District of Columbia

UNIFORM APPLICATION
2011

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_ FY2011

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

NAME: Stephen T. Baron TITLE: Director

AGENCY: Department of Mental Health

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III. STATE FISCAL YEAR

FROM: 10/01/2010 TO: 09/30/2011

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

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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) is currently organized into two major components, i.e., Mental Health Authority and Saint Elizabeths Hospital (inpatient services). The Mental Health Authority also directly operates the Comprehensive Psychiatric Emergency Program (which includes the adult Mobile Crisis Team, extended observation beds and the homeless outreach program), the school-based mental health program (which includes an early childhood consultation program), and the Mental Health Services Division (which consists of several specialty mental health programs, including a physician's practice group that serve approximately 1,000 people).

On September 4, 2009, the District of Columbia filed a "Motion to Vacate the December 12, 2003 Consent Order and to Dismiss Action." The primary reason for taking this action is the District's belief that it has remedied the original violation of law (unnecessarily hospitalizing mental health consumers in Saint Elizabeths Hospital when they could be treated in less restrictive environments); by creating a mental health system that provides treatment in the least restrictive environment through a broad range of community-based services and supports.

The Plaintiffs filed an Opposition on November 18, 2009. The District's reply to the opposition is due by September 7, 2010. The regularly scheduled bi-annual Status Conference will be convened on October 14, 2010.

The main focus for FY 2011 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. Since the submission of the last application, four (4) additional exit criteria have moved to inactive status. As of August 22, 2010, ten (10) of the Exit Criteria are inactive and nine (9) remain with one pending request for inactive monitoring status.

Other areas of focus for FY 2011 include the development and implementation of a system re-design for the community system that addresses both access and range of services; the continued implementation and improvement of services provided by the Mental Health Services Division; and continued focus on improved quality of care at Saint Elizabeths Hospital.

D.C. Community Services Agency Closure

In FY 2007, DMH began 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 (October 1st report). 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 1st 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 certain specialty services, including the community pharmacy, multicultural services program, and the Residents' clinic.

An implementation plan, which projected closure of the DC CSA by March 31, 2010, was developed and submitted to the Council in January 2009. The plan involved transitioning approximately 4,000 DC CSA consumers and continued operation of certain direct care services through the Mental Health Services Division. Consumer transfers occurred throughout FY 2009. In August 2009, the DC CSA officially closed and all remaining government operated services were consolidated into the Mental Health Services Division.

As of March 11, 2010, three thousand one hundred thirty-three (3,133) consumers had been transferred to the private provider network. The Office of Accountability will continue its role in monitoring the transition of consumers from the DC CSA until a full year after the transition so the last survey will occur in Spring 2011.

The Mental Health Services Division serves approximately 3,337 adult and child consumers in the community. This Division is responsible for implementing the government operated mental health services that include: same day service/urgent clinic, physician's practice group (adult and child), psychiatric residents' clinic, multicultural services program, deaf/hard of hearing intellectual disabilities program, outpatient competency restoration program, and pharmacy. The MHSD provides specialized mental health services that are not otherwise readily available within the DMH service system or the private sector.

System Redesign

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 several principles. 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.

A work group was formed that includes consumer, provider, mental health and community-based organizations, and District agencies. During FY 2010, four (4) sub-committees were formed to examine and develop recommendations for the redesign. The sub-committees include: 1) child services (with an emphasis on services to children under age 5); 2) free standing mental health clinics (with an emphasis on co-occurring disorders); 3) health information technology (with an emphasis on high-level needs for the public mental health system); and 4) provider restructuring (with an emphasis on the CSA/sub-provider construct and determining how the provider system will look in the redesign). Each of the sub-committees issued a preliminary report describing the issues and process that would be employed in producing a final report with feedback from the whole work group. The planning activities will continue in FY 2011.

Saint Elizabeths Hospital

The construction of the new Saint Elizabeths Hospital building was completed in December 2009 and the building occupancy permit was issued in January 2010. Staff began moving into the facility in late March. On April 22, 2010, the new Saint Elizabeths Hospital Building was dedicated with the mayor, numerous other city officials, and members of the local and federal judiciary in attendance. On May 3, 2010 individuals in the hospital's care moved into the new building. Later in the same week, they received an orientation to the two Therapeutic Learning Centers and by May 10, 2010 individuals in the hospital's care had resumed participating in a full day of therapeutic programs in the centers.

Saint Elizabeths Hospital continues 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. The Hospital has continued to provide coaching/training to treatment teams on interdisciplinary recovery planning and a contract for additional consultant assistance in this regard was awarded at the end of March 2010. Also, during FY 2010 a positive behavior support team leader and two behavior support technicians were hired and a training overview on positive behavior support provided to the majority of direct care staff. The Hospital continues to focus on improving discharge planning; and continued reductions in size of the hospital census. Between August 24, 2009 and June 30, 2010, the Hospital has decreased its census from 364 (187civil patients and 177 forensic patients) to 316 individuals on its rolls, a 13.2% reduction.

During 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. The Gardens at Saint Elizabeths--A National Memorial of Recovered Dignity will include metal markers from all 50 states and the District of Columbia surrounded by gardens and a pool of water.

System-wide Initiatives and Activities

DMH continues 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.

Olmstead Conference: The DMH Office of Consumer and Family Affairs (OCFA), in collaboration with the D.C. Office of Disability Rights, sponsored the second annual Olmstead Conference on December 18, 2009. The conference was largely organized, planned and attended by consumers. The conference theme, "Social Inclusion and Community Living" was well received by the approximately 250 attendees. Planning has already begun for the third conference in October 2010.

Consumer Initiatives: Several consumer initiatives and support activities that were launched in FY 2009 continued during FY 2010. These include: 1) the Peer Specialist Certification Planning Work Group, 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 made a connection to a new provider, and 3) the Peer Transition Specialists initiative to assist persons in the care of Saint Elizabeths Hospital who have been determined ready for discharge in making a smooth transition to community living.

DMH continues to fund two (2) consumer-run organizations, the Consumer Action Network (CAN) and the Ida Mae Campbell Wellness and Resource Center (WRC). DMH has contracted with CAN for several years, to provide advocacy, obtain consumer feedback, and for training and outreach to consumers. CAN has also provided logistical support for the Community Service Review (CSR) process through a separate contract with the Court Monitor.

The WRC completed its second year as a self-help center. It provides targeted supports for consumers that include computer training, self-advocacy training, and "Double Trouble" (a

program for dealing with both mental illness and addiction issues). The WRC has continued its community education and outreach efforts. During FY 2010, in conjunction with Mental Health Awareness Month (May), WRC held a Mental Health Day forum that focused on issues related to HIV/AIDS. The attendance at the WRC was at 850 as of April 2010, compared to 245 in April 2009.

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: DMH continues to partner with other organizations 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. Sixty (61) officers successfully completed the program in FY 2009 and 93 completed it as of May 2010. The next CIO training is scheduled for the week of September 13-17, 2010.

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:

Integrated Care Division (ICD): This Division manages services that focus exclusively on individuals receiving inpatient services from Saint Elizabeths Hospital, who are in need of intensive care management to remain in the community. The target population includes: 1) consumers who are discharge ready but who are reluctant to leave and/or have complex needs; 2) consumers who are discharge ready and have been at Saint Elizabeths Hospital for six (6) months or more; and 3) consumers who have been admitted to an inpatient setting three (3) or more times in the 12-month period immediately prior to the current hospitalization. The overall goal is to reduce the census at Saint Elizabeths Hospital by avoiding admissions through more intensive community supports and facilitating discharge for the targeted populations. The Division also oversees the Integrated Community Care Project (ICCP), operated under contract by New Directions at Washington Hospital Center.

