

# District of Columbia

## UNIFORM APPLICATION FY 2010 - STATE PLAN

### COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

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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.

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**FACE SHEET**  
**FISCAL YEAR/S COVERED BY THE PLAN**  
**X   FY2010       FY 2010-2011**

STATE NAME: District of Columbia  
DUNS #: 14384031

**I. AGENCY TO RECEIVE GRANT**

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

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AGENCY: Department of Mental Health  
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**III. STATE FISCAL YEAR**

FROM: 10/01/2008 TO: 09/30/2009

**IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION**

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# District of Columbia

## Executive Summary

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

## EXECUTIVE SUMMARY

### Overview of Mental Health System Reform

The District of Columbia's mental health system has experienced tremendous change over the past decade. In June 1997, the mental health system was placed in Receivership by the U.S. District Court for failure to adequately comply with the requirements of various orders in *Dixon et al. v. Fenty* case (the "Dixon Case" or "Dixon"). A Receiver was appointed shortly thereafter. In April 2000, a Transitional Receiver was appointed and charged with developing a comprehensive plan to reform the mental health system. This comprehensive plan, which was adopted by the federal court in April 2001, is referred to as the "Final Court-Ordered Plan."

These requirements were operationalized in the Mental Health Service Delivery Reform Act of 2001 under Title I (Department of Mental Health Establishment Amendment Act of 2001) and Title II (Consumer Rights). In May 2002, the Transitional Receiver certified to the court that the District had the capacity to implement and was implementing the Final Court-Ordered Plan. The U.S. District Court issued an order terminating the Receivership and appointing the former Transitional Receiver as the Court Monitor and approving agreed upon exit criteria. On December 13, 2003, the U.S. District Court adopted revised agreed upon exit criteria, including measurement methodologies, operational definitions and performance targets, which superseded the agreed upon exit criteria adopted in May 2002. There are a total of 19 Exit Criteria, which focus on five (5) general areas: quality, access, specialized services, at-risk populations, and demonstrated efficient use of resources.

The District's mental health system has been restructured in accordance with the requirements of the Final Court-Ordered Plan. The Department of Mental Health (DMH) has been reorganized into three major components, i.e., Mental Health Authority, D.C. Community Services Agency (DC CSA), and Saint Elizabeths Hospital (inpatient services).

The main focus for FY 2010 and beyond is the achievement and maintenance of the performance levels established in the December 13, 2003 Consent Order, so that the federal court oversight of the mental health system will no longer be necessary. In July 2009, the Dixon Court Monitor reported on the status of the 19 Exit Criteria. He noted that six (6) of the exit criteria had moved to inactive monitoring status. Seven (7) more of the exit criteria were described in the category of "Notable Progress but Exit Criterion Not Met – Not Recommended for Inactive Status." The remaining six (6) exit criteria fell into the category of "Some Progress Noted but Major Issues Remain Not Recommended for Inactive Status."

<b>Inactive Exit Criteria</b>	<b>Notable Progress but Exit Criterion Not Met – Not Recommended for Inactive Status</b>	<b>Some Progress Noted but Major Issues Remain Not Recommended for Inactive Status.</b>
Exit Criterion 8 – Services Provided to Adults with Serious Mental Illness	Exit Criterion 4 – Community Service Reviews for Adults	Exit Criterion 1 – Consumer Satisfaction
Exit Criterion 12 – Atypical Medications Prescribed to Adults with SMI and Schizophrenia	Exit Criterion 5 – Services Provided to Children	Exit Criterion 2 – Consumer Functioning
Exit Criterion 13 – Housing First Services Provided to Homeless Adults	Exit Criterion 6 – Services Provided to Children with Serious Emotional Disturbance	Exit Criterion 3 – Community Service Reviews for Children/Youth
Exit Criterion 16 – Engagement of Homeless Children and Youth	Exit Criterion 7 – Services Provided to Adults	Exit Criterion 9 – Supported Housing
Exit Criterion 18 – Community Resources	Exit Criterion 10 – Supported Employment	Exit Criterion 11 – Assertive Community Treatment
Exit Criterion 19 – Collection of Federal Revenue	Exit Criterion 15 – Services to Children and Youth Living in Own or Surrogate Home	Exit Criterion 14 – Children Receiving Service in Natural Settings
		Exit Criterion 17 – Continuity of Care for Adults and Children

A copy of the most recent *Dixon* Court Monitor report is available on the DMH website ([www.dmh.dc.gov](http://www.dmh.dc.gov)). Click on the Dixon Case Information link to access a copy.

Other areas of focus for FY 2010 include the completion of the transition of the majority of community services performed by the DC CSA to DMH’s network of private providers; the development and implementation of a system re-design for the community system that addresses both access and range of services; and continued focus on improved quality of care at Saint Elizabeths Hospital.

#### D.C. Community Services Agency

In FY 2007, DMH began the process of reviewing the role and governance structure of the D.C. Community Services Agency (DC CSA), as required by both the *Dixon* Final Court-Ordered Plan and the Mental Health Establishment Act. This review was completed in FY 2008. The DMH was required by law to submit recommendations about the governance structure for the DC CSA to the Council of the District of Columbia by October 1, 2008. A plan for implementation of the governance structure recommendations was also required to be submitted to the District Council by December 31, 2008. In the October 1<sup>st</sup> report, DMH recommended closing all government operated services that could be provided by the community-based providers. DMH further

recommended that the government continue to operate the community pharmacy, psycho-educational program, multi-cultural services program and the Residents' clinic.

An implementation plan, which projects closure of the DC CSA by March 31, 2010, was developed and submitted to the District Council on January 21, 2009. The DMH began assertive transition activities during the FY 2009 second quarter. This included:

1) submitting Emergency Rules to establish a Consumer Transition Voucher on January 21, 2009, 2) establishing the Continuity of Care Transition Teams (CCTT) in February 2009, 3) establishing a schedule of Consumer Provider Choice Fairs and Provider Open Houses for March through May 2009, 4) developing a series of letters, flyers and brochures to inform and educate consumers and other stakeholders about the transition process, and 5) implementing a monthly newsletter to update stakeholders on transition activities. The DMH met the goal of transitioning 2,500 consumers to the private network by August 19, 2009, with 2,520 consumers enrolled with a new provider agency.

Copies of the October 1, 2008 report and the implementation plan are available on the DMH website ([www.dmh.dc.gov](http://www.dmh.dc.gov)). Click on the DC Community Services Agency Report to the Council link. Information about transition activities is also available on the DMH website ([www.dmh.dc.gov](http://www.dmh.dc.gov)). Click on the DC Community Services Agency Consumer Transition Information link.

### Proposed Delivery System

The proposed restructuring of the District's public mental health delivery system includes expanding community-based clinic services and greater access for uninsured individuals. The plan is currently under development and is guided by principles described in DMH's Report on Recommendations Regarding the Governance of the District of Columbia Community Services Agency dated September 26, 2008 (the "DC CSA Report"). Specifically, the District's public mental health system must offer:

- A rich range of mental health services and supports that endorse best practices, recognizing that there are an increasing number of District residents with complex needs related to co-occurring mental illnesses, substance abuse and physical illnesses;
- Adequate financing to support practice models that have positive impact for primary consumers and family members;
- Services for both Medicaid eligible individuals and uninsured individuals;
- Services which are both Medicaid reimbursable and services that require local funding;
- Promotion of integrated physical health and mental health services;
- Administrative clarity;
- A strong accountability structure; and
- Opportunities for District residents to have a choice of service provider.



The goal is to have a public mental health system, based upon practice based evidence and evidence based practice data that uses information learned from the Dixon Community Service Reviews to improve the quality of services and treatment outcomes.

### Saint Elizabeths Hospital

The construction of the new Saint Elizabeths Hospital building was 95% complete as of July 2009. The building is scheduled for occupancy in early 2010.

At the same time, Saint Elizabeths Hospital is working to comply with the requirements of a CRIPA settlement agreement with the Department of Justice and a Corporate Integrity Agreement regarding Medicare and Medicaid billing practices. Other initiatives include person-centered training that requires all clinicians to participate in developing integrated, interdisciplinary treatment plans; improved discharge planning; and reducing the size of the hospital census to 340 by October 1, 2009.

Mental Health America and other national advocacy organizations selected Saint Elizabeths Hospital as the site of a national consumer memorial to honor hundreds of thousands of patients buried at state psychiatric facilities across the country-- many in unmarked and neglected graves. Saint Elizabeths was selected in recognition of its historic leadership in moral treatment, and DMH staff is actively supporting the project. To honor the occasion, Mayor Fenty proclaimed June 10th National Consumer Memorial Day in the District. A dedication ceremony was held at Saint Elizabeths on June 10, 2009.

The Gardens at Saint Elizabeths--A National Memorial of Recovered Dignity will be woven into the Hospital cemetery where more than 4,500 patients are buried including about 1,800 veterans dating back to the Civil War. The memorial will include metal markers surrounded by gardens and a pool of water from all 50 states and the District of Columbia that list the number of patients buried and at which institutions.

A granite marker bearing the quote "I must fight in the open" from Mental Health America founder Clifford W. Beers was unveiled as a permanent part of the memorial. The construction on the memorial will begin in FY 2010.

### System-wide Initiatives and Activities

The DMH will continue to evolve with ongoing stakeholder involvement and input with an overall mission to support prevention, resiliency and recovery for District residents in need of public mental health services.

Several consumer initiatives and support activities were launched during FY 2009. These include: 1) the Peer Specialist Certification Planning Workgroup, aimed at developing peer services that are Medicaid reimbursable and to expand the spectrum of DMH recovery-oriented services, 2) the inclusion of peers on the DC CSA Continuity of Care Transition Teams who reach out to all affected consumers to ensure that they make a

connection to a new provider, and 3) the Transition Specialists initiative to assist patients at Saint Elizabeths Hospital who have been determined ready for discharge in making a smooth transition to community living. This latter initiative will be launched by the end of FY 2009 with full implementation during FY 2010.

Some initiatives involve collaboration with both public and private agencies. These include but are not limited to the following:

Interface Between Health and Mental Health: The DMH is partnering with several agencies to explore the impact of health conditions on mental health consumers. The findings from these projects will be incorporated into the overall system redesign.

- The D.C. Chronic Care Initiative (CCI) in Mental Health is a partnership of the George Washington University Medical Faculty Associates and Department of Health Policy, Department of Mental Health, Anchor Mental Health, Green Door, Community Connections, Washington Hospital Center, the Medstar Diabetes Program at the Washington Hospital Center, and Howard University Hospital. The primary goal is to improve the health status of seriously mentally ill adults in the District of Columbia who have chronic disease or who are at high risk for developing chronic illness due to modifiable risk factors.
- The DMH has been working closely with Georgetown University Department of Psychiatry and the District of Columbia Primary Care Association (DCPCA), on the different strategies to link primary and behavioral health care. The specific objective of this planning initiative is to develop a sustainable, District-wide partnership between DMH and the District's safety-net primary care clinics to provide needed mental health services to low-income residents and to help our mental health providers link up with primary health care settings.

Crisis Intervention Collaborative: This initiative has been spearheaded by DMH, the District of Columbia Metropolitan Police Department (MPDC), and the National Alliance on Mental Illness (NAMI) to improve the outcomes of police interactions with people with mental illnesses. The Collaborative addresses the diverse professional development needs of officers at various levels of their law enforcement careers. The Crisis Intervention Officer (CIO) Initiative is the newest most extensive activity within the Collaborative, and its framework is based on a survey of crisis intervention response initiatives from law enforcement jurisdictions across the country. This 40-hour training program began in FY 2009.

Other initiatives include advancing promising, best and evidence-based practices in service development and delivery to adults, children/youth and families.

### Adult Services

Initiatives relating to services for adults and families include but are not limited to:

Supported Housing: The housing strategy is intended to use DMH housing dollars to help leverage housing resources from other agencies, most notably the D.C. Housing Authority (DCHA) and the Department of Housing and Community Development (DHCD). During FY 2009, DMH amended the November 2007 agreement with DHCD to develop 300 affordable housing units for DMH consumers by November 2009. The DMH transferred \$14 million in capital funds for this effort that awards grants to developers. These funds are also leveraged with other local and federal funds to increase affordable housing for low income individuals. In July 2009 there were approximately 239 DMH housing units in the pipeline.

Supported Employment: The DMH continues its relationship with the Department on Disability Services (DDS), Rehabilitation Services Administration (RSA) to expand opportunities for supported employment services for individuals in recovery from mental illness. In FY 2009, DMH partnered with RSA to access \$500,000.00 in workforce training funds available through the American Recovery and Reinvestment Act of 2009 (ARRA) to increase capacity by 150 individuals in the DMH contracted supported employment programs.

Homeless Services: The DMH continues to participate in the District's focus improvement areas (FIAs), which targets high crime neighborhoods for increased social services in order to improve them and reduce crime. The methods used include weekly case reviews, identification of service needs, door-to-door engagement of residents, neighborhood walk throughs, and health fairs. The FY 2010 DMH goals include linkages to mental health services, supported employment, and supported housing. The DMH continues to contract with Anchor Mental Health Services, which is part of Catholic Charities, to provide mental health services to people living in homeless shelters. The DMH also continues to partner with the addiction treatment and human services systems to operate the Sobering Station (during hypothermia season) for intoxicated men and women who are homeless and refuse a traditional shelter.

ACT Services: During FY 2008, DMH retained an expert from the New York State ACT Institute to conduct a fidelity assessment of ACT services. The fidelity assessment was conducted June through August 2008. The results of these audits have been useful in expanding system capacity and increasing referrals. During FY 2009, two (2) new ACT teams were added. ACT enrollment has increased from 397 at the end of September 2008 to 523 as of June 1, 2009. Plans are to continue expansion in FY 2010.

Crisis Emergency Services Planning (Adults): The Crisis/Emergency Planning Work Group was created in February 2007 under the leadership of the Director of DMH. This diverse body included 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 plan was finalized in December 2007 and among the recommendations implemented are:

- Court Urgent Care Clinic- June 2009 marked the first year of operation of the 3-year contract DMH awarded to the Psychiatric Institute of

Washington to operate a Court Urgent Care Clinic (CUCC) located at D.C. Superior Court. The CUCC provides easy access to mental health services primarily for individuals who appear in misdemeanor and traffic court who may show signs of mental illness, have been diagnosed as mentally ill, or show signs of both mental illness and substance abuse disorders.

- Comprehensive Psychiatric Emergency Program (CPEP) Renovation - The CPEP renovation was completed in December 2008. There is now dedicated space for the three (3) distinctive components: Psychiatric Emergency Services (PES), Extended Observation Beds (EOB), and Mobile Crisis Services (MCS).
- Adult Mobile Crisis Services- The DMH adult operated Mobile Crisis Services (MCS) officially began on November 1, 2008. The primary goal is to respond to adult individuals throughout the District of Columbia who are experiencing a psychiatric crisis and are unable or unwilling to travel to receive mental health services.

### Children/Youth Services

The Child and Youth Services Division (CYSD), under new leadership, has undertaken an ambitious cross-agency agenda. The four (4) major District child-serving agencies- DMH, Child and Family Services Agency (CFSA), Department of Youth Rehabilitation Services (DYRS) and the D.C. Public Schools (DCPS) are working in a collaborative manner.

One major activity during FY 2009 was the Citywide Conference on Child Mental Health Issues. This one day conference, "Towards A True System of Care" was held on May 8, 2009 in celebration of National Children's Mental Health Day. The conference sponsors were the Department of Mental Health and Children and Youth Investment Corporation. Current effective mental and behavioral health practices, programs and services for young people and their families in the District of Columbia were showcased. From the national stage, Rusty Clark and Karl Dennis highlighted research and work in the areas of Transitioning Youth and Effective Systems of Care. The conference was free to the public.

In addition, the CYSD has begun the process of creating a 3-5 year comprehensive mental health plan for children and youth. The process for this planning effort is currently being finalized. The intent is to develop a plan that speaks to the entire gamut of child/youth issues and challenges. District government agencies, other public and private child-serving agencies, child advocates, and children, youth and families will be included in the planning process. The Children's Roundtable, which is a broadly-based composite of child-serving providers and advocates, was informed of this effort and was strongly supportive. The goal is to have a working draft of the plan by Fall 2009.

There have been a number of major initiatives within CYSD. These include but are not limited to:

DC Choices High-Fidelity Wraparound Pilot: The DMH CYSD in collaboration with CFSA and DYRS developed the Wraparound Initiative. In June 2008, Choices Inc. out of Indiana was awarded the DC Choices Wraparound contract to implement community-based alternative services for District youth at risk for or returning from an out-of-home residential treatment center (RTC) placement and for youth who have experienced multiple placements and/or hospitalizations. During FY 2009, 108 children have been enrolled in the Wraparound program.

Establishment of a Choice Provider Network: In September 2008 DMH awarded Choice Provider contracts to five (5) successful vendors: Family and Child Services of DC, First Home Care, Progressive Life Center, Universal Healthcare Management Services and Community Connections. The goal of the Choice Provider Network is to provide a continuum of care for children in the child welfare system and create a framework for the organization and concentration of existing and planned services.

Children's Mobile Crisis Response Team: In October 2008, Catholic Charities began operating the new Child and Adolescent Mobile Psychiatric Service (ChAMPS) under contract with DMH. The goal of this service is to provide onsite crisis stabilization via rapid response (within 1 hour of a call), but also to provide whatever follow-up visits are needed to stabilize the family situation and/or connect the family to needed support services. The ChAMPS also has the availability of crisis/respite beds as needed for children/youth via Sasha Bruce, St. Anne's Children's Home or in a group of specialized foster homes. As of July 30, 2009, ChAMPS had received a total of 560 crisis calls.

Other CYSD initiatives include: 1) expanding school-based mental health services, 2) developing a draft common standards for all agencies to use in making decisions regarding residential placement, 3) creating specialized community capacity for high need children and youth, 4) providing clinical monitoring to all CFSA, DMH and fee-for-services Medicaid youth who are placed into psychiatric residential treatment facilities (PRTFs), and 5) managing the Assessment Center, which provides comprehensive mental health evaluations for juvenile justice youth and CFSA youth plus any DMH youth being considered for PRTF placement.

## **Attachment A. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS**

FISCAL YEAR 2010

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 State<sup>1</sup> 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 2010, 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).

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

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<sup>21</sup>. The term State shall hereafter be understood to include Territories.

- (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 States 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.

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\_\_\_\_\_  
STEPHEN T. Baron, Director  
XXXXXXXX

\_\_\_\_\_  
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.)

<b>1. Type of Federal Action:</b>  <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	<b>2. Status of Federal Action</b>  <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	<b>3. Report Type:</b>  <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change  <b>For Material Change Only:</b> Year _____ Quarter _____  date of last report _____
<b>4. Name and Address of Reporting Entity:</b>  <div style="display: flex; justify-content: space-between;"> <span>Prime</span> <span>Subawardee</span> </div> <div style="margin-left: 150px;">           Tier _____, if known:         </div>  Congressional District, if known:		<b>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</b>      Congressional District, if known:
<b>6. Federal Department/Agency:</b>	<b>7. Federal Program Name/Description:</b>    CFDA Number, if applicable: _____	
<b>8. Federal Action Number, if known:</b>	<b>9. Award Amount, if known:</b>  \$ _____	
<b>10. a. Name and Address of Lobbying Entity</b> <i>(if individual, last name, first name, MI):</i>	<b>b. Individuals Performing Services</b> <i>(including address if different from No. 10a.)</i> <i>(last name, first name, MI):</i>	
<b>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.</b>	Signature: _____  Print Name: _____  Title: _____  Telephone No.: _____ Date: _____	
<b>Federal Use Only:</b>		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



# 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.

The Draft District of Columbia FY 2010 Community Mental Health Services Block Grant Application will be published on the DMH website and comments solicited from the public. The comments will be integrated into the Plan as appropriate. If the District's FY 2010 Block Grant Application is submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA) before the comment period is completed and changes are deemed warranted by the D.C. State Mental Health Planning Council and the Department of Mental Health, a Plan Amendment will be developed. Any amendment will be forwarded to SAMHSA upon completion and also addressed at the District's FY 2010 Block Grant Consultative Peer Review.

## 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 2008	Estimate/Actual FY 2009
<u>\$6,429,000</u>	<u>\$18,570,774</u>	<u>\$18,704,885</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 2007	Actual FY 2008	Actual/Estimate FY 2009
<u>\$91,322,000</u>	<u>\$96,283,218</u>	<u>\$94,623,403</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.

The District of Columbia uses the same fiscal year as the federal government (October 1st - September 30th). This means that MOE reported in the MHBG applications is estimated.

The actual MOE for FY 2008 is \$91,871,252. This number is adjusted from the Implementation Report and was calculated using the final audited data from the District's Consolidated Annual Financial Report (CAFR) for FY 2008. The FY 2008 CAFR was issued in March 2009. The 2008 CAFR is available on the District's website at [www.ocfo.dc.gov](http://www.ocfo.dc.gov).

The MOE reported for FY 2009 is estimated as of July 31, 2009.

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

<b>Name</b>	<b>Type of Membership</b>	<b>Agency or Organization Represented</b>	<b>Address, Phone and Fax</b>	<b>Email(If available)</b>
Awosika, Samuel O.	Consumers/Survivors/Ex-patients(C/S/X)	DMH/Saint Elizabeths Hospital/Consumer Advocate	4201 Fort Dupont Terrace, SE Washington,DC 20020 PH:202 645-4752 FAX:202 561-8241	samuel.awosika@dc.gov
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	Education	825 N Capitol Street NE Suite 8116 Washington,DC 20002 PH:202-442-5640 FAX:202-442-5602	merita.carter@k12.dc.us
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
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 4330 Washington,DC 20002 PH:202-724-7491	maude.holt@dc.gov

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
			FAX:202-478-1397	



Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Jackson, Lauren	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
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 5th Floor Washington,DC 20002 PH:202-671-4080 FAX:202-673-4386	juanita.reaves@dc.gov
Robinson, Evelyn (Abby)	Family Members of Children with SED	Family Alliance for Community Support	,DC PH:202 246-6292 FAX:	msabby1110@hotmail.com
Simpson, Senora	Family Members of Children with SED		323 Quackenbos Street, NE Washington,DC 20011 PH:202-529-2134 FAX:	ssimps2100@aol.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
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
Taymon, Patrick	Consumers/Survivors/Ex-patients(C/S/X)		3005 Bladensburg Road, NE #907 Washington,DC 20018 PH:202-290-3915 FAX:	patrick.tayman@yahoo.com
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
<b>TOTAL MEMBERSHIP</b>	16	
Consumers/Survivors/Ex-patients(C/S/X)	4	
Family Members of Children with SED	2	
Family Members of adults with SMI	1	
Vacancies(C/S/X and Family Members)	1	
Others(not state employees or providers)	2	
<b>TOTAL C/S/X, Family Members and Others</b>	9	56.25%
State Employees	6	
Providers	1	
Vacancies	0	
<b>TOTAL State Employees and Providers</b>	7	43.75%

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.

Ms. Senora Simpson is a family member of both a child with SED and an adult with SMI.

Ms. Lynne Smith is a family member of both a child with SED and an adult with SMI.

# 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.

<STRONG>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. </STRONG>

During FY 2009, 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 2009 Community Mental Health Services Block Grant include:

- The Council implemented the Request for Projects and review process for funding consideration under the FY 2009 Community Mental Health Services Block Grant. The Director of the Department of Mental Health (DMH) approved the Council's recommendations for project funding that included: the State Mental Health Planning Council, three (3) non-DMH projects (a health worker project, an older adult project for Hispanic seniors, and a project to support community reintegration for forensic consumers), and a DMH housing project for transition age youth and persons leaving jail. The Director added a non-DMH funded weekend day socialization program project for adult consumers with serious mental illness.

Other projects the Council recommended for funding that were approved by the Director include: two (2) non-DMH funded projects for children/youth with serious emotional disturbances (an advocacy and outreach support services project for families and youth, and a youth trauma support program), and the DMH Child and Youth Services Division initiative aimed at reuniting children and youth in psychiatric residential treatment facilities (PRTFs) with their families.

- The Council reviewed and developed comments for the District of Columbia FY 2009 Block Grant Application submitted to the Substance Abuse and Mental Health Administration (SAMHSA) in August 2008.
- The Council's Interim Chair served as a member of the District's team for the FY 2009 Community Mental Health Services Block Grant Regional Consultative Peer Review held in October 2008 in Orlando, Florida. He provided information on the Council's review and comments on the FY 2009 Block Grant and responded to reviewers' questions. The Council was briefed on the review process and issues discussed.
- The Council reviewed and developed comments for the District of Columbia FY 2008 Progress Implementation Report submitted to SAMHSA in December 2008.
- The Council continued to try to recruit new members across all member categories. A family member of a child joined the Council.
- The Council reviewed the proposals, developed questions and hosted presentations for DMH and related requests for funding consideration under the FY 2009 Block Grant. One project was the redesign and transition of the Work Adjustment Training Program (WATP) to a continuum of supported and competitive employment. The

Council recommended funding for this project at the March 2009 meeting. The Council also reviewed a proposal from the DMH Housing Division that was a collaboration with the DMH ACT and Homeless Services Programs to provide housing and residential supports for ACT consumers in a 22-unit building. The proposal was revised and submitted as an unsolicited proposal from the developer for the same population. The Council recommended funding this proposal.

- The Council developed a Letter of Support for the Department's grant application for State and Tribal Youth Suicide Prevention in March 2009.
- Several Council members attended the 19<sup>th</sup> Annual State Mental Health Services Research Conference on Integrated Healthcare: Physical and Behavioral Health Services and Systems in April 2009 in the District.
- The Council initiated the Request for Projects for funding consideration under the District's FY 2010 Block Grant Application in April 2009. The proposal submissions included the following: 1) Resource Opportunity Center, 2) Teaching Consumer Survival Skills, 3) Cornerstone's Summer Air Conditioning Project, 4) DC Mental Health Justice Advocacy Project, 5) Healthy Body Project, 6) Passport to Health, 7) Veterans Family Reunification Project, 8) Lens and Pens Creative Expression Project 2009-2010, 9) FamilyLinks Outreach Center, 10) Development of DMH Volunteer Language Bank, 11) Homeless Outreach Program, 12) Housing Division, 13) Cultural and Linguistic Competence (CLC) and Recovery Workforce Development Project, 14) GuidePost, 15) Youth Court FOCUS Program, and 16) Early Childhood Mental Health Consultation.
- Council members along with the Adult and Child Planners and data staff attended the SAMHSA 2009 National Grantee Conference on the Mental Health Block Grant and Data in June 2009 in the District. Council members also attended the pre-Conference Planning and Advisory Councils' meeting.
- The Council planned and convened the 8<sup>th</sup> Annual Judge Aubrey E. Robinson, Jr. Memorial Mental Health Conference in June 2009. The Conference is named for the jurist who authored the landmark decision that persons with serious mental illness have the right to treatment in the least restrictive environment.
- The Council will review the reports submitted by the FY 2009 Block Grant funded projects.

### 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, health care policy, protection and advocacy issues, 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 2009, as previously referenced under the list of activities, the Council: 1) continued to review the Block Grant and related Plans, 2) reviewed additional projects for funding under the FY 2009 Block Grant, 3) continued to try to recruit new members in all member categories, 4) solicited projects for funding consideration under the FY 2010 annual Block Grant Project Request from consumer, family member and community organizations, providers, and others, 5) participated in national conferences including the SAMHSA 2009 National Grantee Conference and pre-Conference Planning and Advisory Councils' meeting, 6) participated in DMH activities and initiatives, 7) served on DMH advisory bodies and committees, and 8) submitted a Letter of Support for the DMH Suicide Prevention Grant.

#### 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, child/youth coalitions, 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 policy development activities through the DMH Partnership Council, development of housing initiatives through the Housing Advisory Committee, review of the Court Monitor reports through the Stakeholders Coalition, conduct of the Adult and Child Community Services Reviews, and attendance at the DMH Program and Budget Hearings before the District Council.

#### Public Education Role

During FY 2009, the D.C. SMHPC planned and convened the 8<sup>th</sup> Annual Judge Aubrey E. Robinson, Jr. Memorial Mental Health Conference on June 22, 2009. The conference theme was "Towards Independence: Bridging the Gaps in Employment and Housing." The three (3) panels included employment, housing and transition age youth services. The panel moderators included the Chairman of the District Council, a District Councilmember, and the Executive Director of the D.C. Housing Authority. The panels addressed policy issues, barriers, innovative practices, and success stories as well as transition age youth impressions of about their program experiences.

The nearly 250 participants included consumers, family members, providers, students, advocates, and others. 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 19<sup>th</sup> 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 2009 National Grantee Conference on the Mental Health Block Grant and Data.

The Council will hold a retreat in September 2009. The topics will include: membership initiatives, project reporting formats, and a review of the Request for Projects process.

#### Directions for FY 2010

During FY 2010, 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) complete a review of the Request for Project process and make recommendations, 3) develop a membership recruitment strategy including consumer advocates, family members, and various community stakeholders, 4) hold a retreat, and 5) convene the annual mental health conference.

# 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.

## ADULT OVERVIEW OF STATE'S MENTAL HEALTH SYSTEM

### A. Description of Services

The District of Columbia mental health system is comprised of the Mental Health Authority, Saint Elizabeths Hospital, and certified agencies that include the publicly funded District of Columbia Community Services Agency (DC CSA) and a group of private non-profit mental health agencies.

#### 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.

The Authority 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 (9) services (four (4) are classified as core services and five (5) as specialty services) provided by DMH-certified community-based providers.

The Authority acts as an agent of the Department of Health Care Finance (DHCF), formerly the Medicaid Assistance Administration (MAA), in receiving, verifying eligibility, and authorization of claims for services provided. The Agency forwards Medicaid claims to DHCF for payment adjudication.

The Authority has implemented an Access HelpLine (AHL) 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 AHL 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 AHL averaged 2,975 calls per month for the period October 2008 through June 30, 2009.

During FY 2008, the AHL installed a new telephone and reporting system (AVAYA) that went live in June 2008. The installation of the new phone system has assisted staff in answering calls within the recommended number of rings. This information can be pulled in a report and displayed on a wallboard. The wallboard currently displays the data but is in the process of having features enhanced. AVAYA allows for fewer dropped and missed calls due to better configuration of the system. Supervisors can also monitor real time call volume as well as historical.

The AHL became a certified Suicide Lifeline Network provider for Washington, D.C. effective April 2009 and has continued to engage in follow-up activities. Training for all staff has begun and will continue throughout certification. Staff training resources

include: in-house, the DMH Training Institute, and the Suicide Lifeline Network. A SAMHSA monitoring site visit was conducted on July 28, 2009. The AHL is waiting sign-off by SAMHSA to set the go live date. Currently, calls will be taken from 11:00 a.m. to 11:00 p.m. Once call volume and type is discerned, the hours will be expanded to 24 hours a day, 7 days a week. The new initiatives for FY 2010 include beginning the self study process for certification from the American Association of Suicidology.

In 2007, DMH contracted with KPMG to move forward with the priority findings from an earlier report on the assessment of DMH’s administration of its MHRS system. One of the initiatives was the development of an Administrative Services Organization (ASO) request for proposal. The District Council subsequently advised DMH that the Mayor and the Council would implement a District-wide ASO function rather than have each agency that bills Medicaid have its own ASO. The DMH efforts to obtain an ASO have been deferred to the District-wide process.

In April 2008, DMH with the assistance of KPMG assessed final options for the role and governance structure for the DC CSA. This assessment led to the implementation plan, which projects the closure of the DC CSA by the end of March 2010.

In July 2008, DMH engaged KPMG to do a thorough review of human resources (HR), processes and procedures. In addition, KPMG reviewed HR policy and underlying regulations with a focus on needed changes. This work was completed in early January 2009. The report addresses all of the major HR functions including: general program administration; recruitment, retention and selection; training and special programs; labor and employee relations; compensation, benefits and retirement; and information systems and record-keeping. The DMH will use the report’s findings to develop a more streamlined, consistent and less costly HR system.

## 2. Core Service Agencies

The public and private non-profit providers are an integral part of the District’s comprehensive, community-based system for providing services to persons with serious mental illness. They comprise the core service agencies (CSAs). The objective of a core service agency (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.

In June 2009, 43 agencies were certified as DMH MHRS providers. These agency certifications include:

Core Service Agencies (CSAs)	CSAs also Sub-Providers	CSAs also Specialty Providers	Sub-Providers	Specialty Providers
27	27	9	13	16

The publicly funded D.C. Community Services Agency (DC CSA), which has been certified as a CSA and Specialty Provider, is the largest of the DMH-certified CSAs, serving approximately one-third (4,000) of the consumers enrolled in the public mental health system.

The DC CSA was originally established in 2001, through combining the various government-operated outpatient services to ensure that the restructured public mental health system had sufficient capacity to provide community-based services. This was done, consistent with the terms of the *Dixon* Final Court-Ordered Plan. However, the same time, the Court Ordered Plan recommended an evaluation of the structure of the District's core services agency after operations stabilized. See Court Ordered Plan, page 25. In addition, legislation enacted by the Council in 2001 that established the Department of Mental Health mirrored the language in the Court Ordered Plan and required that DMH "directly operate a core services agency for three years from the effective date of this act, or longer as needed, to address the community mental health needs of the District." See D.C. Code §7-1131.03 (6).

Beginning in July 2005, the *Dixon* Court Monitor began raising concerns about the continued fiscal viability of the DC CSA. In April 2008, DMH engaged KPMG manage the assessment and final analysis of options. This process involved key stakeholders (consumer and other advocates, private providers, unions and DC CSA staff).

The KPMG analysis considered the *Dixon* three-part test for determining whether there was a continued need for a government-operated core services agency. Specifically: 1) whether there is adequate capacity in the community to provide the volume of quality services needed, 2) whether the private sector is willing and able to provide a given service, and 3) whether these services can be provided more efficiently through the private sector. The analysis included a review of key issues including: access to care, clinical and program implications, community needs, personnel implications, legal and regulatory issues, and cost implications. The District Council included language in the Budget Support Act (BSA) that required DMH to report to the Council on recommendations for a new governance structure for the DC CSA by October 1, 2008. The BSA further required a plan for implementation by December 31, 2008 and full implementation of the plan by September 30, 2009. DMH submitted its recommendations for a new governance structure to the Council on October 1, 2008. Consistent with the KPMG recommendations, DMH recommended closing all government operated services that could be provided by existing community providers. DMH would retain responsibility for continued operation of the community-pharmacy and a variety of specialty services that could not easily be replicated in the community. A copy of the October 1<sup>st</sup> report is available on the DMH website ([www.dmh.dc.gov](http://www.dmh.dc.gov)).

An implementation plan, which projects closure of the DC CSA by March 31, 2010, was developed and submitted to the Council in January 2009. DMH will retain responsibility for continued operation of the community pharmacy and various specialty services, including a physicians practice group. DMH began assertive transition activities during the second quarter of FY 2009. This included: 1) submitting Emergency Rules to

establish a Consumer Transition Voucher, 2) establishing the Continuity of Care Transition Teams (CCTT), 3) establishing a schedule of Consumer Provider Choice Fairs and Provider Open Houses, 4) developing a series of letters, flyers and brochures to inform and educate consumers and other stakeholders about the the transition process, and 5) establishing a monthly newsletter to update stakeholders on transition activities.

The implementation plan involves transitioning approximately 4,000 DC CSA consumers by March 31, 2010. As of August 19 2009, 2,520 consumers had enrolled with a new provider agency. The remainder of the consumers (approximately 1,480) will be transitioned between October 1, 2009 and March 31, 2010. This latter group will be served by ongoing DMH-run specialty services or a privately operated CSA. A copy of the implementation report is also available on the DMH website ([www.dmh.dc.gov](http://www.dmh.dc.gov)), along with information for consumers about the transition.

### 3. Saint Elizabeths Hospital

Adults requiring mental health treatment in a 24-hour inpatient setting may receive services at Saint Elizabeths Hospital. The three (3) primary programs at Saint Elizabeths Hospital (Hospital) are Acute Care, Continuing Care, and Forensic Services, with both acute and long-term care provided to forensic and non-forensic adults. The Hospital will gradually move toward the sole provision of tertiary care (3-12 months) for individuals who need the structure and security of a public psychiatric hospital. Acute care for civil patients, as planned, will primarily be provided under agreements with local hospitals. The Hospital will continue to provide acute and long-term forensic inpatient services.

The Civil Inpatient Program currently consists of 92 certified beds (4 units) and 108 beds for individuals who require long term care. Through its Therapeutic Learning Center the hospital provides ongoing individualized psychiatric treatment to a wide range of persons with mental disorders based upon their anticipated length of stay.

The Forensic Services Inpatient Program has 225 beds, as well as an outpatient department that provides treatment and/or monitoring for approximately 105 individuals adjudicated “not guilty by reason of insanity” living in the community on court ordered conditional release. 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. Admission to and discharge from the Forensic Program is controlled by the Criminal Division of both courts. Services to individuals in the Hospital’s inpatient forensic programs 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 persons adjudicated incompetent and unlikely to regain competency in the foreseeable future while awaiting civil commitment hearings; treatment of consumers found Not Guilty By Reason of Insanity (NGBRI) and committed for inpatient treatment until released by the court.

The outpatient component of Forensic Pre-Trial and Assessment Services 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. It 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.

In keeping with the recovery-based model of care, the Hospital has established an environment of care that primarily allows non-forensic patients to leave their units during the day and receive the majority of treatment at the Therapeutic Learning Center. This concept promotes community reintegration and assures that all patients are involved in active treatment.

The expansion of therapeutic activities in the Forensic Program also was addressed during the fiscal year, in efforts to approximate the over 4,000 hours of active group treatment that is offered in the Therapeutic Learning Center each month. Clinical disciplines increased the amount of active treatment provided patients and nursing staff alone began conducting over 153 additional groups on a weekly basis. Forensic Services in SEH continues to support the Department's efforts to promote pretrial release of appropriate defendants to community-based case management and treatment by working closely with the CSAs. The Forensic staff's collaboration has helped to facilitate continuity of care for defendant/consumers and their receiving appropriate services in the least restrictive environment. The Forensic Services Pre-trial and Assessment Services staff also works closely with the Department of Corrections to ensure continuity of care when defendants are discharged from the John Howard Pavilion and detained.

In May 2006, the U.S. Department of Justice (DOJ) issued findings identifying a number of areas of concern. The District entered into a Settlement Agreement with the DOJ and this was approved by the Court on June 25, 2007. A Compliance Officer was hired by Saint Elizabeths Hospital to monitor compliance with the Agreement. The three-year Agreement requires two site visits per year by DOJ appointed surveyors as well as a progress report every six months by the Compliance Officer.

The DOJ visited the Hospital again in September 2008 and in its report issued in December 2008 concluded that while the Hospital made some progress, it still was not in compliance with the Court order. Areas in which improvement is required include: 1) protection from harm and risk management, 2) nursing care, 3) treatment planning and psychiatric care, and 4) behavioral management and psychological care.

The DOJ conducted its third site visit on March 30-April 3, 2009 and issued its findings and a summary letter on May 27, 2009. The recent visit noted continued progress on many fronts but also stated in strong terms that the Hospital is significantly behind the 3-year schedule on its overall compliance efforts. The letter noted that the Hospital was to be in compliance with 74 provisions as of December 2008 but was only in compliance with six (6). The DOJ outlined priority concerns to be completed before the next DOJ

visit, which is likely in September 2009. The same areas identified in the December 2008 site visit were identified during the third site visit as priority concerns. As noted by the Dixon Court Monitor, the DOJ visit needs to be put into the context of overall compliance efforts. There are a total of 208 findings that DOJ has reviewed and scored to-date (out of a total maximum of 224 requirements per the Settlement Agreement). Of the current total of 208, the Hospital has achieved substantial compliance on 11 (5%), partial compliance on 157 (75%) and noncompliance on 40 (20%). This 80% score on the partial and substantial compliance scores combined, compares to a 55% level as of the September 2008 DOJ visit. Information on this issue can be found in the most recent *Dixon* Court Monitor report and is available on the DMH website ([www.dmh.dc.gov](http://www.dmh.dc.gov)). Click on the Dixon Case Information link to access. Also click on Department of Justice Settlement Agreement for information about the Hospital and DOJ compliance activities.

In May 2007, DMH began implementing various initiatives to obtain Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation when the new hospital opens in 2010. In August 2008, DMH negotiated a corporate integrity agreement with the U.S. Department of Health and Human Services regarding billing practices at Saint Elizabeths Hospital. Both the DOJ settlement agreement and the corporate integrity agreement include a number of requirements regarding the operation of Saint Elizabeths Hospital.

The construction of the new 293-bed Hospital continued with the overall completion at approximately 95% as of July 2009. The planned occupancy is for early 2010. There are several efforts underway to reduce the census that include: 1) eight (8) extended observation beds at the Comprehensive Psychiatric Emergency Program (CPEP) as result of the recent renovation, 2) the new adult mobile crisis services, 3) increased use of local hospitals for acute care, and 4) the integrated care management project currently aimed at long term inpatients at Saint Elizabeths Hospital whose needs have not been met by the current community-based services and financing structures. The goal is to reduce the Hospital census to 340 by October 1, 2009. As of August 24, 2009, the Hospital census was 364 (187civil patients and 177 forensic patients).



# 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.

## **ADULT NEW DEVELOPMENTS AND ISSUES**

The new developments and issues include the following:

### **Service System Transition**

D.C. Community Services Agency Transition Plan Implementation- During FY 2009, implementation of the Transition Plan to close the DC CSA included: communication and outreach (consumer forums, provider fairs, outreach at targeted sites, a news brief), publishing of rules for the new Consumer Transition Voucher, and transition protocols (Continuity of Care Transition Teams).

### **Peer Specialist Initiative**

Creating a Recovery Culture and Effectively Using Peer Specialists as Service Providers- The DMH, through its Office of Consumer and Family Affairs (OCFA), is developing a Peer Specialist Program intended to demonstrate a sustainable model for providing peer support services within the mental service delivery system. The Peer Specialist Program subscribes to an evidence-based model, which demonstrates that peer supports increase consumers' social skills, decrease inpatient services, and improve their self-confidence. The Peer Specialist Program will solidify existing similar efforts and aims to achieve the following outcomes: 1) meaningful employment of Peer Specialists in the mental health care system, 2) implementation of an evidence-base model that achieves indicators for recovery (fewer hospitalizations, meaningful relationships, gainful employment, etc.), and 3) expansion of DMH service delivery options in recovery. The kick-off planning workshops for this initiative were held July 15-16, 2009.

### **Mental Health and Primary Care Initiatives**

Chronic Care Initiative in Mental Health: The D.C. Chronic Care Initiative (CCI) in Mental Health is a partnership of the George Washington University Medical Faculty Associates and Department of Health Policy, Department of Mental Health, Anchor Mental Health, Green Door, Community Connections, Washington Hospital Center, the Medstar Diabetes Program at the Washington Hospital Center, and Howard University Hospital. The primary goal is to improve the health status of seriously mentally ill adults in the District of Columbia who have chronic disease or who are at high risk for developing chronic illness due to modifiable risk factors. Initially, the project will integrate two (2) nurse medical care managers into the behavioral health care teams of two (2) public community mental health centers (Green Door and Community Connections); and a simple disease registry will be created that includes health and behavioral health information that will facilitate coordination and rapid exchange of health and mental health information on CCI in MH consumer/members. Health risks, health status, medications and medical treatments will be routinely assessed by paper and pencil survey, computerized screening, and medical tests. Results will be provided to consumer/members, the mental health team and consumer/members' primary care providers. Consumer/members will receive print, web-based and telephone health information, self-assessment and self-care management tools and health coaching. The

nurses will facilitate care coordination with primary and specialty care, and provide self-care training on diabetes, metabolic syndrome and other health risks.

Department of Health and DMH Chronic Care Initiative in Mental Health Quality Improvement Study: A chart review was conducted for a random sample of 30 high utilization patients at Saint Elizabeths Hospital as part of the quality improvement study. The preliminary data show that: 1) schizophrenia was the most common psychiatric illness (53%) followed by depressive disorder (29%), 2) fifty-nine percent (59%) were diagnosed with a co-occurring disease at the time of admission with hypertension found in 50% of the sample, 3) eighty-two percent (82%) had a history of drug or alcohol abuse with 71% having a history of poly-substance abuse, and 4) forty-one percent (41%) had a history of either physical or sexual abuse, and 5) forty-one percent (41%) also were current smokers. The preliminary results suggest more discharge planning support is needed. In order to complete the study, the data will be matched with Medicaid utilization data.

Integration of Mental Health Services into Primary Care Settings: The DMH has been working closely with Georgetown University Department of Psychiatry and the District of Columbia Primary Care Association (DCPCA), on the different strategies to link primary and behavioral health care. The specific objective of this planning initiative is to develop a sustainable, District-wide partnership between DMH and the District's safety-net primary care clinics to provide needed mental health services to low-income residents and to help our mental health providers link up with primary health care settings. The steps to meet this objective include the following: 1) develop the necessary rules for the free-standing clinics to ensure that they are easily implemented by primary health settings; 2) develop strategies for the Community Mental Health Centers to have the appropriate protocols for screening medical needs and ensuring individuals receive needed medical attention; 3) identify the training and other capacity building efforts that need to be incorporated; and 4) develop any needed billing and coding procedures. The intent is to have an implementation plan in FY 2010.

