242 6	3.72	5882	15966 9	3.68	916	13083	7.00
Poverty level	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Below 100%	1049 9	95260	11.02	7655	73689	10.39	7655	73689	10.39
100%-199%	4853	67309	7.21	4382	62113	7.06	0	0	0.00
200+ poverty	1254 0	29449 7	4.26	1219 1	29072 4	4.19	0	0	0.00
Residence**	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Household	2422 9	42652 7	5.68	2422 9	42652 7	5.68	7655	73689	10.39
Institution	1514	6475	23.38	0	0	0.00	0	0	0.00
Group quarters	2149	24065	8.93	0	0	0.00	0	0	0.00

**Estimates of Need for Mental Health Services
for Washington DC, Total for 2000
using Severe and Persistent Mental Illness (wspmi01) for Adults**

	Total Population (HH., Inst. & Group)			Household Population			Households <100% poverty		
Total Pop	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
All ages	21436	572059	3.75	19545	539955	3.62	6965	109732	6.35
Youth age 0-17 (*SED)									
Youth	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Youth total	8963	114992	7.79	8773	113428	7.73	3604	36042	10.00
Adults age 18 and older									
Adult total	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Adult total	12473	457067	2.73	10772	426527	2.53	3361	73689	4.56
Age	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
18-24	2803	72637	3.86	1890	54446	3.47	883	17748	4.97
25-34	2186	101762	2.15	2084	99523	2.09	548	14606	3.75
35-44	2881	87677	3.29	2721	85134	3.20	826	13583	6.08
45-54	1753	75310	2.33	1671	72624	2.30	421	10266	4.10
55-59	640	27803	2.30	613	27165	2.26	162	3585	4.51
60-64	492	21980	2.24	474	21552	2.20	126	3061	4.11
65+	1717	69898	2.46	1319	66082	2.00	394	10840	3.63
Gender	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Male	4412	211446	2.09	3755	195653	1.92	1025	29966	3.42
Female	8061	245621	3.28	7017	230874	3.04	2336	43723	5.34
Ethnicity	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
White-NH	3894	14870	2.62	3018	13391	2.25	554	11780	4.70

		7			9				
Black-NH	7400	259914	2.85	6642	247284	2.69	2464	53058	4.64
Asian-NH	80	13863	0.58	66	12033	0.55	22	2607	0.84
Native-NH	35	1057	3.28	18	664	2.64	6	119	4.76
Hispanic	1064	33525	3.17	1028	32627	3.15	315	6126	5.14
Marital status	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Married	3141	143242	2.19	2603	134386	1.94	384	10352	3.71
Sep/Wid/Div	4071	102283	3.98	3636	98269	3.70	1242	20374	6.09
Single	5261	211542	2.49	4533	193872	2.34	1735	42963	4.04
Education	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Grades 00-11	4025	102279	3.93	3546	96815	3.66	1621	28471	5.69
HS graduate	5565	192363	2.89	4419	170043	2.60	1342	32136	4.17
College grad	2883	162426	1.77	2807	159669	1.76	398	13083	3.04
Poverty level	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Below 100%	4737	95260	4.97	3361	73689	4.56	3361	73689	4.56
100%-199%	1960	67309	2.91	1799	62113	2.90	0	0	0.00
200+ poverty	5776	294497	1.96	5612	290724	1.93	0	0	0.00
Residence**	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Household	10772	426527	2.53	10772	426527	2.53	3361	73689	4.56
Institution	693	6475	10.71	0	0	0.00	0	0	0.00
Group quarters	1008	24065	4.19	0	0	0.00	0	0	0.00

District of Columbia

Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

District of Columbia

Adult - Transformation Efforts and Activities in the State in Criteria 2

Adult - Describes mental health transformation efforts and activities in the State in Criteria 2, providing reference to specific goals of the NFC Report to which they relate.

District of Columbia

Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless

The Department of Mental Health (DMH) maintains as part of its overall mission, the ongoing commitment to expand and improve service delivery to persons who are seriously mentally ill and homeless. During FY 2004, services provided to persons who are homeless included:

- a specialized ACT and a specialized community support/case management team, providing Housing-First ACT services for chronically homeless individuals
- medication,
- crisis intervention,
- outreach at a drop-in center serving 50-100 consumers daily (until May 2004 when this center closed),
- a homeless day services program serving 25-30 individuals daily,
- a homeless outreach program, and
- a housing program.

In addition homeless outreach and services to persons who are homeless are now reimbursable under the Department's Mental Health Rehabilitation Services (MHRS) system.

Review of FY 2005 Activities:

- DMH continued to provide, as a priority population, housing for consumers who are mentally ill and homeless.
- DMH continued to utilize the MHRS, which reimburses provider agencies for both outreach (using District funds) and Medicaid reimbursed treatment services.
- DMH provided staffing at the Sobering Station for intoxicated individuals who refuse entrance to a traditional shelter.
- DMH staff was available to provide mental health and referral services as needed by the homeless individuals who visit or are referred to the Cooling Centers (during the summer).
- DMH submitted a PATH Grant application to support the Homeless Outreach Program and to support housing subsidies and one time payments for security deposits and eviction prevention.

Review of FY 2006 Activities:

- DMH continued the activities conducted during FY 2005,
- DMH added six (6) additional staff to the Homeless Outreach Program,
- DMH began implementation of the Children/Youth and Families Homeless Outreach Plan, and
- DMH developed several data collection protocols (daily report form, data form, data procedures).

Review of FY 2007 Activities

- Added six (6) staff members
- Increased liaison services to include family shelters, Adult Protective Services/ Department of Human Services
- Provided transition services/interim case management services to unlinked or underlinked consumers who are homeless or in crisis
- Provided mobile crisis services to non-homeless individuals
- Psychiatry Resident placed in homeless programs
- Worked with DC Linkage Plus program to make referrals and to develop jail diversion pilot project in cooperation with District Metropolitan Police Department (MPD) and Fire Emergency Management Services (F/EMS3)
- Participated on Crisis/Emergency Services Planning Work Group
- Provided technical assistance to F/EMS and DMH in exploring the EMS capacity to provide emergency psychiatric assessments during crisis/emergency calls
- Provided training to shelter providers, hypothermia providers, street outreach workers in working with homeless mentally ill consumers

Homeless Programs

1. Homeless Outreach Program (HOP) – The HOP consists of 10 staff including the DMH Homeless Services Coordinator (social worker), one psychiatrist and eight (8) outreach staff (various backgrounds) that provide the following:

- Quarterly trainings for homeless providers on mental illness and resources and trainings on special topics as needed.
- Visit 14 programs weekly to provide crisis assessments and information on referrals.
- Emergency Rounds case conferences for street-bound homeless individuals considered at risk.
- Staff Sobering Station, a facility that offers homeless alcoholics a safe, warm place to sleep during the hypothermia season and provided extended street outreach during this period. (See data at end of this section on the Sobering Station since its inception).
- Referrals to Travelers Aid to return home, for persons who are mentally ill and stranded in the District of Columbia.
- Psychiatric services at eight (8) sites, provided by the Homeless Services Psychiatrist or the Psychiatry Residents. The DMH has an active residency program, which identifies up to six (6) residents per year to be assigned to shelters for several hours weekly. The Homeless Services Coordinator assigns the resident to an appropriate homeless services setting where the resident will have access to people in need of psychiatric services. The residents learn skills in engagement and assessment while providing appropriate psychiatric services to those individuals willing to accept them.
- Crisis response services from 8:00 am-9:00 pm Monday - Friday.
- Regular weekly visits to soup kitchens and low-barrier shelters.
- Daily distribution of sandwiches and drinks to homeless individuals in the Georgetown area of the District.