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 components include: Psychiatric Emergency Services (PES), Extended Observation Beds (EOB), and Mobile Crisis Services (MCS). During FY 2010, Homeless Outreach Program (HOP) became one of the CPEP programs. For the period October 1, 2009 through June 30, 2010, PES served 2,882 persons (duplicated count).

CPEP/Mobile Crisis Services Homicide Survivor Response Project: The CPEP/Mobile Crisis Services (MCS) will be partnering with the Executive Office of the Mayor (EOM) Office of Victim Services and the Metropolitan Police Department (MPD) to provide 24-hour response to homicide survivors following homicides in the District. MCS will provide homicide survivors with initial non-medical stabilization and mental health assistance, including linkage to ongoing grief and loss and/or other mental health care. If a homicide survivor is experiencing a psychiatric crisis, MCS will assess the individual and link them to the appropriate level of psychiatric care. MCS will provide follow-up services including: completing linkages to ongoing grief and loss and/or other mental health care (when appropriate), providing transportation to initial appointments, accompanying family members to the medical examiner's office (when asked), and attending vigils and funerals (when asked). Currently, MCS is working out the protocol with MPD and plan to begin providing direct services in the community as soon as this process is complete. MCS has already received initial funding through EOM Office of Victim Services.

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 $14M 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 2010 there were approximately 248 DMH housing units in the pipeline. As of June 30, 2010, sixty-three (63) of the pipeline units are online and 61 of the units are occupied. Of the remaining pipeline housing units, 32 are scheduled to come online by the end of 2010 and the remaining 26 are scheduled to come online in 2011.

Also, during FY 2010 DMH was one of several District agencies to partner with the D.C. Housing Authority in developing the application for the Rental Assistance for the Non-Elderly Persons with Disabilities Application. The District is requesting 200 vouchers with services and supports provided by the partner agencies (mental health, human services, health, and disability services).

Supported Employment: 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), which is expected to increase capacity by 150 individuals in the DMH contracted supported employment programs. In FY 2010, the supported employment programs received Mental Health Block Grant funds to provide services for the 43 consumers transferring from the Work Adjustment Training Program to competitive supported employment.

ACT Services: During FY 2009, seven (7) new ACT teams began delivering services and the three (3) DC CSA teams closed; requiring the transfer of all consumers from those teams to new teams. During FY 2010, there were 12 ACT teams. Also during FY 2010, an internal Fidelity Audit Team was developed. The Adult System of Care Manager and the ACT Coordinator served as the fidelity audit team leaders with staff support from other DMH programs (Office of Accountability, Provider Relations, and Integrated Care). The Dartmouth Assertive Community Treatment Scale (DACTS) was used. The results were discussed with the ACT teams and performance improvement plans developed. ACT enrollment increased from 397 at the end of September 2008 to 613 in September 2009. The June 30, 2010 ACT census was 891.

Children/Youth Services

The Child and Youth Services Division (CYSD) has continued to work collaboratively with the other 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).

A major planning initiative during FY 2010 was the initiation of a planning process to develop a Children's System of Care Plan for the District. The main goals of the Child Services Work Group are to: 1) identify the strengths and needs of the system; 2) develop strategic plans to address the identified gaps in the service system; and 3) develop recommendations for redesigning this component of the public mental health system.

One of the significant areas for development to be explored in the plan is the creation of a more robust, early childhood services platform. Other strategic initiatives include: 1) incorporation of a wider range of evidence-based practices; 2) further development of the Choice Provider network; 3) greater involvement of families and youth in service development, delivery and assessment of quality care; and 4) the reduction of the number of youth in psychiatric residential treatment facilities (PRTFs).

There have been a number of other major initiatives within CYSD during FY 2010. These include but are not limited to:

Early Childhood Mental Health Consultation Project: During FY 2010, DMH worked with the Department of Health Early Childhood Comprehensive System (ECCS) Grant Coordinator to launch the start-up phase of this pilot program that focuses on child and family-centered, and program consultation. The District's FY 2010 Mental Health Block Grant was one of the funding sources for this project. The primary goal of child and family-centered consultation is to address an individual child's (and/or family's) difficulties in functioning well in the early childhood setting. The programmatic consultation focuses on improving the overall quality of the program or agency and/or assisting the program to solve a specific issue that affects more than one child, staff member, and/or family. During FY 2010, services were implemented for children (ages 0 to 5) at 27 centers. These services are provided to children and families identified through child/family centered consultation at all centers as well as programmatic consultation to Child Development Center staff. These services will continue during FY 2011.

Parent Infant Early Childhood Enhancement Program (P.I.E.C.E.): During FY 2010, DMH began the process of developing the P.I.E.C.E. Program at the Howard Road site. This program will serve children age 5 and under. The program will serve up to 60 children and is expected to be fully operational by October 1, 2010. DMH began accepting limited referrals to the program that will provide parenting groups, infant observation, play and art therapy, and Parent Child Interaction Therapies.

School Mental Health Program: The DMH School Mental Health Program (SMHP) provides intervention and prevention services in public and charter schools throughout the District. During School Years 2008-2009 and 2009-2010, the SMHP operated in 58 schools. This is expected to continue during School Year 2010- 2011. The DMH Child and Youth Services Division launched the Primary Project in FY 2009 with a one-year grant via the Deputy Mayor of Education and funding continued in FY 2010. This evidence-based practice provides early intervention services to children identified with mild school adjustment issues in kindergarten through first grade, and expanded from 12 to 16 schools in FY 2010. The School Mental Health Crisis Team continued to respond to crises in the D.C. Public Schools.

Functional Family Therapy (FFT): In October 2009, DMH awarded a contract to FFT Inc. to provide training and technical assistance services to child-serving Core Service Agencies (CSAs) designated as Choice Providers. Four (4) of the six (6) Choice Providers began the initial step of readiness assessment. Three (3) phases were identified: 1) pre-implementation training and consultation (October- July 2010); 2) implementation and assessment training (July 2010); and 3) externship (about 6-8 months after the initial clinical training). Also during FY 2010, DMH

initiated the process to amend the Mental Health Rehabilitation Services (MHRS) Regulations to include reimbursement for FFT.

Transition Age Youth Development Project: The District's Mental Health Block Grant provided the funding that allowed DMH CYSD to begin to address some of the system gaps in service delivery to young adults who are transitioning from child services to adult services and from young adults into adulthood. This project was launched in FY 2010. The activities included: adoption of the Transition to Independence Process (TIP) model; two (2) site visits to programs that implemented this model; survey of DMH MHRS providers about young adults served; focus groups with young adults and providers; and contract to child provider to implement services and supports in accordance with the TIP model.

Suicide Prevention Grant: The District was awarded a 3-year Substance Abuse and Mental Health Services Administration (SAMHSA) State/Tribal Youth Suicide Prevention Grant (October 1, 2009 - September 30, 2012). The Capital CARES (Citywide Approach to Reduce Risk for and Eliminate Youth Suicide) grant focuses on preventing suicide and suicide behaviors among all youth in the District of Columbia. The activities during FY 2010 include convening the D.C. Youth Suicide Prevention Coalition; hiring a social marketing agency; the approval of four (4) community-based organizations to receive mini-grants; suicide prevention training; focus groups with youth; and disseminating a newsletter.