### **Behavioral Health System Study Initiative**

Behavioral Health Study- A memorandum of understanding (MOU) between the Department of Health and DMH funds a study that extends the focus on the health of District of Columbia residents to the behavioral health system (mental health and substance abuse treatment). The study is being conducted by the RAND Corporation and will focus on service delivery and financing. This study is phase 3 of an overall assessment of the District's healthcare system commissioned by the Council, to obtain recommendations for investment of funds from the Tobacco litigation settlement into improvement of the healthcare system. The intent is to develop specific and detailed recommendations for improving the behavioral health services delivery system including potential capital investments, modifications to the organization of the delivery of care, changes to the structure of payments for District providers, and improvements to the overall financing of the mental health services and substance use disorder treatment services. The term of the study is May 2009 through September 30, 2010.

MCO Carveout Assessment- The Department of Health Care Financing (DHCF), has retained the George Washington University School of Public Health (GWU) to conduct an assessment to determine whether mental health services should be carved out of the Medicaid managed care contracts. A draft of the initial assessment is expected by the end of FY 2009.

### **Crisis Services Initiatives**

Comprehensive Psychiatric Emergency Program (CPEP) Renovation - The CPEP renovation was completed in December 2008. It has resulted in eight (8) extended observation beds. There is also dedicated space for the other components of CPEP, Psychiatric Emergency Services (PES), and Mobile Crisis Services (MCS).

Adult Mobile Crisis Services- The DMH adult operated Mobile Crisis Services (MCS) officially began on November 1, 2008. The primary goal is to respond to adult individuals throughout the District of Columbia who are experiencing a psychiatric crisis and are unable or unwilling to travel to receive mental health services. The MCS is staffed by a multidisciplinary team that includes Peer Counselors. The program operates daily from 9:00 a.m.- 1:00 a.m. The MCS had 827 contacts for the FY 2009 third quarter. Of these contacts 306 were a crisis response, 27% or 83 were FD-12'd to a community hospital or for psychiatric emergency services, 64 or 21% were voluntarily admitted to a community hospital or to psychiatric emergency services (PES).

Crisis Intervention Collaborative- The DMH collaboration with the D.C. Metropolitan Police Department (MPD) includes: the FY 2009 continuation of the mental health training for newly recruited Police Officers (16 hours), initiation of mandatory Field Officer in-service training (4-hours), and the development and implementation of the Crisis Intervention Officer (CIO) training. To date, two classes have been conducted and 40 officers have been trained. A third class was scheduled the week of August 17-21, 2009.

### **Program Re-Structuring Initiative**

Redesign and Transition of the Work Adjustment Training Program (WATP)- In FY 2009, a proposal was developed to redesign and transition the WATP to a continuum of supported and competitive employment. The D.C. State Mental Health Planning Council recommended FY 2009 Block Grant funding for this project. The primary transition activities included: informing consumers of the pending program closure, helping consumers select supported employment programs and enrolling them in these programs, and meeting with all supported employment programs to orient and inform them of the enrollment process for the WATP participants. As of July 2009, 69 WATP participants have been enrolled/re-enrolled in supported employment programs.

## **Division Re-Structuring Initiative**

Organizational Development Division Expansion- This Division created two (2) new units in FY 2009, the Community Services Review (CSR) Unit and the Research and Clinical Informatics (RCI) Unit. The CSR Unit will provide DMH with the internal capability to oversee and conduct adult and child CSRs, as well as provide technical support and assistance to providers regarding the DMH practice model and practice guidelines. The RCI was formed by creating a workgroup from selected evaluation and data support staff within the Office of Programs. In the future, it will serve as the nerve center and conceptual driver of all evaluation and performance management activities.

## **Integrated Care Initiatives**

Integrated Care Management- This initiative was launched in the Fall of 2008 when a separate unit was created at the DMH Authority with continued implementation planning in FY 2009. The goal is to reduce the census at Saint Elizabeths Hospital by avoiding admissions and facilitating discharge for targeted populations. A contract was signed at the end of March 2009 with the Washington Hospital Center to implement an Integrated Community Care Project.

Affiliated with the Integrated Care Management Initiative is the Transition Specialists Initiative also aimed at helping consumers move from Saint Elizabeths Hospital. The role of the Transition Specialists is to assist patients at Saint Elizabeths Hospital who have been determined ready for discharge in making a smooth transition to community living. The Transition Specialists will draw upon lived experiences as well as their training to provide encouragement and support to those who are returning to the community. This initiative uses Olmstead funding.

## **Saint Elizabeths Hospital Initiatives**

National Consumer Memorial- Saint Elizabeths Hospital was selected as the site of the national consumer memorial in recognition of its historic leadership in moral treatment for people with mental illness. "The Gardens at Saint Elizabeths--A National Memorial of Recovered Dignity" will be woven into the cemetery on the hospital grounds, where more than 4,500 patients are buried, along with several hundred veterans of the Civil War. The memorial will include metal markers surrounded by gardens and a pool of water representing those buried in hospitals from throughout the country, including in the District of Columbia. The memorial construction will begin in FY 2010.

Saint Elizabeths Hospital Person-Centered Training Initiative- During FY 2009 the hospital began implementation of this initiative that requires all clinicians to participate in developing integrated, interdisciplinary treatment plans.

Status of New Hospital- In June 2009 the new hospital construction was nearing the substantial completion milestone. The remaining work includes installation of finishes,

flooring, etc. as well as site work, remaining plantings and associated utility/road work. Commissioning of the new hospital will occur from August to December 2009, approximately 95%. The opening of this facility is scheduled for March 2010.

# District of Columbia

## Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

## ADULT LEGISLATIVE INITIATIVES AND CHANGES

### Regulations

- Home First Subsidies for Mental Health Consumers, 22A D.C. Municipal Regulations (DCMR) Chapter 23. These rules will establish standards for the application process, eligibility determination and issuance of subsidies to eligible DMH consumers, including determination of the amount of the subsidy, annual recertification, maintenance of a waiting list, transfers, termination, and due process rights.

Status and FY 2009 Activity: These rules were published as proposed during the first quarter on October 10, 2008. During the second quarter, DMH reviewed public comments and made revisions to the Notice of Proposed Rulemaking. The revised proposed rules were published on June 26, 2009; a meeting with advocates was held and some additional revisions may occur before the next publication.

- D.C. Community Service Agency Consumer Transition Voucher, 22A DCMR Chapter 33. These rules will provide standards for the payment of a Consumer Transition Voucher to mental health providers serving mental health consumers being transferred from the D.C. Community Services Agency (scheduled to close by March 31, 2010) to facilitate a smooth transition to the consumers' new clinical homes.

Status and FY 2009 Activity: Notice of Emergency and Proposed Rulemaking drafted during second quarter and published on 3/20/09; and published as final rules on May 1, 2009.

- 22 DCMR Chapter 38, Community Residence Facilities for the Mentally Ill - Overhaul of existing rules for the licensing and regulation of mental health community residence facilities (MHCRFs) adopted in 1995 to address new realities including the establishment of the Department of Mental Health, the separation of the delivery of mental health rehabilitation services (MHRS) from the provision of 24-hour supervised residential care in a CRF and changes in the District's administrative hearing body. The proposed rules also include numerous revisions based on the experience of DMH staff in monitoring and regulating providers.

Status and FY 2009 Activity: DMH legal and licensing staff have continued to work on completion of draft regulations for DMH internal review through the first, second, and third quarters of FY 2009.

- Emergency and Proposed Amendment to 22 DCMR Chapter 38, Community Residence Facilities for the Mentally Ill - to add new section authorizing payment to independent MHCRFs for additional services provided to consumers who have



been determined to require a higher level of care pending transfer to a contract MHCRF facility.

Status and FY 2009 Activity: Preliminary Draft was prepared during the second quarter of FY 2009. Pending review within DMH.

- Amendment to 22A DCMR Chapter 34, Mental Health Rehabilitation Services Provider Certification Standards - to add new section establishing process for decertification of MHRS providers including grounds for decertification, notice requirements and appeal process.

Status and FY 2009 Activity: Preliminary Draft prepared during first quarter of FY 2009. Pending review within DMH.

- Amendment to 29 DCMR Chapter 52, Medicaid Reimbursement for Mental Health Rehabilitative Services – DMH worked with the Department of Health Care Finance to amend the Medicaid reimbursement rates for several MHRS services, and to update the HIPAA codes.

Status and FY 2009 Activity: The emergency rules were initially published to be effective November 1, 2008 and extended several times before the final was published May 22, 2009; subsequent emergency rules were made effective June 18, 2009, and the Emergency and Proposed rules were published in the DC Register on July 10, 2009; and final rules will be published August 28, 2009.

# 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.

## **ADULT DESCRIPTION OF STATE AGENCY'S LEADERSHIP**

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.

### Partnership with District of Columbia Metropolitan Police Department (DCMPD)

The DMH has spearheaded the Crisis Intervention Collaborative in partnership with DCMPD, and the National Alliance on Mental Illness (NAMI) to improve the outcomes of police interactions with people with mental illnesses. This Collaborative has been developed to address the diverse professional development needs of officers at various levels of their law enforcement careers. The training provided to police officers includes: recruit training (16-hours), field officer in-service training (4-hours) and crisis intervention officer training (40-hours).

### Participation in the District's Focused Improvement Areas (FIA) Initiative

The FIA initiative is aimed at high crime neighborhoods and addresses community needs in an effort to reduce criminal behavior. The DMH participates in strategies that include: weekly case reviews, the assessment of community needs, door-to-door engagement of residents, neighborhood walk throughs, and health fairs. The DMH goals in FY 2010 include providing linkages to clinical services, supported employment and supported housing.

### Partnership with Department on Disability Services

The DMH and the Department on Disability Services (DDS) have had a cross-agency memorandum of understanding (MOU) since October 2004. The DMH/DDS Joint Project continues to serve approximately 73 consumers who are both developmentally disabled and have an Axis 1 diagnosis.

Recently, there have been regular meetings between DMH, DDS and the Department of Health Care Financing (DHCF) to develop strategies to best serve 15- 20 eligible individuals who are now at Saint Elizabeths Hospital. The goal for FY 2009 is to have five (5) individuals move successfully into the community with intensive individualized services. The DDS has agreed to assume responsibility for coordination of services for consumers jointly served by both systems. The DHCF is also exploring the possibility of DMH (the public system) becoming a DDS waiver provider.

### Veterans Work Group

The Veteran's Work Group developed in April 2009, from DMH's plans to submit an application for the SAMHSA 2009 Grant for diversion services for veterans involved in the criminal justice system. Due to time constraints, DMH decided not to submit the application. The recommendation was that we establish a work group to look at issues and gaps in services to veterans in Washington, D.C. and gather information to prepare for submission of a grant application at a later date. The purpose of the meeting was to determine if we were all on the same track regarding the project and begin the development of the state advisory council (a recommendation mandated by the grant). The participants at the first meeting were representatives from the Criminal Justice Coordinating Council, the D.C. Office of Veterans Affairs, Psychiatric Institute of Washington (they work closely with veterans agencies), DMH, and the Court Services and Offender Supervision Agency. The Veterans Administration was also invited. The plans are to schedule another meeting for September 2009.

### Adult Authority Programs

In order to address the mental health needs of adult consumers, the DMH adult service system includes care integrated care services, assertive community treatment (ACT) services, forensic services, homeless outreach services, supported employment services, supported housing services, and an array of residential services including community residence facilities (CRFs), transitional, and supported independent living (SIL). It is a robust system that offers on site and mobile crisis emergency evaluations and treatment, 72-hour psychiatric observation beds, crisis emergency stabilization beds, 24-hour crisis hotline, and care management. Other supporting functions within the DMH Authority include: Care Coordination, Provider Relations, Office of Accountability, Organizational Development, Office of Consumer and Family Affairs, Office of Strategic Planning, Policy and Evaluation, Office of Finance and Administration, Office of Contracts and Procurement, and Office of the General Counsel.

### Consumer Initiatives

The DMH has supported and/or created a variety of consumer initiatives that include: 1) sponsoring the first District-wide Olmstead Conference in collaboration with the Office of Disability Rights in September 2008, 2) launching a Peer Specialist Training and Certification program for consumers to provide Medicaid billable services (July 14-15, 2009), 3) training and hiring 12 consumers to work as Peer Support Partners on the Continuity of Care Transition Teams as part of the D.C. CSA closure Transition Implementation Plan, 4) developing a Transition Specialists program that allows trained consumers to assist patients at Saint Elizabeths Hospital make a smooth transition to community living by providing encouragement and support, 5) providing funding to operate a community-based consumer run wellness and resource center for mental health advocacy, work skills training, and leadership development, 6) providing funding to support an International Center for Clubhouse Development program, and 7) re-designing

the Work Adjustment Training Program (WATP) into a continuum of supported and competitive employment.

There are also initiatives aimed housing acquisition and maintenance. Two (2) important consumer housing related initiatives include: 1) consumer briefings that began in June 2008 that formally introduce the consumer to tenant and landlord rights and responsibilities, and provides information about how to maintain housing, good housekeeping, and how to be a good neighbor; and 2) the MyHouse Project that uses mediation rather than traditional court proceedings to facilitate landlord/tenant communication in order to avoid potential homelessness.

### 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 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. The grant has served as the mechanism to implement the integrated system of care model. During FY 2009, the grant was in its fourth year of operation. The infrastructure developmental activities are based on four (4) objectives: 1) system supports for integrated service, 2) universal screening, 3) expand workforce competencies in co-occurring disorders, and 4) continuous quality improvement supports for consumer outcomes. A number of projects have been initiated related to each of the objectives. Year 5 of the grant (2010) will focus on evaluation activities.

The DMH also participates on the Mayor's Interagency Task Force on Substance Abuse Prevention, Treatment and Control.

# 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.

## CHILD OVERVIEW OF STATE'S MENTAL HEALTH SYSTEM

The District of Columbia has invested energy and resources in the development of the children's System of Care (SOC) beginning in FY 2002. Today, DMH has strong partnerships with all of the child-serving agencies: child welfare (the Child and Family Services Agency or CFSA); juvenile justice (the Department of Youth Rehabilitation Services or DYRS), education oversight, policy, resources (the Office of the State Superintendent of Education or OSSE), the public school system (the District of Columbia Public School System or DCPS) and the Family Court Division of Superior Court (Family Court)<sup>1</sup>.

The child-serving agencies work together to solve problems and plan for the evolution of the system of care. The Mayor and senior city officials maintain a high 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.

Oversight of the child SOC is primarily handled through the Interagency Collaboration and Services Integration Commission (ICSIC). The ICSIC was established pursuant to the Public Education Reform Act of 2007. The ICSIC is a 25-member group that includes the directors of each of the District's child-serving agencies, including the Director of DMH. It is led by the Mayor and focuses on the needs of at-risk children by reducing juvenile and family violence and promoting social and emotional skills among children and youth through the oversight of a comprehensive integrated service delivery system. The ICSIC is organized around six (6) city-wide goals:

- Goal 1: Children Are Ready for School
- Goal 2: Children and Youth Succeed in School
- Goal 3: Children and Youth Are Healthy and Practice Healthy Behaviors
- Goal 4: Children and Youth Engage in Meaningful Activities
- Goal 5: Children and Youth Live in Healthy, Stable, and Supportive Families
- Goal 6: All Youth Make a Successful Transition into Adulthood

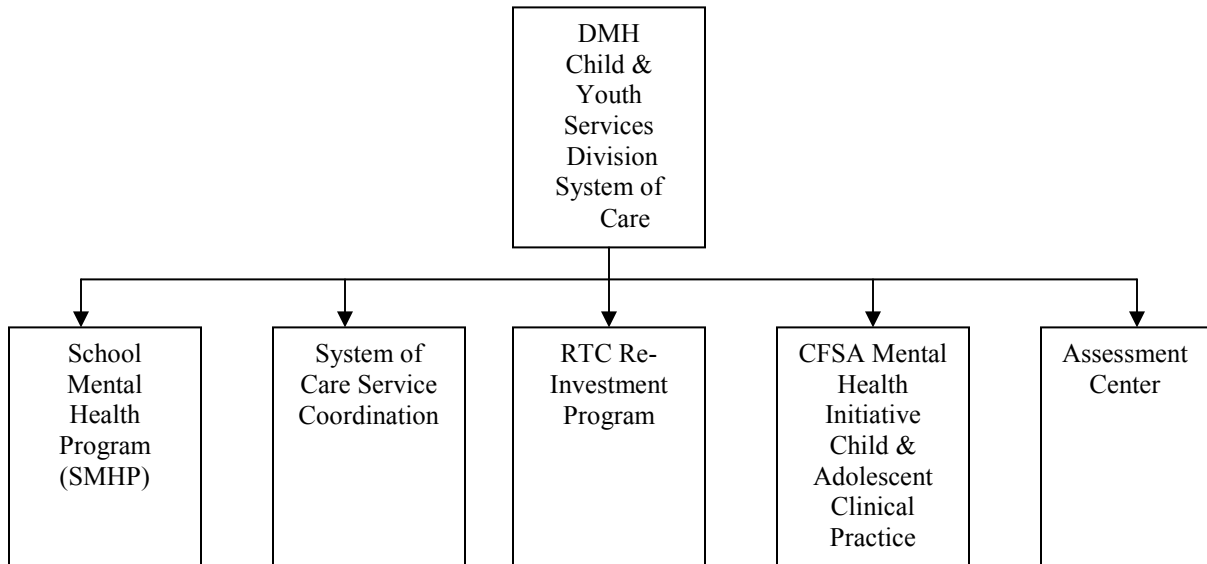
The six (6) goals require the District to work across agency boundaries and with community partners to align critical supports and services for children, youth, and their families. The ICSIC meets monthly to discuss data relating to one (1) of the six (6) goals and discuss how agencies can collaborate to address the needs of children, youth, and their families around the six (6) goals.

The responsibility for development, monitoring and oversight of the children's mental health system is vested in the DMH, Office of Programs, Child and Youth Services Division (CYSD). A new director of CYSD was hired in September 2008. The CYSD is comprised of the following five (5) programs: 1) the School Mental Health Program; 2)

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<sup>1</sup> The District of Columbia Family Court Operations Division includes the following types of cases: abuse and neglect, juvenile, domestic relations, domestic violence, paternity and support, mental health and retardation and adoptions.

the System of Care Service Coordination; 3) the RTC Re-investment; 4) CFSA Mental Health Initiative Child and Adolescent Clinical Practice, and 5) the Assessment Center.



The FY 2009 DMH contracts with child-serving providers of community-based mental health services, including the following:

- Mental health rehabilitation services (diagnostic/assessment, medication/somatic treatment, counseling, community support, crisis intervention, rehabilitation/day treatment, community-based intervention);
- Mobile crisis and crisis stabilization bed services;
- Wraparound services;
- Site-based emergency psychiatric services;
- Psychiatrists and psychologists who perform forensic evaluations;
- Multicultural services and supports;
- School Mental Health Program contracts with two (2) providers to cover six (6) schools;
- Mental health staff collaboration for System of Care Coordination for CYSD; and
- Evidence-based practice trainers for Choice Providers.



# 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.

## CHILD NEW DEVELOPMENTS AND ISSUES

1. Mobile Crisis Response Team: As reported in the FY 2009 application, on June 12, 2008, DMH awarded a contract for children's mobile crisis and crisis stabilization services to Anchor Mental Health of Catholics Charities. This contract is one of the initiatives required by the Amended Implementation Plan in *LaShawn A. v. Fenty* (the child welfare case). The goal is to significantly reduce multiple foster care placement disruptions, particularly those that are the result of avoidable acute care hospitalization. The services are available to all District children and youth, as well as District children living in foster care in Maryland and Virginia.

The Child and Adolescent Mobile Psychiatric Service (ChAMPS) began operations on October 28, 2008. The goal is to provide rapid mobile response within one (1) hour of the call, onsite crisis intervention and stabilization, and also provide linkage and follow-up support to avert future crises. The first quarter in FY 2009 was a start up period with minimal utilization compared to subsequent quarters. During the second and third quarters the data show: the team responded to 240 calls, the calls tended to be initiated most by schools (200) followed by parents (80), the number of hospitalizations was reduced from 21 to 12, most children seen are ages 6-10 (137) followed by ages 15-18 (117).

2. Choice Provider Network: In fulfillment of one of the requirements for the *LaShawn A.* Amended Implementation Plan, on September 8, 2008, DMH awarded Choice Provider contracts to five (5) vendors: Family and Child Services of DC, First Home Care, Progressive Life Center, Universal Healthcare Management Services, and Community Connections. The goal of this Choice Provider Network is to provide a continuum of care for children in the child welfare system and create a framework for the organization and concentration of existing and planned services.

3. Trauma-Focused Cognitive Behavioral Therapy Training and Coaching Initiative: In September 2008, DMH launched its Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) training and coaching initiative with a District-wide orientation for senior leadership of each of the agencies participating in the training. The subsequent training sessions and other follow-up activities were conducted on March 23-24, 2009 and June 8-9, 2009. The final training is scheduled for October 6-7, 2009. The TF-CBT training is part of the multi-year plan, which guides service development and training for Choice Providers. The other planned training for the remainder of FY 2009 and FY 2010 include: Community-Based Intervention (CBI) training for existing and new providers, Parent Child Interactive Therapy (PCIT), Child Parent Psychotherapy for Family Violence (CPPFV), and Functional Family Therapy (FFT).

4. High Fidelity Wraparound Pilot: In June 2008, Choices Inc., was awarded a contract to implement community-based alternative services for District youth at risk for or returning from an out-of-home residential treatment center (RTC) placement and for youth who have experienced multiple placements and/or hospitalizations (wraparound

services). The pilot program, which had the capacity to serve 124 youth, was increased by 10 slots (134 youth) in June 2009 as the result of Block Grant funding.

5. Internal Community Services Review: In FY 2009, an internal Community Services Review (CSR) Unit was established in the Organizational Development Division within the Office of Programs. The 2009 Child CSR continued to show low scores on variables related to overall system performance. The initial steps toward the development of a common practice model for all agencies and staff was launched in June 2009 and will continue in 2010.

6. Transitional Age Youth Services: The DMH and CFSA recognize the need for transitional age youth services to sufficiently meet the needs of the District's young adults between the ages of 16-25. The RTC Reinvestment Program Administrator with the CYSD Director will create a FY 2010 transitional youth plan to include the development of standards and procedures for transitional age youth planning and development activities. This population has created challenges for the District with respect to adequate and appropriate services and supports. The DMH will work collaboratively with other District agencies and stakeholders to ensure development of a comprehensive plan.

7. Interagency Collaboration and Services Integration Commission (ICSIC) Subcommittee on Residential Placement (SRP): The SRP is comprised of child-serving and child policy experts, led by the Department of Mental Health (DMH), who assist the Mayor in ensuring interagency coordination around the placement of District children and youth in psychiatric and non-psychiatric residential treatment facilities. There are eight (8) basic functions of the SRP: 1) develop standards for placement decisions, 2) know who is where (maintain central database), 3) identify quality providers, 4) facilitate coordination of monitoring activities, 5) routinely audit placement decisions/processes, 6) develop financial incentives to achieve vision, 7) initiate change through informed recommendations, and 8) develop capacity for specialty services.

8. Assessment Center Appointment Wait Time: Wait times for Court-ordered juvenile assessments showed considerable improvements for FY 2008 and significant improvements in FY 2009. The initiatives implemented to reduce the wait time thus far have included: 1) streamlining the current process with expected overall process improvement; 2) bringing Managed Care Organizations (MCOs) into the process and; 3) implementing the *Case Expediting Reforms* introduced and agreed to by District Officials on October 25, 2007. In an effort to address the shortage of psychiatrists to conduct psychiatric evaluations, a Request for Proposal (RFP) was issued with the expectation that awards would be made in FY 2009. The outcome did not produce an increased number of psychiatrists, to the contrary, there are fewer psychiatrists for FY 2009 than in FY 2008 and thus remains a continued challenge. For the first seven (7) months of FY 2009, the Assessment Center was successful in meeting the wait time 100% of the time for four (4) consecutive months (November-February). Contract issues and funding are attributed to the three (3) months that adversely effected the wait time. The DMH is in the process of issuing the RFP for contract psychiatrists and psychologists

for FY 2010. A second Request for Proposal (RFP) was issued to identify a group of *Choice Providers* allowing DMH the ability to divert neglect and abuse referrals for mental health treatment assessments from the Assessment Center to the community.

As a result of the initiatives that have taken place since 2007 to address the wait time for the juvenile assessments, the outcomes data for the Assessment Center for FY 2009 (June 2009) shows an average total process time from the time of the Court order to the submission of the evaluation to the Court of 23.1 days. This is a continued improvement of 29% from FY 2008 at 29.8 days and an overall 80% improvement from FY 2007.

9. Citywide Conference on Child Mental Health Issues: This one (1) day conference, “Towards A True System of Care” was held on May 8, 2009 in celebration of National Children’s Mental Health Day. The conference sponsors were the Department of Mental Health and Children and Youth Investment Corporation. Current effective mental and behavioral health practices, programs and services for young people and their families in the District of Columbia were showcased. From the national stage, Rusty Clark and Karl Dennis highlighted research and work in the areas of Transitioning Youth and Effective Systems of Care. The presentations included: Integrated Services in Special Education, Evidence-Based Practices, Transition to Adulthood Systems, Peer Parent\_Support, Accessing Mental Health and Special Education Services: A Legal Perspective, the D.C. School-Based Mental Health Program, the YOUTH Panel, the D.C. Wrap Pilot, and the Power of Positivity: A Radical Clinical Framework The program was free to the public and 482 persons pre-registered via email.

# District of Columbia

## Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

## CHILD LEGISLATIVE ISSUES AND INITIATIVES

- Amendment to 22A DCMR Chapter 34, Mental Health Rehabilitation Services Provider Certification Standards – to add new provisions to establish certification standards and a fee schedule for a Child Choice Provider Network.

Status and FY 2009 Activity: Initial draft prepared and circulated to program staff for comments.

# 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.

## CHILD DESCRIPTION OF STATE AGENCY'S LEADERSHIP

The Child and Youth Services Division (CYSD), under new leadership, has undertaken an ambitious cross-agency agenda. The four (4) major District child-serving agencies—DMH, Child and Family Services Agency (CFSA), Department of Youth Rehabilitation Services (DYRS) and the D.C. Public Schools (DCPS) are working collaboratively toward a common set of goals.

The CYSD has begun the process of creating a 3-5 year comprehensive mental health plan for children and youth. The process for this planning effort is currently being finalized. The intent is to develop a plan that speaks to the entire gamut of child/youth issues and challenges. Other agencies, child advocates and children, youth and families will be included in the process. The Children's Round Table, which is a broadly-based composite of child-serving providers and advocates, was informed of this effort and was strongly supportive. The goal is to have a working draft of this plan by the Fall 2009.

The DMH has the key leadership role in the design and development of the District's System of Care (SOC), working with and through a network of formal and informal collaborations with District child-serving agencies, children's advocates, community-based organizations that promote improved services for children and families, and providers that deliver services.

In FY 2009, focus areas for child/youth services included:

- implementing the children's mobile crisis and stabilization services;
- implementing the child wraparound initiative;
- continuing to host the Children's Roundtable;
- implementing the proposed Commission on Coordination of Psychiatric Residential Treatment Facility/Residential Treatment Center (PRTF/RTC) placements, including drafting common standards for all agencies to use in making decisions regarding residential placement;
- continuing the expansion of the School Mental Health Program; 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.

The DMH leadership role is highly evident in developing the SOC practice model. Evolving out of the SOC pilot—where family team meetings have been used to bring a family-centered, collaborative decision making model into treatment planning for children with deep-end treatment needs—DMH has taken a leadership role with the child-serving agencies and the Office of the City Administrator in the development and implementation planning for a wraparound services pilot. This pilot program was launched in August 2008.



The DMH continues to host a bi-monthly Children's Roundtable, whose members consist of children's providers, behavioral health leads of the managed care organizations (MCOs) and child-serving agency designees, with a focused purpose, which is: drill down into operational processes; eliminate barriers to services; clarify 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.

Currently, DMH and CFSA collaborate on all PRTF assessments and placements. Parallel placements occur via DCPS, DYRS, and the Medicaid Managed Care Organizations (MCOs). In FY 2007, the Mayor assumed responsibility for directly overseeing DCPS, through school reform legislation. The school reform legislation established the Interagency Collaboration and Services Integration Commission (ICSIC), a 25-member Commission aligned around six citywide goals, which outline the District of Columbia's commitment that children and youth make successful transitions from birth to adulthood. The Director of DMH serves on ICSIC. The DMH, through ICSIC, proposed establishing a Unified Residential Treatment Placement Commission (RTPC) to provide a common pathway for placing all District children in PRTFs. It is anticipated that this proposal will be adopted during FY 2010.

# District of Columbia

## Adult - Service System's Strengths and Weaknesses

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

## ADULT SERVICE SYSTEM STRENGTHS AND WEAKNESSES

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 activities listed below are: 1) evidence of a consumer-centered approach to mental health planning, and 2) a commitment to an interdisciplinary and interagency approach to providing mental health services and supports.

- Olmstead Conference- In September 2008, the DMH Office of Consumer and Family Affairs sponsored the first District-wide Olmstead Conference in collaboration with the Office of Disability Rights. The entire conference was planned by consumers and was well-attended by both consumers at Saint Elizabeths Hospital and those living in the community. A second conference is planned for Fall 2009.
- Peer Support Partners- The Office of Consumer and Family Affairs took the lead in training and hiring 12 consumers who are working as Peer Support Partners on the Continuity of Care Transition Teams as part of the D.C. Community Services Agency (DC CSA) closure Transition Implementation Plan. These consumers are proving to be a key component in helping DC CSA consumers understand their options and make a solid connection to their new Core Service Agency.
- Consumer Satisfaction Measures- The DMH has used several methods to assess consumer satisfaction that include: 1) the Mental Health Statistics Improvement Program (MHSIP) survey process for adults and children (a requirement of the Federal Mental Health Block Grant program), and 2) the satisfaction measures in the contract with the Consumer Action Network (focus groups and a convenience sample). These collective measures have allowed for peer administration of telephone surveys, face-to-face interviews, and group formats.
- Consumer Initiatives- The DMH has supported and/or created a variety of consumer initiatives such as: 1) providing funding to operate a community-based consumer run wellness and resource center for mental health advocacy, work skills training, and leadership development, 2) providing funding to support an International Center for Clubhouse Development program, 3) launching a Peer Specialist Training and Certification program for consumers to provide Medicaid billable services, and 4) launching a Transition Specialists program whereby consumers are trained to assist patients at Saint Elizabeths Hospital who have been determined ready for discharge in making a smooth transition to community living by providing encouragement and support.
- Crisis Emergency Services Initiatives- The DMH crisis services initiatives include: 1) opening a Court Urgent Care Clinic at the D.C. Superior Court to provide on-site mental health evaluations and referrals, 2) developing extended observation beds

and mobile crisis services as part of the DMH Comprehensive Psychiatric Emergency Program, and 3) extending the collaboration with the D.C. Metropolitan Police Department to include Crisis Intervention Officer training.

- Evidenced-Based Practices- The DMH is implementing evidenced-based practices related to supported employment, supported housing, 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 individuals who are chronically homeless.
- Organizational Development Division- In FY 2009, the DMH Organization Development Division expanded. It now includes: 1) the DMH Training Institute, 2) an internal Community Services Review Unit, and 3) a Research and Clinical Informatics Unit.

### **System Weaknesses**

The Final Court-Ordered Plan provided the blueprint for the reformed mental health system in 2001. Since 2001 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 implement 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:

- Service System Gaps- The DC CSA transition identified significant service system gaps such as psychiatrist to consumer ratio, and wait- times for intake appointments.
- Information Technology (IT)- The development of an adequate information system has been one of the major challenges for DMH since its inception. While significant progress has been made at Saint Elizabeths Hospital with the AVATAR IT system and the past development of the D.C. Community Services Agency (DC CSA) Anasazi system, the DMH Authority programs do not have an integrated data system. This has caused these programs to create their own databases. The DMH needs to improve the information system to provide greater reporting of client related data including tracking of client outcomes, and client movement across various systems and client movement across service systems (i.e., consumer's utilization of community hospitals and other services). In addition, DMH programs need to be able to generate

reports to inform decision making related to planning, monitoring, evaluation and other issues.

- Consumer Satisfaction Methods- As noted by the Dixon Court Monitor, the challenge with the consumer satisfaction methods that DMH uses has been to create a clear organizational process by which data from these data sources is aggregated and analyzed, followed by a process of prioritization, implementation and follow-up measurement of changes.
- Community Service Reviews- The annual Adult Community Service Reviews (CSRs) have shown problems related to practice issues, lack of social networking and recovery activity among consumers, and in the specific case of system performance, problems tend to be related to service team formation and team functioning. The DMH Adult Services Division and other Authority staff will work with the community providers to increase awareness of these components of treatment and community care. Also, the first internal CSR Unit was established in FY 2009 within the Office of Programs and Policy. This unit will conduct focused reviews and provide technical assistance.

In FY 2010, the focus will be on improving the quality of care for consumers in the system by continuing to introduce evidence-based practices as well as best practices into the repertoire of services and interventions.

# 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.

## ADULT UNMET SERVICE NEEDS

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

### Service System Gaps

The DMH put in place measures to address service system gaps identified through the DC CSA transition process. These include strategies to enhance psychiatrist capacity, and funds for providers to support program infrastructure development related to supporting the additional DC CSA consumers who choose their agency.

### Information Technology

The DMH began to develop a strategy to address the information technology (IT) shortcomings during FY 2008. This included the roll out the Dashboard Technology project. It was envisioned that the project would allow DMH Authority managers to create key metrics for their specific area with the ability to access data that is stored electronically. The DMH developed performance metrics in six general areas: 1) claims processing, 2) consumer enrollment, 3) service authorization, 4) provider funding, 5) Medicaid reimbursement, and (6) call center statistics.

The DMH leadership recognized that the Dashboard project was only the start of building an integrated electronic information system. A preliminary IT structure was developed that would support the multiple needs of the system. This structure would consolidate some of the current IT applications to create efficiencies. Most importantly it would create a new Business Intelligence Unit under the Chief Information Officer (CIO). This unit would take on direct responsibility for Dashboard, SharePoint and MS-Reporting Services. This unit, with a full-time Director reporting to the CIO, would interface with the respective program units to create data support as well as increase reporting and analytic capacity. During FY 2009, budgetary constraints did not allow DMH to move forward with implementation of the new structure, which will not likely be implemented.

The DMH has continued its work on the Data Infrastructure Grant including the work being done in conjunction with the Dixon data collection and reporting. The focus on data collection and data reporting throughout the department has identified a number of areas that require attention, to ensure the integrity of the data collected. During FY 2009, DMH established a Research and Clinical Informatics Unit within the Organizational Development Division that will focus on data collection, reporting and program evaluation.

### Consumer Satisfaction

#### A. Mental Health Statistics Improvement Program (MHSIP) Surveys

The DMH administers an annual Consumer Satisfaction Survey to meet the requirements of the Data Infrastructure Grant and the State Mental Health Block Grant. The survey is conducted with adults and parents and guardians of children and adolescents served by the District's mental health system.

- 2009 MHSIP Survey: The contract to implement the MHSIP Survey process was announced in July 2009. The process cannot begin until the contractor is selected. It is envisioned that once initiated the process will occur over a 90-day period.
- 2008 MHSIP Surveys: The adult survey instruments include the MHSIP Consumer Satisfaction Survey and the Recovery Oriented Systems Indicator (ROSI). The 2008 survey was administered through a telephone survey. For the MHSIP Survey there were approximately 3,231 phone calls made to consumers and 201 participated in the survey. The MHSIP Survey respondents had fairly high percentages of responses indicating satisfaction with the services within the District's mental health system for 2008. The exception was questions pertaining to positive outcomes and functioning. However, the 2008 findings were consistently rated lower than the 2007 findings.

The recommendations include both process issues and participant response issues. The process issues address increasing consumer participation including obtaining accurate contact information, and getting greater buy-in by providers including coordinating the timing of consumer surveys by DMH and the provider network. The findings based on the consumer responses suggest the need for: 1) a greater departmental focus on service outcome, 2) a continued focus on the types of services provided since respondents continue to give lower ratings to the receipt of services needed, and 3) wide dissemination of the survey findings through DMH programs (Provider Relations, Office of Consumer and Family Affairs and Quality Improvement).

#### B. Consumer Action Network Consumer Satisfaction Methods

The Consumer Action Network (CAN) method for assessing consumer satisfaction involves conducting focus groups and convenience sampling. In May 2009, CAN provided the DMH Office of Accountability a summary of focus group findings regarding provider services for the first quarter of calendar year 2009. The three priority concerns expressed by the consumers who participated in the focus groups included: 1) Improved education about psychotropic medications- regarding issues about side effects and any alternatives; 2) Housing- accessibility and affordability; and 3) Coordination of care- addressing the level of sensitivity and responsiveness by program staff regarding consumer needs. The DMH has begun to develop responses to these three (3) areas including identifying the multiple areas that might effect improvement.



### C. Community Services Reviews

The Annual Adult Community Services Reviews (CSR) provides another data source for assessing unmet service needs and system gaps. The Year 7 (2009) Adult CSR was conducted during May 2009.

The 2009 results for individual consumer status was at 74%. This was identical to the 2008 results. The findings for the areas with the higher scores and those with lower scores continue to indicate that basic needs are being met but that consumers are still not consistently engaged in a recovery-focused model of care.

The 2009 results for system performance (which is the Dixon measure) was at 70%. This compares to a score of 74% for 2008. The findings highlight some of the themes that were identified in previous years (i.e., lack of adequate communication between and among caregivers). The external reviewers “strongly recommended that the DMH and provider leadership make client-centered planning and teaming the top priority for refinement this year.”

### Consumer Population Issues

#### A. Transition Age Youth

While DMH is not seeing large numbers of enrollment of individuals 18-26, they are entering an adult system of care with people considerably older than themselves. Services such as supported employment, permanent supported housing, substance abuse treatment and individual therapies are very important for young adult consumers. Transition age youth consumers often come into the system of care via emergency services. Many are reluctant to accept services and tend to enter the system as a diversion from the criminal justice system. The DMH adult system of care needs to include providers with the skill to work with young adults, develop programs geared to younger adults, and ensure that permanent supported housing is available to this population.

#### B. Older Adults

In mid-July 2009, there were approximately 4,164 adults age 50 and above who had received at least one service through the DMH MHRS program. Their service needs are different from consumers who are under the age of 50. Many of the older adult consumers reside in community residential facilities (CRFs), receive 24-hour supervision of medications, and need assistance with activities of daily living. As the DMH population of older adults continues to age, DMH will need to review the service mix and ensure that it addresses primary medical needs as well as mental health concerns. Many of the older adults have chronic medical conditions and as they age, these conditions require as much if not more attention than their mental health needs. The older adult population is not interested in returning to the

workforce, do not need a therapeutic day program, and are more interested in special interest areas, maintaining social relationships, and activities of their own choosing.

# District of Columbia

## Adult - Plans to Address Unmet Needs

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

## **ADULT PLANS TO ADDRESS UNMET NEEDS**

Service System Gaps: In order to address psychiatrist capacity related to the DC CSA transition, DMH created the Physicians Practice Group (PPG). The PPG in part addresses the gap in psychiatrist to consumer ratio and allows consumers to maintain their psychiatrist. During FY 2009, DMH expanded the Psychiatric Residents Program that also assists with providing psychiatric services.

The providers are eligible to receive Consumer Transition Voucher funds for every consumer who chooses their agency. These funds are to be used to build capacity, hire and train staff, secure additional space, etc. The financial incentives also help to alleviate the wait-times for intake appointments.

The Transition Implementation Plan indicates that DMH will continue certain specific government operated services because the capacity does not exist within the provider network. The adult and child services programs that will operate under the Mental Health Services Division include:

- Multicultural Services Team,
- Deaf/Hearing Impaired Services Team,
- Co-Occurring Mental Health and Developmental Disabilities Services Team,
- Outpatient Restoration to Competency Program,
- Same Day Urgent Care Clinic,
- Pharmacy Program,
- Psychoeducational Program,
- Therapeutic Nursery, and
- Healthy Start Program.

Information Technology Issues: In order to address the information technology (IT) challenges, DMH planned to implement a separate Business Intelligence Unit within the IT operational structure. The budgetary constraints, however did not permit this plan to go forward.

One of the key IT strategies is to build an enterprise-wide data platform that would serve as a common IT base for all DMH programs and sub-programs. The belief is that Share Point, a Microsoft product, could provide this support. This is based on the characteristics of Share Point that include: interactivity; the capacity to hold and access multiple data bases; link to Microsoft Outlook software; provide necessary timeline reminders for key tasks; automate operational workflow; versatile enough to allow different units to meet their unique needs; and once it is set up it does not need IT maintenance or intervention unless there are changes. The main obstacle to moving forward in the short-term is the FY 2009 budget.

Adult Community Services Reviews Issues: The Organizational Development Division has created the first internal CSR Unit. The primary focus was on planning and development activities. These development activities include: 1) staff development, 2) identification and dissemination of organizational processes and procedures,

3) cataloging technical assistance tools to address practice points, 4) marketing, and 5) the establishment of both formal and informal agreements.

Over the past six (6) months this small team has been actively involved with the formal Dixon reviews, seeking to learn the requisite skills in logistics, training, facilitating and reviewing the cases. The next steps are to establish the guidelines for how the unit will function, develop priority areas for review, support the child/youth workshop targeted toward improvement in team formation and functioning, and develop formal and informal agreements. The next six (6) months should see the start of actual internal CSR reviews and the beginning of a network of providers committed to improving practice performance. The CSR Unit will address adult and child issues but will be priority driven.

Transition Age Youth: The DMH Child and Youth Services Division (CYSD) is taking the lead on developing a Transition Age Youth Initiative. The DMH Adult Services Division will collaborate with CYSD on this process. The DMH is beginning to focus supported employment efforts toward younger consumers where there is more interest in returning to the workforce. Activities have also been developed for a subset of this population including: 1) collaborating with the Mayor's Office on Working with Gay, Lesbian, Bi-sexual, Trans-gender and Questioning (GLBTQ) Youth, 2) training the DMH 24/7 hotline on working with GLBTQ youth and managing a hotline for these youth, and 3) training on GLBTQ youth by the DMH Training Institute.

Older Adults: While a significant portion of DMH consumers are age 50 and above, there is no comprehensive strategy to address the special needs of these older adults. In order to obtain information and gain a national perspective, the DMH Director of the Adult Services Division (ASD) participates on the National Association of State Mental Health Program Directors (NASMHPD) Older Persons Division. The Director of ASD also serves on the Strategic Work Plan Committee for Older Adults. The goal is to inform NASMHPD Commissioners of the growing and urgent need to address the mental health needs of older Americans.

The DMH FY 2010 goal is to begin to develop integrated services for older adults. In order to achieve this goal DMH will partner with community-based organizations already involved in service delivery to this population including the DMH provider network; as well as public providers such as the D.C. Office on Aging.

# 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.

## ADULT RECENT SIGNIFICANT ACHIEVEMENTS

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

Crisis Emergency Services: As part of the Comprehensive Emergency Psychiatric Program (CPEP), the adult Mobile Crisis Services officially opened in FY 2009. The mobile crisis teams provide crisis intervention services for adults who are unable or unwilling to come to the facility. In addition to onsite crisis stabilization including dispensing medication, the mobile crisis services teams perform assessment for voluntary and involuntary hospitalizations and linkages to other services, including ongoing mental health care and substance abuse detoxification and treatment. The Mobile Crisis Services (MCS) teams also provide support in the aftermath of individual or mass tragedies. The number of unduplicated consumers served since the MCS opened in November 2008 is 972 (as of June 30, 2009).

Crisis Intervention Officer Initiative: During FY 2009, DMH implemented the first Crisis Intervention Officer Initiative, spearheaded by the D.C. Metropolitan Police Department and the DMH Training Institute. The Crisis Intervention Officer (CIO) Initiative represents a groundbreaking effort between law enforcement, mental health and community stakeholders to improve outcomes of police interactions with people with mental illnesses. The desired outcomes include increased citizen and officer safety, and more appropriate involvement in community-based services for individuals who come to the attention of law enforcement, but do not meet the threshold for arrest. The CIO Initiative is one of several collaborations spearheaded by the D.C. Police Department and the DMH Training Institute (DMH), including ongoing training for new recruits.

Integrated Care Division and Integrated Community Care Initiative: This division's primary focus is to identify consumers who are frequent users of emergency services and work with the various treatment teams to provide care in the community, which enhances the consumers ability to manage his/her symptoms with fewer crisis services and fewer involuntary hospitalizations. The team works closely with Saint Elizabeths Hospital to address barriers to discharge for consumers with a hospital stay of longer than 6 months. The contract was signed at the end of March 2009 with the Washington Hospital Center to implement an Integrated Community Care Project.