- Coordination with Saint Elizabeths Hospital, the Comprehensive Psychiatric Emergency Program (CPEP), Adult Protective Services and other community facilities to assure appropriate services.
- Systems integration activities with the homeless provider system and other systems that address the needs of people who are homeless in the District.

**Sobering Station Statistics
FY 2002 – FY 2007**

Year	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007
Bed Nights	965	1,706	964	1000	946
Unduplicated Count	243 (225 men; 18 women)	279 (264men, 15 women)	225 (220 men; 5 women)	331(324 men;7 women)	206 (198 men; 8 women)
Average Nightly Census	9	15	7	7	8
Admissions to Detoxification	20	55	66	53	11
Transports by MPD	1 or 2 nightly	108	312	214	103
Stayed More Than One Night	55	70	50	62	38
Stayed Consistently	15	25 (11 almost every night)	12 (7 almost every night)	15 (7 almost every night)	6

2. Assertive Community Treatment (ACT)- There are eight (8) teams in the District of Columbia providing services to consumers who are psychiatrically unstable and often homeless. While two teams are specifically designed to serve individuals who are chronically homeless (Housing-First teams), many homeless consumers receive services from the other ACT teams. Each team should have the capacity to serve up to 100 consumers who are seriously mentally ill. Referrals are received through the Access HelpLine, the clinical home Core Services Agency (CSA), and are often identified through the Homeless Outreach Program. Each team should consist of a psychiatrist, substance abuse counselor, case managers, program manager, program assistant and an administrative assistant. The teams visit consumers several times per week in the community, either in shelters, on street corners, in hospitals, at a job site, or in housing. Consumers are assisted with obtaining financial and medical benefits, psychiatric treatment, counseling, money management, clothing, food, housing, and employment.

3. Shelter Plus Care- This is a federally- funded program providing housing and support services to individuals who are mentally ill, homeless and may have co-occurring disorders such as substance abuse, and HIV/AIDS. Sponsor-based housing for which

DMH provides the match in the form of services, serves approximately 100 people annually. The applicant and administrator for these projects is the Community Partnership for the Prevention of Homelessness. Several of the DMH CSAs operate Shelter Plus Care supported housing.

4. DMH Rental Subsidy Program- The DMH manages a rental subsidy program to assist clients live independently in the community. A key priority of this program is to subsidize the rental costs for people who are homeless. Currently, rents are paid for these individuals in independent apartments and single room occupancies (SROs), as well as transitional group housing. Flexible funds for furnishing, apartment set-up, and unexpected emergencies are also provided. The hope is to increase the funding and capacity of this successful initiative that has demonstrated that persons who are seriously mentally ill in the District, even those who have been street homeless, can live successfully in independent settings and hold their own leases.

Funding for Homeless Programs

DMH uses federal grant funding to supplement services to persons who are mentally ill and homeless. These funds have included the PATH Grant (\$300,000 per annum), Shelter Plus Care, and the Mental Health Block Grant. Services provided with these funds have included drop-in centers, outreach services, rental subsidies, security deposits and eviction prevention, and infrastructure support to small homeless services agencies to become certified MHRS providers.

Barriers to Access Services

There are a number of barriers that need to be addressed to improve access to mental health services by persons who are homeless and mentally ill in the District. The first is that the DMH service system as a whole has historically been largely an office and clinic-based system. The MHRS and recovery model of care requires that DMH certified programs provide a minimum of 50% of the services in other than office-based settings. The MHRS system design emphasizes continuous responsibility for persons with SMI, and allows for virtually unlimited reimbursement for outreach and engagement services to provide increased incentives to provide more and better services to persons who are homeless. Increasingly services must be provided outside of the normal working day.

Competencies in engagement have been developed in some of the specialized homeless service programs but need to be further developed across the DMH system of care. Training has been implemented with homeless service providers and will continue to address issues relevant to the needs of this population.

District of Columbia

Adult - Rural Area Services

Adult - Describes how community-based services will be provided to individuals in rural areas

Not applicable. The District of Columbia is an urban area.

District of Columbia

Adult - Older Adults

Adult - Describes how community-based services are provided to older adults

See narrative in Criterion 1 regarding the plans for an older adult initiative.

District of Columbia

Adult - Transformation Efforts and Activities in the State in Criteria 4

Adult - Describes mental health transformation efforts and activities in the State in Criteria 4, providing reference to specific goals of the NFC Report to which they relate.

DMH has several ongoing programs and new initiatives involving services to people who are homeless and chronically mentally ill. Ongoing programs include the homeless outreach team, the sobering station, and a homeless day socialization program. New initiatives include expanding the current pilot program with MPD and other police/security agencies in the District, expanding the availability of mental health services in homeless shelters and coordinating more closely with current street outreach programs. All of these programs are consistent with the requirements of NFC goal 5.2.

District of Columbia

Adult - Resources for Providers

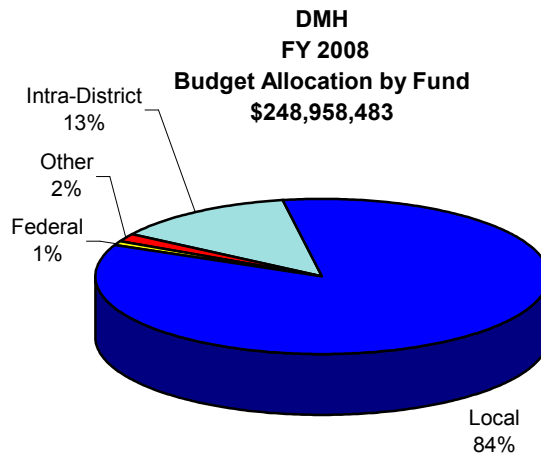
Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

Financial Structure

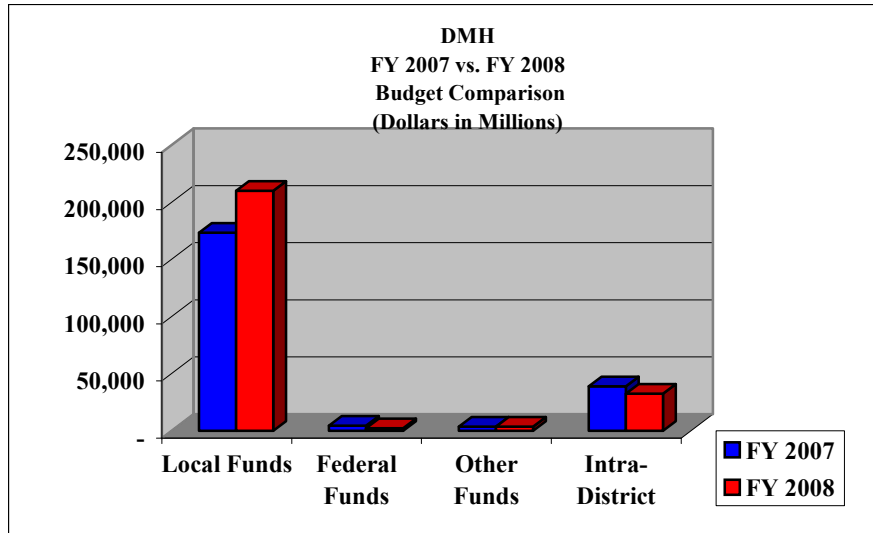
The approved DMH FY 2008 Budget is \$248,958,483. The breakdown of the FY 2008 Budget by program budget category is as follows:

Agency Management	\$18,483,629
Financial Operations	1,614,436
Mental Health Authority	27,521,794
Community Services Agency	34,581,011
St. Elizabeths Hospital	96,985,650
Community Care Providers	69,771,963
	\$248,958,483

Revenue to support the budget comes from four major revenue sources. **Local** funds are the largest funding source and accounts for \$209,980,222 or 84% of the FY2008 Budget.