DC Choices High–Fidelity Wraparound Project: DMH CYSD in collaboration with CFSA and DYRS developed the Wraparound Project, which is operated via contract by DC Choices. The purpose of the contract is 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, the Community Wrap added 10 slots for a total of 34. In FY 2010, the Full Service School Wrap expanded to three (3) middle schools adding 10 slots and bringing the total slots to 110. The DC Wrap now has 144 combined slots.

Choice Provider Network: During FY 2010, there were six (6) active Choice Providers (Community Connections, Family Matters, First Home Care, Hillcrest Children's Center, MD Family Resource, and Universal Healthcare Management Services). 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: During FY 2010, Catholic Charities continued to operate the Child and Adolescent Mobile Psychiatric Service (ChAMPS) under contract with DMH. The goal of this service is to provide on-site 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. In February 2010, ChAMPS began operating the crisis/respite beds as needed for children/youth. During the first three quarters of FY 2010, ChAMPS received 822 crisis calls and deployed response teams for 444 of them. These services will continue in FY 2011, however due to under utilization of the crisis beds, they will not be continued.

Other CYSD initiatives include: 1) adopting criteria related to admission, discharge, continued stay, and exclusion in making decisions regarding residential placement, 2) creating specialized community capacity for high need children and youth, 3) providing clinical monitoring to all CFSA, DMH and fee-for-services Medicaid youth who are placed into psychiatric residential treatment facilities (PRTFs), and 4) 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 2011

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[1] 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 2011, 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:

[21]. 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 Stated Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

_____ _____

Governor Date
Stephen T. Baron, Director
XXXXXXX

OMB Approval No. 0920-0428

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, In eligibility, 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 undersigned, 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 an mental health of the American people.

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

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

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

1. **Type of Federal Action:**	2. **Status of Federal Action**	3. **Report Type:**
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report _____

4. **Name and Address of Reporting Entity:**	5. **If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:**
Prime Subawardee Tier _____ , *if known:* **Congressional District**, *if known:*	**Congressional District,** *if known:*
6. Federal Department/Agency:	7. **Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____
8. **Federal Action Number,** *if known:*	9. **Award Amount,** *if known:* **$**
10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*	**b. Individuals Performing Services** *(including address if different from No. 10a.)* *(last name, first name, MI):*
11. **Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.**	**Signature:** _____ **Print Name:** _____ **Title:** _____ **Telephone No.:** _____ **Date:** _____
Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

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

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

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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 Costal 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 con- struction 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

SF-424B (Rev. 7-97) Back

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.

PUBLIC COMMENTS ON STATE PLAN

The Draft District of Columbia FY 2011 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. þÿ I f t h e D i s t r i c t s F Y 2 0 1 1 B l o c k G r a n t A p 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 þÿ a n d a l s o a d d r e s s e d a t t h e D i s t r i c t s F Y 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 2009	Estimate/Actual FY 2010
$6,429,000	$18,704,885	$15,546,746

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	Actual FY	Actual/Estimate FY

2008	2009	2010
$96,283,218	$94,623,403	$86,685,801

MOE Shortfalls

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

(1). Waiver for Extraordinary Economic Conditions

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

(2). Material Compliance

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

TABLE 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Awosika, Samuel O.	Consumers/Survivors/Ex-patients(C/S/X)	DMH/Saint Elizabeths Hospital/Consumer Advocate	4201 Fort DuPont Terrace, SE Washington,DC 20020 PH:202 299-5157 FAX:202 561-6974	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:202-265-	bhollidaypsy@gmail.com

			8308 FAX:	
Holt, Maude R.	State Employees	Medicaid	825 North Capitol Street, NE Room 4330 Washington,DC 20002 PH:202-724-7491 FAX:202-478-1397	maude.holt@dc.gov

TABLE 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
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
Neboh, Edmund	State Employees	Vocational Rehabilitation	810 First Street, NE, 10th Floor Washington,DC 20002 PH:202-442-8633 FAX:202-442-8742	edmund.neboh@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 (	Family Members of Children with SED	Family Alliance for Community Support	66 Allison Street, NE Washington, D.C.,DC 20011 PH:202- 832-0806 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

TABLE 1. List of Planning Council Members

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:202-526-3449 FAX:	patrick.tayman@yahoo.com
Wheeler, Burton E.	Family Members of adults with SMI		3800 25th Street, NE Washington,DC 20018 PH:202-468-5607 FAX:202-392-1014	burton.globalbiz@gmail.com

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	16	
Consumers/Survivors/Ex-patients(C/S/X)	3	
Family Members of Children with SED	2	
Family Members of adults with SMI	2	
Vacancies(C/S/X and Family Members)	0	
Others(not state employees or providers)	1	
TOTAL C/S/X, Family Members and Others	8	50.00%
State Employees	7	
Providers	1	
Vacancies	0	
TOTAL State Employees and Providers	8	50.00%

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.

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

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

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

B. State Mental Health Planning Council Charge, Role and Activities

During FY 2010, 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 2010 Community Mental Health Services Block Grant include:

- The implementation the Request for Projects and review process for funding consideration under the FY 2010 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, six (6) non-DMH adult projects (teaching consumer survival skills, summer air conditioning, passport to health, veterans family reunification, weekend day socialization program, community reintegration for forensic consumers), and a DMH housing project for transition age youth, persons leaving jail, and persons requiring intensive services).

  The child projects included: 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 for early childhood mental health consultation.

- The Council reviewed and developed comments for the District of Columbia FY 2010 Block Grant Application submitted to the Substance Abuse and Mental Health Administration (SAMHSA) in August 2009.

- A Council representative served as a member of the District's team for the FY 2010 Community Mental Health Services Block Grant Regional Consultative Peer Review held in October 2009 in Charleston, South Carolina. She provided information on the Council's review and comments on the FY 2010 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 2009 Progress Implementation Report submitted to SAMHSA in December 2009.

- The Council continued to try to recruit new members across all member categories. The Department on Disability Services/Rehabilitation Services Administration designated a representative to the Council.

- The Mayoral Order that established the D.C. SMHPC which was originally adopted in 1989 has been revised by the SMHPC and DMH to reflect the changes in District government. Review by District officials responsible for processing Mayoral Orders is still in progress as of the date of this application.

- In order to improve its responsibility to "monitor, review, and evaluate, not less than once a year, the allocation and adequacy of mental health services within the State"- the Council hosted a series of presentations that included program monitoring, research and evaluation (monitoring the monitors). There were presentations on other topics of interest including the viewing of a documentary on DMH forensic clients. The presentations include: 1) Permanent Supportive Housing Strategy- Kimberly Black, Director Mid-Atlantic Corporation Supportive Housing, DMH Housing Consultant and Brandi Gladden, Program Analyst Officer DMH Housing Division; 2) D.C. Community Services Agency (DC CSA) Transition- Dr. Barbara Bazron, DMH Deputy Director Programs, and Policy; 3) D.C. Jail Advocacy Project- Gretchen Rohr, Project Director and Staff Attorney, University Legal Services (ULS); 4) DMH Office of Accountability- Anne Weiss, Deputy Director DMH Office of Accountability and Atiya Frame, Director of Quality Improvement; 5) Evaluation of Behavioral Health and Health Care in the District of Columbia-Janice Blanchard, MD, Ph.D., and Joie D. Acosta, Ph.D. RAND Corporation; 6) American Recovery and Reinvestment Act of 2009 Provisions Relevant to DMH- Anne M. Sturtz, Deputy Director DMH Office of Strategic Planning, Policy and Evaluation; 7) Child and Youth Services Division Overview-Marie Morilus-Black, DMH Director, Child and Youths Services Division; and Transition Age Youth Initiative-Lynne Person, DMH Administrator, Residential Treatment Center (RTC) Reinvestment Program; 8) Applied Research and Evaluation Unit-Dr. Erika Van Buren, Director DMH Organizational Development Division; 9) 2010 Community Services Reviews, Nicki DeLaRosa, Community Services Review Specialist and Patricia Thompson, Community Services Review Analyst, DMH Organizational Development Division; and 10) Mental Health Statistics Improvement Program Surveys- Dr. Erika Van Buren.