Organizational Development Division: The DMH Organizational Development Division includes the DMH Training Institute, which provides internal and external training for DMH staff and the provider network. During FY 2009, the division added two units:

- 1) Community Service Review that will work with the adult system of care and the child/youth system of care to assess consumer status, progress and functioning, and
- 2) Research and Clinical Informatics that will eventually become the conceptual driver of all evaluation and performance management activities.

Care Coordination Division: The DMH operates a 24/7 Access Helpline (AHL) for emergency psychiatric care and enrollment for ongoing mental health services. The AHL

is part of the Care Coordination Division and is now a certified Suicide Lifeline Network provider for the Washington, D.C. area. Staff received training from several sources: in-house, the DMH Training Institute and the Suicide Lifeline Network. The new initiatives for FY 2010 include beginning the self study process for certification from the American Association of Suicidology. Training for all staff will continue throughout certification. The AHL also implemented a Gay, Lesbian, Bi-sexual, Trans-gender and Questioning (GLBTQ) Youth Hotline.

Co-Occurring Disorders: The DMH continues its national “best practice” model for the planning and delivery of integrated services for persons with both mental illness and substance abuse. The DMH and Addiction Prevention and Recovery Administration (APRA) provided joint support of this federally-funded effort through the Co-Occurring State Incentive Grant (CO-SIG). FY 2009 was the fourth year of this grant project. A portfolio of projects have been clustered under the four (4) major objectives: 1) System Supports for Integrated Service Delivery, 2) Universal Screening, 3) Expand Workforce Competencies in Co-Occurring Disorders, and 4) Continuous Quality Improvement Supports for Consumer Outcomes. Year 5 (2010) of the grant is devoted to conducting an evaluation of this infrastructure development initiative.



# 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.

## ADULT STATE'S VISION 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 persons leaving institutional settings (psychiatric and other hospitals and rehabilitation settings, jails or prisons), are homeless, have co-occurring substance use disorder, transition age youth, older adults, and medically compromised consumers.

The Core Service Agencies (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) consumers and families can access support services such as supported employment, supported housing, and other residential services.

A number of program proposals were developed for implementation during FY 2005 that continued through FY 2009 and will continue in FY 2010. These include: 1) shift all civil acute care to community hospitals, 2) enhance community crisis and psychiatric emergency services, and 3) expand ACT 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, and 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 in early 2010 and will have a capacity of 293 beds. 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, DMH 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.

## CHILD SERVICE SYSTEM'S STRENGTHS AND WEAKNESSES

### System Strengths

The programs below represent a commitment to an interdisciplinary, District-wide approach to child and youth mental health service delivery. They include but are not limited to the following:

- Network Capacity- The DMH now has a sufficient number of certified child/youth providers. Access issues do exist, however, and will be addressed as challenges.
- Public and Private Collaboration-The DMH continues to work collaboratively with the local public and private child-serving agencies (CFSA, DYRS, DCPS, OSSE) as well as the Department of Health Care Finance (DHCF) with the common goal of improving the children's mental health service delivery system. In FY 2008, DMH awarded multiple contracts to private contractors for several new initiatives set forth in the *LaShawn A. vs. Fenty* Amended Implementation Plan; which are definite steps toward an improved service delivery system.
- Children's Mobile Crisis Response Team- Provides onsite crisis stabilization, follow-up visits as needed to stabilize the family situation and/or connect the family to needed support services, crisis/respite beds as needed for children/youth; and to reduce the need for inpatient care and/or multiple out-of-home placements.
- Co-Location of Mental Health Staff at CFSA- This team consists of systems coordinator/program manager for Medicaid eligible and non-Medicaid eligible services, a program analyst to analyze data and program effectiveness, CBI coordinator, a staff to coordinate all referrals from CFSA within the public mental health system in collaboration with the CFSA Behavioral Services Unit (BSU), one (1) clinical psychologist and one (1) clinical social worker assigned to the CFSA Child Protective Services (CPS) unit under the direct supervision of the CFSA BSU.
- Establishment of a Choice Provider Network- Provides a continuum of care for children in the child welfare system and creates a framework for the organization and concentration of existing and planned services. In July 2009, over 152 children and youth had been referred to the network for comprehensive Diagnostic Assessments and ongoing mental health treatment.
- Trauma-Focused Cognitive Behavioral Therapy (TF- CBT) Training-In order to implement choice provider network, a TF-CBT training and a coaching initiative was launched in September 2008 with a District-wide orientation for senior leadership of each of the agencies participating in the training. The subsequent training sessions and other follow-up activities were scheduled for March, June and October 2009.
- Child Welfare Mental Health Needs Assessment- The DMH staff partnered with CFSA and a consultant and completed the third chapter of the CFSA Mental Health

Needs Assessment. This led to the development of a Funding Work group comprised of family member, CFSA, DMH, Medicaid, community stakeholders, and advocates. The work of the funding work group resulted in the Mental Health Services Multi-Year Plan, which prioritizes the implementation of new services, training and coaching for Choice Providers over the next three (3) years.

- DC Choices High-Fidelity Wraparound Pilot- The goal of this project is to provide community-based alternative services for District youth at risk for or returning from an out-of-home residential treatment center (RTC) placement and for youth who have experienced multiple placements and/or hospitalizations. This initiative is funded by CFSA, DMH and DYRS. The initial pilot was increased from 124 to 134 slots in June 2009. As of July 2009, 87 of the 134 Wraparound slots were filled and DMH plans to expand the project to include an additional 30 slots, which will result in a larger sample size to gain statistically significant knowledge through data collection and analysis if funding can be secured.
- School Mental Health Program- The DMH School Mental Health Program (SMHP) provides intervention and prevention services in public and charter schools throughout the District. Although the program received no additional funding, at the request of the Mayor it expanded into 58 schools during School Year 2008-2009. During FY 2009, the DMH Child and Youth Services Division launched the Primary Project. This evidence-based practice is in 24 D.C. Public Schools and provides early intervention to children identified with emotional and behavioral difficulties in grades 1 and 2. The School Mental Health Crisis Team continued to respond to crises in the D.C. Public Schools.
- Data Support for Process Monitoring and Outcomes Assessment- In Spring 2007, the Ohio Mental Health Scales (OMHS) were implemented as an outcome measure for children/youth in the System of Care (SOC). While volume and implementation challenges made manual data capture impossible, scanning technology currently being implemented will result in the first available outcomes data for the children's (SOC) and organized assessment of the SOC initiative. The CFSA resources have established a full-time Program Analyst who continues to capture key indicators of system performance and changes over time. While data and evaluation technology and human resources are coming into place, the DMH CYSD now has valid reliable data about system performance with respect to family and child outcomes that can inform the system and be utilized for continuous quality improvement.
- Establishing a Primary Family Organization- The DMH has established a partnership with one family organization, Total Family Care Coalition, to ensure that there is a family member as co-trainer in trainings delivered within the SOC. The family organization has access, with informed consent, to families enrolled in the Wraparound services to assess the level of family support that needs to be negotiated in this process. The family-run organization will: 1) develop an orientation manual that clearly defines what family voice and choice really mean, and how to maximize the benefits of the Wraparound services for their child, 2) play a key role in the

ongoing development of the District's SOC, 3) expand to support and train family advocates for families of children with SED, 4) provide advocates who reflect the cultural and geographic profile of the populations of focus, and 5) serve as a centralized hub for information and referral assistance to families. During FY 2009, the partnership with Total Family Care Coalition was established through a competitive process and funded by DMH and CFSA.

- The District of Columbia Children's Roundtable (Children's Roundtable)- This is a forum to discuss issues that foster cooperation among local agencies to improve services for District children/youth with mental health needs and families. There is representation from numerous government agencies, legal services, MCOs, providers, family organizations, community-based organizations and more. During FY 2009, the meeting schedule changed from every other month to a monthly meeting in order to maximize the potential for information sharing and learning about the numerous new initiatives being implemented in the recent months and the new direction of the System of Care philosophy. Additionally, the Children's Roundtable: 1) enhances service coordination and finds solutions for barriers to treatment, 2) affords DMH a very unique feedback opportunity consistent with the established Continuity of Care Guidelines set forth by the Department and the Team Formation and Team Functioning Practice Guideline, and 3) provides a forum for information sharing including new resources, system changes affecting service delivery, consumer education and outreach efforts.
- DMH Participation in Interagency Collaboration and Services Integration Commission (ICSIC)- This 25-member Commission is aligned around six (6) citywide goals, which outline the District of Columbia's commitment that children and youth make successful transitions from birth to adulthood. This is a Director level governance structure facilitated by the District of Columbia's Mayor. The ICSIC addresses the needs of at-risk children by reducing juvenile and family violence and promoting social and emotional skills among children and youth through the oversight of a comprehensive integrated service delivery system. The Commission meets monthly to discuss data around one (1) of the goals and how agencies can collaborate to address the needs of children, youth, and their families around the six goals. The ICSIC Action Items and timelines are identified for each agency out of the Commission meetings.
- Establishment of a Unified Residential Treatment Placement Commission (RTPC)- The RTPC assists the District ensure that all placements of children in PRTFs are needed, appropriate community-based alternatives have been considered and placements are in the best interest of the youth and their families, and are in accordance with relevant District of Columbia and federal laws. Through the ICSIC and other efforts, DMH has been partnering with sister agencies to embrace best practices for children affected by mental health problems. The ICSIC Sub-committee on Residential Placements (SRP) - which includes the leaders of CFSA, DCPS, OSSE, DYRS, DMH, and the Office of the City Administrator - has been charged to build a better bridge between residential placements and community-based services, thereby facilitating full reintegration into the community and reducing psychiatric

residential treatment facilities (PRTFs) lengths of stay. In May 2008, an ICSIC subcommittee convened a city-wide interagency work group of District child-serving agencies that currently place children/youth in PRTFs. The DMH Director is the chair of this subcommittee that is charged with reviewing how residential placement decisions are made across each respective system. Currently the workgroup is addressing and/or monitoring multiple issues including: 1) streamlining accurate tracking of all children/youth in PRTFs or RTCs, 2) determining readiness for discharge for the existing 539 placements, 3) exploring cost models that would incentivize community alternatives, and 4) building the capacity of High-Fidelity Wraparound.

- Creation of Specialized Community Capacity for High-Need Children and Youth- The CYSD has continued to evolve and refine its Systems of Care (SOC) model for all children who are fee-for-service Medicaid with complex needs and being considered for out-of-home placement. This model has been in place since October 1, 2006. As a baseline for diversion, FY 2007 saw 87 children diverted out of 160 total served by the SOC process (54% diversion rate). This approximate 50% diversion rate has been the norm for the past several years. However, for the period of January through March 2009 the diversion rate – based on 72 referrals – was at 92%. While this very high percentage will not likely stand, it does point to a couple of important improvements in the SOC. First, Family Team Meetings (FTMs) have been reorganized to be more inclusive and productive in finding alternative resources. The Care Coordinators in the SOC unit follow each case for a maximum of 90 days to ensure full implementation of the treatment recommendations and assign continued care coordination to a member of the FTM team for ongoing teaming. Second, the continued development of the first District Wraparound program – which has the capacity to now serve 134 children/youth (10 additional youth as a result of Block Grant funding) who are diverted from residential care. This program, administered by Choices, Inc., has census of 84 (as of July 2009). The hope is that this program will continue to grow to both divert children and to help shorten lengths of stay in institutional settings.
- Reimbursement Rate Enhancement- The DMH, with the help of a consultant worked on a rate study to analyze the MHRS rates in an effort to enhance the rates for MHRS services, particularly Community Support, CBI, and Psychiatrist services rates for children and youth. In November 2008, most MHRS rates were increased. The children rates were increased by approximately 20%.

### **System Weaknesses**

The District of Columbia continues to have critical gaps and barriers in the current service capacity that can potentially be addressed through the D.C. Gateway Project (System of Care Grant submitted in 2009). The list below is based, in part, upon the results of 1½ years of collaboration and planning of an interagency workgroup and an analysis of the minutes and planning session proceedings of the Wraparound Implementation Work Group (WIWG). The WIWG represents a cross section of

stakeholders and includes advocates, family members, agency representatives and community providers.

The specific gaps and barriers to service include:

Limited Integrated Systems of Care for Youth and Families: Since there are multiple entry points to services, families constantly have to re-tell their story. There is no common intake form or shared information system. In addition, each agency within the system has its own mandates and eligibility criteria, which creates confusion for families. There are currently not enough advocates within the system to help families negotiate the service maze.

Limited Family Involvement at All Levels of the System: There has been only a limited focus on family empowerment and utilization of natural supports within the community. Family and youth voices are still not fully heard. The Child and Youth Services Division has re-engaged the family movement in the infrastructure of DMH. The Total Family Care Coalition (TFCC), primary family organization, has been involved in planning activities and is an active member of the Children's Roundtable. The Executive Director of TFCC will be a member of the D.C. Gateway Project Executive Committee.

Limited Community-based Early Identification and Intervention Services: There is currently heavy system reliance on out-of-home placement due to limited effective community-based alternatives. This is evidenced by the fact that currently there are almost 500 youth in residential placements. The implementation of the wraparound pilot and several other new services represents an initial attempt to address this issue.

Limited Education and Outreach to Families: There is a lack of understanding about mental health and continued stigma regarding the use of mental health services. Many families in the District do not understand mental illness. Stigma limits the ability to integrate services in school and other normalized settings.

Limited Culturally and Linguistically Competent Services: Within the current system, the child must fit the services. Providers do not possess the culturally and linguistically responsive practice skills to provide appropriate services to meet the needs of individuals of different cultural groups. The DMH Multicultural Services Program has created a language bank of over 30 languages to facilitate access into the system; however, resources are limited to a small base of constituents.

Limited Infrastructure that Supports or Reinforces the Implementation of Strength-based and Family Focused Approaches: The DMH annually administers the Mental Health System Improvement Project (MHSIP) Surveys and conducts a Community Services Review (CSR), which measures youth and families' satisfaction with service delivery approaches. A strength-based and family-focused approach must be an integral part of each family's experience within the System of Care. Through social marketing, DMH will continue to educate youth, families and the community at large about treatment expectations and Child and Adolescent Service System Program (CASSP) principles.



Limited Youth Advocacy and Voice in the System: Services have been developed without engaging youth to obtain their input regarding the services that best fit their needs.

Limited Services Available to More than 2,000 Children Attending D.C. Public Schools who Have Been Diagnosed with Emotional and Behavioral Challenges that Interfere with Their Learning: In 2008, the School Mental Health Program expanded their population of focus to include special education children. More still needs to be done to meet this gap.

Limited Information Technology Infrastructure to Capture Needed Data to Drive Data Informed Planning and Decision Making: The DMH Authority has longstanding data capture and reporting issues due to the lack of a comprehensive, integrated management information system. The newly created (2009) Research and Clinical Informatics Unit within the Organizational Development Division will be relied upon to assist with developing the data system to support the System of Care.

Overall System Performance as Measured by the CSR: The *Dixon* Court Monitor conducts annual community service reviews (CSRs) of both the child and the adult systems. The CSRs are two (2) of the 19 exit criteria. FY 2009 was the seventh year of the review. The Child/Youth Review was held from March 9- 20, 2009. The final sample included a total of 60 cases that were reviewed. Forty-two per cent (42%) of the cases (25) were also involved with CFSA. The cases were selected from 16 different community providers; however, eight (8) had two (2) or fewer cases reviewed. An effort was made to put particular focus on the five (5) Choice Providers, which accounted for 60% of the cases reviewed.

The results for Year 7 were similar to prior years. The overall percentage of acceptable cases in terms of the child/youth status was 77% compared to 79% (2008) 75% (2007). High acceptable ratings included safety of the child (83%), health/physical well-being (90%) and lawful behavior (86%). The categories scoring less well included functional status (67%) and academic status (60%).

The Dixon measure is on systems performance with a required performance level of 80% in the acceptable range. For 2009, the child/youth systems performance was at 48% compared to 36% (2008) and 48% (2007). Many of the low-scoring areas were present in prior years- e.g., service team functioning (30%), long-term guiding view (18%), individual resiliency plan (32%) and service coordination and continuity (45%). The Human Systems and Outcomes (HSO) Report that detailed the child/youth review recommended a primary focus on two areas: 1) improving the full understanding (assessment) of each child/youth (including diagnosis and functional issues), and 2) the need to create functional teams that include families and cuts across organizational boundaries. This remains a major challenge for the District.

Lack of a Common Assessment Protocol: The DMH currently uses the CALOCUS and the Ohio Mental Health Scales across various programs as a measure of problem severity and functioning in youth. The ICSIC Committee is urging other child-serving

agencies to adopt the same assessment instrument so that there will be a common data set of information across the District, and outcomes can be compared.

Assessment Center Appointments: Scheduling appointments within five (5) days of the referral continue to present challenges for the Assessment Center staff for both psychiatric and psychological and other related evaluations. However, every effort is consistently made by DMH staff to schedule all appointments within five (5) days of the referral and for the majority of the cases this does occur. However, due to mitigating circumstances, in most instances where the appointment was originally scheduled within five (5) days and was later either cancelled or the client failed to call and appear, the overall process time from the referral to the evaluation completion date has exceeded the 30 day reporting time. In some cases where the client failed to appear for the appointment, he/she may have absconded or eloped prior to the scheduled appointment and in the interim the case remains open resulting in an excessive number of overall days from the Court order to case closure.

Shortage of Psychiatrists: There is a significant shortage of psychiatrists in the metropolitan Washington, D.C. area who are willing to accept Medicaid rates. The shortage results in long delays for psychiatric appointments, which is particularly critical for children discharged from the hospital with medications that need to be filled as well as for children and youth in detention awaiting court hearing dispositions. Resolving the shortage will require broad, system-wide interventions in a number of domains.

High Turnover Rate at the Provider Level: Social workers recently out of school come into the public system, obtain the required hours to take the licensure examination, become licensed and leave the public system for the more lucrative private enterprise. During their tenure in the public system, they are trained in community-based practice and, hopefully, specialty services that are required to meet the needs of urban populations, and children/youth associated with the child welfare and juvenile justice systems. Turnover significantly impacts the results of the CSRs. Providers complain that MHRS rates do not adequately compensate for the added expense of home-based therapy, therefore they are not invested in building their capacity. Like the psychiatrist shortage, the social worker turnover issue must be addressed from a system perspective. The District is home to two (2) academic institutions that train social workers and the need is shared by CFSA and DYRS.

Resources Devoted to Children Deep in the System: As is the case with many state mental health authorities, resources are scarce and therefore prioritized for children with the most intensive needs who require *deep end treatment*, or treatment which is most costly and community interventions too frequently occur at the last opportunity before the child is placed in a psychiatric residential facility. Although funding support for the SMHP, which is principally prevention and early intervention, was sustained, the majority of services in the child mental health system are dedicated to children already in the public system (CFSA and DYRS involved youth). Shifting resources toward opportunities to strengthen families before children and families become involved in the system remains a challenge and a priority for the city.

# 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.

## CHILD UNMET SERVICE NEEDS

The limitations discussed under System Weaknesses also address the unmet services needs and are listed below by reference only:

- Limited Integrated Systems of Care for Youth and Families
- Limited Family Involvement at All Levels of the System
- Limited Community-based Early Identification and Intervention Services
- Limited Education and Outreach to Families
- Limited Culturally and Linguistically Competent Services
- Limited Infrastructure that Supports or Reinforces the Implementation of Strength-based and Family Focused Approaches
- Limited Youth Advocacy and Voice in the System
- Limited Services Available to More than 2,000 Children Attending D.C. Public Schools who Have Been Diagnosed with Emotional and Behavioral Challenges that Interfere with Their Learning
- Limited Information Technology Infrastructure to Capture Needed Data to Drive Data Informed Planning and Decision Making
- Overall System Performance as Measured by the CSR
- Lack of a Common Assessment Protocol
- Assessment Center Appointments
- Shortage of Psychiatrists
- High Turnover Rate at the Provider Level
- Resources Devoted to Children Deep in the System

### Consumer Satisfaction

Consumer and family member satisfaction surveys can also inform DMH about unmet service needs. The DMH administers an annual Consumer Satisfaction Survey, using the Mental Health Statistics Improvement Program (MHSIP) Surveys, to meet the requirements of the Data Infrastructure Grant and the State Mental Health Block Grant. The survey is conducted with adults and parents and guardians of children and adolescents served by the District's mental health system.

- 2009 MHSIP Survey

The contract to implement the MHSIP Survey process was announced in July 2009. The process cannot begin until the contractor is selected. It is envisioned that once initiated the process will occur over a 90-day period.

- 2008 MHSIP Survey

Background: The 2008 survey was administered through a telephone survey during the period July-September 2008. The surveys were coordinated by the DMH Office of Strategic Planning, Policy and Evaluation with the assistance of the Family Alliance for

Community Support, Inc., a family advocacy organization. The surveys were administered by a team of consumers and family members who received a 3-day training on survey administration but who came to the training with prior experience. Three (3) instruments continued to be used to generate consumer satisfaction ratings. They were: 1) the MHSIP Consumer Satisfaction Survey, 2) Youth Services Survey for Families (YSS-F), and 3) the Recovery Oriented Systems Indicator (ROSI). The “official version” of each of these instruments was used.

Survey Participants: From a pool of 15,525 duplicated adult service records and 5,467 duplicated child service records, a stratified random sample was employed using a triple sample of 1,292 adults and 1,008 parents/guardians of children. Consumer over sampling was done in an effort to increase the final sample. Participants were comprised of individuals who had a minimum of one paid service with a provider between July 1, 2007 and March 31, 2008. For the YSS-F sample, there were 959 phone calls made to parents/guardians of children and adolescents and 184 participated in the survey.

Parent/Guardian Respondent Characteristics: There were 185 parents/guardians who consented to participate in the YSS-F telephone survey of which 38% were females and 61.2% were males. The participants were 89.7% self identified as African American, 1% self identified as Hispanic and 9.2% self identified as other racial groups. This year’s results showed that 60.5% of parents/guardians had children who had lived with them for the past six months, with only 21.5% living with another family member. A smaller percentage, 13% lived with a foster parent and even smaller percentages lived in a group home (3%) or in a residential setting (2%). In contrast to the adult survey, 80% of the parents/guardians had children who were still receiving mental health services. Fifty-five percent (55%) of the children were on medication.

YSS-F Survey: The standardized YSS-F instrument consists of 28 items, rated on a 5-point Likert scale ranging from 5 (strongly agree) to 1 (strongly disagree). The YSS-F was designed to measure consumer satisfaction with services in the following domains: 1) **Access Domain** (2 items) measures consumers’ perceptions about the accessibility of services; 2) **General Satisfaction Domain** (6 items) measures consumers’ satisfaction with services received; 3) **Outcome Domain** (6 items) measures consumers’ perceptions about treatment outcomes as a result of receiving services; 4) **Participation in Treatment Domain** (3 items) measures how much consumers’ perceptions of participation in their individual service plan; and 5) **Cultural Sensitivity Domain** (4 items) measures consumers’ perceptions of staff sensitivity to the child’s ethnic, cultural and religious customs and or backgrounds.

The National Association of State Mental Health Program Directors, National Research Institute (NASMHPD, NRI) added two (2) additional domains for **Functioning** which is comprised of 5 items and measures functioning as the result of treatment and **Social Connectedness** which is comprised of 4 items and measures consumers’ relationships with persons other than their mental health providers. The NASMHPD, NRI also added questions pertaining to whether the child was currently receiving services; whether the child had been arrested by the police in the past 12 months; where the child had lived in

the past 12 months; school attendance and health services rendered. The NASMHPD NRI also included two (2) qualitative questions related to the quality of services.

Parent/Guardian Survey Findings: For the 2008 YSS-F, respondents' percentages of positive responses were slightly above average range when rating the overall services received. When comparisons were made with the District's 2007 YSS-F, there was a moderate increase in the percentages for the domains: **Access to Services, General Satisfaction, Outcomes, and Participation in Treatment**. However, there was a decrease in **Cultural Sensitivity**.

The percentage of positive responses was within the moderate range for **Access to Service**. The responses pertain to location and times for service delivery. The percentages were slightly higher than the previous year (2007).

The percentages tended to decrease when respondents rated **General Satisfaction with Services**. The highest percentage (85%) was reported for a child having someone to talk to when troubled. Respondents reported more positive ratings than the in 2007. However, percentages were less positive for overall satisfaction with services and having the right services for the family. Most often getting the help wanted and as much help as needed received less positive ratings. The same trend for low ratings continued when outcomes were reported.

Respondents reported a low percentage of positive responses for the **Outcomes** Domain. The highest percent (77 %) was reported for better handling daily life. The outcomes for relations with families and friends were given a low rating. The same low rating was given for the improvement in school work. For 2008, parents/guardians had much lower positive ratings for their children being able to cope when things go wrong. However, the 2007 and 2008 ratings were comparable with the exception of two (2) questions.

The **Participation in Treatment** Domain received ratings within a moderate range compared to the previous year (2007). The results reflect choices parents and guardians had pertaining to their child's treatment goals and services, and how frequently they were involved in their child's treatment. There were a slightly higher percentage of positive responses for **Participation in Treatment** Domain.

Overall, respondents' ratings were high for the **Cultural Sensitivity** Domain. The respondents rated this domain more positively than the three (3) previous domains: **General Satisfaction, Outcomes, and Participation in Treatment**. Cultural Sensitivity is one of the overarching principles of the District's mental health system where individuals receiving services are treated with respect relating to their ethnic, cultural and religious customs and/or backgrounds. The 2008 percentage ratings are much higher than those for 2007. Therefore, these scores suggest that mental health providers are attempting to demonstrate more cultural-related knowledge and skills when servicing ethnically and racially diverse consumers.

Several questions assessed social connectedness and functioning, with ratings of 92% and 73% respectively. Parents/guardians believed that they had people available who they could talk with and who would listen to them. More importantly, in a crisis they would get the help they needed. However, their children's functioning seemingly did not always allow them to better handle daily life or allow them to do things much better.

A final set of questions that were added to the survey focused on arrests. There were 93 responses to these questions. Parents/guardians responding to these questions indicated that 10 youth had arrests prior to receiving services and 11 had arrests while receiving services. There were only three (3) police encounters. The children and youth behavior in school was also queried. There were 29 children and youth who had been suspended, since coming into treatment and the same number had been suspended prior to treatment. Only 31 parents/guardians reported that the children or youth increased their school attendance.

Recommendations from MHSIP and YSS-F Survey Process: The findings of the 2008 Consumer Satisfaction Survey for Adults and the 2008 Youth Services Survey for Families reflect the extent of consumer satisfaction with the public mental health services delivered in the District of Columbia. Overall, adult survey respondents for the MHSIP reported satisfaction across the five (5) domains: **Access, Quality and Appropriateness, Outcomes, Participation in Treatment, General Satisfaction**. Although respondents generally expressed positive experiences with the services they received, there was a moderate decline in the percentage of highly satisfied respondents from the 2007 Adult Consumers Satisfaction Survey compared to the 2008 survey.

For the 2008 YSS-F, parents and guardians indicated moderate percentages of satisfaction regarding the overall services they received for their children within the District's mental health system. However, there was a slight decrease in the **Cultural Sensitivity** Domain. Data for the qualitative sections of the surveys was not captured. The results demonstrate room for improvement in all of the domains on the YSS-F Survey.

The lessons learned from the survey process include:

- The need to identify strategies for increasing the consumer participation and devoting resources to obtaining more accurate consumer contact information for the telephone survey process.
- The need to coordinate the timing of surveys between the DMH administered surveys and the provider network surveys.
- The need for a greater departmental focus on service outcome.
- A continued focus on the types of services provided since respondents continue to give lower ratings to the receipt of services needed.

- The need to get greater buy-in of the survey process from the DMH providers.
- The survey findings should be widely disseminated through the DMH program areas (provider relations, consumer and family, and quality improvement).
- The survey findings should be discussed with various stakeholders to identify ways to improve services. It is important to examine domains with higher or lower scores to determine strengths and deficits in mental health service delivery. This process can be used as a mechanism for planning and feedback at the administrative and service levels. One of the limitations to this survey process was the low participant rate for both the Adult Survey and YSS-F Survey.



# District of Columbia

## Child - Plans to Address Unmet Needs

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

## CHILD PLANS TO ADDRESS UNMET NEEDS

The System Strengths and Weaknesses sections address some of the major strategies to address the unmet needs. These included: new services that have been implemented in FY 2008 and FY 2009, other existing programs and initiatives within CYSD and other DMH programs, cross agency partnerships, and District-wide initiatives and collaborations.

The Department of Mental Health's goal is to continue to remove the existing structural barriers and create a comprehensive System of Care for District children and their families. A brief synopsis of some of the strategies that will be implemented to obtain this goal include:

- Reduce the current reliance on out-of-home and out-of-state (RTC/PRTF) placements for children and youth with serious emotional, socio-emotional and behavioral challenges;
- Focus on strengthening, supporting and engaging families as partners in the provision of mental health treatment as an alternative to child welfare and juvenile justice placements;
- Create a comprehensive array of community-based services that are accessible, available and culturally appropriate and that offer opportunities for early identification and intervention of youth at-risk of out-of-home placement;
- Ensure that families and youth are involved in System of Care development at all levels;
- Implement evidence-based and promising practice models, care coordination, and individualized team-based service planning embedded in strengths-based foci that build resiliency and take into account the cultural strengths of the District's youth and families;
- Maximize the use and blending of Medicaid and other federal funding programs, District funding, and private sector funding to meet the multiple needs of youth with serious emotional, socio-emotional and behavioral challenges and their families, as well as develop strategies to reinvest funds from out-of-home and out-of-state placements to community-based services to address long-term sustainability of the System of Care; and
- Work with child-serving providers and the newly established Community Services Review (CSR) Unit in DMH to improve the overall system performance ratings for the Child CSR process; as well as address issues identified by the MHSIP Survey process (YSS-F).

Other strategies to address unmet needs include:

- Child Community Service Review- As an outgrowth of this year's CSR review, DMH has undertaken a process that is intended to work with the child/youth providers on the core issues uncovered by this process. One of the first steps is the development of a common practice model for all agencies and staff. The kickoff of these efforts was in late June 2009. This very successful workshop was attended by 14 CSAs serving children/youth – with approximately 115 attendees. The DMH Team Formation and Team Functioning Practice Guidelines was distributed and discussed at the session. The goal of the workshop was for each child/youth agency to develop its own action strategies to address the core performance issues that have persisted. The DMH Child/Youth Services Division and the DMH Training Institute will follow-up with agencies to provide technical support and coaching to assist with the implementation of action plan strategies.
- Data Driven Planning- The DMH collects process data on its programs and reports it monthly, quarterly and/or annually to various stakeholders. The DMH Research and Clinical Informatics (RCI) Unit will assist program managers in increasing the efficiency of data collection and how to use data to improve their program areas. In addition, DMH management is working toward the identification and implementation of a clinical practice model that will be necessary to standardize other processes and practices. Along with the national evaluation data and other local benchmarks that will be established, the DMH Child and Youth Services Division (CYSD) intends to measure and track outcomes and create more accountability within the children's mental health system. Data resources to support data driven decision-making is new to children's services and the impact of technology supports continues to be a challenge. The CYSD is working to fulfill the commitment to SOC stakeholders to provide demonstrated outcomes of services and SOC processes—such as follow-up to assure referred children are engaged in needed services.
- System of Care Grant- During 2009, DMH applied for a System of Care Grant from SAMHSA in order to increase capacity and quality of services. If DMH is a successful grantee, some of the initiatives that will be achieved include: 1) increase capacity in Wraparound services from the 134 child and youth pilot to 350 children served by the conclusion of the cooperative agreement (it is anticipated that a total of approximately 800 children will be served through the life of the cooperative agreement); 2) expand the capacity to provide evidence-based practices (Functional Family Therapy (FFT) and Common Sense Parenting); 3) increase current emergency capacity for planned overnight respite care; 4) improve the capacity of the System of Care to serve young children from 0-5 years of age; and 5) improve system performance and other quality improvement issues.

# 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.

## **CHILD RECENT SIGNIFICANT ACHIEVEMENTS**

A summary of significant achievements during FY 2008 and FY 2009 for Child and Youth Services Division include but is not limited to the following:

- Expansion of the SMHP to an additional ten (10) schools for the 2008- 2009 school year (completed in August 2008);
- Partnership with CFSA and DYRS to fund the contract for the Child Wraparound initiative (launched in August 2008);
- Contracted with the five Child Choice Providers (launched September 8, 2008);
- Award of the contract for the Children’s Mobile Crisis and Crisis Stabilization Services required by the LaShawn Amended Implementation Plan (launched October 28, 2008);
- Partnership with OSSE to expand the Child Wraparound initiative in FY 2009 to include special education students;
- Development of draft common standards for all agencies to use in making decisions regarding residential placement (FY 2010);
- Provision of clinical monitoring to all CFSA, DMH and fee-for-services Medicaid youth who are placed into psychiatric residential treatment facilities (PRTFs), began in FY 2009 and will continue in FY 2010;
- Implementation of effective outreach program to homeless children and youth;
- Co-sponsor along with the Children and Youth Investment Corporation of the citywide conference, ‘Towards A True System of Care’ held on May 8, 2009 in celebration of National Children’s Mental Health Day;
- Submission of a Systems of Care Grant (D.C. Gateway Project) application to SAMHSA;
- Submission of a State Wide Suicide Grant application to SAMHSA;
- Submission of a Healthy Transitions Initiative Grant application to SAMHSA for services and supports for youth with serious mental health issues age 16-25; and
- Began the process of creating a 3-5 year comprehensive mental health plan for children and youth.

# 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.

## **CHILD STATE'S VISION FOR THE FUTURE**

When the child mental health system is fully implemented, the District's children will receive the mental health services and supports they need through a comprehensive, seamless system that delivers services at the local level and recognizes that children and their families come first. The District's mental health services system for children will be accessible, culturally competent, and flexible enough to meet individual and family needs; and family-centered and focused on attaining positive outcomes for all children. Children, youth and families will be active participants in the planning, implementation, monitoring and evaluation of the System of Care services and supports.

The DMH Child and Youth Services Division (CYSD) will build upon the energy generated by its new leadership and unprecedented collaboration and partnerships with District public and private child-serving and other agencies. The 3-5 year plan that will be developed under the leadership of the DMH CYSD will not be a DMH plan to address children's mental illness, but rather a District plan for a full spectrum of services and supports needed to provide for the mental health of all children. To that end, the children's mental health system will focus on prevention, early identification and intervention as well as the community-based treatment and hospitalization services that are needed in a comprehensive system. The comprehensive system will include interagency collaboration on policy development, financing and policy initiatives. Services will be evidence-based and organized by developmental stages through a matrix of services, health promotion, access to care, and evaluation and quality monitoring.

# 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.



## ADULT ESTABLISHMENT OF SYSTEM OF CARE

### [Criterion 1: Comprehensive Community-Based Mental Health Service Systems]

The Adult Community Service system is comprised of the Mental Health Authority, certified agencies (including the District of Columbia Community Services Agency and a group of private non-profit mental health agencies) and Saint Elizabeths Hospital. The Hospital includes both the forensic services of the John Howard Pavilion and the civil hospital. The Mental Health Authority, certified provider agencies and Saint Elizabeths Hospital collectively provide a range of mental health services and supports for adults in recovery from mental illness. The FY 2010 State Mental Health Plan describes the community-based organizational structure, as it exists today. The emphasis in the current plan is on the objectives to be carried out within the Mental Health Authority related to system development.

There are a number of formal and informal partnerships with other District agencies that contribute to the services and supports for adult consumers in the public mental health system. These include but are not limited to:

- Department of Health/Addiction Prevention and Recovery Administration- model and infrastructure development for services for co-occurring mental illness and substance use disorder,
- District of Columbia Housing Authority- administration of rental subsidy program and other housing related supports,
- Department of Housing and Community Development- creation of 300 new housing units,
- Department on Disability Services- joint project to serve consumers who are both developmentally disabled and have a mental health diagnosis,
- Department on Disability Services/Rehabilitation Services Administration- financial assistance for the supported employment providers and related projects, and services for co-occurring mental illness and mental retardation,
- District of Columbia Metropolitan Police Department- implementation of the Crisis Intervention Collaborative to improve police interactions with people with mental illnesses, and
- District of Columbia Fire and Emergency Services- training and credentialing to apply for involuntary hospitalization (Officer Agent).

Additionally, there are contracts and other arrangements with a cadre of public and private providers that include: 1) local hospital acute care and other medical services,

2) crisis bed providers, 3) housing services and residential services providers, 4) homeless services providers, 5) supported employment services providers, 6) forensic services providers, 7) a wellness and resource center provider, 8) an International Center for Clubhouse Development model provider, 9) a court urgent care clinic provider, 10) an integrated care model provider, and 11) a variety of training and technical assistance contractors and consultants.

# 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.

## **ADULT AVAILABLE SERVICES**

### **Health, Mental Health and Rehabilitation Services**

#### **Health Services, Health Status and Planning Initiatives**

Health Screening: The DMH Mental Health Rehabilitation Services (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 Service Agency (CSA) clinical manager to assure that the health issues are followed up.

Health Status of Adults via Community Services Review: Health status is one of the person status indicators in the Adult Community Services Review (CSR) protocol. During the 2008 Adult CSR, DMH requested data on health status as it was believed that this information would be helpful to the ongoing health related planning initiatives. There were 88 adults in the 2008 Adult CSR sample. The data showed that 21 consumers or 23.86% had an unacceptable health status rating. Their health status included various combinations of the following disease categories: diabetes, hypertension, hepatitis C, obesity, asthma, Tardive Dyskinesia, arthritis, seizure disorder, substance abuse, serious back injury, chronic pain, chronic obstructive pulmonary disease (COPD), poor dental care, tuberculosis (TB), abnormal gait, neurological problems, HIV positive, sickle cell trait, cataracts, glaucoma, congestive heart failure, and partial paralysis. The 2009 Adult CSR includes an overall health status of consumers.

Saint Elizabeths Hospital Co-Morbidity Study: In April 2008, the DMH Office of Accountability (OA) began a hospital co-morbidity study of consumers with medical and psychiatric diagnoses. The audit tool was created by identifying key documents and processes that would be involved in the identification, evaluation and treatment of physical/medical needs. In June 2009, there were four (4) quarterly reports (April- June 2008, July-September 2008, October-December 2008, and January-March 2009). The same health problems identified in the 2008 Adult CSR sample were also prevalent in the Hospital studies. The OA will conduct a trend analysis of the findings of the four (4) reports, which is anticipated to be completed by September 30, 2009.

Incorporation of Mental Health Items Into Health Survey: The DMH and the Department of Health, via memoranda of understanding (MOU), have incorporated mental health questions into the annual health survey, the Behavioral Risk Factor Surveillance System Survey (BRFSS). The 2007 survey included questions about anxiety and depression. The 2008 survey will include questions about mental health and stigma.

Chronic Care Initiative in Mental Health: The D.C. Chronic Care Initiative (CCI) in Mental Health is a partnership of the George Washington University Medical Faculty Associates and Department of Health Policy, Department of Mental Health, Anchor Mental Health, Green Door, Community Connections, Washington Hospital Center, the Medstar Diabetes Program at the Washington Hospital Center, and Howard University

Hospital. Initially, the project will integrate two (2) nurse medical care managers into the behavioral health care teams of two (2) public community mental health centers (Green Door and Community Connections); and a simple disease registry will be created that includes health and behavioral health information that will facilitate coordination and rapid exchange of health and mental health information on CCI in mental health consumer/members. Health risks, health status, medications and medical treatments will be routinely assessed by paper and pencil survey, computerized screening, and medical tests. Results will be provided to consumer/members, the mental health team and consumer/members' primary care providers. Consumer/members will receive print, web-based and telephone health information, self-assessment and self-care management tools and health coaching. The nurses will facilitate care coordination with primary and specialty care, and provide self-care training on diabetes, metabolic syndrome and other health risks.

The primary goal is to improve the health status of adults with serious mental illness in the District who have chronic disease or who are at high risk for developing chronic illness due to modifiable risk factors. This will be accomplished by testing changes in the following areas: 1) decreased hospital and emergency room utilization rates, 2) increased ambulatory and specialty care utilization rates, 3) increased screening rates for blood pressure, blood glucose levels, tobacco use, lipid levels, alcohol problems, and BMI rates, 4) lowered rates of blood pressure at one (1) year compared to baseline, 5) an increased percentage of enrolled diabetic patients who have HbA1C at or below 7 mg/dl at 12 months, compared to baseline, and 6) an increased percentage of enrolled patients who report quitting smoking, or reducing the number of cigarettes smoked daily at 12 months compared to baseline.

Department of Health and DMH Chronic Care Initiative in Mental Health Quality Improvement Study: A chart review was conducted for a random sample of 30 high utilization patients at Saint Elizabeths Hospital as part of the quality improvement study. The preliminary data show that: 1) schizophrenia was the most common psychiatric illness (53%) followed by depressive disorder (29%), 2) fifty-nine percent (59%) were diagnosed with a co-occurring disease at the time of admission with hypertension found in 50% of the sample, 3) eighty-two percent (82%) had a history of drug or alcohol abuse with 71% having a history of poly-substance abuse, and 4) forty-one percent (41%) had a history of either physical or sexual abuse, and 5) forty-one percent (41%) also were current smokers. The preliminary results suggest more discharge planning support is needed. In order to complete the study, the data will be matched with Medicaid utilization data.

Integration of Mental Health Services into Primary Care Settings: The DMH has been working closely with Georgetown University Department of Psychiatry and the District of Columbia Primary Care Association (DCPCA), on the different strategies to link primary and behavioral health care. The specific objective of this planning initiative is to develop a sustainable, District-wide partnership between DMH and the District's safety-net primary care clinics to provide needed mental health services to low-income residents and to help mental health providers link up with primary health care settings. The steps

to meet this objective include the following: 1) develop the necessary rules for the free-standing clinics to ensure that they are easily implemented by primary health settings; 2) develop strategies for the community mental health centers to have the appropriate protocols for screening medical needs and ensuring individuals receive needed medical attention; 3) identify the training and other capacity building efforts that need to be incorporated; and 4) develop any needed billing and coding procedures. The intent is to have an implementation plan in FY 2010.

## **Mental Health and Rehabilitation Services**

Behavioral Health Study: In 2006, the District of Columbia convened a Health Care Task Force to consider alternatives for investing the tobacco settlement funds into the health of its residents. The Task Force agreed that further research was needed to identify priorities for investment, and the District engaged the RAND Corporation to conduct the study of this issue. Two (2) reports on the District's health care system have been issued. The June 2008 Phase 2 Report recommended further study of the District's behavioral health system (mental health and substance abuse treatment) before making recommendations regarding the investment of funds to improve these services. An MOU between DOH and DMH secured the funds that allowed DMH to establish a grant with the RAND Corporation to analyze the District's behavioral health system. The study period is May 2009 through September 30, 2010. The focus includes: 1) establishing the foundation by which the District can continue to track behavioral health needs on a regular basis over time, 2) characterizing the organizations and financing of public behavioral health services (access points, entities that deliver services, the population that various entities serve and types of behavioral health services provided, including a summary of the flows of funds into and out of entities in the system), 3) tracking utilization of behavioral health services among District residents and identifying gaps and deficiencies in the public delivery system, 4) reviewing literature describing ways in which the public behavioral health system has been financed and organized and the relative advantages and disadvantages of alternative structures, and 5) developing specific and detailed recommendations for improving the behavioral health services delivery system including potential capital investments, modifications to the organization of the delivery of care, changes to the structure of payments for District providers, and improvements to the overall financing of the mental health services and substance use disorder treatment services.

Mental Health Rehabilitation Services (MHRS) Program: The DMH has developed and is implementing a comprehensive set of service standards through the MHRS program. This program consists of four (4) core services (diagnostic/assessment, medication/somatic treatment, counseling, and community support) and five (5) 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. There were a total of 43 MHRS providers in June 2009.

The Core Service Agency (CSA) serves as the consumers' clinical home and is responsible for the coordination of the consumer's 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 CSA's clinical manager and qualified practitioner, the 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.

Technical Assistance and Support for MHRS Providers: The Division of Provider Relations continues to provide support to enhance the success and effectiveness of the Department of Mental Health's provider network development. This includes: providing technical assistance; serving as a liaison between providers, DMH and other government agencies; serving as the primary center for distribution of information, to include provider meeting coordination; and the central point for troubleshooting for provider problems, issues and concerns or responding to stakeholder issues related to the provider network.

MHRS and Other Compliance Related Issues: In FY 2008, the DMH Office of Accountability developed and implemented an audit and Medicaid integrity plan to ensure that the services purchased from providers are delivered in accordance with the requirements of federal and District law. The audit and Medicaid integrity plan were intended to improve the fiscal accountability of the providers and also of DMH. Phase 2 of the audit plan requires continued regular audits and work with the Department of Health Care Finance (DHCF) on recoupment of funds paid for services that did not meet District or federal requirements.