Intra District is the second greatest funding source of the FY2008 budget at \$32,744,888 or 13% of the total. **Federal** funds total \$2,425,253 or 1% of the FY2008 Budget. Finally, the **Other** or Special Purpose Revenue Funds total \$3,808,120 or 2% of the FY2008 Budget.



The DMH FY 2008 Proposed Budget appears in Appendix III.

Information Services

During FY 2006, the DMH Information Services department continued with the legacy hospital patient accounts system that will eventually be replaced by the purchase of a new state-of-the-art Hospital Information System at the end of the year with design and implementation continuing into FY 2007. This system will help with consolidation of many dissimilar systems in preparation of a new Saint Elizabeths Hospital facility structure slated for completion by FY 2009.

The establishment of the WAN and the deployment of personal computers configured with state-of-the-art software has set the stage for the implementation of the Contract Management System (CMS) and other information system applications that comprise the DMH Information System (IS). The DMH Information Services topology is comprised of an integrated WAN of routers connecting multiple locations on a single protected network within the District of Columbia's infrastructure. Each location can access any servers, printers or shared resources within that topology.

This includes the CMS (a Contract Management Information System), Anasazi, a Client Data System for the D.C. Community Services Agencies, and a Legacy Hospital Management Information System, and many small-specialized databases that can be accessed on the network or across the Internet. This will bring together the capability to be able to record data on any of the measures defined and specified to be included in the system. The new IS infrastructure utilizes state-of-the-art networking technology, data warehousing and mining technology, relational database management systems, all of which facilitate easy incorporation of data elements for recordation and reporting.

During FY 2006, DMH continued to work with the Office of Chief Technology Officer (OCTO) in order to test and implement the Safe Passages Information System (SPIS), a District-wide data repository.

The current state mental health system is designed to support the new business model for DMH. In this model, DMH provides services and coordinates payment for services provided by qualified/certified community-based mental health providers. In this new authority role, DMH is implementing a CMS to track and pay providers based upon services rendered and to coordinate Medicaid reimbursement to DMH.

The CMS tracks outpatient services provided by public and private community agencies. It contains a contract on each provider qualified/certified to provide mental health services to DMH. Each contract specifies an agreed upon dollar value, provider demographic data, and rates for services provided. The CMS validates Medicaid eligibility by matching CMS data against the Medical Assistance Administration (MAA) data in a weekly update tape of matching data, to facilitate enrollment and serve as payer of last resort.

Reimbursement must be sought from all other coverage before submitting a claim to DMH. The CMS is designed to conform to HIPAA regulations and adjudicate claims based on certain valid data rules. Once a claim is adjudicated and approved the provider will be paid and DMH will then seek reimbursement from the MAA. The system will also process claims for Medicaid non-reimbursable services, paying providers using locally appropriated funds. The CMS is accessible via the DC-WAN by authorized users and is administered by the DMH Information Services with claims and appeals processing supported by a finance team.

The system serves as the driving force for centralized claims processing, contracts management, provider payment, MAA reimbursement, and budget and accounts management. It also serves as the basis for decision-making in the development of each fiscal year's budget. Grant expenditures will continue to be entered and tracked in DMH finance systems (i.e., Procurement Automated Support System (PASS) and System of Accounting and Reporting (SOARS), the finance packages used by District agencies.

During FY 2007, Information Services began deployment activities for the new Hospital Information System called Avatar. Phase 1 of this implementation, expected to be completed in early 2008, will allow the hospital to have a fully integrated system governing traditional administrative functions (admissions, census, billing, etc) as well as a new laboratory and pharmacy management application. Phase 2 will then bring the project to completion by adding in the clinical tracking functionality.

In addition, DMH intends to continue to enhance the CMS and Anasazi applications to more effectively meet Departmental requirements. Specifically, these include implementation of a Comprehensive Clinical Module in the Anasazi application and the implementation of the Accounts Receivable Module in the CMS application, which will facilitate improved revenue management. Further, the CMS application is being enhanced to include greater transparency and a more flexible service authorization process to minimize data entry errors.

In summary, DMH continues to invest in systems that facilitate the transformation of its role from a provider of services to one of a purchaser of services and manager of the public mental health service delivery network for the residents of the District of Columbia. With the consolidation of shared resources, facilities and personnel throughout, the Department is becoming more reliable, dependable and cost effective.

Human Resources Development Efforts

The total number of DMH staff at the end of FY 2006 was 1484. The total staff in each of the Department's three organizational components includes the following:

The Mental Health Authority	281
The D. C. Community Services Agency	285
Saint Elizabeths Hospital	918

The total number of DMH staff during the third quarter of FY 2007 was 1625. The total staff in each of the Department's three organizational components includes the following:

The Mental Health Authority	329
The D. C. Community Services Agency	320
Saint Elizabeths Hospital	976

The total number of staff projected for the end of FY 2007 is 1594. The total staff in each of the Department's three organizational components is projected to include the following:

The Mental Health Authority	285
The D.C. Community Services Agency	290
Saint Elizabeths Hospital	990

A number of human resource development activities were undertaken during FY 2007. These include: recruiting and hiring staff for key/critical positions, conducting contract negotiations with the Department's unions, developing an implementation strategy for and implementing non-union pay increases, and developing implementation tools to implement the Management and Supervisory Service Program in DMH.

Recruitment and Hiring

The 82 key/critical positions filled in the first three quarters of FY 2007 include the following:

- Medical Officer (GP) 1
- Medical Officer (Psychiatry) (6)
- Social Worker (10)
- Social Worker (Bilingual) (1)
- Director of Contracts & Procurement (1)
- Supervisory Information Technologist (2)
- Clinical Psychologist (4)

- Public Affairs Specialist (1)
- Mental Health Specialist (7)
- Supervisory Mental Health Specialist (1)
- Deputy Director for Strategic Planning & Policy (1)
- Deputy Director for Program Policy (1)
- Psychiatric Nurse (11)
- Care Coordinator (Bilingual) (1)
- Psychiatric Practical Nurse ((10)
- Vocational Rehabilitation Specialist (1)
- Practice Enhancement Specialist (2)
- Health Systems Administrator (1)
- Quality Improvement Coordinator (1)
- Psychiatric Nursing Assistants (14)
- Program Specialist (2)
- Chaplain (1)
- Director of Accountability (1)
- Dental Officer (Periodontist) (1)

During the fourth quarter of FY 2007, it is expected that an additional 91-key/critical positions will be filled. This will include the following positions:

- Social Worker (14)
- Clinical Psychologist (8)
- Recovery Specialist (2)
- Mental Health Specialist (6)
- Medical Records Administrator (1)
- Medical Officer Psych. (7)
- Interpreter ASL (1)
- Supervisory Psychiatric Nurse (3)
- Medical Technologists (2)
- Psychiatric Nurse (11)
- Compliance Officer (1)
- Compliance Analyst (1)
- Director of Consumer Affairs (1)
- Director, Utilization Review (1)
- Forensic Psychiatric Technicians (Co-SIG) (4)
- Pharmacist (2)
- Pharmacy Technician (1)
- Supervisory Medical Officer (2)
- Supervisory Health Systems Specialist (1)
- Supervisory Chaplain (2)
- Creative Arts Therapists (Art) (1)
- Dental Hygienist (1)
- Director of Monitoring Systems (1)
- Training Specialist (1)
- Fire Protection Specialist (1)