  The Council viewed the documentary Lens & Pens: Art in an Unexpected Place with presenters Edward Washington and Joy Jones. The documentary presents the stories of the artists and their art in the Lens & Pens Program at Saint Elizabeths Hospital (SEH). It includes forensic inpatients and outpatients. Ed Washington, visionary and founder of the Lens & Pens Program introduces the viewer to the patients as the film reveals how they have survived and thrived through creative expression (poetry, painting, and photography). Joy Jones, Director of The Spoken Word convenes poetry workshops and coordinates the Reflections Newsletter that features the artists' work. This project has received Block Grant funding and the artists' works have been featured at the Annual Mental Health Conference. The documentary has received several awards.

- The Council developed a Letter of Support for the Department's Data Infrastructure Grant application in February 2010.

- The Council revised the Request for Project process and identified areas of interest for receipt of project proposals for FY 2011 Block Grant funding that included: 1) children/youth with severe emotional disturbances and co-morbid health issues (obesity, diabetes, high cholesterol), 2) older adults with serious mental illness and co-morbid health issues, or activities designed specifically for older adults, and 3) issues related to psychotropic medications (education, weight gain, and other side effects).

- The Council initiated the Request for Projects for funding consideration under the District's FY 2011 Block Grant Application in May 2010. The proposal submissions included the following: 1) Pharmacists Managing Mental Health; 2) Accessing Children's Mental Health Services Training, and Permanent-Supported Housing Model Fidelity Learning Community; 3) Health Services Program; 4) District Youth and Young Adults Transition to Independence (TIP) System Implementation; 5) African Immigrant Adult Mental Health Service; 6) FIT–N-FUN: A Wellness Intervention for Special Youth"; 7) FamilyLinks Outreach Center; 8) Spiritually Overcoming Depression & Obesity (SODO); 9) Permanent Supportive Housing for Special Populations; 10) Learning and Incorporating Risk Management Around HIV/STI and Teen Pregnancy; 11) Acupressure Assisted Exposure Therapy for Women with PTSD: A Pilot Program; 12) Family Learning, Nutrition and Fitness Program; 13) Adolescent Female Forum to Inspire, Respect & Motivate (AFFIRM) Program; 14) "Cooking and Dancing with Flava!"; 15) Building Stronger Community for Low-Income Seniors through Providing Mental Health Care In-Home and On-Site; 16) Moses Powell Marital Arts-Youth; 17) Wellness Communities; 18) Lens & Pens Creative Expression Project; 19) Youth Court Boy's Focus Group ("Focus Group"); 20) "My Design T-Shirt Project; 21) "Therapeutic Approaches for Severely Persistently Mentally Ill" Education Series; and 22) Recovery Is Us.

- Planning Council members along with the Adult and Child Planners and data staff attended the SAMHSA 2010 National Grantee Conference on the Mental Health Block Grant and Data in June 2010 in the District of Columbia. The Planning Council representative also attended the Planning and Advisory Councils' meeting.

- The Council reviewed the status and quarterly reports submitted by the FY 2009 carryover funded and FY 2010 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 2010, as previously referenced under the list of activities, the Council: 1) continued to review the Block Grant and related Plans; 2) hosted presentations at its monthly meeting related to monitoring, research and evaluation and other topics of interest, and viewed a documentary featuring DMH forensic consumers; 3) continued to try to recruit new members in all member categories; 4) solicited projects from consumer, family member, community-based organizations, providers, and others; for funding consideration under the FY 2011 Block Grant through its annual Request for Projects process; 5) participated in the 2010 National Grantee Conference and attended the 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 Data Infrastructure Grant Application.

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

During FY 2010, the Council implemented a "monitoring the monitors" strategy as a way to improve fulfilling its responsibility to monitor, review, and evaluate allocation and adequacy of services and supports. This was achieved by hosting a variety of presentations that addressed general as well as targeted monitoring, research, and evaluation: 1) DC CSA transition and monitoring of consumers; 2) Office of Accountability functions including certification, licensure, major investigations, quality improvement, and provider scorecard); 3) evaluation of the District's mental health and substance abuse systems; 4) overview of the Applied Research and Evaluation Unit; 5) 2010 Community Services Reviews (adult and child); and 5) 2009 Mental Health Statistics Improvement Program Surveys (adult and child).

The Council also 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 2010, the D.C. SMHPC discussed creating a Visiting Lecture Series that could be alternated with the Annual Judge Aubrey E. Robinson, Jr. Memorial Mental Health Conference. This issue will be discussed with the DMH Training Institute Manager at the September meeting. The Planning Council will then decide how to move forward to implement a public forum during FY 2011.

Other Council Activities

The D.C. SMHPC members have participated in various planning initiatives and/or national meetings and conferences. They also attended the 2010 National Grantee Conference on the Mental Health Block Grant and Data.

Directions for FY 2011

During FY 2011, 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, 3) continue membership recruitment including consumer advocates, family members, and various community stakeholders, 4) hold a retreat, and 5) convene the annual mental health conference or other educational forum.

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.

A. Adult Overview of State's Mental Health System

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 Mental Health Services Division 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, information technology, human resource, and facility services; accountability functions; and service planning and policy development.

Provider Certification: 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 includes nine (9) services (four (4) are classified as core services and five (5) as specialty services) provided by DMH-certified community-based providers.

Provider Relations: The Authority provides support to providers to promote the success and effectiveness of their service delivery and billing and claims operations. This includes: 1) operational and technical support; 2) assessments related to service delivery capacity, information technology system adequacy, and billing and claims submission capacity; 3) coordinating mandatory trainings; 4) assisting with resolving fiscal management and service delivery problems; 5) serving as primary communication liaison for providers between DMH and other District agencies; and 6) coordinating provider closures.

Claims Administration/Billing: 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. DMH forwards Medicaid claims to DHCF for payment adjudication.

Accountability Functions: The Authority oversees the performance of DMH providers, thereby assuring excellence of service to DMH consumers through oversight, monitoring, auditing, and quality improvement activities. The services include: certification and monitoring of MHRS providers; licensure and monitoring of community residential facilities (CRFs); claims auditing and recoupment; Medicaid integrity compliance; fraud and abuse management; risk management; management and trending of major unusual incidents and corrective action plans; development and analysis of quality improvement initiatives; quality reviews; focused reviews; major investigations; and development and publication of Provider Scorecard.

Care Coordination: DMH operates 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 enrollment requests as well as requests for persons requiring both urgent and emergency mental health services. The AHL provides functions such as crisis intervention and telephone counseling to callers who are in crisis, dispatching mobile crisis

services, authorization of specialty services and information and referral. Staff also collaborate telephonically with social service agencies, the District Metropolitan Police Department (MPD) and community organizations to ensure access. The AHL averaged 4,203 calls per month for the period October 2009 through June 30, 2010.