The FY 2009 Medicaid Integrity Work Plan summary includes: 1) the infrastructure development to make the claims audit current (developed Audit Team, use of consultants, instituted inter-rater reliability controls, FY 2006 accounts reconciliation and recoupment, developed data formats and databases and generated defined reports), 2) developed system for coordinating overpayment notification, repayment to CMS, DC Treasury, and recoupment from providers with DHCF, 3) developed comprehensive Compliance Program that will keep DMH compliant with all federal and District laws (developed comprehensive Compliance Work Plan, initiated Compliance Committee with major senior leadership, completed agency-wide Compliance training, instituted anonymous Compliance Hot Line administered by external vendor), 4) broadened Investigations Unit (increased depth and quality of investigations, provided certified investigations training to staff, increased investigation staff), 5) developed significant Quality Improvement processes (Internal Quality Committee, Quality Council of Network Providers, Quality Audit Tool/Quality Audit Schedule, Provider Scorecard for pilot in FY 2009 and publication in FY 2010, major research and recommendations regarding overuse of Community Support, focused review of medical co-morbidity at Saint Elizabeths Hospital, complaint database), 6) brought all certifications and re-

certifications current, and 7) developed ongoing process of coordination between Certification, Licensure, and Provider Relations (monthly meetings between CRF operators and CSA case managers, monthly meeting between Certification, Licensure, and Provider Relations, development of a comprehensive, electronic provider record including certification information, sanctions, corrective action plans and complaints).

D.C. Community Services (DC CSA) Agency Transition Plan Implementation: The primary milestones established in the DC CSA Transition Implementation Plan include: downsize the DC CSA, transition 2,500 consumers to private providers, transfer unique programs to the DMH Authority, and establish the Physicians Practice Group. The June 2009 DC CSA Transition News Brief reports that DMH is on track to meet these goals by August 1, 2009.

It is noted that as of June 30, 2009, approximately 2,100 DC CSA consumers were enrolled with new providers. The Continuity of Care Transition Team and Care Management are aggressively tracking each consumer. The DMH has projected that 800 consumers will continue to receive services through the government operated services and will not transfer to the private provider network. These services include: pharmacy, psycho-educational programs, outpatient restoration, psychiatric resident's clinic, multicultural services, and services to the deaf who are also mentally ill.

Several Core Service Agencies (CSAs) are located East of the River in the south east quadrant of the District. The DMH has certified a new CSA, Capital Community Services, LLC, to increase services in this area.

The private providers indicated that they would require assistance from DMH to increase the availability of psychiatrist services. In order to address this issue and support the continuity of care for DC CSA consumers, DMH will provide government operated psychiatric services through the newly formed Psychiatric Practice Group, which will operate through September 2011.

Mental Health and Rehabilitation Services: The DMH funds a number of initiatives that include both MHRS and non-MHRS services. These include but are not limited the programs that follow.

- Assertive Community Treatment (ACT) Services: ACT is an evidence-based practice that provides a proactive, consumer driven, intensive, integrated rehabilitative, crisis treatment, and mental health rehabilitative community support service to adult consumers with serious and persistent mental illness. Services are provided by an interdisciplinary team, with dedicated staff time and specific staff to consumer ratios in order to assist consumers with integration into the community and to meet their goals while in the community.

The ACT rates were increased as of November 1, 2008. During June 2009, there were 11 ACT teams. These include: Pathways DC (3), DC CSA (3), Family Preservation (2), Green Door (1) and Community Connections (2). The two (2)



latter providers were new ACT providers in FY 2009. It is noted that the DC CSA ACT consumers are being transitioned to other ACT providers. A few of these consumers might transition to the traditional community support team in the CSAs. The phase out of the DC CSA teams is scheduled for July 31, 2009. Another ACT team, Anchor Mental Health, is scheduled to come on board by the end of FY 2009.

As of July 1, 2009, there were 542 consumers receiving ACT services; compared to the census of 397 at the end of September 2008. The DMH has met the ACT goal to increase the census by 25%. The ACT referrals have also increased. For the period of April 1, 2008 - March 31, 2009, there were a total of 217 referrals; this compares to 78 total referrals for the same period in the prior year. Clearly ACT is now being utilized as the appropriate service for persons with the highest service needs. An indication of this is that 13 persons in the past year were referred directly from Saint Elizabeths Hospital to ACT.

A number of ACT training and related events were implemented and/or planned in 2009. An ACT "Kick Off" Meeting was held at the end of April. The purpose of meeting was to: 1) introduce the new and current ACT providers, 2) celebrate the District's increased capacity to provide ACT services, and 3) clarify goals and expectations for the ACT teams.

An ACT team 2- day Core Training was held in May. The training targeted newly certified teams and newly hired staff on existing teams. The training addressed the ACT history, philosophy, core values of recovery and cultural competence, stress-vulnerability, ACT services, District of Columbia licensing requirements and organizational tools. The training was based on the SAMHSA toolkit for ACT as an Evidence-Based Practice. The training was scheduled to be offered again in June and September.

Each existing ACT team will receive two (2) additional 4-hour onsite consultation visits to follow-up on learning goals, problem solve on implementation issues, and evaluate the teams' progress on quality indicators to be determined by DMH. The start-up teams will each have a baseline fidelity assessment conducted using the Dartmouth Fidelity Scale. They will also receive 4-half days of onsite consultation. The consultants will provide DMH and the teams with written documentation on each visit.

The 25<sup>th</sup> Annual Assertive Community Treatment Conference was held June 4<sup>th</sup> - 6<sup>th</sup> in Metro-Washington, DC. There was a strong presence of DMH ACT providers as well as CSAs at the Conference. Some ACT providers were facilitators for the various workshops.

A Wellness Self Management and Recovery training has been planned. This is an evidence-based practice that helps people to more effectively manage their mental illness and achieve personal goals. Workshop participants will review the nine

(9) core skill areas of Wellness Self Management and Recovery and strategies to teach these skills. It is recommended that the Team Leader and one additional staff member who will be identified as the Wellness Specialist from each ACT team attend this training and subsequent training session. The training date is pending.

The DMH ACT Services Program has found that increasing the leadership and supervision skills among the ACT Team Leaders is a challenge. In response to this issue, an Annual Team Leader Retreat will be offered to the ACT Team Leaders.

Other plans for the remainder of FY 2009 and FY 2010 include: 1) try to comply with the ACT Dixon Exit Criteria that 85% of persons referred are served within 45 days of referral, 2) continue to increase the ACT census, 3) track and monitor quality of ACT services specifically monitoring that services are provided in the community and the “shared” caseload is implemented, and 4) continue the collaboration with the DMH Employment Program Manager.

- Forensics Services: In January 2008, DMH, the Criminal Justice Coordinating Council (CJCC) and the Substance Abuse and Mental Health Services Taskforce collaborated in the development of a multi-year strategic plan for persons with serious mental illness (SMI) or co-occurring mental health/substance abuse disorders who are involved with the criminal justice system. This planning effort was supported by a 2006 \$50,000 grant from the Bureau of Justice Assistance (BJA). All of the planning efforts are framed around the Sequential Intercept Model, which seeks to connect and divert whenever possible persons with mental illness and co-occurring substance abuse who are involved in the criminal justice system.

The D.C. Linkage Plus began in 2005 and has continued to implement the Sequential Intercept Model in a variety of ways. This program focuses on consumers with serious and persistent mental illness (SPMI) and also with co-occurring substance abuse disorders who are involved in the criminal justice system. There are four (4) distinct points of intercept. The first intercept point is Pre-booking that is performed via CPEP, the Mobile Crisis Team, the Homeless Outreach Program (HOP) and the expanding collaborations with the Metropolitan Police Department (MPD). The second intercept point is Post-booking whereby DMH provides screenings at D.C. Superior Court for the Pre-trial Services Agency (PSA) for individuals following arrest. The Court Liaison is responsible for screening individuals for mental illness and recommending continued follow-up with PSA’s Specialized Supervision Unit, referrals to the Court Urgent Care Clinic for immediate evaluation or recommend referral to the Options Program (a contract private community provider that facilitates immediate contact with the defendant and provides mental health and other supportive services including temporary housing for five (5) males and five (5) females through adjudication of the case. The third intercept point is Jail-based Linkage performed by a full-time DMH Jail

Liaison Coordinator who tracks all individuals with SPMI referred by the mental health staff at the jail and ensures linkage to a CSA upon release. The linkages are made to five (5) private CSAs (Anchor Mental Health, Family Preservation, Green Door, Psychiatric Institute of Washington D.C. and Washington Hospital Center). The DC CSA also provides services to this population. These CSAs have designated criminal justice liaisons who meet with jailed consumers within 48 hours to ensure that linkage to mental health services occurs upon release. As of June 2009, a total of 579 consumers had been assigned to the D.C. Linkage Program since its inception. The fourth intercept point is Re-entry that includes a DMH Mental Health Coordinator on site at the Project Employment Plus program. Mental health screenings and/or assessments are completed on referrals from the Court Services and Offender Supervision Agency (CSOSA), the Office of Ex-Offender Affairs and the Bureau of Prisons. In FY 2008, the Re-entry liaison saw 686 individuals, the majority were ex-offenders and identified 206 with mental illness, and 199 with co-occurring disorders.

The responsibility for the monitoring and tracking of the Streicher consumers is now within the Forensic Services program. The Office of the Attorney General (OAG) reports that there are 184 committed consumers. A total of 103 are in the community and 81 are presently hospitalized at Saint Elizabeths Hospital. There are 131 committed outpatients and 53 committed inpatients. The Associate Chief Clinical Officer provided training in the Spring 2009 to several of the adult providers on the requirements for completion of the certification on committed consumers. Many of the providers found the training very helpful. In addition, the Forensic Program works with the CSAs regarding compliance for those consumers on conditional release from John Howard Pavilion.

The DMH has maintained the community-based Outpatient Competency Restoration Program (OCRP) that began in July 2005. This program provides psycho-educational groups to defendants found incompetent to proceed with trial. The program is located at 1125 Spring Road, N.W. and meets on Monday and Thursdays from 1:00 p.m.- 3 p.m. The Associate Chief Clinical Officer provides clinical oversight and leadership to the program. A social worker, nurse and a Georgetown fellow forensic psychiatrist staff the program. Prospective referrals have a screening and full competency evaluation prior to being Court-Ordered to participate in this unique program at the DC CSA. Status reports are provided to the court regarding attendance and level of participation in the program. A total of 41 (39%) of the defendants who participated in the program between 2005 and 2008 were found competent to proceed with trial. A total of 78 cases during this period were dismissed or nolle. As of June 2009 there have been 17 referrals to OCRP. There have been a total of 99 referrals to the program since 2005.

During FY 2008 and FY 2009, the DMH Director and the Pre-Trial Services Director served as co-chairs of the Substance Abuse and Mental Health Services Task Force. Some of the major areas of focus include: 1) oversee and support the development of the newly created Urgent Care Clinic at the D.C. Superior Court,

2) develop an improved system to assess, treat and refer persons with SMI and co-occurring disorders at the D.C. Jail and move them to community-based services upon discharge from the jail, 3) increase opportunities for crisis intervention and treatment alternatives (versus arrest) through the new DMH Mobile Crisis Services and the Homeless Outreach Team, 4) target specific populations for treatment and diversion opportunities through data analysis to determine programmatic needs of particular populations, and 5) improve data and information sharing within the criminal justice agencies by exploring a mechanism to create a comprehensive data base with the technology for “real time” access to consumer records that would include access to important medical, psychiatric and criminal justice information. The goal would be that all stakeholders should have access to appropriate, available information to improve service delivery.

Proposed Initiatives for FY 2009-2010:

1. The DMH submitted an application for a Bureau of Justice Administration grant to partner with Community Connections to work directly with the Mental Health Diversion Court to provide increased services and offer PTSD groups to women referred to this program.
  2. The DMH collaborated with Department of Corrections on their application for the Second Chance Grant to formalize discharge planning that will focus on women released from incarceration to track and monitor connections to services in the community.
  3. The DMH provided letters of support for the Second Chance Mentoring Grant to the following agencies:
    - Anchor Mental Health to provide supportive employment opportunities for individuals who are mentally involved in the criminal justice system.
    - Fairview Halfway House for Women to provide linkage to mental health services.
    - International Graduate University and the National Association of Concerned Veterans to provide mentoring services to veterans who are mentally ill and involved in the criminal justice system.
  4. The DMH is collaborating with the Corporation for Supportive Housing to explore targeting housing for the homeless mentally ill who come in contact with the criminal justice system.
  5. In collaboration with the Criminal Justice Coordinating Council establishing a work group to look at services to mentally ill veterans involved in the criminal justice system.
- Co-Occurring Mental Illness and Mental Retardation: The DMH and the Department on Disability Services (DDS) have had a memorandum of understanding (MOU) since October 2004. The DMH/DDS Joint Project continues

to serve approximately 73 consumers who are both developmentally disabled and have an Axis 1 diagnosis. Recently, there have been regular meetings between DMH, DDS and the Department of Health Care Financing (DHCF) to develop strategies to best serve 15-20 eligible individuals who are now at Saint Elizabeths Hospital. The goal for FY 2009 is to have five (5) individuals move successfully into the community with intensive individualized services. The DDS has agreed to assume responsibility for coordination of services for consumers jointly served by both systems. The DHCF is also exploring the possibility of DMH (the public system) becoming a DDS waiver provider. There is agreement by all that there are additional individuals in the respective DMH and DDS systems who need a mix of services as part of a cross-agency effort.

Additionally, DMH's Integrated Care Division is working closely with DDS to affect the discharge of 11 consumers who have co-occurring mental illness and mental retardation with significant maladaptive behaviors. These consumers are currently inpatients at Saint Elizabeths Hospital. The months of careful planning and coordination of services between DMH and DDS will result in the discharge of four (4) consumers in July 2009.

- Clubhouse Program: The DMH initially funded an International Center for Clubhouse Development (ICCD) Certified Rehabilitative Clubhouse as grant to a community provider, and in FY 2009 began funding it as a contracted service. The ICCD clubhouse is an evidence-based model founded on the realization that recovery from serious mental illness must involve the whole person in a vital and culturally sensitive community. The participants are called "members" and work in the clubhouse. Their work whether it is clerical, data input, meal preparation or reaching out to their fellow members, provides the core healing process (.i.e., Work Ordered Day). Every opportunity provided is the result of the efforts of the members and small staff, who work side by side, in a unique partnership. The Clubhouse offers an array of specific services from which members can choose as their needs and life goals indicate. Members can take advantage of daytime programming, vocational rehabilitation, employment opportunities, housing support services, case management, social and recreational programs, supported education, advocacy and crisis response services. The Clubhouse also offers services for transitional age youth.
- Wellness and Resource Center: June 2009 marked the first year of the 5-year contract DMH awarded to the Ida Mae Campbell Foundation to open and operate a community based wellness and resource center that includes: communication and education, work enhancement skills and computer training, wellness recovery and peer support, advocacy, creative arts, social activities, a leadership academy, and micro-enterprise academy. The Center is open Monday through Saturday. The Ida Mae Campbell Wellness and Resource Center is run by consumers, called Peer Specialists, and is open to all individuals who want to participate in peer-supported activities regardless of participation in psychiatric treatment or involvement with traditional case management. The founder and Executive Director of the Center is a

self-advocate and has been involved with the District's Peer Recovery Movement since 2003.

- Court Urgent Care Clinic: June 2009 also marked the first year of the 3-year contract DMH awarded to the Psychiatric Institute of Washington to operate a Court Urgent Care Clinic (CUCC) to assist individuals who are in contact with the court system and who may need mental health services and to assist the court in referring defendants to mental health treatment when appropriate. The CUCC is located in the D.C. Superior Court and provides easy access to mental health services primarily for individuals who appear in misdemeanor and traffic court who may show signs of mental illness, have been diagnosed as mentally ill, or show signs of both mental illness and substance abuse disorders. The referrals to the CUCC also include the Mental Health Diversion Program, East of the River Community Court, Criminal Division judges, and the D.C. Pre-trial Services Agency. The CUCC is open 40 hours per week, 8 hours per day, 5 days per week. During the period June 2008 through May 2009, services were provided to 344 consumers.

## Employment Services

### **DMH Supported Employment Program**

The Department of Mental Health (DMH) provides an evidence-based supported employment program designed for consumers with significant mental health diagnoses for whom competitive employment has not traditionally been available or for whom competitive employment has been interrupted or intermittent as a result of a significant mental health problem. Supported employment involves obtaining a part-time or full-time job in which a consumer receives supports in a competitive employment setting and in which the consumer earns at least minimum wage. Supports include ongoing work-based vocational assessments, job development, job placement, job coaching, crisis intervention, development of natural supports and follow-up for each consumer, including offering job options that are diverse and permanent.

The evidence-based model incorporates a standardization of supported employment principles, so that evidence-based supported employment can be clearly described, scientifically studied, and implemented. There are six (6) core principles of the evidence-based model of supported employment: 1) competitive employment is the goal; 2) supported employment is integrated with mental health treatment; 3) service eligibility is based on the consumer's choice; 4) consumer preferences are important; 5) job search starts soon after a consumer expresses interests in working; and 6) follow-along supports are continuous.

Although follow-along supports are continuous, programs provide the service through a three-tiered level of service intensity. The first tier is a high level of intensity where program staff provides all phases of supported employment when the consumer enters the

program and begins to search for a job. The second tier is a medium level of intensity where program staff supports the person on-the-job to help them maintain employment. Once the consumer has maintained employment for six months or longer, program staff places the consumer into the final tier, which is low intensity. At this stage of the program consumers who are successfully working receive follow-up contact on a biweekly to monthly basis through face-to-face meetings on and off the job site, phone calls and emails when possible.

The following is a summary of program activities and outcomes from April 2008 to March 2009:

### **Supported Employment Interagency Agreements and Collaborations**

The DMH partnered with the Department on Disability Services, Rehabilitation Services Administration (DDS/RSA) again in FY 2008 through a formal memorandum of understanding (MOU) to develop and expand supported employment services for individuals with mental illness. The terms required DDS/RSA to transfer \$100,000 to DMH for the provision of supported employment services for individuals with mental illness. Both agencies have agreed to engage in some creative activities that will further expand supported employment activities including:

- Conduct the third Annual Supported Employment Orientation and Training targeted to employers,
- Participate in a Dartmouth/Community Connections research project that focuses on providing supported employment to consumers with co-occurring disorders, and
- A joint venture between DDS/RSA and DMH to establish a program to help individuals with disabilities start small businesses.

The DMH is collaborating with the Department on Disability Services and Department of Labor, Office of Disability Employment Policy to train two (2) DMH approved supported employment programs (Deaf Reach and Psychiatric Center Chartered) on use of a protocol to obtain jobs for individuals with challenging disabilities. The two (2) providers are serving as a pilot for DMH, and will share the skills they learn with other DMH approved supported employment providers through a train-the-trainer approach.

The DMH is also collaborating with George Washington University on a pilot project designed to train supported employment staff to assist consumers in understanding and managing their Social Security benefits. Community Connections and Green Door are participating in this pilot, and information and skills learned will be shared with other DMH supported employment providers. The various aforementioned activities will help DMH and its providers improve the delivery of supported employment services, as well as service quality.

## Supported Employment Provider Programs

In FY 2008 seven (7) programs provided evidence-based supported employment services funded by DMH:

- Anchor Mental Health
- Community Connections, Inc.
- D.C. Community Services Agency
- Deaf Reach, Inc.
- Green Door, Inc.
- Pathways To Housing, Inc.
- Psychiatric Center Chartered, Inc.

## Summary of Supported Employment Referral Sources

Time Period: April 2008 – March 2009

Referral Source	Number of Referrals
DMH Supported Employment Programs	127
Rehabilitation Services Administration	2
Referrals to DMH SE Manager	6
SEH Transition	24
Mayor's Focused Improvement Initiative (FIA)	6
DMH Child & Youth Division	2
Washington Hospital Center	10
DMH Reentry Program	2
Consumer Action Network	1
NAMI-DC	1
<b>Total Referrals:</b>	<b>181</b>

Note: 77 referrals listed in the referral table are not included in the Dixon Exit Criteria Performance table below. Referral information was not complete for those referrals and as a result they have not yet been calculated in the FY 2008 performance measurement.

The DMH has begun development of a pilot project that will track referrals to supported employment programs utilizing the agency's eCura database, which will allow collection and analysis of referral data from all DMH providers ongoing, as well as encourage referrals from across the service delivery system. The pilot is in the initial stages of development and implementation will begin by the end of August 2009.

## Supported Employment Performance Measurement

The Supported Employment Dixon Exit Criteria is that 70% of persons referred receive supported employment services within 120 days of a referral. The FY 2008 overall percentage was 90.4%. The following table lists the performance indicators for the last four quarters:



<b>Fiscal Year</b>	<b>Third Quarter 4/08-6/08</b>	<b>Fourth Quarter 7/08-9/08</b>	<b>First Quarter 10/08-12/08</b>	<b>Second Quarter 1/09-3/09</b>	<b>FY 08 Total</b>
Performance Indicator	87%	100%	84%	94%	90.4%
Numerator (Consumers served Within 120 days)	33	23	21	17	94
Denominator (Consumers Referred)	38	23	25	18	104

The Supported Employment Consumer Outcome Table that follows provides performance data for DMH approved supported employment programs for FY 2008. A successful job placement is defined as a consumer employed for 30 days.

### **Supported Employment Consumer Outcome Data**

<b>Supported Employment Program</b>	<b>Number of Consumers Enrolled in Service</b>		<b>Number of Consumers Placed in Competitive Employment</b>		<b>Average Number of Hours Worked Per Week</b>		<b>Average Hourly Wage</b>	
	<b>FY08</b>	<b>FY09</b>	<b>FY08</b>	<b>FY09</b>	<b>FY08</b>	<b>FY09</b>	<b>FY08</b>	<b>FY09</b>
D.C. Community Services Agency	110	24	32	22	24.0	20.0	\$8.00	\$8.00
Green Door, Inc.	118	110	70	78	25.5	26.97	\$9.79	\$9.61
Anchor Mental Health	64	75	35	39	24.0	30.0	\$9.42	\$11.25
Psychiatric Center Chartered	65	103	30	68	38.4	38.6	\$9.55	\$9.86
Community Connections	50	85	25	45	23.0	24.0	\$9.00	\$9.20
Pathways To Housing	41	67	4	10	17.0	25.0	\$7.66	\$9.50
Deaf Reach, Inc.	29	48	11	10	28.0	28.0	\$9.00	\$9.00
<b>Total:</b>	<b>501</b>	<b>512</b>	<b>223</b>	<b>272</b>	<b>25.70</b>	<b>27.51</b>	<b>\$8.92</b>	<b>\$9.49</b>

### **Consumers Transitioned To Competitive Employment**

Several consumers have maintained employment for one (1) year or longer as a result of participating in supported employment and graduated to competitive employment with follow-up supports provided on an as needed basis. The following table shows the number of consumers who have been working one (1) or more years per supported employment program:

<b>Supported Employment Program</b>	<b>One Year of Employment</b>	<b>Two Years of Employment</b>	<b>Three Years of Employment</b>
Psychiatric Center Chartered	3	2	2
Green Door	2	3	0
Community Connections	3	1	0
Anchor Mental Health	2	1	0
D.C. Community Services Agency	6	3	1
Pathways To Housing	0	0	0
Deaf Reach	1	0	0
<b>Total:</b>	<b>17</b>	<b>10</b>	<b>3</b>

### **Supported Employment Performance Measurement**

Program fidelity audits are conducted annually to determine if supported employment programs are meeting performance measurements based on the DMH Evidence-Based Practice Supported Employment Policy. The most recent audits were conducted in FY 2008 and results were based on the fidelity assessment rating scale which was revised in 2007 by the creator of the fidelity assessment tool, Dartmouth Psychiatric Research Center:

- 115 – 125 = considered Exemplary Fidelity which is defined as the program has incorporated all six (6) of the core principles of evidence-based supported employment and gone beyond the core principles to provide services to consumers.
- 100 – 114 = considered Good Supported Employment which is defined as the program has incorporated all six (6) of the core principles of evidence-based supported employment into the services provided to consumers.
- 74 – 99 = considered Fair Supported Employment which is defined as the program has incorporated three (3) of the six (6) core principles of evidence-based supported employment into the services provided to consumers.
- 73 – below = considered Not Supported Employment which is defined as the program has only incorporated 1-2 of the six (6) core principles of supported employment into the services provided to consumers.

The following table lists FY 2008 fidelity assessment scores for DMH approved programs:

<b>Supported Employment Provider</b>	<b>Fidelity Score</b>	<b>FY08 Supported Employment Fidelity Rating</b>
Community Connections	114	Good Fidelity
Green Door	121	Exemplary Fidelity
Psychiatric Center Chartered	121	Exemplary Fidelity
Deaf Reach	99	Fair Fidelity
Anchor	106	Good Fidelity
Pathways To Housing	110	Good Fidelity
D.C. Community Services Agency	N/A	Assessment not conducted – program closing

## **Supported Employment Programmatic Expansion**

The DMH is collaborating with the Department on Disability Services/Rehabilitation Services Administration (DDS/RSA) on allocation of \$500,000 in federal stimulus funds to DMH approved supported employment programs through a Request for Proposals (RFP) process which will be completed by July 30, 2009. The DDS/RSA has committed to building the funds into their annual budget as ongoing funding for consumers with serious mental illness. Distribution of this funding to DMH supported employment providers will expand DMH's service capacity by 150 slots as each of the six (6) providers will add at least one (1) additional employment specialist who will carry a caseload of 25 consumers. Contracts should be awarded by DDS/RSA during August 2009.

Additional program expansion is occurring as a result of the D.C. Community Services Agency (DC CSA) closing and the termination of the Work Adjustment Training Program (WATP), which operated at the DC CSA, Saint Elizabeths Hospital (SEH), and at Deaf Reach. The WATP is funded by DMH and is a sheltered work program in design and operation. The program will be terminated at the end of FY 2009 due to a lack of funding. A total of 85 consumers in the program will be transitioned to supported employment jobs. The transition activities are underway and 69 consumers were enrolled/re-enrolled with DMH approved supported employment providers by July 2009.

## **Supported Employment Social Marketing**

The DMH continues to implement a social marketing plan to educate clinicians, case workers and consumers about the availability of supported employment services. The social marketing plan consists of the following activities: outreach to providers and consumers, promoting supported employment services through speaking engagements and training for providers and consumers.

The DMH Supported Employment Program Manager collaborated with the DMH Training Institute and developed and implemented ongoing supported employment training targeted to clinicians and consumers. The training for clinicians is designed to help educate clinicians about consumers' ability to work and how to link consumers to supported employment services.

The training for consumers is designed to help them understand the nature of supported employment services, that they can work, and how to request the service. The training continued throughout FY 2008 and FY 2009 for both consumers and clinicians. The initial clinician training session was conducted on March 26, 2008 (11 attendees) and the initial consumer training session was held on March 27, 2008 (5 attendees). Training sessions were also held for consumers on June 26, 2008 (14 attendees) and July 24, 2008 for clinicians (10 attendees), May 21, 2009 for clinicians (20 attendees), and on June 16, 2009 for consumers (8 attendees).

## Housing Services

### **DMH Housing Division**

The DMH Housing Division is responsible for preserving and increasing the supply of quality affordable permanent supportive housing (PSH) available to mental health consumers in the District of Columbia. To this end, the Housing Division is allocated resources for bridge rental housing subsidies and capital dollars for housing development. In addition, the Division obtains resources through grants and partnerships with the local housing agencies including the D.C. Housing Authority (DCHA) and the Department of Housing and Community Development (DHCD).

According to the Corporation for Supportive Housing (CSH), permanent supportive housing is defined as “a cost-effective combination of permanent, affordable housing with services that helps people live more stable, productive lives”. PSH is a proven intervention for individuals and families who are homeless long-term or repeatedly, whose needs often result in frequent and inefficient use of homeless services and increased costs of these systems. The DMH provides supportive housing in scattered site housing; consumers are linked to services through a Core Service Agency (CSA).

According to the National Association of State Mental Health Program Directors (NASMHPD), a supportive housing program is defined by three (3) principles: 1) people must live as members of the community in integrated, stable housing-not in mental health programs; 2) people must receive flexible services and supports that help maximize their opportunities for success over time; and 3) people must be free to exercise choices regarding their housing and support services.

The DMH Supportive Housing Program includes services and supports to assist individuals in obtaining and maintaining appropriate housing arrangements. In the DMH approach, a consumer lives in his or her private housing setting with responsibility for housing upkeep and maintenance. In order to assist with keeping the housing, the consumers receive supportive services including periodic visits from family, DMH staff, and others assigned for the purpose of monitoring and/or assisting with housing responsibilities.

Most participants in the DMH Supportive Housing Program are formerly homeless (street and shelter), or in institutions such as Saint Elizabeths Hospital, jail, or substandard housing, at the time of housing referral. The DMH consumers have extremely low income. The majority receive Supplemental Security Income (SSI) in the amount of \$674 per month and without the availability of DMH supportive housing subsidies, consumers are likely to remain homeless longer. The scarcity of Federal housing dollars and the continued escalating high cost of housing in the District of Columbia is an ongoing challenge for DMH and consumers.

The DMH maintains a formal application process, working through DMH housing liaisons from the referring CSA. Qualified applications are either approved or placed on a

waiting list. The DMH Housing Program maintains a housing vacancy list to assist in the housing search.

Housing is one of the highest priorities for consumers. The District has received a legal opinion from bond counsel regarding the use of capital funds via general revenue bond sales. This legal opinion has facilitated the release of DMH funds that have been transferred to the Department of Housing and Community Development (DHCD). The DMH and DHCD have amended their Memorandum of Understanding (MOU) to extend the period to develop 300 affordable housing units from November 2007 to November 2010. The DMH has transferred \$14 million to DHCD to be awarded as grants and leveraged with other local and federal funds for the development of affordable housing specifically for housing units for people with serious mental illness. This process is targeted to create 100 new units per year.

### **DMH Affordable Housing Strategy**

The DMH strategy is a structured initiative designed to develop more supported housing. It includes the following:

Housing Partnership Model: The DMH is continuously expanding utilization of partnerships to better leverage/maximize supported housing resources. Important partnerships have been established with both public and private housing and related agencies and organizations in the District, including the D.C. Housing Authority, the Department of Housing and Community Development, the Agency for HIV/AIDS, and Advance Dispute Resolution Service (ADRS).

The “supports and services” in supported housing are provided by a network of Mental Health Rehabilitation Services (MHRS) agencies contracted by DMH to provide support, clinical and treatment service.

Housing Advisory Committee: The DMH formed a Housing Advisory Committee to advise on implementing the housing development production goals and to provide continuous planning and monitoring of the DMH Housing Plan. The Advisory Committee represents mental health advocacy groups, consumers, housing and support service providers and others. The group includes representatives from SOME, N Street, Village, DCHA, DHCD, Community Action Network (CAN), Washington Legal Clinic for the Homeless, Pathways DC, the State Mental Health Planning Council, Consumer League, Cornerstone, Community Connections, Green Door and the Office of the Ombudsman.

Housing Liaison Provider Network: Twenty-two (22) core service agencies (CSAs) have designated representatives to serve as the central point of contact (POC) for accessing DMH housing resources and monitoring consumer stability in their housing. Both group and individual meetings are held with the representatives to review monitoring reports, plan and problem solve.

Landlord/Housing Developer Network: The DMH works with over 200 landlords and developers. Special Cluster Meetings with landlords help resolve landlord-tenant problems and expand knowledge and understanding about mental illness and recovery. This partnership is critical to DMH ongoing actions to expand housing quality and quantity. Quarterly meetings are held with this group. Landlords include William C. Smith, Willoughby & Company, Keller Associates, Frank Emmet Company, Golden Rule, Curtis Properties, and Four Walls Development.

Housing Subsidies/Vouchers for Affordability: The DMH Bridge housing subsidies provide “temporary” subsidies until Federal vouchers become available to consumers. Housing is affordable to consumers who pay 30% of their income for rent. The DMH has several Memoranda of Understanding with the DC Housing Authority for Federal voucher programs that provide additional housing for consumers.

### Supported Housing Programs

DMH Housing Programs	Total Capacity	Persons Housed
DMH Home First and Supported Independent Living Housing	750	750
Supported Independent Living	461	401
Federal Vouchers	374	354
Totals	1585	1505

DMH HOUSING REFERRALS ONLY	Housing Capacity	Persons Housed	Vacancies
DMH Home First- Permanent Supportive Housing Bridge Rental Subsidy Program	750	750	
Supported Independent Living DMH Contract	461	401	
FEDERAL PROGRAMS- DMH HOUSING REFERRALS ONLY	Housing Capacity	Persons Housed	Vacancies
Shelter Plus Care/ DMH Grant	15	0	0
Shelter Plus Care/TCP Grant	161	161	0
HUD Mainstream Housing for People with Disabilities/DCHA/DMH MOU	40	40	0
HUD/DCHA Housing Choice Voucher Program- DMH Set-Aside/ DCHA/DMH MOU	50	50	0
HUD Partnerships for Affordable Housing - Project-based HCVP	78	73	5
HUD HCVP Vouchers DMH MOU	30	30	0
<b>TOTAL</b>	<b>374</b>	<b>354</b>	<b>5</b>

### Community Residential Facilities

In addition to the supported housing programs, a number of consumers reside in licensed 24-hour supervised group homes. There are 223 facility beds under contract with DMH and 425 facility beds that are independently operated. All of the facilities are licensed by DMH.

## **Capital Funds Used to Leverage Other Public Sources of Housing Funds**

The DMH MOU with DHCD transferred \$14 million in capital funds to develop 300 housing units by November 30, 2010. As of June 30, 2009, 239 housing units are in the pipeline for development for DMH consumers. Of the total pipeline units 84 will have either federal vouchers or District local rent subsidies attached to them; 23 are funded to preserve DMH housing stock and were previously DMH capital funded; 31 units are targeted for special populations and will have supports on site; and the majority of the new units are in mixed use integrated buildings that already have DMH consumers as tenants. It was projected that the first 10 of the new units would begin coming online for occupancy in April 2009. The remaining housing units are scheduled for occupancy through the remainder of 2009 and early 2010.

## **Strengths and Resources of the DMH Housing Program**

Housing Data Base: The data base is adding the capacity to monitor, track and accurately report critical housing activities. This program tool was started in FY 2007 and will continue to assist in quality improvement of the overall program.

Draft Housing Rules: The current Supported Housing Rule is being revised. New Housing Rules are being drafted and include a review process with many stakeholders. The first notice for public review was October 10, 2008 and comments were received. The second notice was June 26, 2009.

Consumer Briefings: The consumer briefings began in June 2008. This orientation formally introduces the consumer to tenant and landlord rights and responsibilities and provides information about how to maintain housing, good housekeeping, and how to be a good neighbor.

Eviction Prevention/Housing Retention Resources: The DMH utilizes two (2) primary tools for prevention of evictions. They include:

- MyHouse Housing Mediation- 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 and operated in FY 2008 and FY 2009. The project will also be funded in FY 2010.
- Emergency Rental Assistance Program (ERAP)- The ERAP is a Department of Human Services (DHS) program that helps low income citizens who face housing emergencies, including evictions.

## **Federal Housing Grant Resources**

Projects for Assistance in Transition from Homelessness (PATH): The PATH Grant provides \$57,000 for one-time housing payments for persons who are homeless.

Community Mental Health Services Block Grant (MHBG): The MHBG provides \$380,000 for bridge subsidy funding.

Real Choice Systems Grants: The Long-Term Supports and Housing Grant ended September 2008. It was designed 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), and transition age youth. The project brought together government agencies to 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 citizens through an improved infrastructure. The grant began a very positive relationship with the new Department on Disability Services, which is being expanded upon in the new Integrated Care Management program.

## **Shelter Plus Care**

The DMH placed number one in the new programs category in the HUD 2007 SuperNOFA grant process under the Continuum of Care. This resulted in DMH receiving 15 new Shelter Plus Care Program subsidies.

## **Dixon Exit Criteria**

The availability of federal and other housing resources and the imbalance of supply and demand have adversely affected DMH's Housing Dixon Exit Criteria performance, which requires that 70% of adults with serious mental illness receive supported housing services within 45 days of a referral. The DMH and the Court Monitor realize that relying solely on housing to fulfill this requirement is unrealistic and continue to review this issue.

## **Educational Services**

### **General Educational Services**

Educational services for adults are available in the Washington, D.C. community. These services address the individual needs of adults with various disabilities. There is a full range of educational opportunities, from basic literacy through the general equivalency degree (GED) and college.



## **DMH Training Institute**

The DMH Training Institute has continued to modify its program to support ongoing, more intensive, and needs-based workforce development initiatives. The Training Institute offers a variety of recurring introductory and overview trainings for providers, consumers and DMH staff. These trainings occur on a quarterly to bi-annual basis and include the following:

- DMH 101 – Designed for multiple stakeholder audiences to provide an overview of the processes for accessing mental health services.
- Community-Based Intervention (CBI) 101 – Reviews the components, theory and research on CBI, as well as practical information for appropriate recipients of the service, and how to access it.
- System of Care 101 – Provides an overview of Systems of Care philosophy, values and supports within the District.
- Meeting the Mental Health Needs of Youth Receiving Residential Treatment – Provides overview of children/youth receiving psychiatric residential treatment services.
- Supported Employment Training for Consumers and Providers – Provides overview and access information to both consumers and providers.

The Training Institute has also sponsored or co-sponsored the following ongoing training initiatives and series:

- Level of Care Utilization System/Child & Adolescent Level of Care Utilization System (LOCUS/CALOCUS) train-the-trainer initiative,
- Assertive Community Treatment (ACT) workforce development initiative,
- Transgender Mental Health training series,
- Community Service Review (CSR) Adult and Child Review Training,
- COSIG Co-occurring Competency Certificate Training Program and Integrated Treatments Trainings, and
- Negotiation and Conflict Resolution Training for Consumers and Providers.

Other training conducted during FY 2009 includes the following:

- Domestic Violence 101 Teen Dating Violence for Teens,
- Teen Dating Violence Training for Providers,
- DC CSA National Incident Management System (NIMS) Training,
- Lethality and Risk Assessment Training Providers,
- Employee Rights and Responsibilities under the District of Columbia Human Rights Act of 1977,
- Writing Court Reports and Court Ordered Assessments.: 5 Ways to Avoid Having to Go to Court, and
- Community Residential Facility (CRF) Training.

One of the Training Institute's recent successes is the implementation of the Crisis Intervention Collaborative. This initiative has been spearheaded by DMH, the District of Columbia's Metropolitan Police Department (MPDC), and the National Alliance on Mental Illness (NAMI) to improve the outcomes of police interactions with people with

mental illnesses. Some of these desired outcomes might include increased citizen and officer safety and more appropriate involvement in community-based services for individuals who come to the attention of law enforcement but do not meet the threshold for arrest. This Collaborative has been developed to address the diverse professional development needs of officers at various levels of their law enforcement careers. Some of the training for law enforcement officers related to this initiative includes: 1) recruit training, 2) in-service training, 3) the Crisis Intervention Officer Initiative. These initiatives will be described in Criterion 5: Management Systems.

The Training Institute is developing several new initiatives to roll out over the Summer and early Fall 2009. They will include: 1) a clinical supervision initiative, 2) trauma-informed systems initiative, 3) a worker safety initiative, and 4) a cultural and linguistic competence initiative in mental health service delivery.

### **Ida Mae Campbell Wellness and Resource Center**

In addition to the education and work force development training provided by the Ida Mae Campbell Wellness and Resource Center (a consumer-run enterprise), during FY 2009 this program collaborated with the DMH Training Institute on course offerings. This included: 1) History of the Consumer Movement, Peer Recovery and Concepts and Peer Specialist Concepts, and 2) Money Wi\$e Train the Trainer.

The 2009 Annual Mental Health Conference, co-sponsored by the D.C. State Mental Health Planning Council and DMH, included an Employment Panel. The Founder/CEO of the Ida Mae Campbell Foundation was one of the presenters and discussed the Ticket to Work and other work related experiences and issues. This presentation outlined the Ticket to Work basics, employment networks, and discussed the issue of benefits and allowable employment earnings per month.

### **Substance Abuse Services**

The DMH substance abuse services include both inpatient and community programs.

DMH and Provider Programs: All DMH and provider programs are to screen and assess for substance, provide documentation in the treatment plan, and provide care coordination.

Saint Elizabeths Hospital Co-Occurring Programs: These include a co-occurring program in the treatment mall (off unit location where treatment is provided during the day), and stage-wise co-occurring treatment groups.

D.C. Community Services Agency (DC SA): Substance abuse services are provided through the following programs: mental health/addiction/day services, hearing impaired, multicultural, and community support programs. Also, the DC CSA has implemented staff training and continued the coordinating meetings that began as part of the Comprehensive, Continuous, Integrated System of Care (CCISC) model.

Sobering Station: The DMH Homeless Outreach Program (HOP) operates a Sobering Station during hypothermia season for intoxicated men and women who either refuse or are unable to handle the structure of a traditional shelter.

Co-Occurring Disorders- The Co-Occurring Disorders State Incentive Grant (COSIG) was awarded to the District for the period September 1, 2005 through August 31, 2010. The fifth and final year of the grant is the evaluation period. This initiative establishes collaboration between DMH and the Department of Health/Addiction Prevention and Recovery Administration (APRA) with the goal of creating an integrated approach to service delivery where there is “no wrong door” to appropriate treatment for individuals with co-occurring mental illness and substance use disorders in the public mental health and addictions treatment system.

Four (4) operational objectives identify the key areas of COSIG focus where actions are taken to drive systems change: 1) system supports for integrated service delivery, 2) universal screening for co-occurring disorders, 3) expand workforce competencies in co-occurring disorders, and 4) system incentives and infrastructure support for continued improvement of co-occurring disorder consumer outcomes. A portfolio of COSIG projects is clustered under each objective, with an integral evaluation component provided by George Washington University.

### **Medical and Dental Services**

Mental Health Rehabilitation Services (MHRS): The documentation of annual physicals is a MHRS requirement. Health services are available through medical and dental services clinics provided through Saint Elizabeths Hospital, 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).

Dixon Exit Criteria on Newer Generation Medications: 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%. This performance measure was monitored during FY 2008 with continued monitoring during FY 2009.

## Support Services

Office of Consumer and Family Affairs: The Office of Consumer and Family Affairs (OCFA) is responsible for providing leadership and direction in planning, developing and coordinating ways to enhance involvement of consumers and family members in the Department of Mental Health system's planning and delivery efforts for adults and children. The OCFA also serves as the Olmstead and Stigma Coordinator for the DC Department of Mental Health.

The OCFA staff promotes and protects the legal, civil and human rights of consumers. This Office functions as an advisor to the DMH Director and DMH staff regarding issues concerning consumers receiving services in the mental health system. The OCFA incorporates the concepts and inclusion of the "Recovery-based model" of care and self-determination throughout the District of Columbia's mental health system.

A primary responsible of the OCFA is to oversee and monitor the Grievance Resolution Process as required by the Mental Health Establishment Act of 2001. The OCFA is responsible for : oversight and liaison to mental health providers responsible for implementing the grievance review process; receiving and reviewing all grievances and grievance appeals for the external review process; developing and operating a grievance management database for reporting and accountability; providing technical assistance to provider grievance coordinators; reviewing grievance and consumer rights policies as part of the Mental Health Rehabilitation Services (MHRS) certification process and monitoring MHRS providers for compliance with the standards and grievance rule; and providing training and education on the DMH grievance process.

The OCFA also serves as the Contracting Officer's Technical Representative (COTR) for managing and monitoring several organizations as well as individual contractors to ensure compliance with stated contract guidelines, deliverables and accountability. This includes the Consumer Action Network (CAN) that operates the peer grievance process and consumers who are hired and assigned to various DMH Authority offices (General Counsel, Accountability, Strategic Planning Policy and Evaluation).

In FY 2008, OCFA took on the role as contracting officer (COTR) for the first consumer operated Wellness and Resource Center. In addition to acting as COTR, OCFA will provide consultation, technical support, and information to the Center staff. The Center's grand opening was June 25, 2008.

The OCFA FY 2008 budget supported the Housing Mediation Initiative by providing funding for the MyHouse Project. The purpose of the program is to facilitate conflict resolution and mediation between consumers and landlords in an effort to prevent evictions and thereby prevent homelessness. This program operates under the DMH Housing Division.

In September 2008, the OCFA collaborated with the Office of Disability Rights to sponsor the first District-wide Olmstead Conference. The Conference was organized by

consumers. It was well attended by community and hospital consumers. The second conference will be planned for Fall 2009.

One of the OCFA major initiatives in FY 2009 is launching the Peer Specialist Certification and Training Program. The Appalachian Community Group, one of the leading national consumer training groups, will be providing consultation to the OCFA and the Office of Strategic Planning, Policy and Evaluation on this initiative. The expected outcomes of the project include: 1) meaningful employment of mental health consumers and Peer Specialists in the mental health care system, providing services that are Medicaid billable; 2) implementation of an evidence-based model that achieves indicators for recovery (i.e., lesser hospitalizations, meaningful relationships, acceptance of illness and better coping, more quality outreach to the seriously mentally ill population, improved access to needed services, minimized crisis, gainful employment, improved quality of life, quality and consistency of delivery of services); and 3) expansion of DMH service delivery options in recovery. The kick off planning workshops were held July 15-16, 2009.