- Maintenance Mechanic General Foreman (1)
- Financial Services Technician (2)
- Lead Communications Operator (1)
- Hospital Registrar Technician (1)
- Director of Quality Improvement (1)
- Director of Consumer & Family Affairs (1)
- Information Technology Specialist (7)
- Risk Manager (1)
- Decision Support Analyst (1)

Planned Activities for the Fourth Quarter of FY 2007

- Conduct critical labor management/employee relations training,
- Continue recruitment for key/critical positions and an additional 76+ positions at Saint Elizabeths Hospital,
- Implement the Criminal Background/Traffic Records Check Program for DMH Employees and Volunteers who Work With Children,
- Implement pay increases for bargaining unit employees,
- Plan for and implement pay increases for non-union employees,
- Publish the Drug and Alcohol Testing Program,
- Continue critical management training in Employee/Labor relations and EEO,
- Engage in collective bargaining with most unions for re-openers with respect to wages,
- Conduct classification review of position descriptions for implementation of the Management and Supervisory Services System,
- Continue classification and establishment of new positions for Office of Accountability and Saint Elizabeths Hospital.

Negotiations with Unions

- The Department continues to protect the commitments to union employees with whom pay increases were negotiated.
- The Department and the Office of Labor Relations will engage in bargaining with three unions for re-openers for FY 2008 with respect to wages.

Planned Activities for FY 2008

- Implement the Management and Supervisory Services System for DMH Managers and Supervisors,
- Implement the Performance Management Program for DMH supervisors, managers and excepted service employees.
- Complete policy and implement the Drug and Alcohol Testing Program,
- Reinstigate critical management training in Human Resources Management,
- Continue to assist managers in restructuring efforts, and
- Intensify efforts to recruit for critical/key positions vacated due to attrition

DMH Training Institute

The DMH Training Institute has evolved into a primary mental health workforce development training and community education medium for District agencies, human services providers, consumers, family members, and community residents. The Institute's Fall, Winter and Spring training series provide a wealth of information on a range of topics. The Coordinator for DMH Organizational Development has expanded partnerships with consumer, family member, community, academic, professional, federal and local government agencies. An important feature of the DMH Training Institute is the award of continuing education units (CEUs) for several disciplines.

Some of the course offerings and projects during FY 2007 include:

- Evidence-Based Clinical Training- Cognitive Behavior Therapy (CBT) series
- System of Care Clinical Case Consultations- adult and youth consumers and their families
- Community Support Worker Training- Building Essential Skills through Training (B.E.S.T.)- a series of 25 session offerings available to provide basic clinical and recovery skill enhancements to MHRS Community Support Workers and Team Leaders and Community Residential Facilities Workers (e.g. Helping Techniques for Providers Working with Consumers, Clinical Report Writing, Advance Directives for Consumers, Altered States of Consumers: Depression and Schizophrenia
- Professional Ethics in Social Work Practice
- Alzheimer's Disease and Dementia
- Motivational Clinical Interviewing Techniques
- Community Education Forums- Black History Month, World AIDS Day
- Consumer Leadership Skill Building Training/Formulation of D.C. Leadership Academy- training for DMH System of Care consumers, family members, and advocates in consumer leadership skill-building and training techniques (Part I had 12 graduates held May 2007)
- Ethics in Government
- CPR series (in collaboration with DC Dept. of Human Services)
- Homeless Families: Life on the Streets
- Fostering Resiliency in African-American Male Youth
- MHRS Series-Treatment Planning, Medical Necessity and Service Productivity, Day Treatment Services Programming; Clinical Documentation and Medicaid Compliance, MHRS Employee Support and Retention, Evaluating MHRS Agency Productivity, Developing Compliance Programs in MHRS Agencies, Introduction to Community Support
- Medication Issues for Geriatric Consumers
- Administering Psychotropic Medications for Children and Adolescents
- Effective Clinical Services for Gay, Lesbian, Bi-Sexual & Transgender Consumers
- Solutions Skills Focused Brief Therapy
- Serious Incident Investigations and Report Writing Training
- Community Residential Facilities Training Modules (3)
- Racial Identity, Bias and Culture and Their Impact upon Clinical Treatment of African-Americans;

- Maximizing Community Resources for Offenders and their Families
- Grief, Loss and Healing in Children
- Youth and Family Exposure to Homicide
- Equal Employment Opportunity: Sexual Harassment Training Series
- Diversity Training: Understanding Whiteness
- Anger Management and Crisis De-Escalation Techniques
- Trauma Recovery Empowerment Model
- Introduction to Trauma in Male and Female Consumers
- Maintaining Professional Boundaries in Service Delivery with Consumers
- Teen Dating Violence
- Wellness Recovery Action Planning (WRAP)
- Managing Workplace Conflicts and Violence
- ART Therapy Working with Emotionally Disturbed Youth;
- Stages of Child Development through Art Therapy
- Working Effectively with the Adult Forensic Consumer
- The Use of Evidenced-Based Interventions with Youth
- Working Effectively with Adoptive and Foster Families
- Divorce: Unexpected Trauma
- Multi-Dimensional Systems Family Therapy
- Preparing Mental Health Providers for Court Appearances
- Using the Racial Identity Model to Support Positive Change in Clinical and Work Settings
- Bias, Discrimination, Racism and Other Isms
- Culture Shock for Refugee Families and their Therapy Needs

The DMH Training Institute proposes a series of training and education activities in FY 2008 in the following general categories:

- MHRS programmatic and compliance adherence training series
- Evidence-Based training
- Forensic training
- Co-Occurring Disorder training
- Recovery-based training
- Consumer Leadership training
- Cultural Competence training

Specific topics will be finalized with the Deputy Director, Office of Programs and Policy in early FY 2008.

District of Columbia

Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;

Training for Providers of Emergency Health Services Regarding Mental Health

In FY 2006, the D.C. Police Training Academy in partnership with the DMH Training Institute and the DMH Authority Adult Services Division continued to offer the training on “Handling Consumer Crisis Encounters for MPD Police Officers in the Field.” The DMH provided the trainers (two clinical trainers funded through the DMH Training Institute, DMH clinical staff and two private clinicians who volunteered their services when available). The training content provided an overview of mental illness (serious and severe and persistent), observational skills and non-traditional assessment techniques, non-threatening crisis negotiation and management skills, resources for referrals, and the referral process to access mental health services. During FY 2006, approximately 475 officers were trained in this three hour course.

In FY 2007, a crisis restraint training series was developed during the third quarter. The series is scheduled to be implemented in the late fourth quarter (September 2007). The participants will include Comprehensive Psychiatric Emergency Program (CPEP) staff, Saint Elizabeths Hospital staff, and District Core Services Agency crisis staff.

All Hazards Emergency Preparedness and Disaster Mental Health Training

In April 2005, DMH was awarded \$296,610 from the FY 2005 State Homeland Security Grant Program. The funds were used to establish a mental health first-responder-training program on All Hazards Emergency Preparedness and Disaster Mental Health. The training was offered from October 2006 through January 31, 2007. The training participants included primary first and second responders to all hazards in the Metropolitan Washington National Capitol region, including federal agencies, federal intelligence agencies, MPD, F/EMS, District agencies, mental health services providers, community residence facility providers, Council of Government staff, and members of the faith community. Continuing education units (CEUs) were offered for various disciplines including social workers, psychologists, and physicians.