The AHL became a provisionally certified Suicide Lifeline Network provider for Washington, D.C. in April 2009. On average, the AHL receives approximately 15 calls a month from the Suicide Lifeline, which became operational in December 2009. DMH expects to submit the documentation required for full certification by the American Association of Suicidology (AAS) during the Fall 2010. After receipt of full accreditation by the Suicide Prevention Lifeline Network, all calls for the District of Columbia will be routed to AHL.

Human Resources: A thorough review of human resources (HR) policy and underlying regulations, processes and procedures was completed in January 2009. The report addressed 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. During FY 2010, the realignment and integration of core HR functions between the Authority and Saint Elizabeths Hospital was completed. The next phase, the modernization and streamlining of the H.R. system, is projected to be completed during FY 2011.

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. Services are delivered by a group of certified mental health providers. A number of agencies are certified as core service agencies (CSAs) that serve as the clinical home for each person receiving mental health rehabilitation services (MHRS) , ensuring a single point of accountability for service delivery. The CSA model ensures that each adult receiving MHRS 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 August 2010, 37 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
25	25	9	9	4

D.C. Community Services Agency Transition Plan Implementation

The former publicly funded D.C. Community Services Agency (DC CSA) was certified as a CSA and Specialty Provider and served 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. 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 (3) 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 to manage the assessment and final analysis of options. This process involved key stakeholders (consumer and other advocates, private providers, unions and DC CSA staff). KPMG completed its review in the summer of 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.

An implementation plan that projected the closure of the DC CSA by March 31, 2010, and retention of specific government operated services was developed and submitted to the Council in January 2009. DMH began assertive transition activities during the second quarter of FY 2009.

The implementation plan involved transitioning approximately 4,000 DC CSA consumers by March 31, 2010. Over 2,500 consumers selected a new provider during FY 2009. The activities during FY 2010 included the transfer of the remaining consumers and establishing a unit to operate the remaining government operated services (pharmacy and specialty services, including a physicians' practice group, multicultural services, psychoeducational services and services for people with hearing impairments or developmental disabilities).

As of March 11, 2010, three thousand one hundred thirty-three (3,133) consumers had been transferred to the private provider network.

D.C. Community Services Agency Transition Monitoring

DMH Office of Accountability (OA)- has continued its role in monitoring the transition of consumers from the DC CSA to their new mental health rehabilitation services (MHRS) provider. The specific components that OA continues to monitor are: 1) consumer satisfaction survey, and 2) continuity of care monitoring. With regard to consumer satisfaction, the most recent OA report (via a telephone survey of random consumers) indicates that 82% rated their overall experience as positive or very positive. Conversely, 9% were in the negative category and 9% were neutral. This process will continue until a full year after the transition so the last survey will occur in Spring 2011.

In terms of continuity of care, OA audited a sample of 730 consumers of the approximately 3,000 who had transferred as of March 31, 2010. The aggregate results show that 56.4% of consumers had an initial visit within 30 days of the transfer; which grew to 77.1% seen within 90 days of transfer. An attempt was made to measure whether the consumer appeared to be actively engaged with the new provider by using multiple face-to-face visits as the measure for "actively engaged." On this score, the aggregate percentages showed 6l.1% were actively engaged. It is difficult to assess this outcome without being able to compare it to the level of engagement those consumers had previously with the DC CSA.

DMH Community Services Review Unit- conducted a focused review of consumers who transitioned from DC CSA between December 2009 and February 2010. Twenty-six (26) consumers were identified for the sample, however the focused review included the 17 consumers who consented to participate. The findings suggest that the majority of the consumers within the sample transitioned successfully, as evidenced by consumer status ratings, sustained stability, positive engagement, access to services and coordination efforts by at least one (1) individual on the team. The majority continued to receive the same or more services, predominately reflected by community support contacts, as average medication management declined following the transition. The results suggest that the significant variability in intensity of the post-transition services across consumers may represent a customization of individual service needs, or an increase in level of care for a few high needs consumers to support their transition.

Mental Health Services Division

The Mental Health Services Division (MHSD) was established to provide the remaining government operated functions formerly provided by the DC CSA. MHSD is a new Division that operates under the auspices of the DMH Office of Programs and Policy. This Division is responsible for implementing mental health services that include: same day service/urgent clinic, physician's practice group (adult and child), psychiatric residents' clinic, multicultural services program, deaf/hard of hearing intellectual disabilities program, outpatient competency restoration program, and pharmacy. MHSD provides specialized mental health services that are not otherwise readily available within the DMH service system or the private sector.

3. Saint Elizabeths Hospital

Adults requiring mental health treatment in a 24-hour inpatient setting may receive services at Saint Elizabeths Hospital. At the time of its move to the new building, the Hospital reorganized its services and programs and implemented a one hospital model. Program assignment no longer is determined by an individual's legal status but rather is based upon the level of care required consistent with the individual's clinical presentation. The two new primary hospital programs are Intensive Treatment and Transitional Treatment. Each program has its own Therapeutic Learning Center (treatment mall) that includes rooms for group and individual therapies, treatment team meetings, occupational, vocational and educational groups, a full size gymnasium and associated rooms for recreational therapies, a patient library, barber/beauty shop, and an efficiency apartment where patients can learn and practice skills necessary for independent living.

The new building has also enabled Saint Elizabeths Hospital to fully implement an inpatient treatment model that parallels life in the community for the vast majority of individuals in the hospital's care. Patients have breakfast and dinner, relax and sleep in their houses (units) and during the day attend the Therapeutic Learning Center or associated support program and engage in the "work" of recovering sufficiently to return to the community. Such a model minimizes the differences in daily activities between life in the hospital and the community and facilitates recovery and successful community reintegration.

Currently, the Hospital provides both acute and long-term care to adults with either a forensic or civil legal status. The Hospital gradually is moving toward the sole provision of tertiary care (3-12 months) for individuals in a civil legal status who need the structure and security of a public psychiatric hospital. Acute care for patients in a civil legal status will primarily be provided under agreements with local hospitals. The Hospital will continue to provide acute and long-term services to individuals in a forensic legal status.

The Intensive Treatment Program serves individuals living on seven houses. Four houses (104 beds) are predominantly for newly admitted patients while the remaining three units (81) beds are for individuals requiring continuing or longer term intensive treatment. The Transitional Treatment Program serves individuals living on four houses (108 beds) in the new building and one house in the RMB Annex (27 beds). A second house in the RMB Annex (27 beds) primarily is for individuals attending psychosocial day programs in the community. The Transitional Treatment Program focuses on preparing individuals to successfully leave the hospital and live independently in the community or in another type of residence.

The Hospital continues to provide a full range of mental health services to pre and post-trial individuals in a forensic legal status and committed by the Criminal Divisions of the District of Columbia and Federal Courts. Through its Outpatient Department housed at 35 K Street N.E., the Hospital also provides treatment and monitoring services to approximately 105 individuals in a forensic legal status who have been adjudicated "not guilty by reason of insanity" and are living in the community on court ordered conditional release. Admission to and discharge from the Hospital of individuals in a forensic legal status is controlled by the Criminal Division of both courts. Inpatient services to individuals with a forensic legal status 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 individuals found Not Guilty By Reason of Insanity (NGBRI) and committed for inpatient treatment until released by the court.

The outpatient component of the Hospital's services to individuals in a forensic legal status includes 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. This program 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.