### **Services Provided by Local School Systems Under the Individuals with Disabilities Education Act (IDEA)**

#### **Discussed under the Child Plan**

#### **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 provides case management 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 and 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 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.

### **Services for Persons with Co-Occurring (Substance Abuse/Mental Health) Disorders**

During FY 2009, DMH will conclude the fourth year of the Co-occurring State Incentive Grant (COSIG). The DMH and the Addiction Prevention and Recovery Administration (APRA) continue to provide joint support to implement this national “best practice” model for the planning and delivery of integrated services for persons with both mental illness and substance abuse. The status of the four (4) major objectives for this initiative include the following:

1. System Supports for Integrated Service Delivery- Activities include: a) established Inter-agency Leadership Group with DMH and APRA Senior Leadership meeting monthly to guide project work, b) developed standards and tested process for DMH and APRA provider agencies to achieve a designation of Co-Occurring Competency, c) collaborated with other DMH, APRA, and District key initiatives (i.e., APRA’s Access to Recovery and State Substance Use and Adolescent Care Coordination, technical assistance and training on co-occurring disorders to homeless services providers), and d) worked with partners to close gap in youth substance use and co-occurring services by developing expanded integrated network of Medicaid reimbursable youth substance use disorders and co-occurring disorder (COD) services.
2. Universal Screening for Co-Occurring Disorders- Both DMH and APRA have adapted standards that require all consumers seeking service to be screened for co-occurring disorders and provide performance monitoring and feedback for quality improvement.
3. Expand Workforce Competencies in Co-Occurring Disorders– The DMH has

developed a comprehensive Clinical Competency Certificate Program that was initially a 100-hour course and was subsequently revised to 72 hours. There have been over 120 persons trained with an additional 60 by Summer 2009. Over 300 other staff have received elements of the COD training that has included: provider agency mental health and substance use clinicians, clinical supervisors and program managers, train-the-trainer programs, psychiatric bedside teaching, and homeless services providers. There has also been work with consumers to develop a self-sustaining network of Double Trouble Recovery self-help 12-step programs.

4. Continuous Quality Improvement Supports for Cross-Agency Improvement of Consumer Outcomes- Activities include: clinical chart audits; co-occurring disorder cross agency continuous quality improvement teams working with emergency services, detoxification and stabilization, assessment referral center, youth continuity of care and improvement project, and Saint Elizabeths Hospital. The DMH, with the assistance of George Washington University, has developed a Clinically Informed Outcome Management (CIOM) project. The CIOM project collects consumer self-reports on treatment effectiveness on a continuous basis and provides immediate feedback to treatment teams.

Once the grant expires, the plan is for the training for co-occurring disorders to be fully included in the DMH Training Institute. The Dixon Court Monitor notes that “it will be critical for DMH leadership to keep this issue alive and moving – given the known high levels of COD in the population.”

### **Other Activities Leading to Reduction of Hospitalization**

The DMH has a number of programs and initiatives in place or planned that will lead to a reduction in hospitalization.

Crisis Stabilization: Each Core Service Agency (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.

Crisis Beds: The DMH currently funds two (2) providers for a total of 15 crisis beds. These include eight (8) at Jordan House and seven (7) at Crossing Place. For the period October through May 2009, the Jordan House beds had an average utilization rate of 76% and an average length of stay of 7.9%. The data for the Crossing Place beds for the same variables was 70% and 7.6%, respectively.

Transition Specialists: In FY 2009, the Office of Consumer and Family Affairs and Saint Elizabeths Hospital began discussions about this initiative, which is aimed at helping consumers leave the hospital. The role of the Transition Specialists is to assist patients at

the Hospital who have been determined ready for discharge in making a smooth transition to community living. The Transition Specialists will draw upon lived experiences as well as their training to provide encouragement and support to those who are returning to the community. It is expected that the initiative will be launched by the end of FY 2009 with full implementation in FY 2010. This initiative uses Olmstead funding.

Use of Local Hospitals for Acute Care: The Dixon Court Monitor has noted that DMH has shown dramatic progress in this area. During the four (4) months of February 2009-May 2009, DMH had only 12 acute admissions to Saint Elizabeths Hospital (SEH), an average of three (3) per month. By contrast, for the four (4) months of October 2008 – January 2009, the average of acute admissions was 18 per month. The key has been the additional acute care beds that DMH now has available per service contracts with United Medical Center and Providence Hospital. There are now a total of 54 beds that are potentially available – the highest it has ever been (34 at UMC and 20 at Providence). The fact that acute bed capacity is no longer the problem is borne out by the fact that over the past four (4) months (February- May, 2009) there was only one (1) acute admission to SEH due to the lack of an available community bed.

The SEH continues to get transfers after a patient has not stabilized within 14 days. These admissions are averaging about 11 per month. The net effect of this is that civil-side admissions to SEH are now averaging approximately 20/month. This compares to recent year patterns which have had approximately 45 total civil admissions per month. This takes bed pressure off of SEH, shortens acute lengths of stay, and allows for consumers to remain connected with families and current living situations.

Comprehensive Psychiatric Emergency Program (CPEP): The CPEP is managed by the DMH Mental Health Authority and provides emergency psychiatric services for District residents who are 18 years of age and older and need crisis services. The program provides services 24 hours a day, 7 days a week and includes crisis assessment and stabilization. It provides acute psychiatric and medical screening and assessment, observation and intensive psycho-pharmacological and psychotherapeutic services. The CPEP renovation was completed in December 2008, which added space for extended observation beds. The space accommodates each of the CPEP three (3) distinctive components: Psychiatric Emergency Services, Extended Observation Beds, and Mobile Crisis Services.

The Psychiatric Emergency Services (PES) includes two (2) observation beds and two (2) restraining beds (reserved for persons who present a danger to self or others). These individuals are usually brought to CPEP by the D.C. Metropolitan Police Department (MPD) and admitted involuntarily. Restrained consumers require one-on-one observation and monitoring and in some instances, require staff to handle their violent or combative behavior.

The Extended Observation Beds (EOB) is also an important component CPEP. There are eight (8) EOB beds.



Although CPEP provides intensive psychiatric and medical care, there are also a number of other related functions that CPEP staff perform in connection with a consumer's care. These functions include: psychiatric and nursing assessments, assisting with activities of daily living, delousing infected consumers, laundering their soiled clothes or providing them with new ones, monitoring vitals, counseling, feeding consumers, transporting them for care upon release from CPEP, preparing legal documents for the Attorney General and any other legally required paperwork, processing billing forms, and providing an educational experience for residents, nursing and medical students.

The CPEP Mobile Crisis Services officially began providing services to adults experiencing mental health crises in the community on November 1, 2008. The daily hours of operation are 9:00 a.m. - 1:00 a.m.

Mobile Crisis Services is staffed by a multidisciplinary team of mental health workers including: peer counselors, mental health counselors, mental health specialists, addiction treatment specialists, social workers, and psychiatrists.

The program's objectives are to: 1) respond to adults throughout the District who are experiencing a psychiatric crisis and are unable or unwilling to travel to receive mental health services, 2) spend as much time as needed with consumers to ensure crisis stabilization, make an appropriate disposition, and provide necessary follow-up services, 3) be available to address the concerns of the individual in crisis, family members, concerned citizens, mental health providers, and other referring agencies, 4) offer a range of services including but not limited to on-site crisis intervention and stabilization, assessment for voluntary and involuntary hospitalization, and linkage to other services such as ongoing mental health care, crisis beds, substance abuse detoxification and treatment, and medical care.

During FY 2008, CPEP served an average of 281 individuals per month. In FY 2009 through June, CPEP served an average of 327 individuals per month while the Mobile Crisis Services program served an average 234.

Integrated Care Project: Consumers initially served through this Project are currently inpatients at Saint Elizabeths Hospital, who have clinically challenging needs that have not been met by the current community-based service system and financing structures. As a result, they have become long-term inpatients, which is an expensive and ineffective "solution" both for the individuals involved and the system. This requires that new community capacities, structures and resources be developed to support consumers who can live in the community with adequate community supports thereby reducing their reliance on long-term inpatient care.

The DMH is committed to providing an Integrated Care Model with a Case Rate financing mechanism that promotes and supports individualized, flexible, effective and efficient services designed to assist these consumers to function effectively in the community. To this end, DMH proposed a new funding model that incorporates an

aggregate Case Rate that includes the continued use of the Mental Health Rehabilitation Service (MHRS) fee for service structure. The goal of this financing structure is to provide the vendor with the necessary resources and flexibility to add services as needed and defined by the consumer. The cost of all needed services will be covered by the combination of the aggregated rate and reimbursement for MHRS services. The model also incorporates outcome measures and goals based on systemic values that are combined with guidance, oversight and training provided by DMH. There is ample evidence that with creative, flexible, individualized approaches, these individuals can succeed in the community. The literature and experience of similar projects strongly support the potential for success.

This Project is important to DMH because it allows the service provider and consumers to achieve their full potential when provided with flexible funding, strong leadership, appropriate outcome and clinical training. A contract was signed at the end of March 2009 with the Washington Hospital Center to implement an Integrated Community Care Project.

High Utilizers Initiative: The high utilizers initiative is an outgrowth of the Integrated Care Management Program. During FY 2009, the High Utilizer meetings with the Comprehensive Psychiatric Emergency Program (CPEP), Saint Elizabeths Hospital (SEH), Integrated Care Management, and the Homeless Outreach Program (HOP) were conducted bi-monthly to address needs of consumers experiencing multiple involuntary admissions. The focus is on identifying consumers with three (3) or more hospitalizations in one (1) year who are then referred to assertive community treatment (ACT) services.

In July 2009, there were 98 high utilizers being followed by the Integrated Care Management Division. This division tracks provider compliance and consumer progress with individual recovery plan (IRP) goals, housing, day activity, medical, substance use status, psychiatric status, committed outpatient and ACT status and consumer progress towards stability.

Saint Elizabeths Hospital Census Reduction Initiative: 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). During FY 2007, there was an average census of 428 patients (210-Civil and 218-Forensic) and during FY 2008 there was an average census of 403 (213-Civil and 190-Forensic). The hospital census is in the process of being reduced to accommodate a 293-bed new facility projected to open in early 2010.

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 in 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 developmental disabilities, 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.

Saint Elizabeths Hospital 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, Saint Elizabeths Hospital and the D.C. Community Services Agency (DC 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 DC CSA and Forensic Pre-Trial and Assessment Services' clinical staff. The DMH in collaboration with Saint Elizabeths Hospital, the Court and other criminal justice stakeholders continue 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.

### **Annual Adult Community Services Reviews**

The Year 7 (2009) Adult Consumer Services Review (CSR) included a total of 88 consumers and was conducted May 4-15, 2009. The total was at the target set in order to have a statistically acceptable sample size from which to generalize about the adult system. The same basic protocols were followed for the 2008 adult CSR. Fifty-three (53) of the reviewed cases were conducted with Human Systems and Outcomes (HSO) as the lead reviewer and 35 with DMH staff as lead reviewer. The practice started in 2008 continued whereby, all DMH reviewers met with an HSO-assigned case judge to review relevant facts and information that would support ratings. This case-judging process is viewed as critical to assuring inter-rater reliability across reviewers.

The Year 7 results for individual consumer status was at 74%. This matches the 2008 results that were also at 74%. The areas that scored well in terms of consumer status included: safety (85%); economic security (85%); living arrangements (83%); and satisfaction with services (91%). The areas that scored low included: social network (60%); education/career preparations (41%); work (57%); and recovery activities (58%).

This data continues to indicate that basic needs are being met but that consumers are still not consistently engaged in a recovery-focused model of care.

The Year 7 results for system performance, which is the Dixon measure, was at 70%. This compares to a score of 74% for 2008. The adult system continues to score well in terms of engagement efforts by staff (85%) and culturally appropriate practice (93%). However, the areas where it continues to lag are in service team functioning (49%), personal recovery goals (63%), and individualized recovery plan (55%). The HSO Report on the adult CSR review pointed to many of the themes that have been identified in previous years – i.e. lack of adequate communication between and among caregivers. HSO “strongly recommended that the DMH and provider leadership make client-centered planning and teaming the top priority for refinement this year. If this is done successfully, it is anticipated that DMH should meet the Dixon Exit Criteria for CSR reviews in the next review cycle.” The Court Monitor concurred with this assessment.

# 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

## ADULT ESTIMATE OF PREVALENCE

### [Criterion 2: Mental Health System Data Epidemiology]

#### 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. Fenty* 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) 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:

District of Columbia residents;

- (a) Who are over the age of 18 (or over the age of 21 if in special education, MRDDA, or in foster care);
- (b) 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 was revisited during FY 2008.

During, FY 2008, a Mental Health System Review Steering Committee was established which was charged with conducting an intensive review of the public mental health system and to make recommendations to improve the District's public mental health system. Of particular, concern for the Mental Health System Review Steering Committee has been gaps in services and populations that are currently not served but in need of service.

#### 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 (5) 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 July 2009, there were approximately 11,839 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 2009 (September 30, 2009) to allow for a full year of data. This data will be reported in the District of Columbia FY 2009 Progress Implementation Report (submitted to SAMHSA on December 1, 2009).

At the beginning of FY 2003, the DMH MIS changed to a claims processing system (eCura). 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.

<b>DIG Table</b>	<b>Report Data</b>	<b>Enhancements/Reporting</b>
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 eCura 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 stored these data, which are being reported for federal purposes. A new system was implemented in July 2008.
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.

<b>DIG Table</b>	<b>Report Data</b>	<b>Enhancements/Reporting</b>
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 will be reported for federal project 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 using eCura and independent data bases.
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. Data will be reported 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 being 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	Partial	Reviewed operational definitions, assessed methodology for data collection, and modified information systems to capture data. Data collection process needs to be

DIG Table	Report Data	Enhancements/Reporting
Juvenile Justice System, and Adults who have had Contact with the Criminal Justice System		validated. Data are used with caveats.
Table 20. Rate of Readmission to State Psychiatric Hospitals within 30 Days and 180 days	Yes	Reviewed operational definition and modified DMH information systems. Working with private hospitals to collect data from their systems.

Mental Health Transformational Activities

In July 2009, the DMH Division of Organizational Development, Research and Clinical Informatics Unit completed a review of the independent databases at DMH and began working on completing a report of the findings. The Mental Health Block Grant and Data Infrastructure Grant staff provided documents and data related to this project. It is envisioned that these findings will facilitate accessing data within DMH.

# District of Columbia

## Adult - Quantitative Targets

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



## ADULT QUANTITATIVE TARGETS

### B. Performance Goals, Targets and Action Plans

#### Criterion 1: FY 2010 Goals, Targets and Action Plans

##### Goal 1: Improve Continuity of Care

###### Targets:

1. Maintain the number of adults re-admitted to Saint Elizabeths Hospital within 30 days of discharge at 10%.
2. FY 2010 target will be set after FY 2009 data is developed.

###### Action Plans:

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 and Core Service 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, 5) continue the Integrated Care Project to address the needs of some of the most clinically challenging inpatients to support them in the community, and 6) full implementation of the Transition Specialist Project where peers provide encouragement and support to consumers leaving the hospital, and 7) continue to review with the Dixon Court Monitor the status of the Dixon Performance Target that 80% of adults discharged from inpatient care must be seen within seven days.

**DISTRICT OF COLUMBIA  
FY 2010 STATE PLANNING AND MONITORING  
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

**Name:** Improve Continuity of Care

**Goal:** Reduce number of adults re-admitted to hospital within 30 days

**NOM:** Reduced Utilization of Psychiatric Inpatient Beds

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

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

**Indicator 1:** Number of adults re-admitted to Saint Elizabeths Hospital within 30 days of discharge

**Target:** Decrease number of adults re-admitted to Saint Elizabeths Hospital within 30 days of discharge to 10% in FY 2010

**Performance Indicator Value:**

Numerator: Number of adults re-admitted to Saint Elizabeths Hospital within 30 days of discharge in FY 2010

Denominator: Number of adults discharged from Saint Elizabeths in FY 2010

**Sources of Information:** Hospital Management Information System

**Significance:** DMH has a Saint Elizabeths Hospital Census Reduction Initiative.

**Special Issues:** DMH is building a new state-of-the-art 293-bed hospital and needs reduce beds accordingly. The completion date is early 2010. An overflow plan has been developed.

<b>Name of Performance Indicator:</b> Improve Continuity of Care				
<b>Population:</b> Adults with mental illness in the District of Columbia			<b>Criterion 1:</b> Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2007 Actual</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Projected</b>	<b>FY 2010 Target</b>
<b>Performance Indicator (Value)</b>	8.8%	10.04%	12.6%	10%
<b>Numerator</b>	85	49	34	---
<b>Denominator</b>	962	488	270	---

**Note:** Only FY 2007 data includes civil and forensic clients.

**DISTRICT OF COLUMBIA  
FY 2010 STATE PLANNING AND MONITORING  
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

**Name:** Improve Continuity of Care

**Goal:** Reduce number of adults re-admitted to hospital within 180 days

**NOM:** Reduced Utilization of Psychiatric Inpatient Beds

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

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

**Indicator 1:** Number of adults re-admitted to Saint Elizabeths Hospital (SEH) within 180 days of discharge

**Target:** FY 2010 target will be set after the FY 2009 data is developed

**Performance Indicator Value:**

Numerator: Number of adults re-admitted to Saint Elizabeths Hospital within 180 days of discharge in FY 2010

Denominator: Number of adults discharged from Saint Elizabeths in FY 2010

**Sources of Information:** Hospital Management Information System

**Significance:** DMH has a Saint Elizabeths Hospital Census Reduction Initiative.

**Special Issues:** DMH is building a new state-of-the-art 293-bed hospital and needs to reduce beds accordingly. The completion date is early 2010. An overflow plan has been developed. FY 2009 data not yet available and FY 2010 target will be set based on this data.

<b>Name of Performance Indicator:</b> Improve Continuity of Care				
<b>Population:</b> Adults with mental illness in the District of Columbia			<b>Criterion 1:</b> Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2007 Actual</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Projected</b>	<b>FY 2010 Target</b>
<b>Performance Indicator (Value)</b>	20.27%	23.36%	23%	---
<b>Numerator</b>	195	114	---	---
<b>Denominator</b>	962	488	---	---

**Note:** FY 2007 data includes civil and forensic clients. FY 2010 target will be set after FY 2009 data developed.

## **Goal 2: Improve Access to Evidence-Based Practices**

Evidence-based practices data, as reported in Developmental Tables 16 and 17, will not be developed until after the end of FY 2009 (September 30, 2009). This data will be reported in the FY 2009 District of Columbia Community Mental Health Services Progress Implementation Report (submitted to SAMHSA on December 1, 2009) for categories for which there is data in the Contract Management System.

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

### Targets:

1. Continue to monitor the ACT teams in FY 2010.
2. Increase the number of persons receiving evidence-based practices in FY 2009:
  - 2-1- Broaden the Dixon Performance Target definition for what can be measured as providing housing 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.

### Action Plans:

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 disorder services into the service delivery system. The DMH will: 1) continue to provide housing and support services to consumers most in need and try to broaden the spectrum of housing services and supports that can be measured related to the Dixon Performance Target (70% of persons receive housing services within 45 days of a referral), 2) continue the collaboration with the Department on Disability Services to support mental health consumers in supported employment programs, continue the social marketing strategy including training for consumers and clinicians and orientation for potential employers, and try to maintain the Dixon Performance Target to provide employment related services to 70% of persons referred within 120 days of a referral, 3) continue to monitor the ACT teams to addresses overall referrals, capacity, staffing and service delivery issues including training and technical assistance based on fidelity audits, and try to reach

the Dixon Performance Target to provide ACT services to 85% of persons referred 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, and 5) evaluate the infrastructure development for an integrated systems model for persons with co-occurring disorders through the Co-Occurring State Incentive Grant (COSIG).

It is noted that DMH encountered a tracking problem when trying to measure the ACT performance target using the service Authorization Plan. 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 has continued.

As of July 1, 2009, there were 542 consumers receiving ACT services. The FY 2008 census was 397. The program met its goal to increase the census by 25%.

**DISTRICT OF COLUMBIA  
FY 2010 STATE PLANNING AND MONITORING  
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

**Name:** Improve Access to Evidence-Based Practices

**Goal:** Improve and/or increase number of evidence-based practices

**NOM:** Increased Evidence-Based Practices

**Transformation:** Advance Evidence-Based Practices (NFC Report Goal 5.2)

**Population:** Adults with serious mental illness in the District of Columbia

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

**Target:** Continue to monitor ACT Teams in FY 2010

**Source of Information:** Fidelity Audits, Care Coordination, Contract Management System

**Significance:** The overall performance of ACT teams is part of the Dixon Court Order.

**Special Issues:** At the end of FY 2006 there were 8 ACT teams, with no planned expansion during FY 2007-FY 2008. The ACT fidelity audits and overall review process began in FY 2008 and continued in FY 2009. While there was no planned expansion in FY 2009, 3 new teams were added by June 2009, bringing the total to 11 ACT teams: Community Connections=2, DC CSA=3, Family Preservation =2, Green Door=1 and Pathways DC=3. Another team is expected to be added by September 2009. It should be noted that the DC CSA ACT Teams will be phased out by July 31, 2009. It is likely that 2 new teams will be added in FY 2010, therefore the target is 13 ACT teams.

<b>Name of Performance Indicator:</b> Improve Access to Evidence-Based Practices				
<b>Population:</b> Adults with SMI in the District of Columbia			<b>Criterion 1:</b> Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2007 Actual</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Projected</b>	<b>FY 2010 Target</b>
<b>Performance Indicator</b>	8	8	No target projected, instead service improvement following baseline audits	13

**DISTRICT OF COLUMBIA  
FY 2010 STATE PLANNING AND MONITORING  
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

**Name:** Improve Access to Evidence-Based Practices

**Goal:** Increase number of adults receiving supported housing services

**NOM:** Increased Evidence-Based Practices

**Transformation:** Advance Evidence-Based Practices (NFC Report Goal 5.2)

**Population:** Adults with serious mental illness in the District of Columbia

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

**Target:** Broaden measures to increase to 70% the number of adults with SMI receiving supported housing services within 45 days of a referral in FY 2010

**Performance Indicator Value:**

Numerator: Number of adults receiving supported housing services within 45 days of referral in FY 2010

Denominator: Number of adults referred for supported housing in FY 2010

**Source of Information:** DMH Housing Division Database and Other Sources to be Identified

**Significance:** This measure is a Dixon Exit Criteria for vacating the Dixon Court Order.

**Special Issues:** During FY 2008 DMH and the Court Monitor began to discuss that housing services was too narrowly defined (solely as housing) and that housing placement within 45 days was not a reasonable expectation. There are also budgetary constraints. The data highlight these issues. FY 2007 and FY 2008 data show that 12% and 14% (respectively) were housed in 45 days. FY 2009 data for three quarters shows 12.7%. The target remains at 70% until a revised approved approach is adopted.

<b>Name of Performance Indicator:</b> Improve Access to Evidence-Based Practices				
<b>Population:</b> Adults with serious mental illness in the District of Columbia			<b>Criterion 1:</b> Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2007 Actual</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Projected</b>	<b>FY 2010 Target</b>
<b>Performance Indicator (Value)</b>	12%	14.4%	12.7%	70%
<b>Numerator</b>	28	15	7	---
<b>Denominator</b>	242	104	55	---

**Note:** FY 2009 data is for the period October 1, 2008- June 30, 2009.

**DISTRICT OF COLUMBIA  
FY 2010 STATE PLANNING AND MONITORING  
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

**Name:** Improve Access to Evidence-Based Practices

**Goal:** Increase number of adults receiving supported employment services

**NOM:** Increased Evidence-Based Practices

**Transformation:** Advance Evidence-Based Practices (NFC Report Goal 5.2)

**Population:** Adults with serious mental illness in the District of Columbia

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

**Target:** Maintain at 70% the number of adults with SMI receiving supported employment services within 120 days of a referral in FY 2010

**Performance Indicator Value:**

Numerator: Number of adults receiving supported employment services within 120 days of referral in FY 2010

Denominator: Number of adults referred for supported employment in FY 2010

**Source of Information:** DMH Authority Supported Employment Database

**Significance:** This measure is a Dixon Exit Criteria for vacating the Dixon Court Order.

**Special Issues:** In FY 2007, the Supported Employment algorithm was used unlike previous years. It includes quarterly and annual referrals. During FY 2007, FY 2008 and three quarters of FY 2009 data exceed the Dixon Performance Target (89%, 95%, 88%, respectively). However, the Court Monitor wants to ensure that consumers who want this service are able to access it. A Supported Employment Promotion, Outreach and Training Plan was implemented in FY 2008 and continued in FY 2009. The FY 2010 target remains 70%.

<b>Name of Performance Indicator:</b> Improve Access to Evidence-Based Practices				
<b>Population:</b> Adults with serious mental illness in the District of Columbia			<b>Criterion 1:</b> Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2007 Actual</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Projected</b>	<b>FY 2010 Target</b>
<b>Performance Indicator (Value)</b>	89%	95%	88.37%	70%
<b>Numerator**</b>	98	77	38	---
<b>Denominator**</b>	109	81	43	---

**Note:** FY 2009 data is for the period October 1, 2008- June 30, 2009.



**DISTRICT OF COLUMBIA  
FY 2010 STATE PLANNING AND MONITORING  
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

**Name:** Improve Access to Evidence-Based Practices

**Goal:** Increase number of adults receiving ACT services

**NOM:** Increased Evidence-Based Practices

**Transformation:** Advance Evidence-Based Practices (NFC Report Goal 5.2)

**Population:** Adults with serious mental illness in the District of Columbia

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

**Target:** Complete review and follow-up activities to increase to 85% the number of adults with SMI receiving ACT within 45 days of a referral in FY 2010

**Performance Indicator Value:**

Numerator: Number of adults receiving ACT services within 45 days of referral in FY 2010

Denominator: Number of adults referred for ACT service in FY 2010

**Source of Information:** Contract Management System

**Significance:** This measure is a Dixon Exit Criteria for vacating the Dixon Court Order.

**Special Issues:** In FY 2007 baseline data was reported to the Court Monitor. The data show that 51.52% of persons referred received ACT services within 45 days of a referral. The FY 2008 data show 65.8%. The fidelity audits that began in FY 2008 were continued along with training and technical assistance in FY 2009. The FY 2009 data is 70%. The FY 2010 target remains at 85%.

<b>Name of Performance Indicator:</b> Improve Access to Evidence-Based Practices				
<b>Population:</b> Adults with serious mental illness in the District of Columbia			<b>Criterion 1:</b> Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target
<b>Performance Indicator (Value)</b>	51.52%	65.81%	70%	85%
<b>Numerator</b>	34	77	211	---
<b>Denominator</b>	66	117	301	---

**DISTRICT OF COLUMBIA  
FY 2010 STATE PLANNING AND MONITORING  
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

**Name:** Improve Access to Evidence-Based Practices

**Goal:** Increase number of adults with schizophrenia receiving new generation antipsychotic medications

**NOM:** Increased Evidence-Based Practices

**Transformation:** Advance Evidence-Based Practices (NFC Report Goal 5.2)

**Population:** Adults with serious mental illness in the District of Columbia

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

**Target:** Maintain at 70% the number of adults with schizophrenia receiving new generation antipsychotic medications

**Performance Indicator Value:**

Numerator: Number of adults of with schizophrenia receiving new generation antipsychotic medications in FY 2010

Denominator: Number of adults with schizophrenia in FY 2010

**Source of Information:** Contract Management System

**Significance:** This measure is a Dixon Exit Criteria for vacating the Dixon Court Order.

**Special Issues:** While the Court Monitor agrees that DMH met this criterion in FY 2007, DMH still has to monitor this performance target.

<b>Name of Performance Indicator:</b> Improve Access to Evidence-Based Practices				
<b>Population:</b> Adults with serious mental illness in the District of Columbia			<b>Criterion 1:</b> Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2007 Actual</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Projected</b>	<b>FY 2010 Target</b>
<b>Performance Indicator (Value)</b>	85.32%	85.6%	86.69%	70%
<b>Numerator</b>	3,028	3,231	3,582	---
<b>Denominator</b>	3,549	3,771	4,123	---

### **Goal 3: Improve Client Perception of Care**

#### **Mental Health Statistics Improvement Program (MHSIP) Surveys**

##### 2009 MHSIP Survey

The contract to implement the MHSIP Survey process was announced in July 2009. The process cannot begin until the contractor is selected. It is envisioned that once initiated the process will occur over a 90-day period.

##### 2008 MHSIP Survey

Background: The 2008 survey was administered through a telephone survey during the period July-September 2008. The surveys were coordinated by the DMH Office of Strategic Planning, Policy and Evaluation with the assistance of the Family Alliance for Community Support, Inc., a family advocacy organization. The surveys were administered by a team of consumers and family members who received a 3-day training on survey administration but who came to the training with prior experience. Three (3) instruments continued to be used to generate consumer satisfaction ratings. They were: 1) the MHSIP Consumer Satisfaction Survey, 2) Youth Services Survey for Families (YSS-F), and 3) the Recovery Oriented Systems Indicator (ROSI). The “official version” of each of these instruments was used.

Survey Participants: From a pool of 15,525 duplicated adult service records and 5,467 duplicated child service records, a stratified random sample was employed using a triple sample of 1,292 adults and 1,008 parents of children. Consumer over sampling was done in an effort to increase the final sample. Participants were comprised of individuals who had a minimum of one paid service with a provider between July 1, 2007 and March 31, 2008. For the MHSIP Survey there were approximately 3,231 phone calls made to consumers and 201 participated in the survey. A total of 145 consumers who participated in the MHSIP Survey also agreed to participate in the ROSI. Participation in the ROSI was optional.

Adult Respondents Characteristics: Of the adult respondents for the MHSIP, 41% were males and 59% were females. With respect to ethnicity, 78 % self identified as African Americans, 10% self identified as White, and 8.5% self identified as Hispanic. The remaining participants did not indicate their race. The educational levels of the consumers revealed that 19% had less than high school, 37% completed high school/GED, 27% completed college/technical training, and 15% completed graduate school. At the time of the survey, 12% of the respondents were receiving mental health services for more than 3years and 48% received services for more than 5 years.

MHSIP Adult Survey: The survey consists of 28 items, rated on a 5-point Likert scale ranging from 1 (strongly agree) to 5 (strongly disagree). The MHSIP Survey is comprised

of the following domains: 1) **Access Domain** (6 items) measures consumers' perceptions about the accessibility of services, 2) **Quality and Appropriateness Domain** (9 items) measures consumers' perceptions of the quality and appropriateness of services, 3) **Outcome Domain** (8 items) measures consumers' perceptions about treatment outcomes resulting from services, 4) **Participation in Treatment Domain** (2 items) measures consumers' perceptions of how much they participated in their individual service plan, and 5) **General Satisfaction Domain** (3 items) measures consumer satisfaction with services received.

The National Association of State Mental Health Program Directors, National Research Institute (NASMHPD, NRI) added a **Functioning Domain** (4 items) measures improved functioning as the result of treatment and a **Social Connectedness Domain** (4 items) and measures consumers' relationships with persons other than their mental health providers. Additional questions are asked regarding arrests and current status of mental health treatment.

Adult Survey Findings: The MHSIP Survey respondents had fairly high percentages of responses indicating satisfaction with the services within the District's mental health system for 2008. The exception was questions pertaining to positive outcomes and functioning. However, the 2008 findings were consistently rated lower than the 2007 findings.

Although respondents generally expressed positive experiences with the services received in 2008, when compared with scores from the 2007 MHSIP Survey, there was a moderate decrease in the domains of Access to Services, Quality and Appropriateness, Positive Outcomes, Participation in Treatment Planning, and General Satisfaction with Services.

Recovery Oriented System Indicators (ROSI) Consumer Survey: Respondents were asked to participate in this optional survey following the administration of the MHSIP. The ROSI survey instrument consists of 42 items designed to assess the concept of recovery within community mental health systems for adults who have been diagnosed with serious mental illness that are characterized by prolonged psychiatric disorders. Section one is comprised of 16 items and responses range from "Strongly Disagree" to "Strongly Agree." Section two is comprised of 24 items with responses ranging from "Never/Rarely" to "Almost Always/Always." In section three, a qualitative question was asked on issues relating to how services help or hinder recovery. In section four, questions pertaining to demographic data were collected.

There were 142 consumers who responded to the ROSI. The sample size is much larger than the 2007 sample of 57. The majority of respondents reported a high percentage of satisfaction with the services they received. Less than 50% of the respondents believe mental health services make them more dependent and that they lack the information or resources to uphold their client rights and basic human rights. However, 65% of the respondents believe the services help them develop the skills they need. Less positive responses were given for questions pertaining to education and employment. Consumers do not have an opportunity to advance their education and the services do not help them

get or keep employment. Contrary to the 2007 findings, 59% of the respondents believe they had housing they could afford. There were 71% and 80% of the respondents respectively who believe they have a say in what happens when they are in a crisis and believe staff believe they can grow, change, and recover. Unfortunately only 46% of the respondents believe that they have a consumer peer advocate to turn to when they need one. Therefore, the results suggest that there is still need for improvement in the areas of focus.

The responses to social connectedness and functioning received ratings of 79% and 76% respectively. These ratings were much lower than the 2007 ratings of 93% and 89% respectively. Consumers tended to rate their friendships, people they do things with, and feelings of belonging in their communities less favorably. Similarly, improved functioning was also rated less positively when it came to being able to care for ones needs, do things that are more meaningful, handle things when they go wrong, and being better able to do things that one wants to do.

Some questions, at the end of the survey, focused on consumer arrests. A few respondents provided answers to questions pertaining to arrests and encounters with the police. There were five (5) respondents who had been arrested during the last 12 months and nine (9) arrested 12 months prior to the survey. However, the responses indicated that 151 had been arrested since they had received mental health services, while 143 reported that they had no arrests during the prior 12 month period.

Recommendations from MHSIP Survey Process: The following recommendations are offered: 1) the need to identify strategies for increasing the consumer participation and devoting resources to obtaining more accurate consumer contact information for the telephone survey process; 2) the need to coordinate the timing of surveys between the DMH administered surveys and the provider network surveys; 3) the continued need to get greater buy-in for the survey process from the DMH providers; 4) the findings suggest the need for a greater departmental focus on service outcome; 5) a continued focus on the types of services provided since respondents continue to give lower ratings to the receipt of services needed; and 6) the survey findings should be disseminated widely through the DMH programs related provider issues, consumer and family issues, and quality improvement issues.

### **Adult Community Services Reviews**

During FY 2009, the Annual Community Services Review (CSR) was conducted. The target reported here is related to the Adult CSR process.

#### Target:

1. Increase the ratings related to the system performance measures in the Annual Adult CSR.

Action Plans:

In FY 2009, DMH established a Community Services Review Unit within the Organizational Development Division in the Office Programs and Policy. This unit will assist DMH staff and the provider network address some of the longstanding issues related to team formation and team functioning and eventually assume responsibility for the CSR process on an ongoing basis.

The Year 7 (2009) adult CSR results for individual consumer status was at 70%. The Health Systems and Outcomes (HSO) report pointed to many of the themes that have been identified in previous years such as the lack of adequate communication between and among caregivers. It was recommended that DMH and the provider leadership make client-centered planning and teaming the top priority for refinement. Moreover, it was noted that if this is done successfully, it is anticipated that DMH should meet the Dixon Exit Criteria for CSR reviews in the next review cycle.

**DISTRICT OF COLUMBIA  
FY 2010 STATE PLANNING AND MONITORING  
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

**Name:** Improve Client Perception of Care

**Goal:** Improve system performance ratings on Adult Community Service Reviews (CSR)

**NOM:** Client Perception of Care

**Transformation:** Involvement of consumers and families fully in orienting mental health system toward recovery (NFC Report Goal 2.2)

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

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

**Target:** Increase to 80% the ratings for system performance measures in the Annual Adult CSR in FY 2010

**Performance Indicator Value:**

Numerator: Number of adults considered having acceptable system performance ratings in FY 2010

Denominator: Number of adult cases surveyed in FY 2010

**Source of Information:** Human Systems and Outcomes (HSO)

**Significance:** This measure is a Dixon Exit Criteria for vacating the Dixon Court Order.

**Special Issues:** The Dixon Performance Target is 80% and HSO calculates the data. The FY 2007 data show an acceptable level of system performance was rated at 80%. While the performance target was met, issues related to sample size and inter-rater reliability were addressed beginning in FY 2008. The FY 2008 score was 74% and the FY 2009 score 70%. The FY 2010 target remains at 80%.

<b>Name of Performance Indicator:</b> Improve Client Perception of Care				
<b>Population:</b> Adults with mental illness in the District of Columbia			<b>Criterion 1:</b> Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2007 Actual</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Actual</b>	<b>FY 2010 Target</b>
<b>Performance Indicator</b>	80%	74%	70%	80%
<b>Numerator</b>	44	65	62	---
<b>Denominator</b>	55	88	88	---

## **Criterion 2: FY 2010 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 2009 (September 30, 2009) and reported in the FY 2009 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 for adults.
2. Increase the number of adults with SMI receiving mental health services by 2% of the District Census 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 Care Coordination Division/Access HelpLine, 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 2010 STATE PLANNING AND MONITORING  
 MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

**Name:** Improve Access to Community-based Mental Health Services

**Goal:** Increase number of adults receiving mental health rehabilitation services (MHRS)

**NOM:** Increased Access to Services

**Population:** Adults with Mental Illness in the District of Columbia

**Criterion 2:** Mental Health System Data Epidemiology

**Target:** Increase the number of adults receiving MHRS in FY 2010 by 3% of the District Census for adults

**Performance Indicator Value:**

Numerator: Number of adults receiving MHRS in FY 2010

Denominator: Number of adults based on District Census

**Source of Information:** Contract Management System

**Significance:** This measure is a Dixon Exit Criteria for vacating the Dixon Court Order.

**Special Issues:** The Dixon Performance Target is 3%. The Court Monitor's July 2007 Report shows a rate of 2.10%. The FY 2008 data shows a rate of 2.66% and August 2009 data a rate of 2.47%. The FY 2010 target remains at 3%.

<b>Name of Performance Indicator:</b> Improve Access to Community-based Mental Health Services				
<b>Population:</b> Adults with mental illness in the District of Columbia			<b>Criterion 2:</b> Mental Health System Data Epidemiology	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2007 Actual</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Projected</b>	<b>FY 2010 Target</b>
<b>Performance Indicator (Value)</b>	2.10%	2.66%	2.47%	3%
<b>Numerator</b>	9,307	11,839	11,803	---
<b>Denominator</b>	443,976	443,976	476,894	---

FY 2009 denominator based on NRI/SDICC for CMHS 7/13/09. FY 2009 data is as of 8/13/09.

**DISTRICT OF COLUMBIA  
 FY 2010 STATE PLANNING AND MONITORING  
 MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

**Name:** Improve Access to Community-based Mental Health Services

**Goal:** Increase number of adults with SMI receiving mental health rehabilitation services (MHRS)

**NOM:** Increased Access to Services

**Population:** Adults with SMI in the District of Columbia

**Criterion 2:** Mental Health System Data Epidemiology

**Target:** Increase the number of adults with SMI receiving MHRS in FY 2010 by 2% of the District Census for adults

**Performance Indicator Value:**

Numerator: Number of adults with SMI receiving MHRS in FY 2010

Denominator: Number of adults based on District Census

**Source of Information:** Contract Management System

**Significance:** This measure is a Dixon Exit Criteria for vacating the Dixon Court Order.

**Special Issues:** The Dixon Performance Target is 2%. The Court Monitor's July 2007 Report shows a rate of 1.80%. The FY 2008 data show a rate of 1.93% and the FY 2009 data 2.24%. This performance indicator has been moved to inactive status but continues to be measured. FY 2010 target remain at 2%.

<b>Name of Performance Indicator:</b> Improve Access to Community-based Mental Health Services				
<b>Population:</b> Adults with SMI in the District of Columbia			<b>Criterion 2:</b> Mental Health System Data Epidemiology	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2007 Actual</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Projected</b>	<b>FY 2010 Target</b>
<b>Performance Indicator (Value)</b>	1.80%	1.93%	2.24%	2%
<b>Numerator</b>	7,989	8,594	10,710	---
<b>Denominator</b>	443,976	443,976	476,894	---

FY 2009 denominator based on NRI/SDICC for CMHS 7/13/09. FY 2009 data is as of 8/18/09.

# District of Columbia

## Adult - Outreach to Homeless

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

## **ADULT OUTREACH TO HOMELESS**

### **[Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults]**

The District of Columbia is urban and does not include any rural areas. Therefore, there are no services targeted to rural populations.

The DMH Homeless Services Strategy was developed in accordance with the overall strategy for ending homelessness that has been developed by the Government of the District of Columbia (the “District”) and is subject to change from time to time, based upon the needs of District residents.

#### **The Interagency Council on Homelessness**

In 2005, the Council of the District of Columbia enacted the Homeless Services Reform Act of 2005 (the “Reform Act”). The Reform Act established the Interagency Council on Homelessness (the “Interagency Council”). The Interagency Council is chaired by the City Administrator and includes the directors of various cabinet agencies, including the Director of DMH. There must be a majority of Department Directors at each meeting in order to vote. All policy and programming issues pertinent to families and individuals who are homeless or at imminent risk of becoming homeless (the “homeless”) are discussed in this forum. Consumers who are homeless are provided the opportunity to discuss their concerns with the Committee.

Among other things, the Interagency Council is responsible for developing the annual plan describing how the District will provide or arrange for services to the homeless. In addition, the Interagency Council is responsible for the annual plan describing how the District will provide hypothermia shelter.

The District Department of Human Services (“DHS”) is the lead agency responsible for the coordination of homeless services in the District. The DHS contracts with The Community Partnership for the Prevention of Homelessness, an independent non-profit corporation (“TCP”) to manage the District of Columbia’s Continuum of Care services funded through the federal Department of Housing and Urban Development (“HUD”) on behalf of the city. The DHS has recently begun directly funding street outreach services and Hypothermia Hotline and transportation services.

#### **Housing First Permanent Supportive Housing Plan**

The Housing First Permanent Supportive Housing Plan was one of Mayor Fenty’s policy initiatives to end chronic homelessness. Permanent supportive housing (PSH) was defined as long-term, community-based housing that has supportive services for homeless persons with disabilities. The District’s mental health consumers were also beneficiaries of the Housing First PSH initiative.

The DHS, the District’s lead agency in addressing the needs of homeless individuals and families, was charged with implementing a person-centric approach to the delivery of

human services. This is a significant departure from the way the District has delivered homeless services in the past. Rather than simply meeting the survival needs of individuals and families by providing blankets and shelter, the agency engages each individual in the system with comprehensive case management intended to address the root causes of homelessness and provide them with what they need to move beyond homelessness.

The permanent supportive housing plan allowed DHS to rapidly provide supportive services to the most vulnerable homeless residents and families and move them into scattered-site and site-based permanent supportive housing units throughout the District. The plan targeted 400 of the city's most vulnerable, longest-stayers in the District's shelter system over a six-month period with a goal of decreasing the need for emergency shelter beds.

The Housing First PSH Initiative was kicked off in late Summer 2008. The first part of this effort included a vulnerability assessment tool that allowed the prioritizing of individuals with the greatest special needs. Housing began in early Fall 2008 and to date over 400 individuals who are homeless have been housed through this initiative. Housing placement included linkages to DHS contracted case management programs. The DMH Homeless Outreach Program staff was present at all housing placement events and have assisted with coordinating services and providing some training on an as needed basis.

The DMH is committed to meeting the changing needs of consumers who are chronically or temporarily homeless and have mental illness. The DMH directly provides or contracts for a range of services that have been identified as appropriate for addressing the needs of this population. The DMH, in conjunction with the other District providers of homeless services continually assess the effectiveness of the program mix and reserves the right to alter the array of services offered as needed to address budgetary constraints or changes in demand.

### **Focused Improvement Areas (FIA)**

During FY 2009, DMH continued to participate in the District's FIA initiative, which targets neighborhoods with high crime for increased social services in order to improve them and reduce crime. All District agencies are required to address the neighborhood needs within their administrative purview. The strategies employed include: weekly case reviews, identification of service needs, door-to-door engagement of residents, walk throughs, and health fairs. The FY 2010 DMH goals include linkages to mental health services, supported employment and supported housing.

### **DMH Office of Homeless Services**

The DMH Office of Homeless Services works closely with the TCP. The data from the TCP January 2009 Point in Time Survey indicate that:

- 6,228 homeless singles and individuals in families were counted in the District of Columbia,
- 1,923 were chronically homeless according to the HUD definition,

- 321 were unsheltered on the night of the survey,
- the total represents a 3% increase from the 2008 Point in Time Survey (6,044), and
- estimated that 33% of this population has a serious mental illness.