During FY 2006, the Access HelpLine (AHL) engaged two vendors to provide training, the International Critical Incident Stress Foundation (Baltimore, MD) and the Crisis Management Institute (Salem, OR). The training focused on disaster management, first responder issues and stress management in times of emergency. The AHL staff, coordinators and counselors attended training.

District of Columbia

Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

Portion of the State Mental Health Funds Allocated to Innovative Programs

The D.C. State Mental Health Planning Council (SMHPC) initiated the Request for Projects from consumer, family member (focus on programs serving adults and children/youth), and community organizations for funding consideration under the FY 2008 Block Grant. A total of 17 projects were submitted in response to the Request for Projects. There were 12 proposals submitted by consumer, family member and community-based organizations, and five (5) proposals submitted by the Department of Mental Health (DMH) programs. The Council’s recommendation was to fund 11 projects and the Council. The DMH Director reviewed and accepted all of the Council’s recommendations.

The FY 2008 Block Grant award is based on the FY 2007 federal allocation. The breakdown is as follows:

Award: \$771,392.00
Administrative Fee: \$38,569.60
Funds for Projects: \$732,822.40

All of the proposed FY 2008 Block Grant funded projects are presented in the table below. The Adult Plan projects are listed first and include transition age youth. The Child Plan projects are identified as Child/Youth.

Type of Project	Organization	Project Description	Funding
Adult and Child/Youth	DC SMHPC	Mayoral appointed body to oversee mental health system planning and Block Grant	\$25,000.00
Adult	DMH Training Institute	Chris Hairston Consumer and Family Member Education Academy	\$10,000.00
Transition Age Youth/Adults	DMH Housing Division	Supportive Housing for Transition Age Youth and Persons Involved with the Criminal Justice System	\$380,000.00
Adult	FamilyLinks Outreach Center, Inc.	Weekend Day Socialization Program for Adults with SMI	\$8,000.00
Adult	DC SMHPC and DMH	Older Adult Initiative	\$30,031.20
Transition Age Youth/Adults	DC SMHPC and DMH	Transition Age Youth Initiative	\$30,031.20
Child/Youth	Pride Youth Services, Inc.	The Adolescent Female Forum to Inspire, Respect and Motivate (AFFIRM)	\$14,760.00

Child/Youth	Time Dollar Youth Court Diversion Program	Time Dollar Youth Court Mental Health Services Referral Pilot Program	\$20,000.00
Child/Youth	Northwest Child and Family Center and Family Alliance for Community Support	Self Awareness and Empowerment Teen Group	\$5,000.00
Child/Youth	Total Family Care Coalition	Expose It Youth Program	\$10,000.00
Child/Youth	DMH Child/Youth Division	Child/Youth Initiatives	\$200,000.00

Table 4
FY 2008 – FY 2010 MHBG Transformation Expenditures Reporting Form
State: District of Columbia

Number	State Transformation Activity	FY 2008 MHBG Planned Expenditure Amount	FY 2008 Other State Funding Source Amount
1	Improving coordination of care among multiple systems		10,300,000
2	Support for culturally competent services		100,000
3	Involving consumers and families fully in orienting the MH system toward recovery	20,000	64,000
4	Support for consumer- and family-operated programs, including Statewide consumer networks	13,000	309,900
5	Services for co-occurring mental and substance use disorders		1,097,802
6	Eliminating disparities in access to and quality of care	60,062.40	
7	Support for integrated electronic health record and personal health information systems		800,000
8	Improving consumer access to employment and affordable housing	380,000	5,557,288
9	Provision of Evidence Based Practices		4,207,376
10	Aligning financing for mental health services for maximum benefit		2,000,000
11	Supporting individualized plans of care for consumers		
12	Supporting use of peer specialist		20,000
13	Linking mental health care with primary care		1,457,776.80
14	Supporting school mental health programs		4,216,402
15	Supporting early mental health screening, assessment, and referral to services		1,436,897
16	Suicide prevention		142,079
17	Supporting reduction of the stigma associated with mental illness		10,000
18	Use of health technology and telehealth to improve access and coordination of mental health care		
19	Supporting workforce development activities		515,500
20	Other (specify)		

Table 4 includes expenditure for both children/youth and adults.

Line 1 is primarily funds that have been transferred to the D.C. Housing Finance Agency for the development and expansion of affordable housing over the next two years.

Line 2 is the budgeted expenditure of funds required by the District of Columbia for DMH to implement the Biennial Language Access Plan.

Line 3 block grant budgeted expenditures represent two (2) FY 2008 projects. The state budgeted expenditures include the cost of WRAP training; relapse training; training on person-centered planning, self-advocacy, St. Elizabeths Hospital governance group, staff role in recovery, how to access other systems such as housing, HIV/AIDs, health, education and motor vehicle.

Line 4 budgeted block grant expenditures are for two FY 2008 family-oriented projects. The state funds are for a consumer operated wellness center and consumer leadership forum.

Line 5 is budgeted expenditures under the COSIG grant.

Line 6 budgeted block grant expenditures are for two projects, one for transition aged youth, the other for older adults.

Line 8 represents only budgeted expenditures for affordable housing, which is primarily housing subsidies.

Line 9 is a combination of budgeted expenditures for ACT, supported employment and community-based intervention/MST (for children/youth).

Line 10 is budgeted expenditures for the KPMG engagement and ASO management and transition.

Line 11. No data reported. 2006 was the last year that DMH required providers to bill separately for the preparation of individual plans. Not all providers billed for this service. There have been changes in the overall composition of providers since 2006, so projecting the 2006 data to 2008 would not provide useful information.

Line 12 is budgeted expenditure of an Olmstead grant.

Line 13 represents the total amount of budgeted expenditures for 3 mental health providers that also provide primary care services (Unity Healthcare, Washington Hospital Center and Mary's Center).

Line 15 includes 1.3 million budgeted for the cost of the assessment center for FY 2008. Also includes actual expenditures year to date for diagnostic assessment services.

Line 16 is the carryover of the STOP suicide grant from FY 2007 into FY 2008. DMH has applied for another grant for FY 2008.

Line 19 is the budgeted expenditures for workforce training on CBI, ACT, community support/behavioral coaching, child/youth services staff training and DMH Training institute.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Data currently not available. DMH plans to report this data in the FY 07 status report, which is due on December 1, 2007. This will allow for a full fiscal year of reporting, since the District of Columbia's fiscal year ends on September 30th.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	16.23	10.87	10	10	N/A	N/A
Numerator	81	75	--	--	--	--
Denominator	499	690	--	--	--	--

Table Descriptors:

Goal: To improve continuity of care.

Target: Decrease the number of adults re-admitted to Saint Elizabeths Hospital within 30 days of discharge to 10%.

Population: Adults with mental illness living in the District of Columbia.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of adults re-admitted to Saint Elizabeths Hospital within 30 days of discharge during the reporting period.

Measure: Number of adults discharged from Saint Elizabeths Hospital during the reporting period.

Sources of Information: Hospital Information Management System

Special Issues: As of August 2007, the return rate is 8.3%.

Significance: Achievement of this performance measure will facilitate the reduction in the size of the public hospital, from 400 beds to 292. Current census ranges between 388 - 392. The new hospital building is scheduled to open in 2009. Reducing short term admissions is also an indicator that more effective discharge planning is occurring, in accordance with the terms of the settlement with the DOJ. Longer stays in the community after discharge also is an indicator that the District is complying with the requirements of the Dixon consent order, because consumers are receiving services in the community, in the least restrictive environment.