Saint Elizabeths Hospital continues to support DMH's efforts to promote pretrial release of appropriate defendants to community-based case management and treatment by working closely with the CSAs. The collaboration of staff working with patients in a forensic legal status has helped to facilitate continuity of care for defendant/consumers and their receiving appropriate services in the least restrictive environment. These Hospital staff also work closely with the Department of Corrections to ensure continuity of care when defendants are discharged from the hospital and detained.

In keeping with the recovery-based model of care, the new building has enabled Saint Elizabeths Hospital to establish an environment of care that allows most individuals in its care, irrespective of their legal status, to leave their units during the day and receive the majority of treatment at the Therapeutic Learning Centers. This concept promotes community reintegration and assures that all individuals in the hospital are involved in active treatment.

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 conducted its fourth site visit on September 21-25, 2009 and issued its findings and a summary letter on December 14, 2009. The recent visit noted continued progress on many fronts but also stated in strong terms that the Hospital remains significantly behind the 3-year schedule on its overall compliance efforts. The DOJ outlined priority concerns to be completed before the next DOJ visit, which recently occurred from May 24-28, 2010. Areas identified as priority concerns include protection from harm and risk management, nursing care, treatment planning and psychiatric care, and behavioral management and psychological care. Out of a total of 224 requirements in the Settlement Agreement, the Hospital has achieved substantial compliance on 23 (11%), partial compliance on 163 (78%), and noncompliance on 23 (11%). This 89% score on the partial and substantial compliance scores combined, compares to a 80% level as of the April 2009 DOJ visit.

In May 2007, DMH began implementing various initiatives to obtain Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation after 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 Department's ongoing efforts to reduce the census that include: 1) eight (8) extended observation beds at the Comprehensive Psychiatric Emergency Program (CPEP), 2) 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 have proven effective. Between August 24, 2009 and June 30, 2010, the

Hospital has decreased its census from 364 (187civil patients and 177 forensic patients) to 316 individuals on its rolls, a 13.2% reduction.

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.

B. Adult New Developments and Issues

The new developments and issues include the following:

1. Outreach to Haitian Community

DMH Outreach Initiatives to the Haitian Community- On January 12, 2010, Haiti experienced an earthquake of catastrophic magnitude with the damage measured by destruction to property and people. A Haitian Release Response Service Center was opened on January 15, 2010 at one of the Mental Health Services Division sites at 35 K Street, N.E., Washington, D.C. The Center provided t triage, crisis counseling, referrals, linkage to a mental health rehabilitation services (MHRS) provider, and assessments. An Emergency Response Team was deployed to several community events. In response to outreach needs for the Haitian Embassy, DMH staffed the Embassy with grief counselors. A network of volunteers from DMH and the community participated in an orientation/training that included information about the Haitian culture. Approximately 15 of the 45 volunteers who were trained were scheduled on a regular basis to the Embassy for approximately six (6) weeks.

2. Documentary on DMH Forensic Consumers

Lens & Pens: Art in An Unexpected Place - This captivating documentary presents the stories of the artists and their art in the Lens & Pens Program at Saint Elizabeths Hospital and forensic inpatients and outpatients. Edward Washington, visionary and founder of the Lens & Pens Program introduces the viewer to the patients as the film reveals how they have survived and thrived through creative expression (poetry, painting, and photography). The film was produced by Howard University Television (WHUT) and has won several awards.

3. Service System Transition

D.C. Community Services Agency Closure- DMH met the target date of March 31, 2010 for the closure of the D.C. Community Services Agency (DC CSA). During FY 2009, approximately 2,500 consumers were transferred to new provider programs. On March 11, 2010, approximately 3,133 consumers were transferred concluding the transfer process.

Mental Health Services Division- DMH established the Mental Health Services Division (MHSD) for the management of the continuing government operated community services that are not available and/or are not easily managed within the private provider network. These services include: 1) same day/urgent clinic; 2) physicians' practice group; 3) psychiatric residents' clinic, 4) multicultural program; 5) deaf/hard of hearing and intellectual disability program; 6) outpatient competency restoration program; and 7) pharmacy.

Opening of Saint Elizabeths Hospital- A symposium in conjunction with the opening of the newly constructed Saint Elizabeths Hospital was held on April 22, 2010. The symposium described the Hospital's new vision for treatment, recovery, and community integration and how the new facility strengthens and supports its vision. It focused on the Hospital's discharge planning process and the supports put in place to maintain community living. Hospital leaders,

staff involved with the discharge and re-integration process, and peer specialists participated in the symposium.

4. Mental Health Rehabilitation Services Billing

Efforts to Increase Medicaid Reimbursable Services (Adults and Children)- During FY 2010, DMH forwarded draft rules to the Department of Health Care Finance (DHCF) to establish a modifier for ACT group rates, a rate for clubhouse services, and a rate for CBI Level IV-Functional Family Therapy services. DHCF is working with DMH on these rules. It is anticipated that the implementation of the new service rates will occur during FY 2011.

5. Interagency Partnerships

Rental Assistance for the Non-Elderly Persons with Disabilities Application- The D.C. Housing Authority collaborated with several District agencies in developing the application to respond to the HUD NOFA. The agencies include: the Department of Mental Health, Department of Human Services, Department of Health, and the Department on Disability Services. The District's Housing Authority is requesting 200 vouchers with services and supports provided by the partner agencies. The funds awarded in response to the HUD NOFA will be available in October 2010.

Housing Improvement Program Initiative- Cornerstone, which finances supportive housing for people with mental illness in the District, was awarded a $1M grant by the Department of Housing and Community Development (DHCD). The funds are appropriated capital funds from DMH. Cornerstone initiated a 2010 loan and grant program for the rehabilitation of units in small multi-family buildings (2 to 25 units) and community residence facilities (CRFs) currently housing DMH tenants. These funds can be used for kitchen and bathroom upgrades, HVAC and electrical upgrades, energy efficiency improvements, roof repairs, other electrical and interior improvements, and replacing carpet with tiling and other flooring.

Comprehensive Psychiatric Emergency Program- The DMH Comprehensive Psychiatric Emergency Program (CPEP) is a twenty-four hour/seven day a week operation that provides emergency psychiatric services, mobile crisis services, homeless outreach services, and extended observation beds for individuals 18 years of age and older. The Department of Health Addiction Prevention and Recovery Administration (DOH/APRA) has made CPEP a satellite site. This will enable CPEP to refer consumers directly to substance use disorder treatment facilities. Two (2) of the CPEP three (3) Addiction Treatment Specialists were trained on March 5, 2010 to initiate this process.

CPEP/Mobile Crisis Services Homicide Survivor Response Project: The CPEP/Mobile Crisis Services (MCS) will be partnering with the Executive Office of the Mayor (EOM) Office of Victim Services and the Metropolitan Police Department (MPD) to provide 24-hour response to homicide survivors following homicides in the District MCS will provide homicide survivors with initial non-medical stabilization and mental health assistance, including linkage to ongoing grief and loss and/or other mental health care. If a homicide survivor is experiencing a psychiatric crisis, MCS will assess the individual and link them to the appropriate level of psychiatric care. MCS will provide follow-up services including: completing linkages to

ongoing grief and loss and/or other mental health care (when appropriate), providing transportation to initial appointments, accompanying family members to the medical examiner's office (when asked), and attending vigils and funerals (when asked). Currently, MCS is working out the protocol with MPD and plan to begin providing direct services in the community as soon as this process is complete. MCS has already received initial funding through EOM Office of Victim Services.