The DMH Office of Homeless Services includes the following programs and activities: 1) Homeless Outreach Program, 2) Psychiatry Residency Training Program Placements, 3) Hermano Pedro Drop-In Center, 4) FAST Shelter Outreach Program, and 5) the Sobering Station.

**Homeless Outreach Program**

The DMH Homeless Outreach Program (HOP) continues to provide outreach, engagement, linkage, psychiatric treatment and follow-up services to individuals who are homeless. The HOP has also continued to provide community consultation to the provider network most closely involved with the population. The HOP consumers are unsheltered, reside in low barrier shelters, transitional programs, abandoned vehicles or buildings or other temporary residences.

The HOP staff includes 8 FTEs. Three (3) of the staff are funded by the Projects for Assistance in Transition from Homelessness (PATH) Grant. The HOP lost one vacant position in December 2008 due to budget constraints.

New initiatives involve working with the Community Partnership for the Prevention of Homelessness (TCP) to begin to track data using the Homeless Information Management System (HMIS), which is utilized throughout the District of Columbia by programs that work with individuals and families who are homeless. This system is required for programs that receive the federal Housing and Urban Development (HUD) funding and has been adopted by many others as well.

In June 2009, the HOP was preliminarily approved to receive Technical Assistance from the PATH program in the form of financial and staff resources. This assistance should begin during the remainder of FY 2009 and extend through FY 2010.

The HOP statistics are based on requirements for the Dixon Exit Criteria for adults and children that includes: 1) a comprehensive strategy and serving 150 adults who are homeless with serious mental illness and, 2) a comprehensive strategy and serving 100 children/youth who are homeless.

The HOP statistics related to the Dixon Exit Criteria for the period April 1, 2008 through March 31, 2009 includes the following:

Adults (unduplicated count)	1,330
Children (unduplicated count)	185
Adults, Children & Families (face-to-face)	3,465

## **Psychiatry Residency Training**

The HOP psychiatrist serves as faculty to the Saint Elizabeths Psychiatry Residency Training Program. Residents in their third year of training are placed at a variety of homeless shelter programs, soup kitchens and street outreach programs in order to learn other approaches to providing mental health services in community-based settings that serve people who are homeless. The available statistics for the Psychiatry Residency Training Program (first two quarters of FY 2009, 10/1/08-3/31/09) show that residents saw 150 different individuals who were homeless.

In the past there has been at least one (1) full psychiatry residence class assigned for a year to a homeless services program rotation. Due to budgetary constraints, in FY 2010 only half the class will be placed at a time.

## **FAST Program (Shelter Outreach Program)**

This program operated from August 2007 through November 2008 under contract with Anchor Mental Health Association. It provided outreach in a men's shelter and the services included: referrals, counseling, linkage to mental health and substance abuse services, and mental health treatment. While the closing of this shelter was part of the Housing First PSH, there were budget issues that did not allow the modification of the contract to include services at other facilities or to combine it with the homeless drop in center DMH had just begun funding.

The statistics for the FAST Program for the duration of the DMH contract (8/07-11/08) include the following:

<b>Services Delivered</b>	
Total Face-to-Face Contacts	2,225
Total Unduplicated Consumers	136
Total Referrals for Substance Abuse Detoxification or Treatment Program	531
Mental Health Services	373

## **Hermano Pedro Drop-In Center**

This program began in December 2007 and operates under contract with the Anchor Mental Health Association. The services provided include: laundry, showers, snacks, clothing, referral for services, case management, and groups for men and women who are homeless with co-occurring disorders. The program will continue in FY 2010.

The program statistics for the first two quarters of FY 2009 (10/1/08-3/31/09) include the following:

Total Unduplicated Consumers	138
Total Face-to-Face Contacts/Sessions	3, 288

### **The Sobering Station**

The Sobering Station offers individuals who are intoxicated with a bed, shower, snacks, and basic referrals. This program is available during Hypothermia Season.

The program statistics for the Sobering Station for the FY 2009 Hypothermia Season (12/1/08-3/31/09) include the following:

Total Unduplicated Guests	261
Total Women	8
Total Men	253
Total Visits	463

### **DMH Initiatives Affecting Homeless Services**

#### Comprehensive Psychiatric Emergency Program/Mobile Crisis Services (CPEP/MCS):

The CPEP/MCS team has taken over all crisis services to individuals who are not homeless, with the exception of services provided to individuals who are formerly homeless, such as the federal Housing and Urban Development (HUD) funded chronic homeless initiatives. The DMH Homeless Outreach Program has continued to provide some crisis services to chronically homeless individuals and families.

Development of Letter of Agreement with the Community Partnership for the Prevention of Homelessness (TCP): The DMH and TCP finalized a Letter of Agreement (LOA) on August 20, 2008 related to coordinating services and reporting requirements for a number of initiatives related to housing and homelessness; specifically support for consumers residing in HUD funded and locally funded housing initiatives. The LOA includes meeting on alternate months. These meetings include the DMH Housing Division, Homeless Services Coordinator and Team Leader for Homeless Outreach, and the Director of Adult Services. TCP sends its Shelter Plus Care Program Coordinator, Director of Federal Programs and Director of Clinical Services.



**DISTRICT OF COLUMBIA  
FY 2010 STATE PLANNING AND MONITORING  
MENTAL HEALTH PERFORMANCE INDICATORS**

**Name:** Improve Services for Homeless Populations

**Goal:** Increase engagement of adults with SMI who are homeless

**Population:** Adults with SMI who are homeless

**Criterion 4:** Targeted Services to Rural and Homeless Populations and to Older Adults

**Target:** Engage 150 adults with SMI who are homeless in FY 2010

**Sources of Information:** Pathways D.C. Housing-First Program

**Significance:** This measure is a Dixon Exit Criteria or vacating the Dixon Court Order.

**Special Issues:** The Dixon Performance Target is to engage 150 adults with SMI who are homeless through the Pathways D.C. Housing First Program plus a comprehensive strategy. The data is reported quarterly for the Dixon reporting period. FY 2008 third and fourth quarter data is In FY 2008, DMH validated the homeless metric and revised the Homeless Strategy. In FY 2009 the Court Monitor placed this performance measure in inactive status but it still needs to be monitored. The FY 2010 target remains at 150.

<b>Name of Performance Indicator:</b> Improve Services for Homeless Populations					
<b>Population:</b> Adults with SMI in the District of Columbia				<b>Criterion 4:</b> Targeted Services to Rural and Homeless Populations and Older Adults	
(1)	(2)	(3)	(4)	(5)	(5)
<b>Fiscal Year</b>	<b>FY 2008 3<sup>rd</sup> Quarter</b>	<b>FY 2008 4<sup>th</sup> Quarter</b>	<b>FY 2009 1st Quarter</b>	<b>FY 2009 2<sup>nd</sup> Quarter</b>	<b>FY 2010 Target</b>
<b>Performance Indicator</b>	142	147	158	172	150

**Note:** FY 2009 data is based on Dixon Court reporting period (4/1/08-3/31/09). The requirement is that the average across four consecutive quarters equals or is greater than the target (150). The average is 154.75.

**DISTRICT OF COLUMBIA  
FY 2010 STATE PLANNING AND MONITORING  
MENTAL HEALTH PERFORMANCE INDICATORS**

**Name:** Improve Services for Homeless Populations

**Goal:** Increase engagement of adults with SMI who are homeless

**Population:** Adults with SMI who are homeless

**Criterion 4:** Targeted Services to Rural and Homeless Populations and to Older Adults

**Target:** Engage 500 adults with SMI who are homeless quarterly in FY 2010

**Sources of Information:** DMH Authority Homeless Outreach Program Database

**Significance:** This measure represents a goal set by the DMH Homeless Outreach Program.

**Special Issues:** The DMH Homeless Outreach Program would like to increase its engagement of adults who are homeless to 500 per quarter in FY 2010.

<b>Name of Performance Indicator:</b> Improve Services for Homeless Populations					
<b>Population:</b> Adults with SMI in the District of Columbia				<b>Criterion 4:</b> Targeted Services to Rural and Homeless Populations and Older Adults	
(1)	(2)	(3)	(4)	(5)	(5)
<b>Fiscal Year</b>	<b>FY 2010 1st Quarter</b>	<b>FY 2010 2<sup>nd</sup> Quarter</b>	<b>FY 2010 3<sup>rd</sup> Quarter</b>	<b>FY 2010 4<sup>th</sup> Quarter</b>	<b>FY 2010 Target Per Quarter</b>
<b>Performance Indicator</b>	---	---	---	---	500

**Note:** This is a new performance measure beginning in FY 2010.

# 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

## OLDER ADULTS

The DMH older adult consumers who are outpatients receive MHRS and other services necessary for living in the community through the service teams of the core service agencies (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.

A faculty member in The Catholic University School of Social received a small one-year grant on hoarding issues. A task force was convened of community agencies and along with the D.C. Adult Protective Services (APS), a community forum was held in July 2008 to brainstorm. The Director of the D.C. Office on Aging and the former DMH Director of Adult Services participated in the forum on excessive hoarding in older adults. Their role was to provide comments and feedback for the recommendations that were developed by the service development group and the policy development group. A report on the task force findings is pending.

On June 5, 2009, the Compulsive Hoarding: Legal, Ethical, and Psychosocial Interventions one-day conference was held at The Catholic University of America, Columbus School of Law. This was the third annual conference sponsored by the D.C. Office on Aging, Elder Abuse Prevention Committee in partnership with the Columbus School of Law. Eighty eight (88) social workers, case managers, home care workers, lawyers, judges, and representatives from Councilmember Tommy Wells' office attended. The Committee plans to provide additional programs during FY 2010, and may be able to provide additional information or training on this subject.

The DMH initiated a planning process in April 2009 with District nursing homes to develop the system capacity to accept and care for consumers who are currently receiving inpatient services from Saint Elizabeths Hospital, but who could live in the community at the nursing home level of care. Several areas of policy and service development and support are being identified in this process that should result in real solutions to increase availability of nursing home beds for this population.

In mid-July 2009, approximately 4,164 adult consumers age 50 and over had received at least one service through the DMH MHRS program. While a significant number of older adults are served by the provider network, there is no comprehensive service strategy for this population. In order to obtain information and gain a national perspective, the DMH Director of the Adult Services Division (ASD) participates on the National Association of State Mental Health Program Directors (NASMHPD) Older Persons Division. The Director of ASD also serves on the Strategic Work Plan Committee for Older Adults. The goal is to inform NASMHPD Commissioners of the growing and urgent need to address the mental health needs of older Americans.

In order to develop integrated services for older adults, the adult services programs will collaborate with internal and external partners. These will include: DMH programs, the

D.C. Office on Aging and other District agencies , and public and private community-based organizations including the DMH provider network.

# District of Columbia

## Adult - Resources for Providers

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



## ADULT RESOURCES FOR PROVIDERS

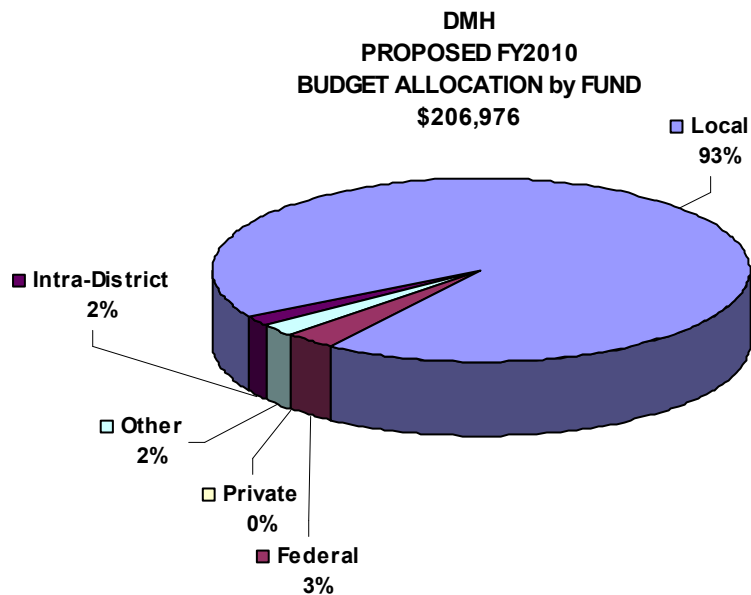
### Financial Structure

#### [Criterion 5: Management Systems]

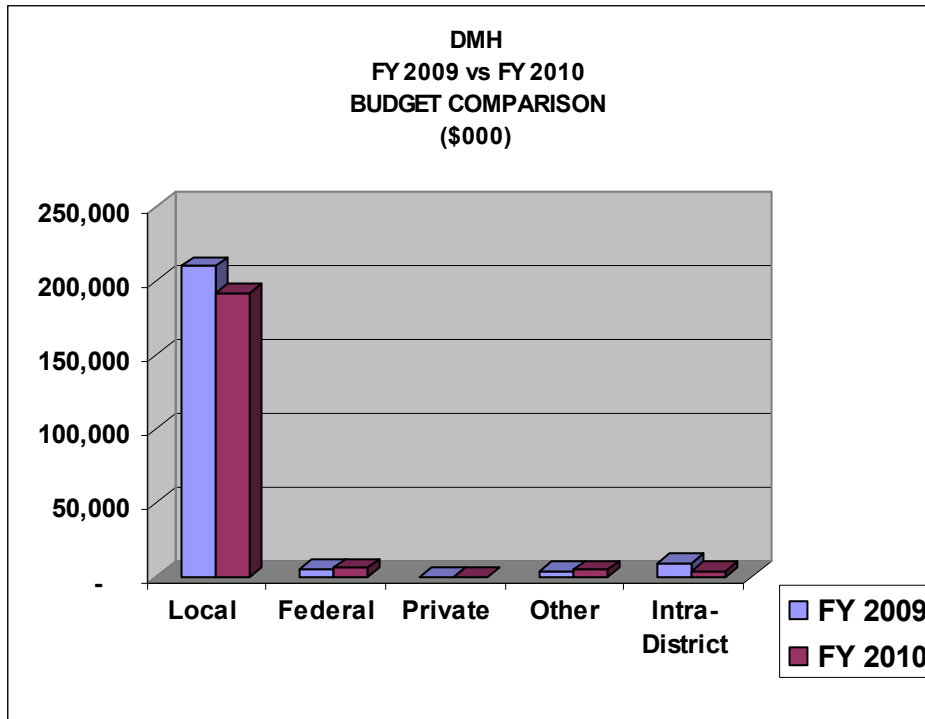
The approved DMH FY 2010 Budget is \$206,975,759. The breakdown of the FY 2010 Budget by program budget category is as follows:

Agency Management	\$19,836,982	9.6%
Financial Operations	1,626,547	0.8%
Mental Health Authority	69,225,560	33.4%
Community Services Agency	3,415,031	1.6%
St. Elizabeths Hospital	94,852,484	45.8%
Community Care Providers	18,019,155	8.7%
	<b>\$206,975,759</b>	<b>100%</b>

Revenue to support the budget comes from four major revenue sources. **Local** funds are the largest funding source and accounts for \$191,790,452 or 92.7% of the FY 2010 Budget.



**Federal** is the second greatest funding source of the FY 2010 budget at \$6,434,819 or 3.1% of the total. **Special Revenue (Other)** funds total \$4,424,120 or 2.1% of the FY 2010 Budget. Finally, the **Intra District** Funds total \$4,209,125 or 2% of the FY 2010 Budget.



**Information Services**

During FY 2006 and FY 2007, the DMH Information Services office continued with the legacy hospital patient accounts system that would eventually be replaced by the end of FY 2008 into FY 2009 by the purchase of a new state-of-the-art Hospital Information System. The new system, AVATAR, will help with consolidation of many dissimilar systems in preparation for the new Saint Elizabeths Hospital facility projected for occupancy in or about March 2010.

The establishment of the WAN and the deployment of personal computers configured with state-of-the-art software set the stage for the implementation of the Contract Management System 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 of the servers, printers or shared resources within that topology.

This includes the Contract Management Information System (CMS), Anasazi, a Client Data System for the D.C. Community Services Agencies, and many small-specialized databases that can be accessed on the network or across the Internet. This provides the capability to record data on any of the measures defined and specified to be included in the system. The new DMH 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.

The current state mental health system is designed to support the 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 authority role, the DMH CMS tracks and pays providers based upon services rendered and coordinates Medicaid reimbursement through the Department of Health Care Finance (DHCF) formerly the Medical Assistance Administration (MAA).

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 DHCF data in a weekly update tape of matching data, to facilitate enrollment and serves 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 seek reimbursement from the DHCF. 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, DHCF 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, the DMH Information Services office implemented activities for the new Hospital Information System (AVATAR). Phase 1 of this implementation, allows the hospital to have a fully integrated system governing traditional administrative functions (admissions, census, etc) as well as a new laboratory and pharmacy management application. Phase 2 brings 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 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.

During FY 2008, DMH Information Services began implementing Phase I of the AVATAR Hospital system. This phase activated the Admission, Treatment Mall, Census, Discharge, Pharmacy and Lab modules. In FY 2009, DMH Information Services plans include the completion of Phase II of the AVATAR Hospital system by June 30, 2009. This phase will initialize the clinical and Billing modules of AVATAR.

Additionally, in FY 2008, DMH Information Services implemented the Accounts Receivable (AR) Module in the CMS application. This functionality allows CMS to automatically post and reconcile payments and report AR information. The DMH Information Services also implemented a major change in provider payment for services rendered to DMH eligible consumers. Effective November 1, 2007 DMH implemented a transition that allows DHCF to pay providers directly for Medicaid services. The DMH continues to authorize services and ensure that claims from providers are adjudicated against authorized services, but now sends the approved Medicaid eligible claims to DHCF for payment to providers. This change minimizes the pay-and-chase practice in the previous DMH payment model and standardizes the payment process for Medicaid services. The method for processing claims for Medicaid non-reimbursable services, paying providers using locally appropriated funds, is unchanged.

In July FY 2008, DMH implemented the Dashboard Technology project. This project allows DMH Authority managers to create key metrics for their specific area with the ability to access data that is stored electronically. These metrics can be displayed in easily readable formats that allow the aggregation as well as “drill downs” on specific metrics. The DMH has developed performance metrics in six general areas: 1) claims processing, 2) consumer enrollment, 3) service authorization, 4) provider funding, 5) Medicaid reimbursement, and 6) call center statistics. This technology has wide replicability within the DMH Authority and Saint Elizabeths Hospital and the D.C. Community Services Agency.

The DMH leadership recognizes that the Dashboard project is only the start of building an integrated electronic information system. The Senior DMH leadership is committed to building a more adequate Information Technology (IT) system. A preliminary IT structure has been developed that is intended to support the multiple IT needs of the system. This structure would consolidate some of the current IT applications to create efficiencies. Most importantly it would create a new Business Intelligence Unit under the Chief Information Officer (CIO). This unit would take on direct responsibility for Dashboard, SharePoint and MS-Reporting Services. This unit, with a full-time Director reporting to the CIO, would interface with the respective program units to create data

support as well as increasing reporting and analytic capacity. The budgetary constraints in FY 2009 did not allow DMH to implement this new structure.

The DMH Information Services plans included, by the end of FY 2008 and into FY 2009, the installation of the latest version of the CMS software to improve the authorization process and to also reconfigure the CMS application so that consumer DHCF eligibility data can be better managed to stay aligned with the Income Maintenance Administration (IMA) data and to eliminate many manual activities currently employed to coordinate DHCF eligibility in the system.

The 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.

### **Human Resources Development Efforts**

The total number of DMH staff at the end of FY 2008 was 1,696. The total in each of the Department's three (3) organizational components include the following:

The Mental Health Authority	332
The D. C. Community Services Agency	305
Saint Elizabeths Hospital	1,059

The total number of DMH staff during the third quarter of FY 2009 was 1,613. The total staff in each of the Department's three (3) organizational components includes the following:

The Mental Health Authority	346
The D. C. Community Services Agency	249
Saint Elizabeths Hospital	1,018

The total number of DMH staff projected for the end of FY 2009 is 1,627. The total staff in each of the Department's three (3) organizational components includes the following:

The Mental Health Authority	238.5
The D. C. Community Services Agency	300.8
Saint Elizabeth's Hospital	993

There are additional 77 (Agency Management), and 18 (Chief Financial Officer) FTEs included in the 1,627.

### **Filling Vacancies in FY 2009**

Critical vacancies/positions filled in the first three quarters of FY 2009 (October 1, 2008 through June 30, 2009) include the following:

- Medical Officer (Psych.) (2)
- Supervisory Medical Officer (1)

- Deputy Director Civil Programs (1)
- Director of Business Operations (1)
- Social Worker (8)
- Clinical Psychologist (2)
- Chief Nursing Executive (1)
- Psychiatric Nurse (5)
- Clinical Nurse (3)
- Mental Health Specialist (2)
- Mental Health Counselor/Peer Counselor (10)
- Creative Arts Therapist (Dance) (1)
- Forensic Psych. Technician (5)
- Psychiatric Nursing Assistant (8)
- Psychiatric Practical Nurse (4)
- Psychiatric Residency Monitor (1)
- Information Technology Specialist (9)
- Training Instructor (1)

During the fourth quarter of FY 2009, it is expected that additional key/critical positions will be filled. This will include the following positions:

- Social Worker (5)
- Psychiatric Nursing Assistant (6)
- Psychiatric Nurse (5)

#### Human Resources Activities in FY 2009

A number of significant human resource development activities were undertaken during FY 2009. These include:

- Implementation of the new ePerformance System for all DMH employees
- Management of Reduction-in-Force (RIF) for DMH employees
- Management of Early Out and Retirement Incentive Program for DMH
- Conducted Benefits Entitlement/Information Sessions for DC CSA employees
- Coordinated Career Fairs for DC CSA employees
- Conducted RIF counseling sessions for affected employees
- In conjunction with the D.C. Office of Labor Relations, engaged in bargaining with four (4) DMH unions for re-openers of contracts
- Planned and managed an expanded nine (9) week Mayor's Summer Youth Program
- Management of the implementation of the Department's Alternative Work Schedule Program
- Implementation and management of the Mandatory Drug and Alcohol Testing Program for DMH Employees Serving Children and Youth
- Active Participation in the City-Wide Job Fair
- Implementation of the DMH transition to the Employee Self Service PeopleSoft Module for time entry including Electronic Time Reporting System-E-Time
- Completed classification reviews for selected DMH positions.

- Completed work with KPMG as they reviewed and documented HR business processes

#### Planned Activities for the Fourth Quarter of FY 2009

Some of the activities planned by the end of FY 2009 include:

- Complete Reduction-in-Force activity work
- Coordinate Rapid Response/Department of Employment Services (DOES) activities for Riffed employees
- Complete classification and staffing actions for DC CSA transition activities
- Conduct ARPP/DEP regulatory activities
- Continue recruitment for identified key/critical positions
- Continue Random/Periodic Drug and Alcohol Testing
- Manage the first ePerformance evaluation phase for DMH
- Develop ePerformance Resolution/Reconsideration process

#### **DMH Training Institute and Other Training**

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 training series provide a wealth of information on a range of topics. Over the years, partnerships have been established with consumer, family member, community, academic, professional, and federal and local government agencies. An important feature of the DMH Training Institute is the award of continuing education units (CEUs) for several disciplines.

At the end of FY 2008 and during FY 2009, the Training Institute hosted a wide range of training activities for providers, DMH staff, and consumers. These trainings include:

#### **Fall 2008 Training**

- Helping Keep Children Safe: The Identification and Reporting of Child Victimization
- National Incident Management System (NIMS)
- The NTU Approach to Health and Healing
- COSIG: Basic Principles of Integrated Treatment and Best Practices
- Service Authorization for Clinicians and Direct Service Staff
- ACT 101 Core Training: An Overview
- ACT 101 Core Training: An Overview
- Culturally and Linguistically Responsive Practice Training
- DMH 101: Overview of Services and Support offered through the DC DMH
- Ethical Practice in Contemporary Mental Health Practice
- Domestic Violence 101 for Providers
- Meeting the Mental Health Needs of Youth Receiving Residential Treatment
- Domestic Violence 101 Teen Dating Violence for Teens
- Teen Dating Violence Training for Providers
- COSIG Stages of Change

- Community-Based Intervention
- DC CSA National Incident Management System (NIMS) Training
- LOCUS Super user Train-the-Trainer
- CALOCUS Super User Train-the-Trainer
- Lethality and Risk Assessment Training Providers
- Employee Rights & Responsibilities under the District of Columbia Human Rights Act of 1977
- Writing Court Reports and Court Ordered Assessments. 5 Ways to Avoid Having to Go to Court
- COSIG Basic Principles of Integrated Treatment
- COSIG Stages of Change
- System of Care Basic Training
- Community Residential Facility (CRF) Training

The LOCUS/CALOCUS is related to the Dixon Exit criterion on Consumer Functioning Method(s). The implementation of the web-based LOCUS/CALOCUS application is on track. The DMH completed its train-the-trainer phase in November 2008 and went live with its new web-based application on February 1, 2009. The next major task is to ensure that clinical staff in all of the provider agencies have completed the 4-hour training that is required, so that each agency has qualified trainers on staff. The goal to complete this task is August 31, 2009.

### **Spring 2009 Training**

- Compliance Community of Practice
- Self-Advocacy 101
- Accessing Mental Health Services (Modified DMH 101)
- ADA Title II Training
- Community Service Review New Reviewer Training
- Community Service Review Refresher Training
- Co-Occurring Disorders: Basic Principles and Clinical Competencies of Integrated Treatment
- Using the Ohio Scales to Inform Case Conceptualization and Ongoing Treatment Planning
- Co-Occurring Treatment and Stages of Change
- Introduction to Motivational Interviewing
- CALOCUS Super User Train-the-Trainer
- LOCUS Super User Train-the-Trainer
- History of the Consumer Movement, Peer Recovery Concepts and Peer Specialist Concepts
- Money Wi\$e Train the Trainer
- System of Care Basic Training

Upcoming projects for the DMH Training Institute include the development of a Clinical Supervision Initiative, and Trauma-Informed Systems Initiative. The Training Institute will also provide support for a multi-faceted Disaster Mental Health Initiative involving the development and implementation of a comprehensive training curricula. The DMH



Training Institute will also develop a data management and utility workshop series for providers, program leadership, and internal research staff.

## **Criterion 5: Goals, Targets and Action Plans**

### **Goal 1: Increase Resources Directed Toward Community Services**

#### **Targets:**

1. Increase the percentage of total resources directed toward community-based services to 60% (consistent with the Dixon Exit Criteria).
2. Increase the percentage of federal reimbursement of mental health rehabilitation services (MHRS) to 49% or above (consistent with the Dixon Exit Criteria).

#### **Action Plans:**

The MHRS program is the cornerstone of the reformed mental health system. The DMH will continue to implement this program as it develops the community-based system of care. During this process, DMH will: 1) continue to review provider services to ensure that these services are consistent with system strategic planning including priority population needs, and 2) certify MHRS providers accordingly. Re-investment strategies will be developed to continue to fund community service options. The DMH will also continue to forge meaningful partnerships and engage in resource generation through grants and other mechanisms, as well as resource sharing.

The activities to maximize Medicaid funding to support community-based services are ongoing. These include: conducting audits to ensure clean claims, initiating quarterly provider reconciliation meetings, increasing the number of consumers who are Medicaid eligible, and expanding the community provider network as needed.

During FY 2008, DMH completed the migration to the Department of Health Care Finance (DHCF), formerly the Medical Assistance Administration (MAA), for provider direct Medicaid reimbursement. The DMH no longer bills DHCF on behalf of the providers. In FY 2009, a claims accountability staff was assigned daily monitoring of batches sent by the providers.

**DISTRICT OF COLUMBIA  
FY 2010 STATE PLANNING AND MONITORING  
MENTAL HEALTH PERFORMANCE INDICATORS**

**Name:** Increase Resources Directed Toward Community Services

**Goal:** Increase resources for community-based Mental Health Rehabilitation Services (MHRS)

**Population:** Recipients of community-based mental health services

**Criterion 5:** Management Systems

**Target:** Increase mental health expenditures for community services to 60% of total expenditures

**Performance Indicator Value:**

Numerator: Mental health expenditures for community services in FY 2010

Denominator: Total mental health expenditures in FY 2010

**Source of Information:** Financial Management Information System

**Significance:** This measure is a Dixon Exit Criteria for vacating the Dixon Court Order.

**Special Issues:** The DMH contracted with KPMG to do a detailed analysis of all expenditures for FY 2006. These expenditures were reviewed and allocated for 107 different index codes (cost centers). Based on this analysis, 60.45% of total expenditures were for community-based services and activities. Given that this exceeds the Court-imposed compliance level of 60%, the Court Monitor has recommended that this Exit Criteria move to inactive status. DMH applied this methodology to the FY 2007 data. FY 2007, FY 2008 and FY 2009 data show a rate of 59%. This criterion will need to continue to be measured for future reporting periods and remains at 60%..

<b>Name of Performance Indicator:</b> Increase Resources Directed Toward Community Services				
<b>Population:</b> Recipients of community-based mental health services			<b>Criterion 5:</b> Management Systems	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2007 Actual</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Projected</b>	<b>FY 2010 Target</b>
<b>Performance Indicator (Value)</b>	59%	59%	59%	60%
<b>Numerator</b>	\$144,494,336.96	\$134,593,329	\$134,806,565	---
<b>Denominator</b>	\$244,341,952.92	\$229,078,601	\$228,485,704	---

**Note:** FY 2009 data is reported in August 2009.

**DISTRICT OF COLUMBIA  
FY 2010 STATE PLANNING AND MONITORING  
MENTAL HEALTH PERFORMANCE INDICATORS**

**Name:** Increase Resources Directed Toward Community Services

**Goal:** Increase federal reimbursement for Mental Health Rehabilitation Services (MHRS) billings

**Population:** Recipients of community-based mental health services

**Criterion 5:** Management Systems

**Target:** Increase federal reimbursement for MHRS billings at or above 49%.

**Performance Indicator Value:**

Numerator: Medicaid reimbursement for MHRS billings in FY 2010

Denominator: Number of MHRS billings in FY 2010

**Source of Information:** Financial Management Information System

**Significance:** This measure is a Dixon Exit Criteria for vacating the Dixon Court Order.

**Special Issues:** The Court Monitor recommended that this Exit Criteria move to inactive status in FY 2008. This criterion continues to be measured for future reporting periods.

<b>Name of Performance Indicator:</b> Increase Resources Directed Toward Community Services				
<b>Population:</b> Recipients of community-based mental health services			<b>Criterion 5:</b> Management Systems	
(1)	(2)	(3)	(4)	(5)
<b>Fiscal Year</b>	<b>FY 2007 Actual</b>	<b>FY 2008 Actual</b>	<b>FY 2009 Projected</b>	<b>FY 2010 Target</b>
<b>Performance Indicator (Value)</b>	47%	50.63%	49.3%	49%
<b>Numerator</b>	\$16,919,968	\$28,437,143	\$20,295,597	---
<b>Denominator</b>	\$35,827,490	\$56,168,040	\$41,188,027	---

**Note:** FY 2008 numerator is not final, pending outstanding revenue. FY 2009 data is reported in August 2009.

# District of Columbia

## Adult - Emergency Service Provider Training

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

## ADULT EMERGENCY SERVICE PROVIDER TRAINING

Crisis Intervention Collaborative: The DMH Training Institute has had many recent successes, including implementation of the Crisis Intervention Collaborative. This initiative has been spearheaded by DMH, the District of Columbia Metropolitan Police Department (MPDC), and the National Alliance on Mental Illness (NAMI) to improve the outcomes of police interactions with people with mental illnesses. Some of the desired outcomes include increased citizen and officer safety and more appropriate involvement in community-based services for individuals who come to the attention of law enforcement but do not meet the threshold for arrest. This Collaborative has been developed to address the diverse professional development needs of officers at various levels of their law enforcement careers.

1. Recruit Training: This 16-hour basic training is specific for police cadets and introduces new law enforcement officers to key mental health concepts and skill development in appropriate interaction with individuals who are mentally ill.
2. In-service Training: This mandatory training will offer both web-based and face-to-face mental health training, and will be developed and implemented in 2009 for field officers.
3. Crisis Intervention Officer (CIO) Initiative: The CIO Initiative is the newest most extensive activity within the Collaborative, and its framework is based on a survey of crisis intervention response initiatives from law enforcement jurisdictions across the country. While the CIO Initiative has been inspired by other state and county models, including the Memphis Police Department, the CIO Initiative is a dynamic and evolving effort that is customized to meet the changing needs of the citizens of the District of Columbia. The CIO Initiative includes several key components, all of which are essential to its success. These components include:
  - a 40 hour training program for law enforcement officers will be implemented on a quarterly basis. This includes basic information about mental illnesses and how to recognize them; information about the local mental health system and local laws; learning first-hand from consumers and family members about their experiences; and verbal de-escalation training and role-plays.
  - Community collaboration between mental health providers, law enforcement, and family and consumer advocates is critical. The CIO training also addresses strategies to transfer people with mental illness from police custody to the mental health system, and ensure that there are adequate facilities for mental health triage. To this end, the Collaborative has enlisted the support and participation of other District government and community-based organizations to serve as trainers and advisors for the CIO throughout the initiative.
  - Consumer and family involvement are an integral part of the planning and training sessions. The D.C. Chapter of the National Alliance on Mental Illness (D.C. NAMI)

serves as the primary coordinating agency for all of the MPDC/DMH Crisis Intervention Collaborative activities. NAMI's core functions include organizing and maintaining a consumer and family trainer pool for all initiatives; coordinating and implementing consumer and family training modules; and Chairing a Consumer and Family Advisory Committee which includes representation from other key consumer groups within the community.

DMH Disaster Mental Health Program: The DMH continues its planning process to increase the ability to respond to catastrophic emergencies by increasing the number of Emergency Response Teams (ERTs) and provide disaster mental health training to team members and to the provider network staff. The Department is in the process of developing a disaster training plan that will include a curricula of basic disaster counseling, National Incident Management System/Incident Command Structure (NIMS/ICS) and a cadre of trainers. This training plan is expected to be completed by the end FY 2009 with full implementation over the next two years (2010-2011). In the meantime, DMH is collaborating with the Department of Health/Health Emergency Preparedness Response Agency (DOH/HEPRA) to schedule a series of grief trainings in FY 2010.

Suicide Prevention Training: The DMH School-based Youth Suicide Prevention Grant program coordinated and hosted the Strategic Planning for Suicide Prevention Training for the D.C. Suicide Prevention Council on March 25, 2009. The majority of the trainees were officers with the District of Columbia Metropolitan Police Department.

# 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



## ADULT GRANT EXPENDITURE MANNER

### 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 2010 Block Grant. A total of 16 projects were submitted in response to the Request for Projects: two (2) were submitted by consumer organizations, one (1) by an adult family member organization, one (1) by a DMH provider agency, one (1) by a housing finance organization, one (1) by a health literacy organization, one (1) by a community-based feeding program, one (1) by an outreach program for veterans, one (1) by an organization serving forensic populations, four (4) from DMH adult programs, one (1) by a child family program, one (1) by a youth program, and one (1) from the DMH Child and Youth Services Division. The Council recommended funding 10 projects and the D.C. State Mental Health Planning Council. The DMH Director reviewed the recommendations with the Council at the August 19, 2009 meeting and approved them without revision.

The FY 2010 Block Grant award is based on the FY 2009 federal allocation. The breakdown is as follows:

<b>FY 2010 Award:</b>	<b>\$766,324.00</b>
<b>Administrative Fee (5%):</b>	<b>\$38,316.20</b>
<b>Funds for Projects:</b>	<b>\$728,007.80</b>

All of the proposed FY 2010 Block Grant funded projects are presented in the table that follows. The Adult Plan projects are listed first and the Child Plan projects are identified as Child/Youth. The D.C. State Mental Health Planning Council is identified as Adult and Child/Youth.

Type of Project	Organization	Project Name	Purpose	Amount
Adult and Child	DC State Mental Health Planning Council	No proposal required from this Federally Mandated Citizen Advisory Body	To implement activities related to the District's Block Grant including Annual Mental Health Conference	<b>\$25,000.00</b>
Adult	Consumer Leadership Forum	Teaching Consumer Survival Skills	Help consumers become self-sufficient and self-reliant.	<b>\$14,822.60</b>
Adult	Cornerstone	Cornerstone's Summer Air Conditioning Project	Ensure consumers have air conditioners as a basic right of housing tenancy.	<b>\$10,000.00</b>
Adult	Miriam's Kitchen	Passport to Health	Provide clients with the knowledge, skills and support systems	<b>\$20,000.00</b>

Type of Project	Organization	Project Name	Purpose	Amount
			necessary to achieve stable mental and physical health.	
Adult	Positive Kinship Bonding	Veterans Family Reunification Project	Design an outreach program for veterans based on the Positive Kinship Bonding Model.	<b>\$5,000.00</b>
Adult	The Spoken Word	Lens and Pens Creative Expression Project 2009-2010	Use of artistic disciplines poetry, painting, photography in the recovery process and foster community reintegration.	<b>\$7,462.60</b>
Adult	FamilyLinks Outreach Center, Inc.	FamilyLinks Outreach Center	Provide a weekend socialization program including workshops, social, recreational activities, and meal.	<b>\$18,260.00</b>
Adult	Department of Mental Health	Housing Division	Provide housing services for transition age youth, persons leaving jail, and those who require intensive services in order to live in housing.	<b>\$380,000.00</b>
Child	Total Family Care Coalition	GuidePost	Advocacy and outreach support services for families and youth.	<b>\$7,462.60</b>
Child	Time Dollar Youth Court Inc.	Youth Court FOCUS Program	Services for youth who have experienced trauma	<b>\$20,000.40</b>
Child	Department of Mental Health	Early Childhood Mental Health Consultation	Development and Implementation of an Early Childhood Program	<b>\$220,000.00</b>

**Table C. MHBG Funding for Transformation Activities  
State: District of Columbia**

	<b>Column 1</b>	<b>Column 2</b>	
	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the <i>actual</i> <b>or</b> <i>estimated</i> amount of MHBG funding that will be used to support this transformation goal in FY2010	
		<b>Actual</b>	<b>Estimated</b>
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	<input checked="" type="checkbox"/>	20,000	
GOAL 2: Mental Health Care is Consumer and Family Driven	<input checked="" type="checkbox"/>	463,007.80	
GOAL 3: Disparities in Mental Health Services are Eliminated	<input type="checkbox"/>		
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	<input checked="" type="checkbox"/>	220,000	
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	<input type="checkbox"/>		
GOAL 6: Technology Is Used to Access Mental Health Care and Information	<input type="checkbox"/>		
<b>Total MHBG Funds</b>	N/A	703,007.80	0

\*Goal 5 of the Final Report of the President's New Freedom Commission on Mental Health states: Excellent Mental Health Care is Delivered and Research is Accelerated. However, Section XX of the MHBG statute provides that research ... Therefore, States are asked to report expected MHBG expenditures related to program evaluation, rather than research.

# District of Columbia

## Table C - Description of Transformation Activities

For each mental health transformation goal provided in Table C, briefly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State's transformation activities are described elsewhere in this application, you may simply refer to that section(s).

## TABLE C- DESCRIPTION OF TRANSFORMATION ACTIVITIES

### Goal 1: Americans Understand that Mental Health is Essential to Overall Health

FY 2010 Block Grant funds will be used to support Miriam's Kitchen Passport to Health Project (\$20,000.00). This project is a health promotion campaign specifically for clients who are homeless. Upon entering the program, clients will be given a "passport" with a listing of the Passport to Health activities available to them, which include but are not limited to assistance: enrolling in a Core Service Agency (CSA); signing up for the D.C. Alliance or Medicaid benefits; helping to find a psychiatrist, therapist and/or medical doctor; establishing a medical home base by scheduling and attending an initial appointment; obtaining HIV testing and counseling; obtaining mammograms or prostate screenings; life skills classes (e.g., medication management, support systems, navigating the mental health system, nutrition, diabetes, sexual health and proper hygiene); and safety education for street-bound homeless clients.

The FY 2010 Block Grant Application also describes non-Block Grant funded mental health and primary health initiatives that include:

- D.C. Chronic Care (CCI) Initiative in Mental Health: This is a partnership of the George Washington University Medical Faculty Associates and Department of Health Policy, Department of Mental Health, Anchor Mental Health, Green Door, Community Connections, Washington Hospital Center, the Medstar Diabetes Program at the Washington Hospital Center, and Howard University Hospital. The primary goal is to improve the health status of adults with serious mental illness in the District who have chronic disease or who are at high risk for developing chronic illness due to modifiable risk factors. Initially, the project will integrate two (2) nurse medical care managers into the behavioral health care teams of two (2) public community mental health centers (Green Door and Community Connections); and a simple disease registry will be created that includes health and behavioral health information that will facilitate coordination and rapid exchange of health and mental health information on CCI in mental health consumer/members. Health risks, health status, medications and medical treatments will be routinely assessed.
- Integration of Mental Health Services into Primary Care Settings: The DMH has been working closely with Georgetown University Department of Psychiatry and the District of Columbia Primary Care Association (DCPCA) on the different strategies to link primary and behavioral health care. The specific objective of this planning initiative is to develop a sustainable, District-wide partnership between DMH and the District's safety-net primary care clinics to provide needed mental health services to low-income residents and to help mental health providers link up with primary health care settings. The steps to meet this objective include the following: 1) develop the necessary rules for the free-standing clinics to ensure that they are easily implemented by primary health settings; 2) develop strategies for the community mental health centers to have the appropriate protocols for screening medical needs and ensuring individuals receive needed medical attention;

3) identify the training and other capacity building efforts that need to be incorporated; and 4) develop any needed billing and coding procedures. The intent is to have an implementation plan in FY 2010.

## Goal 2: Mental Health Care is Consumer and Family Driven

Several of the FY 2010 Mental Health Block Grant funded projects are related to consumer and family driven initiatives. These include:

- Consumer Leadership Forum's Teaching Consumer Survival Skills Project (\$14,822.60)- hands on experience related to: living independently, traveling around the city, learning how to shop, basic household skills, and taking care of personal needs;
- Cornerstone's Summer Air Conditioning Project (\$10,000.00)- supplies air conditioning units to District residents with mental illness, as consumers taking medications for various illnesses are particularly vulnerable to excessive heat;
- Positive Kinship Bonding's Veterans Family Unification Project (\$5,000.00)- veterans residing at the Southeast Veterans Service Center/Chesapeake Veteran House who desire to reunite with their children, spouse or other family members: will work with mental health professional and case manager to gain family members' interest and support to join the project, develop consumer driven leisure time activities to implement with their family members, and utilize the therapy milieu of leisure time activities and informal group discussion to improve basic communication and listening skills.
- The Spoken Word's Lens and Pens Project Creative Expression Project(\$7,462.60)- increases forensic consumers with serious mental illness (SMI) interests and skills in writing and literacy, photography and visual arts, publishes an issue of *Reflection* (the consumer newsletter), and mounts and displays consumers' artwork, to foster community re-integration.
- FamilyLinks Outreach Center, Inc. Project (\$18,260.00)- provides a weekend socialization program including workshops, discussion of current events, social and recreational activities, and meal for consumers with SMI, most of who reside in community residential facilities.
- The DMH Housing Division's Project (\$380,000.00)- provides housing services for transition age youth, persons leaving jail, and those who require intensive services in order to live in housing.
- Total Family Care Coalition's GuidePost Project (\$7,462.60)- provides advocacy and outreach support services for families, children and youth in apartment complexes in Ward 6 and Ward 7.

- Time Dollar Youth Court, Inc.'s Youth Court FOCUS Project (\$20,000.00)- addresses the violence that youth have experienced by including opportunities for Life Skills instruction, recreational activities, professional facilitation and referrals to outreach services (when and if necessary), self-awareness and advocacy, personal development, and manhood.
- The Department of Mental Child and Youth Services Division's Early Childhood Mental Health Consultation Project (\$220,000.00)- targets children age birth to 5 served by child development centers by: supporting and empowering others to "become therapeutic" and deliver care and interventions in the context of the child's and caregiver's everyday activities; and providing child-centered, family-centered, and staff-centered consultation.

Aspects of the Project Related to GOAL 3 (Disparities in Mental Health Services are Eliminated):

The intensive training provided by the University of Maryland will include a module which will include cultural competency. In addition, the project will draw upon training modules developed by the Center on Social and Emotional Foundations for Early Learning (CSEFEL). The content of the modules are consistent with evidence-based practices identified through a thorough review of the literature and include the National Association of the Education of Young Children (NAEYC) cultural competency practice standards. The Early Childhood Mental Health Consultation (ECMHC) Project will also draw upon evidence-based programs such as the Incredible Years and its off-shoot the Chicago Parenting Program to ensure that cultural issues are included in all facets.