Action Plan: The DMH will continue to implement the strategies aimed at supporting adult consumers in the least restrictive setting and reducing the number of beds at Saint Elizabeths Hospital. This will include: 1) continue emphasis on adherence to the Continuity of Care Policy Practice Guidelines that assure every inpatient is seen within 48 hours of admission to the Hospital, 2) continue the meetings held between Hospital, Authority sand Core Services Agency (CSA) staff to review all clients in the Hospital 30 days or longer, 3) continue the housing priority to place individuals leaving the Hospital, 4) continue Assertive Community Treatment (ACT) services placement priority for individuals leaving the Hospital, and 5) continue to try to reach the Dixon Performance Target that 80% of adults discharged from inpatient care must be seen within seven days. The matching of data across the hospital and contract monitoring systems to track this measure proved very difficult. In June FY 2007, DMH developed a preliminary data base to track this variable. The DMH will continue to refine the data base, validate the data, and do baseline reporting in FY 2008.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	41.68	28.99	19	25	N/A	N/A
Numerator	208	200	--	--	--	--
Denominator	499	690	--	--	--	--

Table Descriptors:

Goal: Improve Continuity of Care

Target: Decrease the number of adults re-admitted to Saint Elizabeths Hospital within 180 days of discharge to 25%.

Population: Adults with mental illness living in the District of Columbia

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of adults re-admitted to Saint Elizabeths Hospital within 180 days of discharge during the reporting period.

Measure: Number of adults discharged from Saint Elizabeths Hospital during the reporting period.

Sources of Information: Hospital Management Information System.

Special Issues: Data includes civil and forensic consumers.

Significance: Achievement of this performance measure will facilitate the reduction in the size of the public hospital, from 400 beds to 292. Current census ranges between 388 - 392. The new hospital building is scheduled to open in 2009. Reducing short term admissions is also an indicator that more effective discharge planning is occurring, in accordance with the terms of the settlement with the DOJ. Longer stays in the community after discharge also is an indicator that the District is complying with the requirements of the Dixon consent order, because consumers are receiving services in the community, in the least restrictive environment.

Action Plan: See action plan for NOM for reduced utilization of psychiatric inpatient beds for patients re-admitted within 30 days of discharge.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Improve access to Evidence Based Practices.

Target: Increase the number of persons receiving evidenced-based practices during the reporting period. See further details in state indicators.

Population: Adults with SMI living in the District of Columbia.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of evidence based practices.

Measure:

Sources of Information: DMH Authority Access Helpline/Care Coordination

Special Issues: Evidence-based practices data, as reported in Developmental Tables 16 and 17, will not be developed until after the end of FY 2007 (September 30, 2007). This data will be reported in the FY 2007 District of Columbia Community Mental Health Services Progress Implementation Report (submitted to SAMHSA on December 1, 2007) for categories for which there is data in the Contract Management System.

The targets set for evidence-based practices as reported in the State indicators, are based on the Dixon Performance Targets for evidence-based and promising practices.

Targets:

1. Continue to review the ACT teams in FY 2008.
2. Increase the number of persons receiving evidence-based practices in FY 2008:
 - 2-1-Continue to try to reach the Dixon Performance Target to provide housing related services to 70% of persons referred within 45 days of a referral.
 - 2-2-Continue to maintain the Dixon Performance Target to provide employment related services to 70% of persons referred within 120 days of a referral.
 - 2-3-Continue to try to reach the Dixon Performance Target to provide ACT services to 85% of persons referred within 45 days of a referral.
 - 2-4-Continue to maintain the Dixon Performance Target to provide new generation antipsychotic medications to 70% of adults with schizophrenia.

Significance: The DMH has made the development of evidence-based practices a focal point for the

reformed mental health system. In this regard, DMH has incorporated supported housing, supported employment, ACT teams, medication algorithms, and co-occurring disorders services into the service delivery system.

Action Plan:

The DMH will continue to:

- 1) provide housing and support services to consumers most in need and try to reach the Dixon Performance Target to provide housing related services to 70% of persons referred within 45 days of a referral, 2) increase the daily rate, expand the supported employment demonstration sites and try to maintain Dixon Performance Target to provide employment related services to 70% of persons referred within 120 days of a referral,
- 3) continue to review the ACT teams that addresses overall referrals, capacity, staffing and service delivery issues, and try to reach the Dixon Performance Target to provide ACT to 85% of persons referred services within 45 days of a referral, 4) maintain the Dixon Performance Target to ensure that 70% of adults with schizophrenia have access to the newer generation antipsychotic medications, 5) continue to implement the integrated systems model for persons with co-occurring disorders through the COSIG.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Supported Housing (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Improve access to Evidence-Based Practices.

Target: See State Indicator. Target is the percentage of people receiving supported employment services within 120 days of referral.

Population: Adults with SMI living in the District of Columbia.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of persons receiving supported employment

Measure:

Sources of Information: Contract management system.

Special Issues: Note: The Dixon Performance Target is 70%. FY 2005 data for the 3rd and 4th quarters show that 44% of individuals received housing placement within 45 days of a referral. FY 2006 data for the 1st and 2nd quarters show a rate of 51%. FY 2007 data for 3 quarters show 11.6% were housed in 45 days, however 71 consumers were housed for the reporting period. During the FY 2007 2nd and 3rd quarters concerns about staying within the budget caused a slow down in housing that accounts for this lower rate of persons housed within 45 days. The FY 2008 target remains 70%.

Significance: The DMH has made the development of evidence-based practices a focal point for the reformed mental health system. Achievement of the target of providing supported housing to 70% of adult consumers with SMI within 45 days of referral is also a performance target established in the Dixon consent order. Achievement of this performance level is necessary for the District to exit from continued court oversight of the mental health system and to complete the system reform envisioned in the 2001 Final Court Ordered Plan. It is also consistent with NFC Goal 5.2.

Action Plan: See action plan described in NOM Evidence-based practices regarding supported housing.

ADULT - GOALS TARGETS AND ACTION PLANS
Evidence Based - Number of Persons Receiving Supported Housing
Foot Notes

Data about receipt of supported housing is collected in accordance with the Dixon exit criteria. The data is reported as a percentage of referrals who received supported housing within 45 days of referral. The block grant format does not support entry of the data in this format. Data is reported in the section of this form entitled "Special Issues."

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Supported Employment (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Improve access to evidence-based practices.

Target: Increase to 70% the number of adults with SMI receiving supported employment services within 120 days of a referral.

Population: Adults with SMI living in the District of Columbia.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of persons receiving evidence based practices.

Measure:

Sources of Information: Contract management system.

Special Issues: Note: The Dixon Performance Target is 70%. FY 2005 data for 3/05-9/05 show that 62% of persons referred receive supported employment services within 120 days of a referral. FY 2006 data show a rate of 77%. FY 2007 data show a rate of 97.10%. The FY 2008 target remains 70%.

Significance: The DMH has made the development of evidence-based practices a focal point for the reformed mental health system. Achievement of the target of providing supported employment to 70% of adult consumers with SMI within 120 days of referral is also a performance target established in the Dixon consent order. Achievement of this performance level is necessary for the District to exit from continued court oversight of the mental health system and to complete the system reform envisioned in the 2001 Final Court Ordered Plan. It is also consistent with NFC Goal 5.2.

Action Plan: During FY 2008, DMH will continue to focus on building service capacity. The DMH is increasing the supported employment hourly rate from \$45 to \$65. This will allow current and future services providers to cover the costs associated with providing supported employment services as well as add more staff to serve more consumers. The DMH will also implement an outreach plan to disseminate information about the availability of supported employment services to consumers and clinicians to increase access to the service. This will include ongoing supported employment training targeted to clinicians and consumers. The training will help to educate clinicians that consumers can work and how to link consumers to supported employment services. The consumer training will help consumers understand the service, that they can work, and how to request the service.