Memorandum of Understanding with Metropolitan Police Department (MPD)- This agreement with MPD is for the delivery of mobile crisis services. It addresses the process by which MPD can access these services including: making referrals to the adult and child mobile crisis teams; providing estimated response time; providing or ensuring the provision of appropriate mental health services; regular communication and monthly meetings to address coordination of mobile crisis services; providing officers with updated training on how to handle individuals including children and youth with mental health issues; and the mobile crisis teams being available to provide real time consultation to MPD via telephone, email, or in person.

Memorandum of Understanding with Department of Human Services- The District Department of Human Services (DHS) and the Department of Housing and Community Development (DHCD) administer the Homeless Prevention and Rapid Re-Housing Program (HPRP), made possible by federal stimulus funding. Under a memorandum of understanding (MOU) between DMH and DHS, the DMH Homeless Outreach Team (HOT) does case finding and screening. The individuals are then processed through one of the eligibility centers that perform intake and provide assistance in obtaining services.

Memorandum of Agreement with Department of Health Care Finance- During FY 2011, the Department of Health Care Finance (DHCF) and DMH will have a memorandum of agreement (MOA) in place that allows DMH to authorize the placement of individuals living in Mental Health Community Residence Facilities (MHCRFs) for the purposes of eligibility for the District of Columbia Optional State Supplement Payment (OSP). The OSP is a special supplement paid to eligible individuals who reside in what the Social Security Administration (SSA) refers to as Adult Foster Care Homes. The District refers to facilities where it places individuals eligible for the Adult Foster Care Home state supplement program as CRFs. The CRFs for individuals with mental illness are Mental Health CRFs.

Memorandum of Agreement with Department of Human Services Income Maintenance Administration- During FY 2010, DMH and DHS Income Maintenance Administration (DHS/IMA) began working on a memorandum of agreement (MOA) to work collaboratively to coordinate a range of services and supports for Temporary Assistance for Needy Families (TANF) clients who have a history and/or symptoms of mental illness to achieve greater degrees of self-sufficiency. Some of the proposed areas of collaboration include: 1) pilot program for transition age youth (TAY) ages 16-25 that focuses on PATHWAYS to Success using the Transition to Independence (TIP) process model; 2) data sharing for service coordination for services provided by DHS/IMA and DMH; 3) access to supported employment programs; and 4) cross training of DHS/IMA and DMH staff. The Draft MOA is being reviewed and it is anticipated that it will be finalized by the end of FY 2010.

6. Planning Initiatives

SSI/SSDI Outreach, Access and Recovery (SOAR) Initiative- is a strategy that helps states to increase access to mainstream benefits for people who are homeless or at risk of homelessness through training, technical assistance and strategic planning. During FY 2010, DMH engaged in the following activities related to the District SOAR Initiative: 1) sponsored an all consensus building process to identify a plan to improve processing times for SSI and SSDI; 2) created a SOAR Steering Committee to develop strategies and monitor plan progress; 3) identified two (2) new trainers who will assist the two (2) existing trainers in providing training to individuals who will assist consumers in applying for SSI and SSDI; 4) sent two (2) new trainers to a Train-the-Trainer training in Seattle, Washington (August 9-12, 2010); and 5) identified a target audience to provide training to during the Fall 2010.

Reporting Work Group- In an effort to address some of the longstanding concerns related to data development and reporting, DMH established the Reporting Work Group in February 2010. This group was formed to develop a comprehensive, centralized and fully automated data access and delivery system that meets the DMH' information needs. Five (5) teams were created consistent with the core functional areas that include: 1) process; 2) requirements; 3) lexicon; 4) code standardization; and 5) reporting infrastructure.

Community Residential Facility Taskforce- This body held its first meeting in April 2010. The purpose is to develop a proposed service and funding structure to support the delivery of quality care to individuals enrolled in the public mental health system that require placement in community residential facilities (CRFs). The primary tasks include: 1) develop procedures to determine if an individual is best suited for an independent CRF (ICRF) or DMH contracted CRF; 2) summarize system barriers and solutions to care in contracted CRFs and ICRFs; 3) develop a process to improve communication between CRF operators and CSAs and a process to monitor adherence to established guidelines; 4) ensure CRFs receive adequate support from the community providers for residents in their facilities; 5) develop a process to provide additional supports to meet the service needs of consumers who require more care than ICRFs are able to provide within their current structure; 6) develop a process and criteria for moving CRF consumers to appropriate level of care for housing; 7) design a dispute resolution process for moving individual consumers already in residential placements; 8) develop a methodology for providing ICRFs with funding to support the range of services required to address the needs of people with more symptomatic needs who are placed temporarily in these facilities; and 9) present recommendations for changing the service and funding structure to the DMH Director.

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.

7. Staff Development and Training

Brown Bag Series- On March 19, 2010, the DMH Division of Organizational Development announced a Brown Bag Series for calendar year 2010. The topics include the following:

- Logic Modeling Your Way to Program Improvement: Developing a Framework for Planning and Evaluation (March and April)
- Uniform Reporting System (URS) and the National Outcome Measures (NOMs) (May)
- National Datasets on Mental Health: What Do They Track and How Can It be Useful in Program Management? (June)
- The Use of Mixed Methods Research in System Reform (August)
- Improving Public Mental Health Through Geographic Information Systems (GIS) (September)
- Jail Diversion Models and Strategies (October)
- Is Your Program Co-Occurring Competent? (November)
- Putting Together a Successful Presentation Through the Training Institute (December)

Disaster Mental Health Series- In an effort to improve the District's preparedness for immediate and long-term disaster response, a Disaster Mental Health Training Series was conducted from May through July 2010. The courses included: 1) Essential Concepts in Disaster Mental Health; 2) Psychological First Aid; 3) Advanced Psychological First Aid; 4) Grief, Loss, Suicide in the Wake of Disasters; and 5) Ethical and Legal Issues in Disaster Mental Health.

Adult - Legislative initiatives and changes, if any.

C. Adult Legislative Initiatives and Changes

Legislation

Data Sharing and Information Coordination Amendment Act of 2010. If this bill becomes law, it will authorize the creation of a single or combined data system, amend several District statutes to authorize sharing of health and human services information among District health and human services agencies for specified purposes consistent with federal and District law, and impose penalties for unlawful disclosure of certain individually identifiable information.

> Status and FY 2010 Activity: Bill 18-0356, was finally adopted by the Council of the District of Columbia on June 29, 2010 and signed by the Mayor on July 20, 2010. It is now Act # A18-0489, and must go to the Congress of the United States for their 30-day review period. Since Congress has to be in session during the 30 days, the bill is not likely to become law prior to at least mid-October 2010; however, it could be November or December 2010.

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 2010 Activity: These rules were first published as proposed on October 10, 2008. Revised proposed rules were published on June 26, 2009. A third notice of proposed rulemaking was published May 7, 2010. Currently reviewing comments received from the third publication. If no further substantive changes are made, the final rules should be published before the end of the fiscal year.

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 2010 Activity: The internal review by DMH legal and licensing staff continued through the first three quarters of FY 2010. DMH is preparing to send the rules to the Office of the City Administrator (OCA) and the Office of Policy and Legislative Affairs (OPLA) for comment. Once any concerns are addressed and the rules are approved, they will be forwarded to the Office of the Attorney General Legal Counsel Division for a legal sufficiency determination.

Mental Health Clubhouses: 22- A D.C. Municipal Regulations (DCMR) Chapter 39. These rules establish standards for a Mental Health Clubhouse as a Medicaid service. A Clubhouse allows consumers to participate in their own recovery process by working and socializing in a safe and welcoming environment. The rules will allow a program that has been previously paid for with local dollars to be reimbursed by Medicaid funds.