Aspects of the Project Related to GOAL 5 (Excellent Mental Health Care Is Delivered and Programs are Evaluated):

In partnership with Georgetown University and Development Services Group, Inc., (outside evaluators from the District's Interagency Collaboration and Services Integration Commission for child services) the following project outcomes have been preliminarily selected:

**Child<sup>±</sup>**

- Reduction in the number of children expelled from their child care programs
- Increase in the number of children screened for early identification of social-emotional issues
- Improved emotional competence
- Increased social interaction
- Reductions in children's problem behaviors (intermediate)
- Increases in their social skills as intermediate outcomes (intermediate)\*

**Parent**

- Parents indicate satisfaction with the ECMHC program

**Staff**

- Staff indicates satisfaction with the ECMHC program<sup>±</sup>
- Increased knowledge
- Increased teacher sensitivity
- Decreased teacher harshness, detachment, permissiveness
- Improved staff interactions with children
- Staff turnover decreases
- Improvement in teachers' behaviors, classroom management strategies and routines
- Staff more competent in accessing mental health resources-for Child initiated consultation only

\* This would only be applicable to children who receive the Devereux Early Childhood Assessment (DECA)

<sup>±</sup> Would only be applicable to parents of children child-initiated evaluation

A Pre-School/Infant Mental Health Climate survey will be used pre/post and the DECA will be used for all child initiated services in order to determine changes in child outcomes for those children who have received direct services by the consultant with parental consent. Childcare Administrator Surveys will also be distributed in the fall and again in the spring to measure satisfaction with the consultation. A waitlist control group is being considered in which a second group of centers who would not receive consultation but could be included in a second year would complete the surveys as a comparison to those centers who received the actual consultation services.



**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	10,123	11,854	11,803	14,000	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

- Goal:** To improve access to care.
- Target:** Target is consistent with the penetration rate target for adults established by Dixon Exit criterion #7 - 3% of the estimated adult population for the District of Columbia.
- Population:** Estimated adult (18 and over) population for the District of Columbia.
- Criterion:** 2:Mental Health System Data Epidemiology  
3:Children's Services
- Indicator:** Number of adults receiving at least one mental health service during the reporting period.
- Measure:** Number of adults receiving at least one mental health service during the reporting period.
- Sources of Information:** Contract management system.
- Special Issues:** DMH has resolved issues with the Medicaid MCO's regarding coordination of and reporting of mental health services provided to adults enrolled in the Medicaid MCOs. The FY 09 data is as of 8/13/09. The FY 2010 target is 1,400.
- Significance:** Required to exit from court oversight.
- Action Plan:** Continue MOU with DHCF regarding MCOs to improve data collection and integrity. This will improve overall performance and facilitate exit from court oversight.

**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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	8.84	10.04	12.60	10	N/A
Numerator	85	49	--	--	--
Denominator	962	488	--	--	--

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:** DMH is building a new state-of-the art 293-bed hospital and needs to reduce beds accordingly. The completion date for construction is early 2010. An overflow plan has been developed.
- Significance:** Achievement of this performance measure will facilitate the reduction in the size of the public hospital, from 400 beds to 293. The average end of month census for October 2008 - May 2009 is 395. The plan is to reduce the census to 340 by October 1, 2009. The new hospital building is scheduled to open in 2010. 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 and Core Service 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, 5) continue the Integrated Care Project to address the needs of some of the most clinically challenging inpatients to support them in the community and 6) continue to try to reach the Dixon Performance Target that 80% of adults discharged from inpatient care must be seen within seven (7)days. The DMH will continue to refine the data base, validate the data, and in FY 2010 assess performance with respect to the FY 2009 baseline reporting.

**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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	20.27	23.36	23	N/A	N/A
Numerator	195	114	--	--	--
Denominator	962	488	--	--	--

Table Descriptors:

- Goal:** Improve Continuity of Care
- Target:** FY 2010 target will be set after the FY 2009 data is developed.
- 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:** DMH is building a new state-of-the-art 293 bed hospital and needs to reduce beds accordingly. The completion date for the new hospital is early 2010. An overflow plan has been developed. FY 2009 data is not available at this time, and FY 2010 target will be set based on this data.
- Significance:** Achievement of this performance measure will facilitate the reduction in the size of the public hospital, from 400 beds to 293. The current monthly census is 395. The plan is to reduce census to 340 by October 1, 2009. The new hospital building is scheduled to open in 2010. 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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	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:** Data on evidence-based practices is reported in state indicator tables. This data is based on the Dixon Performance Targets for evidence-based and promising practices.

Targets:

1. Continue to review the ACT teams in FY 2009.
2. Increase the number of persons receiving evidence-based practices in FY 2009:
  - 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) evaluate 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 - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	11.57	14.42	12.70	70	N/A
Numerator	28	15	--	--	--
Denominator	242	104	--	--	--

Table Descriptors:

- Goal:** Improve access to Evidence-Based Practices.
- Target:** Target is consent with Dixon Exit criterion #9- that 70% of people with SMI receive supported housing 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 supported housing within 45 days of referral.
- Measure:** Number of person referred for supported housing.
- Sources of Information:** DMH Housing Division database and other sources.
- Special Issues:** During FY 2009 DMH and the Court Monitor began to discuss that housing services was too narrowly defined (solely as housing) and that housing placement within 45 days was not a reasonable expectation. There are also budgetary constraints. The data highlight these issues. FY 2007 and FY 2008 data show that 12% and 14% (respectively) were housed in 45 days. FY 2009 data for three quarters shows 12.7%. The target remains at 70% until a revised approved approach is adopted.
- 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:** During FY 2010, DMH will continue to provide housing and support services to consumers most in need. DMH will also continue working with the Court Monitor on revising the data collection and reporting metric for this measure that might include broadening the spectrum of housing services and supports that can be measured, so that it truly reflects supportive housing best practice.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	89.91	95.06	88.37	70	N/A
Numerator	98	77	--	--	--
Denominator	109	81	--	--	--

Table Descriptors:

**Goal:** Improve access to evidence-based practices.

**Target:** Target is consistent with Dixon Exit criterion #10- that 70% of adults with SMI receive 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 supported employment within 120 days of referral.

**Measure:** Number of persons referred to supported employment

**Sources of Information:** Contract management system.

**Special Issues:** In FY 2007, the Supported Employment algorithm was used unlike previous years. It includes quarterly and annual referrals. During FY 2007, FY 2008 and three quarters of FY 2009 data exceed the Dixon Performance Target (89%, 95%, 88%, respectively). However, the Court Monitor wants to ensure that consumers who want this service are able to access it. A Supported Employment Promotion, Outreach and Training Plan was implemented in FY 2008 and continued in FY 2009. The FY 2010 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 2010, DMH will continue to focus on building service capacity. The DMH will continue to implement its Supported Employment Promotion, Outreach and Training 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 2010, 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**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	51.52	65.81	70	85	N/A
Numerator	34	77	--	--	--
Denominator	66	117	--	--	--

Table Descriptors:

**Goal:** Improve access to evidence-based practices.

**Target:** Target is consistent with Dixon Exit Criterion #11 - that 85% of adults with SMI receive 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 ACT services within 45 days of referral.

**Measure:** Number of persons referred to ACT services.

**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. Due to problems with matching service authorizations with service delivery dates, the reporting of baseline data did not begin until FY 2007 for the period April 2006 through March 2007. The FY 2008 and FY 2009 data show increases of 65% and 70%, respectively. The FY 2009 data is as of 8/13/09. The FY 2010 target remains at 85%.

**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 2010, 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 fidelity audits will continue and technical assistance and training provided as necessary. The DMH will also try to continue to reach the Dixon Exit Criteria measure to provide ACT services to 85% of the persons referred within 45 days of referral. The overall plan is to increase ACT capacity to 950 by the end of FY 2011.



**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	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:** Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	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:** Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	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:** Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	80	73.86	70	80	N/A
Numerator	44	65	--	--	--
Denominator	55	88	--	--	--

Table Descriptors:

**Goal:** Improve client perception of care.

**Target:** Target is consistent with Dixon Exit criterion #3- to maintain the rating of 80% for system performance measures in the annual Adult Community Service Review (CSR).

**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:** Total number of clients receiving overall practice performance ratings of 4, 5, and 6 (considered to have “acceptable system performance”) on District of Columbia CSRs.

**Measure:** Total number of cases surveyed during the CSR process for each year.

**Sources of Information:** Annual community service reviews, conducted by the Dixon Court Monitor through its contractor, Health Systems and Outcomes(HSO).

**Special Issues:** This is one of the Dixon exit criteria. The performance target of 80% system performance was established performance in the Dixon consent order. The target for existing active monitoring is 80% and will remain at 80% for FY 2010. The system performance level for FY 2007 was 80%. While the performance target was met, issues related to sample size and inter-rater reliability were addressed beginning in FY 2008. The FY 2008 score was 74% and the FY 2009 score 70%. The FY 2010 target remains at 80%.

**Significance:** Achievement of 80% systems performance is required to exit from federal court oversight.

**Action Plan:** In FY 2009, DMH established a Community Services Review Unit within the Organizational Development Division in the Office Programs and Policy. This unit will assist DMH staff and the provider network address some of the longstanding issues related to team formation and team functioning and eventually assume responsibility for the CSR process on an ongoing basis. The HSO report on the 2009 CSR pointed to many of the themes that have been identified in previous years such as the lack of adequate communication between and among caregivers. It was recommended that DMH and the provider leadership make client-centered planning and teaming the top priority for refinement.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	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 2009 Progress Report (DIG URS Tables), which is due on December 1, 2009. 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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	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 2009 Progress Report (DIG URS Tables), which is due on December 1, 2009. 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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	88.84	78.83	85	85	N/A
Numerator	892	633	--	--	--
Denominator	1,004	803	--	--	--

Table Descriptors:

- Goal:** To improve consumer outcomes related to social supports/social connectedness.
- Target:** Increase to 85% consumers participating in the MHSIP reporting positively about social connectedness.
- 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 adult consumers surveyed in the MHSIP report positively on social connectedness questions.
- Measure:** Number of adult consumers responding to MHSIP survey.
- Sources of Information:** MHSIP
- Special Issues:** A long-standing issue with the administration of the MHSIP Survey has been low consumer participation due to a number of factors: 1) difficulty in obtaining accurate consumer contact information from the eCura claims data system, 2) the telephone survey process, which is contingent on consumers having a telephone and the system having current telephone information, 3) little or no coordination on the timing of surveys administered by DMH and the provider network, and 4) little or no buy-in for the survey process from the DMH providers. The FY 2008 survey findings recommend addressing these issues for subsequent survey administration. The FY 2009 survey will be completed during the first quarter of FY 2010.
- Significance:** The administration of the MHSIP Surveys is a requirement of the Data Infrastructure Grant and the State Mental Health Block Grant. The survey results are reported nationally for each state and territory.
- Action Plan:** The administration of the FY 2009 survey will attempt to address some of the historic problems with the survey process. The DMH is planning to change its contract requirements to include mail responses for unsuccessful telephone efforts. Additionally, a small cash incentive will be offered to participants. The goal is to sample approximately 600 total individuals (adults and parents/guardians of children/youth).

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	89.64	76.12	85	85	N/A
Numerator	675	612	--	--	--
Denominator	753	804	--	--	--

Table Descriptors:

- Goal:** To improve consumer functioning.
- Target:** Increase to 85% consumers participating in the MHSIP reporting positively about level of functioning.
- Population:** Adults with mental illness living in the District of Columbia.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services  
4:Targeted Services to Rural and Homeless Populations
- Indicator:** Number of adult consumers surveyed in the MHSIP report positively on level of functioning questions.
- Measure:** Number of adult consumers responding to MHSIP survey
- Sources of Information:** MHSIP
- Special Issues:** A long-standing issue with the administration of the MHSIP Survey has been low consumer participation due to a number of factors: 1)difficulty in obtaining accurate consumer contact information from the eCura claims data system, 2) the telephone survey process, which is contingent on consumers having a telephone and the system having current telephone information, 3) little or no coordination on the timing of surveys administered by DMH and the provider network, and 4) little or no buy-in for the survey process from the DMH providers. The FY 2008 survey findings recommend addressing these issues for subsequent survey administration. The FY 2009 survey will be completed during the first quarter of FY 2010.
- Significance:** The administration of the MHSIP Surveys is a requirement of the Data Infrastructure Grant and the State Mental Health Block Grant. The survey results are reported nationally for each state and territory.
- Action Plan:** The administration of the FY 2009 survey will attempt to address some of the historic problems with the survey process. The DMH is planning to change its contract requirements to include mail responses for unsuccessful telephone efforts. Additionally, a small cash incentive will be offered to participants. The goal is to sample approximately 600 total individuals (adults and parents/guardians of children/youth).

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** ACT Teams

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	8	8	N/A	13	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

- Goal:** Improve access to evidence-based practices.
- Target:** Maintain the 13 ACT teams in FY2010
- 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:** At the end of FY 2006 there were 8 ACT teams, with no planned expansion during FY 2007-FY 2008. The ACT fidelity audits and overall review process began in FY 2008 and continued in FY 2009. While there was no planned expansion in FY 2009, 3 new teams were added by June 2009, bringing the total to 11 ACT teams: Community Connections=2, DC CSA=3, Family Preservation =2, Green Door=1 and Pathways DC=3. Another team is expected to be added by September 2009. It should be noted that the DC CSA ACT Teams will be phased out by July 31, 2009. It is likely that 2 new teams will be added in FY 2010, therefore the target is 13 ACT teams.
- 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:** During FY 2010, 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. This will include conducting fidelity audits and providing technical assistance and training about the ACT model. DMH will continue to increase the ACT census and referrals. The DMH will also try to continue to reach 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:**

**Name of Performance Indicator:** Availability of Newer Generation Medications

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	85.30	85.60	86.70	70	N/A
Numerator	3,028	3,231	--	--	--
Denominator	3,549	3,771	--	--	--

Table Descriptors:

- Goal:** To increase access to new generation antipsychotic medications.
- Target:** Target is consistent with Dixon Exit criterion #12- to maintain at 70% the number of adults with schizophrenia receiving newer 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 2007, FY 2008 and FY 2009 data show that the target is exceeded. While the Dixon Court Monitor agrees that this target was met in FY 2007, DMH still has to monitor this performance target. The FY 2010 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:** Continue to maintain the Dixon performance target that 70% of adults with schizophrenia will receive new generation antipsychotic medications.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Continuity of Care

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	51.40	70	80	N/A
Numerator	N/A	486	--	--	--
Denominator	N/A	945	--	--	--

Table Descriptors:

- Goal:** Improve continuity of care.
- Target:** Target is consistent with Dixon Exit criterion #17- that 80% of adults receive 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:** Eighty per cent (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. 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. Work on refining the data collection system and validating the data collected continued throughout FY 2009. DMH had preliminary and unvalidated data for the first two quarters of FY 2007. The FY 2008 data show 51% are seen within 7 days of discharge from inpatient care. The FY 2009 calculation is pending receipt of Medicaid data. The FY 2010 target is 80% consistent with the Dixon performance measure.
- 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. 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 consumer.

# 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.

## **CHILD ESTABLISHMENT OF SYSTEM OF CARE**

The Department of Mental Health (DMH) is a cabinet-level agency whose Director reports to the Mayor of the District of Columbia. The mission of DMH is to support prevention, resiliency and recovery for District residents in need of public mental health services.

The DMH is responsible for developing, supporting and overseeing a comprehensive, community-based, consumer driven, culturally competent, quality mental health system that is responsive and accessible to children, youth, adults, and their families. DMH contracts with a network of community-based, private providers and also provides direct services to children and youth through the Homeless Outreach Program and the School-Based Mental Health Program. The Child and Youth Services Division will assume responsibility for the Psychoeducation, Therapeutic Nursery and Healthy Start Programs, formerly operated by the DC CSA. Contracted services include mental health rehabilitation services (medication/somatic treatment, counseling, community-based intervention, multi-systemic therapy) and some school-based services. DMH also contracts with the Children's National Medical Center for the provision of site-based psychiatric emergency services. New services include:

- Mobile crisis and stabilization services for children,
- Wraparound initiative, and
- Expansion of the School Mental Health Program.

The DMH works collaboratively with the Child and Family Services Agency (child welfare), the Department of Youth Rehabilitation Services (juvenile justice), the Office of the State Superintendent of Education (oversight, policy and resources), and the District of Columbia Public School System (education), as well as the charter schools to provide needed mental health services.

# 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.



## **CHILD AVAILABLE SERVICES**

### **[Criterion 1: Comprehensive Community-based Mental Health Service Systems]**

#### **Health, Mental Health and Rehabilitation Services**

##### **Health**

The mental health rehabilitation service (MHRS) providers collaborate with the District's Medicaid D.C. Healthy Families program to assure delivery of comprehensive medical and dental services and early periodic screening, diagnosis and treatment (EPSDT) benefits to eligible District children. In addition to D.C. Healthy Families, District children are also eligible to receive Medicaid benefit-level services through the District's Health Program.

##### **Mental Health and Rehabilitation Services**

The Child Plan addresses the reliable and effective provision of mental health and related rehabilitation services to children/youth and their families, no matter how complex their needs, with maximum consideration given to child/youth and family choice in treatment.

As a mechanism for achieving reliable and effective services, DMH implemented the MHRS program to provide for a comprehensive, integrated system of community-based care for children, adults and their families by ensuring quality improvement, provider oversight, planning and policy development, and administration of Medicaid reimbursement to community-based public and private provider agencies. Under a State Plan Amendment establishing the Medicaid Rehabilitation Option, MHRS services are eligible for a 70% federal match, thus moving appropriate services and supports within the MHRS framework is an important strategy toward assuring sustainability of needed services.

A fundamental principle of the MHRS program is organizing the system in a manner that assures that each child/youth has his/her own "clinical home," an entity responsible for and accountable to that child/youth, for the full array of his/her service and support needs on a continuous basis, regardless of the child/youth's legal, clinical or physical status. Known as a Core Services Agency (CSA), the clinical home assures access, promotes continuity, and works to prevent cost-shifting through inappropriate institutional placement. Monitoring the efficacy of the CSAs with respect to the quality of processes and the achievement of desired outcomes is a key responsibility of DMH Office of Accountability.

The MHRS allows children/youth access to the following Medicaid-supported services:

- Diagnostic/assessment;
- Medication and somatic treatment;
- Counseling;
- Community support;

- Crisis/emergency (a required service of all CSAs; also offered by a provider as a niche, or specialty service);
- Community-based intervention/ CBI (focused on in-home supports);
- Intensive day treatment;
- Day services (rehabilitation); and
- CBI (may be provided by a CSA or by a provider offering CBI as a niche service, such as the Multi-Systemic Therapy/MST provider).

In addition, the DMH may make other services available through the use of local-dollar only funded services such as:

- Adjunctive child therapy (i.e., psychodrama, art therapy, music therapy);
- Acute inpatient psychiatric services;
- Residential services;
- Psycho-educational services; and
- Peer and family supports.

Treatment through the CSA model is guided by an Individual Plan of Care (IPC), which the CSA updates in collaboration with the parent every 90 days. Development and monitoring of the plan is an opportunity to set resilience-based goals and to assess where and when additional services and supports are required.

Access to the MHRS system is coordinated through the Access HelpLine, a 24-hour, 7-days-a-week telephone hotline and service hub operated by DMH Care Coordination Division.

The District of Columbia Children System of Care has made substantial progress over the past two (2) years in building the infrastructure and support required to develop a coordinated System of Care (SOC). Specifically, all of the major child/youth serving agencies are actively engaged in joint planning and decision-making activities. These agencies include: the Department of Mental Health (DMH); the Child and Family Services Agency (CFSA), the District's child foster care agency; the Department of Youth Rehabilitation Services (DYRS), the District's juvenile justice agency; the D.C. Public Schools (DCPS); and the Office of the State Superintendent of Education (OSSE). In addition, there is an ongoing and dedicated commitment from the Executive Office of the Mayor and the Department of Health Care Finance (District's Medicaid Agency), which has proven essential to the support and success of the SOC. The DMH Child and Youth Services Division (CYSD) will continue to build on the successful collaboration among these agencies and government entities to achieve the overall goal of developing a comprehensive integrated child mental health system.

The strong interagency partnerships and collaborative efforts has led to meaningful strides in the development of a comprehensive array of community-based services to support children and youth with serious emotional disturbances and their families. These accomplishments include the development and refinement of critical community-based services including intensive home and CBI services, MST services, and a High-Fidelity

Wraparound pilot. In addition, formal planning and decision-making structures have been conceptualized and are currently in place. These structures involve all of the child and youth serving agencies, including the Family and Juvenile court system. One key example is the Interagency Collaboration and Services Integration Commission (ICSIC), which was mandated by the Public Education Reform Act of 2007. The purpose of this Commission is to address the needs of at-risk children by reducing juvenile and family violence and promoting social and emotional skills among children and youth through the oversight of a comprehensive integrated service delivery system. The ICSIC is chaired by the Mayor who requires that all agency directors attend and actively participate in this cross-agency planning effort. ICSIC is one of the major vehicles that will be used to support the development of the District of Columbia's System of Care. The Department of Mental Health has been a lead entity in these developments.

### **Mobile Crisis Services**

The DMH new Child and Adolescent Mobile Psychiatric Service (ChAMPS) began operating in October 2008 under contract with by Anchor Mental Health of Catholics Charities. The goal of the crisis team is to provide rapid mobile response within one (1) hour of the call, onsite crisis intervention and stabilization, and also to provide linkage and follow-up support to avert future crises. This team has staff physically present from 7 a.m.-11 p.m. and is available on-call after 11:00 p.m. for emergencies. Four (4) crisis/respite beds are available to the team as an alternative, when appropriate, to acute psychiatric hospitalization. One of the goals of this new team is to reduce the percentage of children who end up in emergency rooms or in inpatient care (voluntary and involuntary), and help reduce the number of children in the care and custody of CFSA having to change foster care placements due to untreated behavioral health needs. Crisis services are geared toward children and youth in the District and also service children in the foster care system residing in Maryland and Virginia.

### **Employment Services**

The Department on Disability Services, Rehabilitation Services Administration (DDS/RSA) works closely with the D.C. Public Schools system to provide vocational rehabilitation transition services for in-school youth with disabilities and those transitioning from school to other activities including employment training and employment. With respect to the latter category, services include career/vocational guidance and counseling and further assessments (as deemed appropriate and based on school findings) including vocational, medical, psychological, and assistive technology. The DDS/RSA works with the school system to identify youth, some of whom are referred to the DMH Supported Employment provider network.

In FY 2009, the DMH CYSD began working on a transition age youth initiative. This initiative will focus on education, employment, and housing. In order to support the initiative, DMH developed a grant proposal in response to the SAMHSA Healthy Transitions Initiative for services and supports for youth with serious mental health issues age 16-25. The DMH CYSD partnered with the Department on Disability Services on the

development of the grant application. The DMH should know whether it is a successful grantee before the end of FY 2009. The DMH CYSD is committed to going forward with the transition age youth initiative irrespective of whether federal funding is secured.

### **Housing Services**

The DMH Supported Housing Division coordinates housing services for children/youth and families. The identified client might be a child/youth or an adult family member. The DMH Long-Term Supports and Housing Grant that originally included homeownership as a housing option for persons with mental illness and a developmental disability, was expanded during FY 2006 to include youth aging out of the foster care system (transition age youth).

The project brought together government agencies to 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 citizens through an improved infrastructure. The grant ended September 2008. It began a very positive relationship with DDS, which is being expanded in the new Integrated Care Management program.

### **Educational Services**

The DMH Training Institute provides education and training services on a variety of issues related to adult and child and youth systems of care. It also offers recurring introductory and overview trainings for providers, consumers, and DMH staff. These trainings occur on a quarterly to bi-annual basis and include the following child/youth and family related topics:

- DMH 101 – Designed for multiple stakeholder audiences to provide an overview of the processes for accessing mental health services.
- Community-Based Intervention (CBI) 101 – Reviews the components, theory and research on CBI, as well as practical information for appropriate recipients of the service, and how to access it.
- System of Care 101 – Provides an overview of Systems of Care philosophy, values and supports within the District.
- Meeting the Mental Health Needs of Youth Receiving Residential Treatment – Provides overview of children/youth receiving psychiatric residential treatment services.

The Training Institute has also sponsored or co-sponsored the following ongoing training initiatives and series:

- Level of Care Utilization System/Child & Adolescent Level of Care Utilization System (LOCUS/CALOCUS) train-the-trainer initiative
- Community Service Review (CSR) Adult and Child Review Training

Other training conducted during in FY 2009 includes the following:

- Domestic Violence 101 Teen Dating Violence for Teens

- Teen Dating Violence Training for Providers

### **Substance Abuse Services**

Child and youth service providers have been actively involved in the DMH co-occurring disorders initiative (COSIG) to develop a comprehensive, integrated system model. Several activities related to youth were developed under the first objective to establish system supports for integrated service delivery for individuals with co-occurring mental illness and substance use disorders. The DMH COSIG project collaboration included:

- Working with the Addiction Prevention and Recovery Administration (APRA) on the State Adolescent Substance Use Care Coordination Project to incorporate basic co-occurring competency as an aspect of their work, and enable them to build on the COSIG work to advance their own initiatives.
- Working with partners to develop an interagency work plan to establish a Medicaid reimbursable network of youth providers in the District of Columbia to provide substance use treatment services and integrated services for co-occurring disorders.
- Recruiting providers for expanded provider network, adding six (6) agencies to the APRA youth network, of which four (4) are dually certified by DMH and APRA.
- Providing technical assistance to DMH certified providers around provision of co-occurring disorder (COD) services for youth and achievement of Agency Competency Designation in COD.

### **Medical and Dental Services**

The MHRS service providers collaborate with the District's Medicaid D.C. Healthy Families program to assure delivery of comprehensive medical and dental services and EPSDT benefits to eligible District children, which includes children of families with household incomes at or below 200% of the Federal Poverty Guidelines. In addition to D.C. Healthy Families, District children are also eligible to receive Medicaid benefit-level services through the District's Health Program, a District funded program for adults who are not eligible for Medicaid because there are no children in the home and children who are not eligible for federally funded benefits, including children of immigrants who are undocumented or otherwise ineligible for federally supported services. Through the D.C. Health Program and D.C. Healthy Families, the District's Medicaid expansion program, low income District children and their families are eligible for health benefits including medical and dental services.

### **Support Services**

One of the elements of the DMH System of Care is to increase family involvement at all levels. The DMH has added Family Advocacy Services through grants to the Children and Youth Investment Trust Corporation, which then advertises and awards sub-grants to appropriate non-profit community-based organizations. A total of four (4) family support partners (advocates) and additional peer parents have been employed by grassroots, neighborhood-based organizations called Healthy Families/Thriving Community Collaboratives as well as the Total Family Care Coalition, that provide traditional and

non-traditional supports and services to children and their families. The advocates are family members who provide peer support to other families attempting to navigate the service system.

Another element of the DMH System of Care for children/youth and families is to provide treatment and support services in their homes and in natural settings. The Dixon Performance Targets related to these settings include:

1. Eighty-five percent (85%) of children/youth with serious emotional disturbances (SED) should receive services in their own homes or surrogate homes.
2. Seventy-five percent (75%) of children/youth with SED should receive services in a natural setting (i.e., schools).

The DMH will continue its efforts to improve performance with respect to these targets during FY 2010.

### **Services in Collaboration with School System under Individuals with Disabilities Education ACT (IDEA)**

The D.C. Community Services Agency (DC CSA) operates two (2) psycho-educational programs with support from the D.C. Public Schools (DCPS). These programs will be transferred to the Child and Youth Services Division in FY 2010. They include:

- Therapeutic Nursery- serves children ages 3-5 at Wilkerson Elementary School. A certified Special Education Teacher and classroom Aide are provided by DCPS. Other staff include a psychiatrist (medication management) and Social Worker (individual and group therapy). Parent services include education about medication and developmental issues.
- Psychoeducation Program- serves children age 6-12. The Principal and certified Special Education Teachers are provided by DCPS. Other staff include: an Art Therapist, Social Workers (3), a Psychiatrist, a Psychologist, and Case Managers (2). The mental health services wraparound the program.

### **School Mental Health Program**

The DMH School Mental Health Program (SMHP) provides intervention and prevention services in public and charter schools in the District of Columbia. During FY 2009, the SMHP expansion included providing services in 10 additional schools (increasing the number of schools from 48 to 58). A tiered model was designed and implemented to allow for the expansion into the 10 additional schools. Thirty-seven (37) schools received full-time clinicians providing school mental health services including prevention, early intervention and treatment. Twenty-one (21) schools received part-time services. The decision as to which schools should receive full-time versus part-time services was made based upon three (3) critical factors: enrollment, demonstration of

need, and readiness for the program. As a result, the SMHP program serves families and children in 11 Charter Schools and 47 D.C. Public Schools (DCPS). Mental health clinicians are assigned to each of the 58 schools. Services include an array of early intervention and treatment services, along with consultation for teachers, psychiatric services and case management. During School Year 2008-2009, DMH joined with DCPS in providing some services to include special education populations, and is currently working with the managed care organizations (MCOs) and the Department of Health Care Finance (Medicaid agency), to bill for the children in the schools receiving counseling, crisis intervention, family therapy at school, and limited supportive case management. The re-investment dollars generated through billable services will allow the SMHP to remain in the 58 schools with the current staffing level.

Other school expansion included: partnering with OSSE to provide services to special education students in eight (8) middle schools, and developing a program model for an early mental health consultation project. This project will be implemented during FY 2010.

School Mental Health Crisis Team: This team, comprised of a specialized group of trained SMHP clinicians, in partnership with D.C. Public Schools, responds to a range of crises that impact students and their families, including unexpected death, neighborhood violence and child abuse. A 2006-2007 Safe Schools/Healthy Students grant to the Center for Student Support Services, to which DMH is a collaborating partner, supports a contract with George Washington University's School for Health and Health in Schools to assess the strength of the SMHP evaluation plan, identify evidence based and promising practices in similar urban school settings across the country, interview key system stakeholders and nationally recognized school mental health experts, and develop recommendations for the clinical program--including prevention, early intervention and treatment components--and an evaluation design. The first report was developed in Fall 2007 and the final report in 2008. This report will serve as a guide for developing, with stakeholders, a strategic plan for future growth and development of the SMHP; however, due to the fiscal challenges in 2009 and 2010, the program is unable to expand at this time.

School-Based Teen Outreach Program for Suicide (STOP Suicide) Grant: The DMH was awarded a two-year grant in September 2005. This grant was scheduled to run until the end of September 2007 but with no cost extensions funding is available until September 2009. The goals include: 1) increasing the number of adolescents identified as at risk and assessed for suicide or suicidal behavior; 2) enhancing the ability of child mental health providers to identify and assess for risk of suicide; 3) providing training to school staff and community leaders on depression and suicide prevention; 4) improving the coordination of care provided to students at risk for suicide and their families; and 5) improving family/caregiver education and access to mental health resources and services.

The STOP Suicide program found that of the 786 youth screened, 37% (293) screened positive for some mental health issue; 17% (108) screened positive for a history of or

current suicide ideation or attempt, and 5% (14) of youth were referred for an immediate evaluation or to the hospital. Anecdotally, many of the youth reported that this was the first time they had ever told anyone about these thoughts or attempts. These youth were also at great risk for other mental health issues. Among all youth screened, 65% reported feeling at least some problem with losing their temper or being mad in the last three (3) months, 51% reported feeling sad or unhappy, 41% reported feeling nervous or afraid and 7.5% reported problems with drugs or alcohol. Several more youth endorsed that they wanted help for something even though their responses didn't reach a clinical threshold in the screening.

The STOP Suicide Program also conducted gatekeeper training with school staff. Participants were administered a survey about their previous training in suicide, their perceptions of their abilities to address suicidal youth, and the numbers of suicidal youth that they have encountered. Pre-test to post-test results reveals teacher's knowledge of suicide and knowledge of appropriate responses to kids with suicidal ideation went up. Eighty-four percent (84%) reported that they had encountered distressed/depressed youth in the last 6 months but only 39% asked specifically about suicide. Fifty-four percent (54%) of school staff had received no prior suicide prevention training. On average, participants reported only 1.5 hours per year of prior suicide prevention but 74% of participants felt well prepared to talk with students about suicide. The results suggest that while school staff may be frequently encountering youth with depressive symptoms and taking action to ask about the depression, they are not asking about suicidal ideation. Additionally, teachers in the District are encountering depressed youth at high rates but they have little formal training in discussing mental health issues with youth. Several activities that were completed will also be undertaken for the new grant as DMH now has developed the knowledge and expertise to successfully carry out some of these interventions.

This highlights some of the distinct ways in which youth in the District are struggling. While youth in the District may not be dying directly from suicide, they are making suicide attempts at rates higher than the national average and are experiencing depression, anger, and anxiety, all risk factors for suicidal behavior at alarming rates. Furthermore, youth in the District engage in other potentially lethal behaviors at staggering rates. These behaviors are arguably subtle forms of suicidality: gang involvement, substance use, early and unprotected sexual intercourse, and exposure to HIV; and warrant special interventions to reduce youth suicide rates.

During FY 2009, DMH applied for a SAMHSA State Wide Suicide Grant to further expand the work into the community. DMH hopes to hear by September 2009 whether the application will be funded. Multiple political factors in the District are colliding now making this an appropriate and exciting time for the District to apply for this grant. The success and distinction of the STOP Suicide Program has provided DMH with the momentum and experience to bring suicide training, education, screening, and outreach to a wider audience. At the same time, due to several recent suicide deaths, the Child Fatality Review Community (CFRC), under the jurisdiction of the Mayor, tasked DMH with developing citywide guidelines for suicide prevention, creating a public awareness



campaign, ensuring continuity of care for these youth, and providing training and education to school staff. The CFRC and DMH, along with community partners, will be held accountable by the Mayor for carrying out these tasks. Finally, the police have seen a significant rise in suicide related calls from schools since 2006 in elementary, middle and high schools. Due to risk factors present and documented suicidality problems among District youth, this is an important population to receive comprehensive suicide prevention efforts.

### **Case Management Services**

The current DMH CYSD array of services and supports for children, youth and families includes initiatives designed to focus on the individual and specific needs of service recipients and families. These include but are not limited to:

1. Choice Providers- In order to effectively address the mental health needs of children in foster care and their families, DMH and CFSA developed the concept of specialty or choice providers. These providers receive specialized training to respond to the unique needs of children and families in the child welfare system.
2. High Fidelity Wraparound Services- This pilot program provides intensive home and community-based services to prevent out-of-home placement using the wraparound process. Flexible funding is available to support non-traditional services.
3. Community Based Intervention (CBI)-These are time-limited intensive mental health interventions intended to prevent out-of-home placement. Services are delivered in the family setting and are designed to enhance one's ability to function within a family environment. Mental health services and supports are available 24 hours a day, seven (7) days per week to improve the ability of parents, legal guardians or significant others to care for children and youth with severe mental health issues. Three (3) providers are certified to provide this service.

### **Co-Occurring (Substance Abuse/Mental Health) Disorders**

The DMH Co-Occurring State Incentive Grant (CO-SIG) involved close collaboration with the Department of Health, Addiction Prevention and Recovery Administration (APRA) to develop the infrastructure to address the service needs of individuals with co-occurring substance use and mental health disorders. Child and youth service providers have been actively involved in this process. Some of the youth initiatives have included the incorporation of the basic competency principles into the State Adolescent Substance Use Care Coordination Project, technical assistance to DMH certified providers on co-occurring disorder services for youth, and recruitment to expand the APRA youth provider network.

## **Activities to Reduce Hospitalization**

Two (2) hospitals provide acute services to District children and adolescents: Children's National Medical Center (CNMC) and the Psychiatric Institute of Washington (PIW). Several initiatives are aimed at reducing hospitalization.

Children's Mobile Crisis Response Team - The DMH contracted Child and Adolescent Mobile Psychiatric Service (ChAMPS) began operating in October 2008. The goal of the crisis team is to provide rapid mobile response within one (1) hour of the call, onsite crisis intervention and stabilization, and also to provide linkage and follow-up support to avert future crises. This team has staff physically present for 16 hours daily and is available on-call at other times for emergencies. Four crisis/respite beds are available to the team as an alternative, when appropriate, to acute psychiatric hospitalization. One of the goals of this new team is to reduce the percentage of children who end up in emergency rooms or in inpatient care (voluntary and involuntary), and help reduce the number of children in the care and custody of CFSA having to change foster care placements due to untreated behavioral health needs. Crisis services are geared toward children and youth in the District and also service children in the foster care system residing in Maryland and Virginia.

Federal and District Performance Indicators- Complying with federal and the Dixon Exit Criteria challenged the DMH to establish baseline measures to effect System of Care improvements to meet the following performance targets:

1. Decrease the number of children/youth re-admitted to inpatient care within 30 days of discharge,
2. Decrease the number of children/youth re-admitted to inpatient care within 180 days of discharge, and
3. Eighty (80%) of children/youth discharged from inpatient care must be seen within seven (7) days.

# 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

## CHILD ESTIMATE OF PREVALENCE

### [Criterion 2: Mental Health System Data Epidemiology]

The DMH has continued to experience challenges in both data gathering and reporting with regard to children's services. The DMH is working to correct issues that contribute to the reporting difficulties. One concern with the child data is the large number of children who receive mental health services through Medicaid managed care organizations (MCOs). Another concern with the child data is the fact that complete inpatient data is not available for reporting purposes. Children are admitted to private hospitals within the District of Columbia for acute care services. The DMH has been working with child-serving providers through the Children's Roundtable to improve data collection and data integrity. In addition, DMH has a memorandum of understanding (MOU) with the Department of Health Care Finance (DHCF) and the Medicaid MCOs regarding data and data reporting. There is a workgroup developing custom reports, which should improve the data collection and integrity of data about mental health services provided to children. During FY 2009, the Research and Clinical Informatics (RCI) Unit was created within the Organizational Development Division in the DMH Office of Programs and Policy. The RCI Unit has inventoried the various program databases and will develop and disseminate findings and recommendations. This unit will work closely with the DMH CYSD to develop data reporting protocols to support the child, youth and families System of Care.

#### Prevalence and Definition of Serious Emotional Disturbances

The Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA) published a methodology for estimating the prevalence of Serious Emotional Disturbance (SED) in children in the Federal Register, July 17, 1998 (Volume 63, Number 137). This methodology uses 1995 census data and provides prevalence percentages based on assessed level of poverty and selected levels of functioning using the Children's Global Assessment Scale (CGAS). The methodology offers a range of prevalence for two (2) Levels of Functioning (LOF): the more conservative LOF 50 (and below) and the less conservative LOF 60 (and below).

Within the SAMHSA methodology, the District of Columbia is assessed as having a high percentage of children living in poverty (Group C). The range of prevalence percentages for LOF 50 in Group C is 7%-9%. The SAMHSA methodology estimates the population of children ages 9-17 and does not include children ages 0-9. The DC CSA clients between the ages of 0-5 account for approximately 10 % of its population, while clients between the ages of 6-12 account for approximately 53% of its population.

The District continues to build upon the earlier work of SAMHSA and over the past several years a number of activities have been undertaken to refine the prevalence estimates for serious emotional disturbances. In FY 1999, DMH contracted with the University of Texas, Department of Psychiatry and Behavioral Sciences to provide prevalence and service analyses for the District of Columbia. The final report, District of Columbia Mental Health Needs and Services Estimation Project was made available at

the beginning of FY 2000. "Chapter 7: Estimate Procedures for Children and Adolescents" contains prevalence estimates for the District of Columbia. The child and adolescent estimates are based on the method of estimation as published by SAMHSA, Center for Mental Health Services (CMHS). While the CMHS estimates are for ages 9-17, the District of Columbia estimates are 0-17. The District of Columbia estimates are also based on the SAMHSA 1993 definition of SED. The CMHS defines children with serious emotional disturbances as follows:

“Children with serious emotional disturbance, are from birth up to age 18; who currently or at any time during the past year, has had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R, that resulted in functional impairment which substantially interferes with or limits the child’s role or functioning in family school or community activities.”

The definition goes on to indicate that “these disorders include any mental disorder, including those of biological etiology listed in the DSM-III-R or the ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-III-R ‘V’ codes, substance abuse and developmental disorders which are excluded unless they co-occur with another diagnosable serious emotional disturbance.”

Further, the definition indicates that “functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills. Functional impairments of episodic, recurrent and continuous duration are included unless they are temporary and expected responses to stressful events in their environment. Children who would have met the functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition” (previously cited Federal Register, p. 29425).

During FY 2002 an update of the 1999 prevalence estimates was undertaken through a contractual arrangement with the University of Texas. This update is based on the 2000 Census data and was completed during FY 2003. The estimates include projections for years 2001 through 2005. Attention was focused on possible limitations of the earlier projections, which over-estimated the number of children in the District of Columbia. The update utilized the newly developed definition of serious emotional disturbance delineated in Priority Populations, Chapter 12, Title 22A, DCMR. This definition is as follows:

“Children or youth with serious emotional disturbance includes children/youth under age 22 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 the DSM-IV or the ICD9-CM equivalent, except for DSM-IV “V” codes; is neither a substance abuse disorder nor a developmental disorder, unless co-occurring with another diagnosable serious emotional disturbance;

results, resulted in, or will without treatment or other support services, result in a functional impairment that either substantially interferes with or limits the consumer's role or functioning in family, school, or community activities, or that limits the consumer from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, or adaptive skills, and includes functional impairments of episodic, recurrent, and continuous duration but not temporary and expected responses to stressful events in the consumer's environment."

During FY 2006, a work group chaired by the DMH Chief Clinical Officer, which included provider representation, 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 Children and Youth priority population is defined as follows:

During FY 2006, a DMH work group chaired by the Chief Clinical Officer, which included provider representation, 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 Children and Youth priority population is defined as follows:

1201            **CHILDREN OR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE**

1201.1        Children or youth with serious emotional disturbance are:

- (a)        District of Columbia residents;
- (b)        Under the age of 18 (or age 18 to less than 22 if enrolled in special education services, or committed to the child welfare or juvenile justice system);
- (c)        Have at any time in the twelve (12) month period immediately preceding the request for certification as "a child or youth with serious emotional disturbance," received a DSM Axis I diagnosis, excluding individuals whose sole DSM Axis I is that of substance abuse;
- (d)        Have a Global Assessment of Functioning Scale rating of fifty (50) or below, and a Child and Adolescent Level of Care Utilization System (CALOCUS) composite score of level four (4) or higher;
- (e)        Have either a:

- (1) documented significant treatment history as defined in §1201.2; or
- (2) coexisting condition or circumstance as defined in §1201.3.

1201.2 A significant treatment history is defined as any one of the following:

- (a) Current residence in or discharge from an inpatient psychiatric facility or correctional inpatient mental health service more than one (1) time within the last year;
- (b) Two (2) or more face-to-face contacts with mobile crisis or emergency services within the past year; or
- (c) A treatment history that is characterized by a demonstrated and frequent vulnerability to stressors, resulting in periods of sustained distress and the hindrance of developmental progress, where intensive and/or repeated treatment has not yielded symptom control for even limited periods of time.

1201.3 A coexisting condition or circumstance is defined as any one of the following circumstances:

- (a) Homelessness;
  - (b) Release from a criminal detention facility within the last year;
  - (c) HIV/AIDS diagnosis;
  - (d) Court ordered to treatment;
- (e) 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 or homicidal ideation with expressed intentions, which may include a past history of carrying out such behavior, and the child and/or the child's caretakers have expressed ambivalence or are unable to carry out a safety plan or to contract for safety;
  - (2) A history of chronic impulsive suicidal or homicidal behavior or physical or sexual aggression that is significantly endangering to self or others;

- (3) An indication of consistent deficits in ability to care for self, use environmental/community resources, or access helpful adults to achieve safety;
- (4) A recent pattern of excessive substance use resulting in clearly harmful or risky behaviors and little or no indication that the child or caretakers can restrict this use; or
- (5) Serious to extreme risks for victimization, abuse, or neglect.

An expanded work group, including clinicians and administrators with financial and data expertise began to use the clinical criteria to frame how Priority Populations would be operationalized in FY 2007. In FY 2008, a MHRS work group was developed to review the overall service delivery system. It was envisioned that this process would address the Priority Populations.

The estimates for **Severe Emotional Disturbance** for all youth, including those in institutions, are:

7.67% (8070 cases) for 1990,
7.46% (9230 cases) for 1999 (projected), and
7.79% (8961 cases) for 2000 (from 2000 Census).

For the household population only, the estimates are:

7.41% (7644 cases) for 1990,
7.33% (8876 cases) for 1999 (projected), and
7.73% (8770 cases) for 2000 (from 2000 Census).

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

The FY 2004 Community Mental Health Services Block Grant reported that based on discussions with the Court Monitor and an external panel of experts, DMH was modifying its penetration goals to 5% for children/youth and 3% for children/youth with serious emotional disturbances (SED) in FY 2005. During FY 2005, DMH expanded its child/youth service provider capacity with 59% of the 43 certified MHRS providers having the capability to serve children/youth and families. In FY 2006, 63% of the 51 certified MHRS providers had this capacity.

**Data Infrastructure Grant**

Through the DMH Data Infrastructure Grant, attention has focused on capturing data that provides a demographic profile of children/youth within the DMH service system. Historical challenges have been the capture of inpatient acute care stays, school



attendance, and involvement in the juvenile justice system and other developmental measures associated with the grant. Beginning in FY 2007 and continuing through FY 2010, a concerted effort will be made to begin populating child/youth data for all the required tables.