Also during FY 2008, DMH will continue to work with all service providers to help them develop and provide supported employment services that are programmatically effective and financially efficient. The DMH will also try to continue to maintain the Dixon Exit Criteria measure to provide supported employment services to 70% of the persons referred within 120 days of referral.

ADULT - GOALS TARGETS AND ACTION PLANS
Evidence Based - Number of Persons Receiving Supported Employment
Foot Notes

DMH collects data about supported employment in accordance with the Dixon exit criteria. The data is collected as a percentage of persons referred for supported employment who receive services within 120 days of referral. The block grant form will not accept the data in this format. It is reported in the section of this form entitled "Significant Issues."

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Assertive Community Treatment (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	400	400	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Improve access to evidence-based practices.

Target: Increase to 85% the number of adults with SMI receiving ACT services within 45 days of a referral.

Population: Adults with SMI living in the District of Columbia.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of persons receiving evidence-based practices.

Measure:

Sources of Information: Contract management system.

Special Issues: This is one of the Dixon exit criteria. The performance level is set at 85%. The performance level of 85% is established in the consent order setting forth the exit criteria. It will remain the same for FY 2008. DMH is not able to report data for FY 2005 or FY 2006 because of issues matching service authorizations with service delivery dates. In order to address this issue DMH had to develop a module that would allow services authorization and services delivery to be matched. The reporting of this baseline data began in FY 2007 for the period April 2006 through March 2007. This reporting will continue in FY 2008.

Significance: The DMH has made the development of evidence-based practices a focal point for the reformed mental health system. Achievement of the target of providing ACT to 85% of adult consumers with SMI within 45 days of referral is also a performance target established in the Dixon consent order. Achievement of this performance level is necessary for the District to exit from continued court oversight of the mental health system and to complete the system reform envisioned in the 2001 Final Court Ordered Plan. It is also consistent with NFC Goal 5.2.

Action Plan: During FY 2008, DMH will continue to address its data collection and tracking issues. At the same time, DMH will continue to work with all service providers to help them develop and provide ACT services that are programmatically effective and financially efficient. The DMH will also try to continue to maintain the Dixon Exit Criteria measure to provide ACT services to 85% of the persons referred within 45 days of referral.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: **Indicator Data Not Applicable:**

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Family Psychoeducation (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: **Indicator Data Not Applicable:**

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: **Indicator Data Not Applicable:**

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Illness Self-Management (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: **Indicator Data Not Applicable:**

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Medication Management (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	80	80	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Improve client perception of care.

Target: Maintain the rating of 80% for system performance measures in the annual Adult Community Service Review.

Population: Adults with mental illness living in the District of Columbia who receive publicly funded mental health services.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Positive report by independent review team using an agreed upon instrument to measure system performance.

Measure: Cases pulled for review by independent review team. Projected that 88 cases to be reviewed in FY 2008 to ensure statistically valid results.

Sources of Information: Annual community service reviews, conducted by the Dixon Court Monitor through its contractor, HSO.

Annual MHSIP, including the ROSI. Consumer satisfaction surveys conducted by consumer organization through convenience sampling and focus groups.

Special Issues: This is one of the Dixon exit criteria. The performance target of 80% system performance was established in the consent ordering setting forth the exit criteria. The target for exiting active monitoring on this exit criteria is 80% and will remain at 80% for FY 2008. Data for FY 2005 and FY 2006 show continued improvements.

Significance: Achievement of 80% systems performance is

Action Plan: The results of the FY 2006 CAN Report suggest the need for improvements related to: 1) Housing (affordable that meets unique consumer needs), 2) Appropriate services (consistent individualized consumer-driven care), and 3) Access to information (clear and concise information about mental health and other related services). The DMH Quality Council reviewed the Report and made a series of recommendations noting that issues related to housing should be a top priority.

The results from the FY 2006 and FY 2007 Annual Adult CSR suggested the need to address social network, work and recovery activities. The systems performance score (Dixon requirement) was rated much higher in 2006 (69%) than in 2005 (51%). However, it was still lower than the required 80%. In 2007, the system performance score of 80% was achieved. Although the target was met, going forward issues such as appropriate sample size and inter-rater reliability will need to be addressed.

In FY 2007, the DMH Director and Senior Staff asked the Court Monitor and Human Systems and Outcomes, Inc. (HSO) to present themes, trends, and data points over the past five years from the Annual CSR process. These findings were discussed extensively with senior leaders as

part of an initiative that DMH has undertaken via the Institute for Healthcare Improvement (IHI). The overall goal is to identify specific practice or system performance areas in which DMH can make a real impact. This process will continue in FY 2008.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Data currently not available. DMH plans to report this data in the FY 07 status report, which is due on December 1, 2007. This will allow for a full fiscal year of reporting, since the District of Columbia's fiscal year ends on September 30th.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Data currently not available. DMH plans to report this data in the FY 07 status report, which is due on December 1, 2007. This will allow for a full fiscal year of reporting, since the District of Columbia's fiscal year ends on September 30th.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Data currently not available. DMH plans to report this data in the FY 07 status report, which is due on December 1, 2007. This will allow for a full fiscal year of reporting, since the District of Columbia's fiscal year ends on September 30th.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Data currently not available. DMH plans to report this data in the FY 07 status report, which is due on December 1, 2007. This will allow for a full fiscal year of reporting, since the District of Columbia's fiscal year ends on September 30th.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Data currently not available. DMH plans to report this data in the FY 07 status report, which is due on December 1, 2007. This will allow for a full fiscal year of reporting, since the District of Columbia's fiscal year ends on September 30th.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: ACT Teams

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	9	8	8	8	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Improve access to evidence-based practices.

Target: Continue review of ACT services and ACT teams in FY 2008.

Population: Adults with SMI living in the District of Columbia.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Number of evidence-based practices.

Measure: Number of ACT teams operating in the District of Columbia.

Sources of Information: Access Helpline/Care Coordination.

Special Issues: By the end of FY 2005 there were 9 ACT teams (DC CSA=3, Psychotherapeutic Outreach Services =1, Pathways to Housing =2 (chronically homeless teams), Marshall Heights =1 (mental illness/developmental disabilities, and Family Preservation Services, Inc. = 2 (forensics and mental illness/developmental disabilities teams). During FY 2006 , Marshall Heights stopped providing mental health services (6/30/06) reducing the number of teams to 8. The planned two teams were not added in FY 2006 and none were planned in FY 2007 pending the review of the ACT team services. The review of the ACT teams focuses on referrals, capacity, staffing, and service delivery issues and will continue in FY 2008. The target remains 8.

Significance: ACT is one of the evidence-based practices that DMH has identified as needed in the District of Columbia. The DMH has made the development of evidence-based practices a focal point for the reformed mental health system. There is a Dixon exit criteria that specifically addresses ACT referrals (which is addressed in another state indicator). Achievement of that performance target is required for the District to exit from court oversight of the mental health system. Capacity to deliver ACT services in fidelity to the evidence-based practice model is a critical component of a functioning mental health system in the District.