<b>Estimates of Serious Emotional Disturbance (SED) for Washington DC, Total for 2000</b>									
	<b>Total Population (HH, Inst. &amp; Group)</b>			<b>Household Population</b>			<b>Households &lt;100% poverty</b>		
	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
<b>Youth</b>	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Youth total	8963	114992	7.79	8773	113428	7.73	3604	36042	10.00
<b>Age</b>	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
00-06	3607	46404	7.77	3583	46182	7.76	1535	15354	10.00
07-12	3165	40375	7.84	3143	40168	7.82	1286	12856	10.00
13-17	2191	28213	7.77	2047	27079	7.56	783	7832	10.00
<b>Gender</b>	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Male	4539	57920	7.84	4404	56851	7.75	1809	18092	10.00
Female	4424	57072	7.75	4369	56578	7.72	1795	17950	10.00
<b>Ethnicity</b>	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
White-NH	873	14038	6.22	873	14038	6.22	51	507	10.00
Black-NH	7019	87470	8.02	6880	86332	7.97	3219	32193	10.00
Asian-NH	143	1812	7.90	115	1576	7.29	40	402	10.00
Native-NH	26	244	10.81	4	54	6.57	1	8	10.00
Hispanic	902	11428	7.89	902	11428	7.89	293	2933	10.00
<b>Poverty level</b>	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Below 100%	3760	37286	10.09	3604	36042	10.00	3604	36042	10.00
100%-199%	2115	26375	8.02	2101	26268	8.00	0	0	0.00
200%+ pov	3088	51331	6.01	3067	51118	6.00	0	0	0.00
<b>Residence</b>	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Household	8773	113428	7.73	8773	113428	7.73	3604	36042	10.00
Institution	82	405	20.25	0	0	0.00	0	0	0.00
Group	108	1158	9.35	0	0	0.00	0	0	0.00

# District of Columbia

## Child - Quantitative Targets

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

Pursuant to the terms of the Dixon Consent Order, DMH is required to provide arrange for mental health services to 5% of the estimated child/youth population (0 - 17) annually. The target for FY 2009 is 5,525. Sixty percent (60%) of those children should have an SED diagnosis or 3,315. Currently, DMH includes only children receiving MHRS services in reporting data. However, work is underway to include children who receive a school-based mental health service and children who receive a service from a Medicaid MCO in this count.

# 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.

## CHILD SYSTEM OF INTEGRATED SERVICES

### [Criterion 3: Children's Services]

DMH is partnering with District government agencies CFSA (child welfare), DYRS (juvenile justice), DCPS (education), OSSE (education oversight, policy, resources), DHCF (Medicaid agency), the Office of the City Administrator and Mayor, other public and private agencies, families, and advocates to ensure that children receive all needed services. A number of structures, supports and services have been put in place to improve the District's child mental health system.

District of Columbia Children's Roundtable (Children's Roundtable): A forum to discuss issues that foster cooperation among local agencies to improve services for District children/youth with mental health needs and families. The Children's Roundtable was organized by DMH in FY 2005. Meetings are held bi-monthly. There is representation from CFSA, DYRS, DCPS, OSSE, legal services, Court Social Services, Medicaid MCOs, providers, family organizations, community-based organizations and more.

Community Partnerships, Consumer Outreach and Education: The District of Columbia is extremely fortunate to have The Healthy Families/Thriving Community Collaborative Council (the "Collaborative") operating in the District. There are seven (7) independent Collaborative Agencies, operating in seven (7) of the eight (8) wards of the District. Each Collaborative Agency: (1) is an independent 501(C) 3 led by individual community-based boards of directors; (2) draws upon the unique capabilities and services found within its network of neighborhood providers to assist at risk children and families; (3) has a vision that is fully in line with the mission and vision of System of Care; (4) is a core member of the Children's Roundtable and a formal partner with DMH; and (5) will be a key partner as DMH moves to transform the District's children System of Care. The Collaborative provides care coordination in two (2) wards (Georgia Avenue-Ward 4/5 and Far Southeast-Ward 8). The Care Coordinators organize and facilitate the Child and Family Team process in order to develop a family-driven, youth-guided, community-based Plan of Care (POC); that diverts youth from institutionalized placements. Additionally, they ensure that the plan is coordinated and implemented. They have partnered with DMH as it looks to expand care coordination capacity in all seven wards that will serve the entire District.

DMH Participation in Interagency Collaboration and Services Integration Commission (ICSIC): A 25-member Commission aligned around six citywide goals, which outline the District of Columbia's commitment that children and youth make successful transitions from birth to adulthood. ICSIC is a Director level governance structure facilitated by the District of Columbia's Mayor. It was established in 2007.

Partnership with Child Welfare System: The five-year collaboration with CFSA has evolved into a solid partnership. A shared vision is operationalized through both joint planning and problem solving forums. The partnership does not mean that staff across the two (2) agencies views cases from a similar perspective; system change is not without

tension and tension most often plays out at the case level. The partnership, however does mean that there is a framework within which problems are resolved in the best interest of the child. The issues that arise around cases are seen as opportunities to fix larger system problems and the focus is consistently maintained on the safety and well-being of children and families. The establishment of the CFSA Mental Health Program Manager (in February 2007 and filled June 2007) and hired by DMH has resulted in significant reduction in communication barriers. Although housed at DMH, this manager serves as a liaison and a single point of contact for both agencies whenever issues arise.

In 2008, an interdisciplinary team formed the Wraparound Implementation Workgroup (WIWG) to develop and implement the 24 slot wraparound pilot between DMH, CFSA and DYRS, and an additional 100 slots for DCPS youth. In 2009, 10 slots were added for a total of 134. The processes and outcomes for the 134 youth are being monitored and tracked by the team, which is made up of representatives from all child-serving agencies in the District, the District's Medicaid agency, the Office of the City Administrator, DCPS, families, and community-based organizations.

The *LaShawn A.* Amended Implementation Plan has provided support for several initiatives: (1) the DMH contracted child mobile crisis and stabilization services; (2) the co-location of a six (6) member team of Mental Health staff at CFSA; and (3) the DMH contracted choice provider network.

Residential Treatment Center (RTC) Reinvestment Program and Psychiatric Residential Treatment Facility (PRTF) Clinical Monitoring Program: The DMH clinical team is comprised of a licensed psychologist, who serves as the Clinical Program Manager, a licensed independent social worker, who serves as the Residential Clinical Supervisor and four (4) Residential Clinical Coordinators who perform at least three (3) on-site clinical reviews and participate telephonically for monthly treatment planning and discharge staffing meetings for CFSA and DMH PRTF placements. With the addition of a new position (Residential Clinical Supervisor) coupled with a significant reduction of CFSA placements in PRTFs, the RTC Reinvestment program has begun monitoring District placements in Medicaid psychiatric residential treatment facilities (PRTF) regardless of placing agency. Clinical Monitoring has five (5) primary objectives: 1) assuring the treatment program meets clinical needs identified in the treatment plan; 2) assuring that the clinical program is adequate to meet the psychiatric and behavioral needs of the child; 3) assuring appropriate and adequate lengths of stay through monitoring of medical necessity for continued stay; 4) participating in discharge planning and working collaboratively with CFSA (for CFSA placements only) to assure services are in place at discharge; and 5) following discharged youth for at least six (6) months after discharge to support the youth's successful reintegration into the community.

The DMH RTC Reinvestment Program staff continues to successfully carry out its function as a change agent in the provision of mental health services to District children (CFSA and DMH placements) in PRTFs. Effective June 2009, RTC Reinvestment Clinical Coordinators begin implementation of CALOCUS for all PRTF placements monitored as an additional undertaking of the site visit. As the impetus responsible for

facility practice changes, the DMH Clinical Program Manager, Residential Clinical Supervisor and staff have and continue to diligently work in partnership with the providers to address areas of improvement identified by DMH. The DMH residential clinical coordinators generate a comprehensive site visit report following each site visit. As a result, DMH has been very demonstrative on several occasions in impacting policy and practice changes and are making recommendations whose end results include provider consistency with best practices and improvement in the provision of mental health treatment and service delivery.

Partnership with Juvenile Justice System: Over the past two (2) years, the partnership between DMH and the District's juvenile justice system has been further strengthened through participation in monthly meetings and bi-weekly conference calls between DMH and CFSA leadership teams. The DYRS is one of the funders for the High Fidelity Wraparound Community Pilot and serves on the Steering Committee (monitors this pilot) along with CFSA and DMH.

The DMH and DYRS have continued their partnerships on many initiatives including:

- Training DYRS case managers in the youth-family team meeting model. The DMH SOC Practice Manager devotes a substantial portion of time training and coaching DYRS staff in the Youth Family Team Meeting (YFTM) unit, and supervisors in the FTM team-based services planning model. This represents a fundamental shift in the DYRS services structure, in order to place the youth and family in the driver's seat for the planning and managing their re-engagement with the community.
- Working with DHCF to optimize Medicaid funding for CSAs to provide services in DYRS detention facilities for youth that are awaiting placement. A workgroup commissioned by the Children's Roundtable determined that the District had taken an overly restrictive interpretation of federal law and was not claiming federal match on any Medicaid youth once they entered detention. Federal law allows claiming so long as the youth is awaiting placement, which applies to all but a small population in DYRS facilities. The DMH and DYRS did a joint training for providers and DMH created a billing code to enable providers to bill local dollars for services not deemed Medicaid billable for DYRS youth. Establishing mechanisms to bring community providers into DYRS facilities opens up new opportunities to engage youth in need of mental health services by establishing relationships while the youth is detained so that those relationships can follow the youth out into the community and help to support his/her reintegration.
- Assessment Center Services: The DMH CYSD continues to manage the Assessment Center, which provides comprehensive mental health evaluations for Juvenile Justice youth and CFSA youth plus any DMH youth being considered for PRTF placement. In FY 2008, a total of 643 assessments were performed. The turnaround time for completion of assessments continues to improve. The standard under the Jerry M case is 15 days. The current average is 15.2 days. If one outlier (38 days due to scheduling difficulties with the family) is eliminated from the

sample, the average would be 12.4 days – significantly under the target for the Jerry M. case.

### **School Mental Health Program**

The DMH School Mental Health Program (SMHP) continues to focus on the social and emotional development of students through a variety of prevention, early intervention and treatment services to youth, families, teachers and school staff. During School Year 2008-2009, SMHP was required to provide services in 10 additional schools. The SMHP also developed a Joint Crisis Protocol with DCPS, ChAMPS and MPD for all public schools to address day to day crisis interventions, whereby trained SMHP clinicians work in close collaboration with DCPS staff.

The Blackman Jones settlement agreement with the District regarding special education, resulted in the transfer of \$1M from the Office of the State Superintendent of Education (OSSE) to DMH. These funds are to provide intense wraparound services for up to 100 students in eight (8) DCPS model schools that have been targeted as “full service schools” – intending to combine academics, mental health, Positive Behavior Intervention (PBIS) and an intensive wraparound component for the highest-need students. The DMH contracted with Choices, Inc. to manage this effort. As of May 2009, there were 72 students served through the wraparound program. The indications are that this initiative is gaining momentum via increased common understanding of the program and positive outcomes for students referred. The intent is to expand this program for School Year 2009-2010 to 135 students in eleven (11) middle schools. Each of the targeted schools also has a full-time mental health clinician assigned as part of the overall SMHP program.

### **Medical and Dental Services**

The MHRS service providers collaborate with the District’s Medicaid D.C. Healthy Families program to assure delivery of comprehensive medical and dental services and EPSDT benefits to eligible District children, which includes children of families with household incomes at or below 200% of the Federal Poverty Guidelines. In addition to D.C. Healthy Families, District children are also eligible to receive Medicaid benefit level services through the District’s Health Program, a District funded program for adults who are not eligible for Medicaid because there are no children in the home and children who are not eligible for federally funded benefits, including children of immigrants who are undocumented or otherwise ineligible for federally supported services.

### **Substance Abuse Services**

Children’s service providers have been actively involved in DMH’s co-occurring disorders initiative to develop a comprehensive, integrated system model. The DMH COSIG project collaborated with several District initiatives related to youth substance use disorder and co-occurring disorder. This included an interagency work plan to establish a Medicaid reimbursable network of youth providers and recruitment of



providers to expand the addiction system's youth network. The Addiction Prevention and Recovery Administration (APRA) will continue this effort in FY 2010.

### **Comprehensive Child and Youth Mental Health Plan**

The CYSD has begun the process of creating a 3-5 year comprehensive mental health plan for children and youth. The process for this planning effort is currently being finalized. The intent is to develop a plan that speaks to the entire gamut of child/youth issues and challenges. Other agencies, child advocates, and children/youth and families will be included in the process. The Children's Roundtable, which is a broadly-based composite of child-serving providers and advocates, was informed of this effort and was strongly supportive. The goal is to have a working draft of this plan by the end of 2009.

# District of Columbia

## Child - Geographic Area Definition

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

Services are provided throughout the District of Columbia. The Child and Adolescent Mobile Psychiatric Service (ChAMPS) also serve children enrolled in the foster care system residing with foster parents or in other programs located in Maryland and Virginia.

# District of Columbia

## Child - Outreach to Homeless

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

## CHILD HOMELESS SERVICES

### [Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults]

#### District Strategy

The District of Columbia homeless services strategy has evolved as follows:

- In 2004, Mayor Anthony A. Williams released “Homeless No More: A Strategy for Ending Homelessness in the District of Columbia by 2014” (the “District’s Homeless Services Strategy”).
- In 2005, the Council of the District of Columbia enacted the Homeless Services Reform Act of 2005, D.C. Law 16-35 (the “Reform Act”), which established the Interagency Council on Homelessness (ICH). The ICH is chaired by the City Administrator and includes the directors of various cabinet agencies, including the Director of DMH. The ICH is responsible for providing leadership in the development of strategies and policies that guide the implementation of the District’s policies and programs for meeting the needs of the homeless or those at imminent risk of becoming homeless. (the “homeless”). Among other things, the ICH is responsible for developing the annual plan describing how the District will provide or arrange for services to the homeless, including hypothermia shelter. The DMH strategies and plans for providing or arranging for services to the homeless are driven by the District’s annual plan. More details about DMH’s homeless strategy are found in the Homeless Services section of the Adult plan. A copy of the DMH Homeless Services Strategy (“DMH Strategy”) is available on the DMH website ([www.dmh.dc.gov](http://www.dmh.dc.gov)). Click on the Homeless Services link. There is a link on the Homeless Services page to the DMH Strategy.
- In 2005, the Council of the District of Columbia enacted the Homeless Services Reform Act of 2005, D.C. Law 16-35 (the “Reform Act”), which established the Interagency Council on Homelessness (ICH). This Council is chaired by the City Administrator and includes the directors of various cabinet agencies, including the Director of DMH. The ICH is responsible for providing leadership in the development of strategies and policies that guide the implementation of the District’s policies and programs for meeting the needs of the homeless or those at imminent risk of becoming homeless. (the “homeless”). Among other things, the Interagency Council is responsible for developing the annual plan describing how the District will provide or arrange for services to the homeless, including hypothermia shelter. The DMH strategies and plans for providing or arranging for services to the homeless are driven by the District’s annual plan.

## **DMH Strategy**

The DMH Homeless Outreach Program (HOP) continues to provide outreach, engagement, linkage, psychiatric treatment and follow-up services to individuals who are homeless. The HOP has also continued to provide community consultation to the provider network most closely involved with the population. The HOP consumers are unsheltered, residing in low barrier shelter, transitional programs, abandoned vehicles or buildings or other temporary residences.

The HOP staff includes 8 FTEs. Three (3) of the staff are funded by the Projects for Assistance in Transition from Homelessness (PATH) Grant.

## **Services for Children**

The DMH HOP has hired staff to work with children/youth and their families who are homeless. The activities include but are not limited to the following:

- Regular visits to programs for families and children who are homeless;
- Make referrals and connect parents and children who are homeless to other DMH programs and services, including as appropriate school mental health, multi-systemic therapy (MST), community-based intervention (CBI), etc.;
- Provide training as necessary to family providers and the D.C. Metropolitan Police Department (in collaboration with the DMH Training Institute and the Community Partnership for the Prevention of Homelessness as appropriate);
- Arrange emergency or crisis services as needed;
- Assist with housing resources as appropriate;
- Develop Family Emergency Rounds case coordination activity to meet monthly with all providers of family services working with families who are at risk of losing their children, their housing or in psychiatric or substance abuse crisis;
- Regular participation in monthly meetings (Family Focus Group, DMH Children's Provider Meeting); and
- Coordinate care with School Mental Health Program staff, Access HelpLine, Mental Health Rehabilitation Services (MHRS) providers, Children's Hospital etc.

The anticipated result of this work is that DMH will engage 100 or more children/youth who are homeless each year, which is consistent with target for Dixon Exit Criterion #16 – Engagement of Homeless Children and Youth.

The HOP statistics related to the Dixon Exit Criteria for the period April 1, 2008 through March 31, 2009 includes the following:

Adults (unduplicated count)	1,330
Children (unduplicated count)	185
Adults, Children & Families (face-to-face)	3,465

# 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 - Resources for Providers

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

## **CHILD RESOURCES FOR PROVIDERS**

### **Financial Resources**

See Adult Plan – Resources for Providers – Financial Resources for details about FY 2010 funding for mental health services.

The planned resources from Intra-District transfers include the following:

- Child and Family Services Agency (CFSA)- \$2.5M toward sustaining the Choice Provider contracts, enhancing and building capacity in implementing evidence-based practices.
- Department of Youth Rehabilitation Services (DYRS)- \$226,523 and CFSA- \$452,046 Wraparound services.
- Office of the State Superintendent of Education (OSSE)- \$1.3M for Wraparound services.

### **Information Systems**

See Adult Plan – Resources for Providers - Information Systems for details about information systems for children.

### **Human Resource Development Issues**

See Adult Plan – Resources for Providers – Human Resource Development Issues for details about staffing of child/youth programs and human resource development for child providers.

### **DMH Training Institute and Training for Child Mental Health Services Providers**

#### **Training for Child Mental Health Services Providers**

The training for the Choice Providers will include:

- Trauma Focused Cognitive Behavior Therapy,
- Functional Family Therapy,
- Parent Child Interactive Therapy,
- Child Parent Psychotherapy for Family Violence, and
- Community-Based Intervention (CBI).

The DMH Training Institute provides education and training services on a variety of issues related to child and youth systems of care. It also offers recurring introductory and overview trainings for providers, consumers and DMH staff. These trainings occur on a quarterly to bi-annual basis and include the following child/youth and family related topics:

- DMH 101 – Designed for multiple stakeholder audiences to provide an overview of the processes for accessing mental health services.
- Community-Based Intervention (CBI) 101 – Reviews the components, theory and research on CBI, as well as practical information for appropriate recipients of the service, and how to access it.
- System of Care 101 – Provides an overview of Systems of Care philosophy, values and supports within the District.
- Meeting the Mental Health Needs of Youth Receiving Residential Treatment – Provides overview of children/youth receiving psychiatric residential treatment services.

The Training Institute has also sponsored or co-sponsored the following ongoing training initiatives and series directed toward child/youth providers:

- Level of Care Utilization System/Child & Adolescent Level of Care Utilization System (LOCUS/CALOCUS) train-the-trainer initiative
- Community Service Review (CSR) Child Review Training

Other training conducted during in FY 2009 includes the following:

- Domestic Violence 101 Teen Dating Violence for Teens
- Teen Dating Violence Training for Providers

# District of Columbia

## Child - Emergency Service Provider Training

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

See Adult Plan for information about emergency service training for child providers.

# 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

See Adult Plan for grant expenditures for information about the allocation of the  
FY 2010 Block grant funds for child projects.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	3,123	3,245	3,123	5,525	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:** To improve access to care.

**Target:** Target is consistent with the penetration rate target for children established by Dixon Exit Criterion #5 - 5% of the estimated child/youth population in the District of Columbia.

**Population:** Estimated child/youth population in the District of Columbia

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

**Indicator:** Number of children/youth receiving at least one mental health service during the reporting period.

**Measure:** Number of children/youth receiving at least one mental health service during the reporting period as a percentage of the total population of children and youth.

**Sources of Information:** Contract management system.

**Special Issues:** During FY 2009, the Department on Health Care Finance (DHFC) and DMH developed an MOU with respect to the District’s enrollees in Medicaid and the D.C. Alliance Health Care Managed Care Programs including the coordination and reporting of mental health services provided to children and youth enrolled in the Medicaid MCOs.

**Significance:** Required to exit from Court Oversight.

**Action Plan:** Continue MOU with DHCF to improve data collection and integrity for the MCOs. Also, during FY 2010, DMH will move toward full implementation of Medicaid billing pilot for the School Mental Health Program.



**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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	22.81	2.56	3.40	4	N/A
Numerator	13	2	--	--	--
Denominator	57	78	--	--	--

Table Descriptors:

- Goal:** Improve continuity of care.
- Target:** Establish number of children/youth re-admitted to inpatient care within 30 days of discharge at 4.0%.
- 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 Care Finance Data.
- Special Issues:** During FY 2007, DMH began to analyze the historical data and to collect new data for analysis. It was determined that there may be problems with the integrity of the historical data and that further work was required to ensure data integrity. In February 2008, Riverside Hospital closed leaving two providers, Children’s National Medical Center (CNMC) and Psychiatric Institute of Washington (PIW). Given the issues for FY 2007 and FY 2008, and the data for FY 2009 is not a complete fiscal year, the FY 2010 target is set at 4.0%.
- Significance:** This is a national outcome measure.
- Action Plan:** The DMH refers children to two facilities for inpatient care (Children’s National Medical Center and Psychiatric Institute of Washington). During FY 2007- FY 2009 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). DMH also 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 2010.

**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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	12.28	6.85	6.82	8	N/A
Numerator	7	5	--	--	--
Denominator	57	73	--	--	--

Table Descriptors:

- Goal:** Improve continuity of care.
- Target:** Establish the number of children re-admitted to inpatient care within 180 days of discharge at 8.0%.
- 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 during the reporting period.
- Measure:** Number of children/youth discharged from inpatient care during the reporting period.
- Sources of Information:** Contract management system, Department of Health, Medical Assistance Administration data.
- Special Issues:** During FY 2007, DMH began to analyze the historical data and to collect new data for analysis. It was determined that there may be problems with the integrity of the historical data and that further work was required to ensure data integrity. In February 2008, Riverside Hospital closed leaving two providers, Children’s National Medical Center (CNMC) and Psychiatric Institute of Washington (PIW). Given the issues for FY 2007 and FY 2008, and the data for FY 2009 is not a complete fiscal year, the FY 2010 is set at 8.0%.
- Significance:** Required to exit from Court Oversight.
- Action Plan:** The DMH refers children to two facilities for inpatient care (NCCMC and PIW). During FY 2007- FY 2009, 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). DMH also 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 2010.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	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 - Children with SED Receiving Therapeutic Foster Care  
(Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	25.32	24.61	25	25	N/A
Numerator	568	555	--	--	--
Denominator	2,243	2,255	--	--	--

Table Descriptors:

- Goal:** To improve the array of community-based services and supports available to children/youth with the most complex needs and divert them from more restrictive levels of care, such as psychiatric residential treatment facilities (PRTFs).
- Target:** Maintain the children and youth who receive therapeutic foster care at 25% in FY 2010.
- Population:** Children and youth in the District of Columbia who require more intense services to remain in the community
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Number of children/youth receiving therapeutic foster care for the reporting period
- Measure:** Number of children/youth in foster care for the reporting period
- Sources of Information:** Child and Family Services Agency (CFSA) FACES- electronic records database
- Special Issues:** This is a child welfare system goal and outcome.
- Significance:** Therapeutic foster care is part of a continuum of services aimed at maintaining children/youth in the foster care system, in their communities versus more restrictive levels of care such as PRTFs.
- Action Plan:** Through its partnership with CFSA DMH will continue to advocate for increased therapeutic foster care placements for youth who require intensive services to remain in the community.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Children with SED Receiving Multi-Systemic Therapy  
(Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	3.04	3.17	2.80	3	N/A
Numerator	95	103	--	--	--
Denominator	3,123	3,245	--	--	--

Table Descriptors:

- Goal:** To improve the range of services available to children and youth and to divert them from psychiatric residential treatment facility (PRTF) placement.
- Target:** The FY 2010 target remains at 3%.
- Population:** Children and youth at risk of admission to a PRTF.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Number of children and youth who receive MST.
- Measure:** Number of children and youth who receive at least one MHRS.
- Sources of Information:** Contract management system -- Medicaid claims.
- Special Issues:** There is only one MST provider, Youth Villages.
- Significance:** One of the evidence-based practices used in the child system of care, intended to provide alternatives to PRTF admission for children and youth with SED who are also involved in the child welfare and juvenile justice systems.
- Action Plan:** Continue to make service available in fidelity to the model.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Children with SED Receiving Family Functional Therapy  
(Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	48.08	35.62	48	80	N/A
Numerator	25	26	--	--	--
Denominator	52	73	--	--	--

Table Descriptors:

- Goal:** Increase the system performance rating for services provided to children/youth as measured by the annual Dixon community service review.
- Target:** Target is consistent with the Dixon Exit criterion #4- that system performance is measured at 80% in the annual Child/Youth Community Service Review.
- Population:** Children/youth 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.
- Sources of Information:** Annual community service reviews, conducted by the Dixon Court Monitor. Annual Youth Services Survey for Families (YSS-F), as part of the MHSIP Survey process. Consumer satisfaction surveys conducted by consumer organizations.
- Special Issues:** This is one of the Dixon exit criteria. The performance target of 80% system performance was established in the consent order setting forth the exit criteria. In FY 2007, FY 2008 and FY 2009 the performance was 48%, 36% and 48%, respectively. Longstanding issues include lack of effective team formation and team functioning. The target for exiting active monitoring for this exit criterion is 80% system performance and will remain at 80% for FY 2010.
- Significance:** Achievement of 80% systems performance is required by the terms of the Dixon consent order to exit from federal court oversight.
- Action Plan:** In FY 2009, DMH created a Community Service Review Unit within the Office of Programs and Policy. This unit will assume an increasing role in the CSR process. An outgrowth of the 2009 review was a workshop attended by 14 CSAs serving children/youth, where issues that have persisted were addressed (team formation and team functioning). Follow-up activities will continue in FY 2010. Also, there will be continued emphasis on the family/child team model that offers a family-centered, evidence-based approach to strengthening the work of teams.

**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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	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 Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	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)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	78.61	92.30	80	85	N/A
Numerator	632	683	--	--	--
Denominator	804	740	--	--	--

Table Descriptors:

**Goal:** To improve child social supports/social connectedness.

**Target:** Increase social connectedness at 85%.

**Population:** Children and youth

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

**Indicator:** MHSIP survey.

**Measure:**

**Sources of Information:** MHSIP.

**Special Issues:** The FY 2009 MSHIP Survey will not begin implementation until the beginning of FY 2010.

**Significance:** This is a federal reporting requirement for the Data Infrastructure Grant(DIG) and the Mental Health Block Grant.

**Action Plan:** The DMH will complete the FY 2009 MHSIP Survey process including the Youth Services Survey for Families (YSS-F) during the first quarter of FY 2010.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	74.46	72.86	75	75	N/A
Numerator	752	674	--	--	--
Denominator	1,010	925	--	--	--

Table Descriptors:

**Goal:** To improve child outcomes by improving functioning.

**Target:** Maintain level of functioning at 75%.

**Population:** Children and youth

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

**Indicator:** MHSIP Survey

**Measure:**

**Sources of Information:** MHSIP

**Special Issues:** The FY 2009 MSHIP Survey will not begin implementation until the beginning of FY 2010.

**Significance:** This is a federal reporting requirement for the Data Infrastructure Grant (DIG) and the Mental Health Block Grant.

**Action Plan:** The DMH will complete the FY 2009 MHSIP Survey process including the Youth Services Survey for Families (YSS-F) during the first quarter of FY2010.

# District of Columbia

## Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan

**DISTRICT OF COLUMBIA  
STATE MENTAL HEALTH PLANNING COUNCIL**



August 28, 2009

Barbara Orlando  
Grants Management Specialist  
Division of Grants Management, OPS, SAMHSA  
1 Choke Cherry Road, Room 7-1091  
Rockville, Maryland 20857

Dear Ms. Orlando:

I am submitting this letter on behalf of the District of Columbia State Mental Health Planning Council (D.C.SMHPC) to convey our views about the District of Columbia FY 2010 Community Mental Health Services Block Grant Application.

**D.C. SMHPC View of Department of Mental Health Initiatives, Programs, and Services**

Our Council's fundamental belief about the Department of Mental Health (DMH) initiatives, programs and services in general, and those specifically funded by the Mental Health Block Grant, is that they should: 1) directly benefit children and youth with serious emotional disturbances (SED) and their families, and adults with serious mental illness (SMI), 2) be innovative including use of evidence-based and/or promising practices, 3) identify measurable results, 4) describe consumer outcomes, and 5) be monitored and evaluated. It is this belief that guides our Council's deliberations and activities, participation in DMH and other planning initiatives, and our review and critique of the District's Mental Health Plan.

**Some DMH Noteworthy Initiatives**

There are a number of DMH initiatives that are noteworthy. These include but are not limited to the following: 1) creating a Peer Specialist Certification program, 2) examining the interface between primary health and behavioral health, 3) implementing a Crisis Intervention Collaborative to positively impact the interactions between the police and persons with mental illnesses, 4) expanding crisis services to include adult mobile crisis services and child and youth mobile crisis services and stabilization beds, 5) forming interagency partnerships that will expand the supported housing units and the supported

employment services available to DMH consumers, 6) forming interagency partnerships that provide resources for the child and youth Choice Provider network and the wraparound services, 7) expanding the School Mental Health Program including the populations served, 8) completing the first year of operation for the consumer Wellness and Resource Center and the Court Urgent Care Clinic, and 9) initiating the process to create a 3-5 year comprehensive mental health plan for children and youth.

## **Issues of Concern**

### Housing for Mental Health Consumers

Our Council is concerned about housing for mental health consumers. The District's permanent supportive housing (PSH) initiative for homeless persons with disabilities targeted the shelter population. Also, some of the DMH provider agencies have PSH initiatives for persons within their network of programs. The DMH Housing Division provides housing for a number of mental health consumers that include persons leaving inpatient settings, persons leaving jail, persons who are homeless, persons living in group homes (community residence facilities and transitional settings), and transition age youth. How do these and other housing initiatives in the District come together in a way that expands the housing options for mental health consumers and other disability categories?

Our Council believes that DMH should develop a 5-year Housing Plan. This would involve: 1) a representative group of people from public and private housing, 2) a representative group of people from the different types of populations to be housed, 3) data collection on the number of persons housed, the number of persons on a wait list to be housed, length of time on the wait list, housing units coming on line annually, existing and potential opportunities to secure units in housing development throughout the District, 4) benchmark other urban areas to determine what works and what does not work, 5) an assessment of the housing continuum from group homes through supported housing to independent living (including the stepwise progression to other subsidized and non-subsidized housing), 6) an assessment of the different housing services and supports that are needed at different stages of recovery (including the role of the case worker), 7) an assessment of available public property such as school buildings not in use, 8) an assessment of financial resources for developing and implementing various phases of the plan including public, private, and grant funding, and 9) an assessment of the resources (people and money) to implement a viable housing program.

### Transition Age Youth and Older Adults

Our Council has long believed that services for transition age youth and older adults represent two major service system gaps. The Council initiated a Special Request for Projects to be supported under the FY 2008 Block Grant for both populations. The funding supported the development of a Transition Youth Guide and adult projects that focused on creative expression (art, photography, prose) for older adult forensic populations, the integration of a mental health program in a Spanish Senior Center, and a Senior Health and Wellness Project for persons who are homeless. Absent a conceptual

framework that addresses the service needs of these populations, it is unclear whether these projects met program needs versus system service delivery needs.

While the FY 2010 Block Grant Application mentions developing a plan for transition age youth, and beginning to forge partnerships related to older adults, no details were provided. Our Council puts forth the following questions for consideration in developing a clearly articulated service strategy for addressing the needs of both transition age youth and older adults. What do we know about these populations? How many are in the system? Where are they in the system? What unique service needs do they represent? What services do they receive? What is the relationship between the services they need and those they receive? What public and private community resources are available to assist DMH address their service needs? What partnerships can DMH form related to available resources for these populations? How do other states address the service needs of these populations? What resources will be identified to implement the planned service strategies for these populations?

#### Monitoring of DC CSA Transition

At the Council's August 19, 2009 meeting, concern was expressed about monitoring the DC CSA consumers enrolling with a new provider agency. The DC CSA Consumer Transition Monitoring Plan (revised 4/9/09) was subsequently provided to the Council for review. The Office of Accountability has primary responsibility for monitoring the DC CSA transition process. This monitoring includes: 1) Consumer Satisfaction Surveys (initial 90 days, follow-up 9 to 12 month from date of transition), 2) Continuity of Care Monitoring (initial focus on timely provision of services following transfer, continuation of pre-transfer services and frequency of service provision, any changes in diagnosis or medications prescribed since transfer; one year follow-up same items), and 3) Consumer Transition Voucher (CTV) Claims Auditing (provider agencies receiving DC CSA consumers are eligible for CTV payments that are audited to ensure compliance with the CTV Rule).

Our Council's questions include the following:

- What is the process when the consumer expresses dissatisfaction with the new provider agency and is the remedy immediate or contingent upon factors such as whether there is open enrollment among the other provider agencies?
- Is the only baseline the pre-transfer status of the consumer?
- Will other post-transfer variables be assessed that might signal "a red flag" such as: 1) utilization of crisis services (crisis beds, mobile crisis team, extended observation beds, inpatient hospitalization, etc), 2) increased suicidal ideation and/or suicide attempts, 3) medical hospitalizations, 4) loss of housing, and 5) loss of employment?
- Will other post-transfer variables be assessed considered to represent positive adjustment and/or development?

The Council will invite appropriate DMH staff to an upcoming meeting to begin discussion about these issues.



### Displacement of Parent Group

Our Council learned of the displacement of a parent group as a result of the DC CSA transition process. The Family Alliance and Children and Adults with Attention Deficit Disorders (CHAD) met at one of the DC CSA facilities. The group of 15-20 families met twice a month, 6:30 p.m-8:30 p.m., and were provided a meal and child care. The goal is to try to get the parents back together and give them stability. Our Council recommends that DMH assist them in this process.

### System Re-Design

The details of the system re-design is not outlined and may not be available at this time. Our Council is concerned about consumers with intensive service needs. Some intensive services as well as other services may not be perceived as profitable and may not lend themselves to contractual arrangement. However, these services may represent a real need among the consumer population. The Council recommends that DMH identify these kinds of service needs and a strategy for how they will be addressed in the system re-design.

Our Council looks forward to continuing to work with DMH programs in order to improve the delivery of mental health services for District residents.

Sincerely,



Burton E. Wheeler, Jr.

Interim Chair D.C. State Mental Health Planning Council

# 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.



**D.C. Department of Mental Health  
Certified MHRS Providers**

**MHRS Provider**

**CEO**

**Street**

**City**

**State**

**Zip**

**Phone/email**

**Provider Relations**

API Associates	Dr. James Williams	7826 Eastern Avenue, N.W. Suite LL18	Wash.	DC	20012	202-291-0912 jwilliams@apiassociatesinc.com	T. Crews
Affordable Behavioral Consultants	Ms. Christine Williams	1400 Mercantile Lane Suite 206 212 Riggs Rd., NE	Largo Wash	MD DC	20774 20011	301-386-7722 202-636-4520 <a href="mailto:Christine.Williams@abccares.net">Christine.Williams@abccares.net</a>	J. Alleyne
*Anchor Mental Health	Ms. Denise Capaci	1001 Lawrence St., NE	Wash.	DC	20017	202-635-5900 Denise.Capaci@catholiccharitiesdc.org	T. Crews
Boys and Girls Town of Washington DC	Lyn Corbett	4801 Sergeant Road, NE	Wash.	DC	20017	832-7343 Ext.307 Corbett@girlsandboystown.org	T. Crews
CARECO	Mr. Dennis Lewis Corporate Office	6323 Georgia Avenue, NW Suite 206 8555 16 <sup>th</sup> St., Suite 240	Wash. SS	DC MD	20011 20910	202-722-1397 <a href="mailto:dennislewis@carecogroup.com">dennislewis@carecogroup.com</a> 301-565-9400	J. Alleyne
*Capital community Services, LLC	Mr. Dwayne Jones	1310 Southern Avenue, SE	Wash.	DC	20020	202-574-6054 dwaynejones@aol.com	T. Crews
*Community Action Group	Janice Gordan	3325 13 <sup>th</sup> St., SE Pennsylvania Ave., SE	Wash.	DC	20003	202-373-0655 202-543-4558 Ext-101 Jgordon@communityactiongroup.org	T. Crews
*Community Connections, Inc.	Ms. Helen Bergman	801 Pa. Ave. SE	Wash.	DC	20003	202-546-1512 <a href="mailto:Hbergman@CCDC1.org">Hbergman@CCDC1.org</a>	V. Hamilton
CPEP	Ms. Cynthia Holloway	1905 E Street, SE	Wash.	DC	20003	202-673-9319 <a href="mailto:Cynthia.holloway@dc.gov">Cynthia.holloway@dc.gov</a>	T. Crews
*District of Columbia Community Services Agency (DC CSA)	Michael Biernoff, Md	35 K Street, NE	Wash.	DC	20002	202-671-4027 Michael.Biernoff@dc.gov	V. Hamilton
Deaf-Reach	Ms. Sara Brown	3521 12th St. NE	Wash.	DC	20017	202-832-6681 <a href="mailto:browns@deaf-reach.org">browns@deaf-reach.org</a>	T. Crews

*Family Matters of Greater Washington	Ms. Tonya Jackson Smallwood	1509 16 <sup>th</sup> Street, NW	Wash.	DC	20036	202-289-1510 TSmallwood@fcsdc.com	T. Crews
*Family Preservation	Mr. Rick Smith Mr. Harold Singletary	810 Potomac Avenue, SE	Wash.	DC	20003	540-761-7999 rsmith@fpscpcorp.com 202-543-0387 hsingletary@fpscpcorp.com	T. Crews
*Fihankra Place, Inc	Mr. Kelvin Elmore	2041 Martin Luther King Jr., Ave Suite 205	Wash	DC	20020	202-547-8450 kelmore@fihankraplace.org	T. Crews

**MHRS Provider  
Relations**

	<b>CEO</b>	<b>Street</b>	<b>City</b>	<b>State</b>	<b>Zip</b>	<b>Phone/email</b>	<b>Provider</b>
*First Home Care Corporation	Ms. Rose Bruzzo	1012 14th St., NW, #1400	Wash.	DC	20005	202-737-2554 Rose.bruzzo@absfirst.com	T. Crews
*GUH-Kids Mobile Medical Clinic	Dr. Matthew D. Levy	3800 Reservoir Road, NW	Wash.	DC	20007	202-444-2215 md12@georgetown.edu	J. Alleyne
*Green Door	Ms. Judith Johnson	1221 Taylor St., NW	Wash.	DC	20011	202-464-9200 <a href="mailto:Judith.Johnson@greendoor.org">Judith.Johnson@greendoor.org</a>	J. Alleyne
*Hillicrest Children's Center	Ms. Juanita Price 1 <sup>st</sup> Floor	2570 Sherman Avenue, NW	Wash.	DC	20009	202-232-6100 ext 12 mPrice@hillicrestchildrenscenter.org	T. Crews
Integrated Behavioral Services Group	Ms. Mary Samba	2041 Martin Luther King Jr. Ave. Suite 201	Wash	DC	20032	202-610-1444 IBSG2003@yahoo.com	J. Alleyne
*LAUNCH, LLC	Ms Rhonda Baskerville	6856 Eastern Ave., NW, Suite 286	Wash.	DC	20012	202-723-6600-291-0951 Rhonda.baskerville@LAUNCH4change.com	T. Crews
*Latin American Youth Center	Mr. Carlos Vera	1419 Columbia Rd., NW	Wash.	DC	20009	202-319-2225 <a href="mailto:carlos@layc-dc.org">carlos@layc-dc.org</a>	J. Alleyne
*Life Stride, Inc.	Ms. Joyce L. Drumming	3005 Bladensburg Rd. NE	Wash.	DC	20018	202-635-2320 jdrumming@earthlink.net	V. Hamilton
*Mary's Center	Ms. Maria Gomez	2333 Ontario Road, NW	Wash.	DC	20009	202-483-8319 MGomez@MarysCenter.org	J. Alleyne
*MD/DC Family Resource	Mr. Leonard Bivins	6192 Oxon Hill Road(suite 202) Dr. Beth Crawford	Oxon Hill	MD	20745	301-567-8311-301-333-2980 Landover MD 20785	J. Alleyne
<a href="mailto:lbivins@mfrinonline.com/bcrawford@mfrinonline.com">lbivins@mfrinonline.com/bcrawford@mfrinonline.com</a>							

*McClendon Center	Mr. Richard Davis	1313 New York Ave., NW 1338 North Capitol Street, NW	Wash. Wash.	DC DC	20005 20002	202-737-6191 202-745-0073 ddavis@mcclendondc.org	J. Alleyne
*Neighbors Consejo	Ms. Judy Diaz	3118 16 <sup>th</sup> Street, NW	Wash.	DC	20010	202-234-6855 Judy@neighborsconsejo.org	J. Alleyne
Pathways To Housing	Ms. Linda Kaufman	101 Q Street, NE Suite G	Wash.	DC	20002	202-529-2972 lkaufman@pathwaysdc.org	J. Alleyne
Positive Nature Inc.	Ms. Jennifer Murphy	3030 G. Street, SE	Wash.	DC	20019	202-698-1795 jmurphy@positivenatureinc.com	T. Crews
*PSI	Dr. Yvonne Ali Mr. William Howard	770 M Street, SE	Wash.	DC	20003	202-547-3870 <a href="mailto:YAli@PSIfamilyservices.com">YAli@PSIfamilyservices.com</a>	T. Crews whoward@asiworks.com

**MHRS Provider Relations**

	CEO	Street	City	State	Zip	Phone/Email	Provider
*Psychiatric Center Chartered	Ms. Elere Hall	3001 Bladensburg Rd. NE	Wash.	DC	20018	202-635-3577 ehall@psych-center.com	V. Hamilton
Pride Youth Services	Mr. Ludley Howard	3230 Pennsylvania Ave., SE Suite 210	Wash.	DC	20020	202-575-0238 <a href="mailto:lhoward@prideyouthservices.org">lhoward@prideyouthservices.org</a>	J. Alleyne
*Progressive Life	Dr. Laurence Jackson	1704 17 <sup>th</sup> Street, NE	Wash.	DC	20002	202-842-2016 ljackson@picntu.org	J. Alleyne
*RC+DC Counseling Center	Dr. David Zahm	2526 Pennsylvania Ave., SE	Wash.	DC	20020	202-581-6328/410-223-1088 dzahm.roi.corp@verizon.net	T. Crews
Sasha Bruce Youthwork, Inc.	Ms. Deborah Shore	741 8 <sup>th</sup> Street, SE	Wash.	DC	20003	202-675-9340 dshore@sashabruce.org	T. Crews
*Scruples Corporation	Ms. Sharon Yorke-Cyrus	2811 Pennsylvania Ave., SE	Wash.	DC	20020	202-581-2457or 2455 <a href="http://svcyrus@scruplescorporation.org">svcyrus@scruplescorporation.org</a>	T. Crews
St Paul House	Rev. Darrell Macklin	1611 Brentwood Road, NE	Wash.	DC	20018	202-832-1218 Saintpaulhouse@RCN.com	J. Alleyne

*Universal Healthcare Management	Ms. Terry N. Patterson	3230 Pennsylvania Ave., SE Suite 213	Wash. DC	20020	202-583-1181 <a href="mailto:tpatterson@uhmsdc.com">tpatterson@uhmsdc.com</a>	J. Alleyne
*Volunteers of America Chesapeake	Mr. Russ Snyder	7901 Annapolis Road 1330 New Hampshire, Ave.	Lanham Wash DC	20706 20009	301-459-2020 202-223-9630 Rsnyder@voaches.org	T. Crews
Wade & Wade	Ms. Zenobia Wade	3005 Bladensburg Rd., NE	Wash. DC	20018	202-269-3506 or 202-607-6769 zwade1@aol.com	J. Alleyne
*Washington Hospital Center	Dr. Lourdes G. Griffin	216 Michigan Ave., NE	Wash. DC	20017	202-877-6333 lourdes.g.griffin@medstar.net	J. Alleyne
Woodley House Inc.	Mr. Gary Fyre	1221 Taylor Street, NW	Wash. DC	20011	202-328-4069 gfyre@woodleyhouse.org	J. Alleyne
Youth Villages	Mr. Paul Enderson Ms. Lily Sojourner	2020 North 14 <sup>th</sup> Street	Arlington VA	22201	865-560-2548 -703-516-6950 <a href="mailto:paul.enderson@youthvillages.org">paul.enderson@youthvillages.org</a> Lily.sojourner@youthvillages.org	T. Crews

Updated 7/27/09

### Child/Youth Serving Agencies

**\* CSAs**