Action Plan: See action plan for evidence-based practices.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Availability of Newer Generation Medications

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	69.30	69.30	84.30	70	N/A	N/A
Numerator	2,392	2,392	--	--	--	--
Denominator	3,452	3,452	--	--	--	--

Table Descriptors:

- Goal:** To increase access to new generation antipsychotic medications.
- Target:** To increase to 70% the number of adults with schizophrenia receiving new generation antipsychotic medications.
- Population:** Adults with SMI living in the District of Columbia.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Number of persons receiving evidence-based practices.
- Measure:** Number of adults with schizophrenia living in the District of Columbia.
- Sources of Information:** Contract management system and Office of the Chief Clinical Officer.
- Special Issues:** The Dixon Performance Target is 70%. FY 2005 and FY 2006 data is based on the Court Monitor’s July 2006 Report (4/05-3/06), showing a rate of 69.3%. FY 2007 data is based on the July 2007 Report (4/06-3/07), showing a rate of 84.37%. While the Court Monitor agrees that DMH met this target in FY 2007, DMH still has to monitor this performance target. The FY 2008 target remains 70%.
- Significance:** Achievement of the performance target established in the Dixon consent order is required for the District to exit from court oversight of the mental health system.
- Action Plan:** See action plan for NOM regarding evidence-based practices.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Continuity of Care

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	71	80	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** Improve continuity of care.
- Target:** Increase the number of adults receiving a community-based mental health service (other than a crisis service) within 7 days of discharge from an inpatient psychiatric unit.
- Population:** Adults with mental illness living in the District of Columbia.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** 80% of adults (all known inpatient discharges) who received a documented non-emergency service from a CSA/provider within 7 days of discharge from an inpatient psychiatric unit (including Saint Elizabeths Hospital).
- Measure:** All known discharges from an inpatient psychiatric unit, including Saint Elizabeths Hospital.
- Sources of Information:** Contract management system, information about discharges provided by local community hospitals and the Department of Health's Medical Assistance Administration.
- Special Issues:** This performance indicator is one of the Dixon exit criteria. During FY 2005 and FY 2006, DMH worked on addressing a number of data matching issues, as well as establishing a process for obtaining accurate data about discharges from community hospitals. In addition, work was done to develop a data collection and extraction method that complied with the requirements of the Dixon consent order. The data collection and matching issues have been very complicated. However, DMH is able to report preliminary and unvalidated data for the first two quarters of FY 07.
- Significance:** Achievement of the performance target of 80% is required for the District to exit from court oversight of the mental health system.
- Action Plan:** See action plan for NOMs regarding the re-admission of adult patients to Saint Elizabeths Hospital. Work on refining the data collection system and validating the data collected will continue throughout FY 2008. Other plans for improving the performance of the mental health system with regard to this specific performance indicator include staff of the Access Helpline contacting providers after notice of a hospital discharge is received, to ensure that the provider is following up with the patient.

ADULT - GOALS TARGETS AND ACTION PLANS

Continuity of Care

Foot Notes

This performance indicator, which is required by the Dixon consent order is actually a percentage of patients known to be discharged, who receive a non-emergency, community-based service within 7 days of discharge from an inpatient psychiatric unit.

The performance indicators for this measure are percentages. The form does not permit entry of percentages in the performance indicator box. The projected performance target for FY 07 is 84.3% The projected performance target for FY 08 is 70%.

District of Columbia

Child - Establishment of System of Care

Child - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

District of Columbia

Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing services;
Educational services;
Substance abuse services;
Medical and dental services;
Support services;
Services provided by local school systems under the Individuals with Disabilities Education Act;
Case management services;
Services for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities leading to reduction of hospitalization.

District of Columbia

Child - Transformation Efforts and Activities in the State in Criteria 1

Child - Describes mental health transformation efforts and activities in the State in Criteria 1, providing reference to specific goals of the NFC Report to which they relate.

District of Columbia

Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

District of Columbia

Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

District of Columbia

Child - Transformation Efforts and Activities in the State in Criteria 2

Child - Describes mental health transformation efforts and activities in the State in Criteria 2, providing reference to specific goals of the NFC Report to which they relate.

District of Columbia

Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

Social services;
Educational services, including services provided under the Individuals with Disabilities Education Act;
Juvenile justice services;
Substance abuse services; and

Health and mental health services.

District of Columbia

Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.

District of Columbia

Child - Transformation Efforts and Activities in the State in Criteria 3

Child - Describes mental health transformation efforts and activities in the State in Criteria 3, providing reference to specific goals of the NFC Report to which they relate.

District of Columbia

Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless

District of Columbia

Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas

Not applicable. The District of Columbia is an urban area.

District of Columbia

Child - Transformation Efforts and Activities in the State in Criteria 4

Child - Describes mental health transformation efforts and activities in the State in Criteria 4, providing reference to specific goals of the NFC Report to which they relate.

District of Columbia

Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

District of Columbia

Child - Emergency Service Provider Training

Child - Provides for training of providers of emergency health services regarding mental health;

District of Columbia

Child - Grant Expenditure Manner

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Improve continuity of care.

Target: Decrease number of children/youth re-admitted to inpatient care within 30 days of discharge by 65%.

Population: Children/youth with SED living in the District of Columbia.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of children/youth re-admitted to inpatient care within 30 days of discharge.

Measure: Number of children/youth discharged from inpatient care during reporting period.

Sources of Information: Contract management system. Department of Health, Medical Assistance Administration Data.

Special Issues: DMH has previously reported data

Significance:

Action Plan: The DMH refers children to three facilities for inpatient care (Children’s National Medical Center, Psychiatric Institute of Washington, Riverside Hospital). During FY 2006, DMH continued the “linkage meetings” between various child-serving agencies and other stakeholders regarding linkages between providers and inpatient care facilities, residential treatment, etc. These meetings serve as a forum for discussion of continuity of care issues and problem resolution (i.e., re-admission to inpatient care, and service linkage leading to discharge). Also during FY 2006, DMH continued to try to reach the Dixon Performance Target that 80% of children/youth discharged from inpatient care must be seen within seven (7) days. These strategies and performance target will be continued in FY 2007.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	3.76	.44	4	.40	N/A	N/A
Numerator	27	2	--	--	--	--
Denominator	719	450	--	--	--	--

Table Descriptors:

Goal: Improve continuity of care.

Target: Decrease the number of children re-admitted to inpatient care within 180 days of discharge to .4%

Population: Children/youth with mental illness living in the District of Columbia.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of children/youth re-admitted to inpatient care within 180 days of discharge.

Measure:

Sources of Information: Contract management system

Special Issues: Note: FY 2004 data from Psychiatric Institute of Washington and Riverside Hospital shows that .4% of children/youth discharged from inpatient care are re-admitted within 180 days. The FY 2005 data included Children’s National Medical Center and shows the rate was 4%. August 2005 data, however showed the rate was .5%. The FY 2006 projection was based on that data. In FY 2006, the rate was .4% for the period 10/1/05-6/30/06. DMH will need to review this data to resolve any inconsistencies. The FY 2007 target remains .4% pending the review

Significance:

Action Plan: The DMH refers children to three facilities for inpatient care (Children’s National Medical Center, Psychiatric Institute of Washington, Riverside Hospital). During FY 2006, DMH continued the “linkage meetings” between various child-serving agencies and other stakeholders regarding linkages between providers and inpatient care facilities, residential treatment, etc. These meetings serve as a forum for discussion of continuity of care issues and problem resolution (i.e., re-admission to inpatient care, and service linkage leading to discharge). Also during FY 2006, DMH continued to try to reach the Dixon Performance Target that 80% of children/youth discharged from inpatient care must be seen within seven (7) days. These strategies and performance target will be continued in FY 2007.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Therapeutic Foster Care (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Multi-Systemic Therapy (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Family Functional Therapy
(Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

District of Columbia

Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan

District of Columbia

Appendix A (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.