> Status and FY 2010 Activity: These rules were published as emergency and proposed on May 7, 2010. Some corrections were noted and a second set of emergency and proposed rules was published on August 20, 2010.

Supported Employment Program – Reimbursement Rate: 22-A D.C. Municipal Regulations (DCMR) Chapter 51. These rules establish a published reimbursement rate at which DMH will reimburse its contracted Supported Employment program service providers.

> Status and FY 2010 Activity: The rules are currently at the Executive Office of the Mayor for review, after which they will be forwarded to the Office of Legal Counsel for legal certification. These rules will be published as proposed rules. Final rules are expected to be published prior to the end of this year.

Amendment to 22A DCMR Chapter 34, Mental Health Rehabilitation Services Provider Certification Standards. The amendment is to add a new section establishing the process for decertification of MHRS providers including grounds for decertification, notice requirements and appeal process; add clarification of when Licensed Professional Counselors qualify as Approved Qualifying Practitioners; and clarify the definition of an Approving Qualified Practitioner.

> Status and FY 2010 Activity: Draft prepared in FY 2009. Still pending review within DMH. First publication anticipated before end of the year

Amendment to 29 DCMR Chapter 52, Medicaid Reimbursement for Mental Health Rehabilitative Services. DMH worked with the Department of Health Care Finance (DHCF) to amend the Medicaid reimbursement rates for new MHRS services including Clubhouse, and a modifier for ACT Group rates. These rules have been submitted to DHCF for final review and publication.

> Status and FY 2010 Activity: Two different proposed draft rules were forwarded to DHCF- one to establish a modifier for ACT group rates; and one to establish a rate for Clubhouse services. DHCF is working with DMH to finalize these rules.

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

E. 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 (web-based and face-to-face) 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. DMH continues to participate in this initiative along with other District agencies (e.g., Metropolitan Police Department, Department of Human Services, Department of Health, Office on Aging, Department of Employment Services, DC Housing Authority, Department of Consumer and Regulatory Affairs, Department of Parks and Recreation). 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 primary goal is to link residents with mental health needs to the public mental health system. These linkages include clinical services, supported employment, supported housing, and other appropriate services and supports.

Partnership with Department on Disability Services- The DMH and the Department on Disability Services (DDS) developed a cross-agency memorandum of understanding (MOU) in October 2004 to develop a pilot project to jointly serve individuals who have a mental illness and are developmentally disabled (MI/DD). These agencies continue to work collaboratively to address the needs of this population in both inpatient and community settings. The persons with MI/DD in Saint Elizabeths Hospital are included in the Integrated Care Program and 10 are expected to be discharged by the end of FY 2010. DMH has transferred a total of $500,000 to support services for this group of individuals ($300,000 to DDS and $200,000 to the health care finance agency).

DMH also provides services to persons diagnosed with MI/DD already in the community. The Mental Health Services Division (MHSD) has a specialized practice exclusively for this population and is serving 124 consumers.

Veterans Work Group- DMH assembled a group in 2009 to consider submitting an application for the SAMHSA Grant for diversion services for veterans involved in the criminal justice system. While a grant was not submitted, the recommendation was that a work group be established to look at issues and gaps in services to veterans in the District and gather information to prepare for submission of a grant application at a later date.

In FY 2010 a Work Group on Veterans Issues was established. It includes the following agencies: 1) Criminal Justice Coordinating Committee (CJCC); 2) Pre-Trial Services Agency (PSA); 3) Court Services Offender Supervision Agency (CSOSA); 4) Friendship Place; 5) The Fairness Coalition (a peer run outreach organization); 5) Community Connections; and 6) DMH Adult Services Division. The initial meeting on July 1, 2010 addressed issues related to statistics, program ideas, gaps, and to share general information about issues related to veterans nationally and locally. The group plans to meet regularly.

Adult Authority Programs- In order to address the mental health needs of adult consumers, the DMH adult service system includes integrated care services, assertive community treatment (ACT) services, forensic 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, homeless outreach services, 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) starting a planning process for 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) amending rules to make portions of the International Center for Clubhouse Development program Medicaid reimbursable; 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- DMH partnered with the Addiction Prevention and Recovery Administration (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 provided training and technical assistance in the model's implementation to the DMH provider network and training was also 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 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 were 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 were initiated related to each of the objectives. FY 2010 was Year 5 of the grant and focused on evaluation activities.

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

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 PLAN

Section I. Description of State Service System

A. 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) since 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)1.

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, 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 Statewide Commission on Children, Youth and their Families (SCCYF) that serves as a coordinating body for all of the District's services for children. The SCCYF, formerly known as the Interagency Collaboration and Services Integration Commission or ICSIC was established pursuant to the Public Education Reform Act of 2007. The purpose of the Commission is to improve services for vulnerable children by promoting social and emotional skills among children and youth through the oversight of a comprehensive integrated delivery system. The Commission also pilots and evaluates evidence-based programs at schools and in the community throughout the District to further its mission. The SCCYF has organized around six (6) citywide goals, which outline the District's commitment to ensure that children and youth successfully transition from birth to adulthood. They include:

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

Chaired by the Mayor, the SCCYF meets quarterly to discuss data and interagency collaboration to address the needs of children, youth, and their families. Because implementing the six (6) citywide goals requires the District to work across agencies and with community partners,

1 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.

directors from all child- and family-serving District Government agencies, the President of the Children and Youth Investment Trust Corporation, the President of the State Board of Education, and five (5) community representatives participate in Commission meetings.

The responsibility for development, monitoring and oversight of the children's mental health system is vested in the DMH, Office of Programs and Policy, Child and Youth Services Division (CYSD). The CYSD is comprised of the following nine (9) programs: 1) Early Childhood Mental Health Consultation; 2) School Mental Health Program; 3) Child and Adolescent Clinical Practice/Choice Providers; 4) Mobile Crisis and Stabilization Services; 5) System of Care Service Coordination/Wraparound Services; 6) Residential Treatment Center (RTC) Re-investment; 7) Assessment Center; 8) Transition Age Youth; and 9) Suicide Prevention.

The FY 2011 DMH contracts with child-serving providers of community-based mental health services include 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 stabilization services;
- Wraparound services;
- Site-based emergency psychiatric services;
- Psychiatrists and psychologists who perform forensic evaluations;
- Multicultural services and supports;
- School Mental Health Program six (6) schools; and
- Evidence-based practice trainers for Choice Providers.

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.

B. Child New Developments and Issues

1. Child System Plan Development: The child system re-design planning process was initiated during FY 2010. The purpose of this process is to develop a plan that will address a broad spectrum of issues, challenges, and possibilities to improve the District's child, youth and family service system. Some of the guiding principles of the plan development process include: 1) all team members are brought to the table in the spirit of collaboration; 2) service providers regularly communicate with all interested parties; and 3) families are critical team members and should be supported in this role. District agencies, community-based organizations including child-serving agencies, child advocates, and children, youth and families are a part of the planning process. The planning committees include:1) service delivery/early identification/family engagement (incorporate evidence-based and best practices within the System of Care (SOC)/enhance early intervention, assessment and treatment/and enhance family engagement practices and support); 2) accountability and systems integration (create a quality-driven mental health system and improve coordination among interagency service networks); and 3) financial strategies and workforce development (develop financial strategies to support the work in a cost effective manner that maximizes Medicaid funding and builds a qualified and adequately trained workforce).

2. Early Childhood Mental Health Consultation (Healthy Futures): This initiative began as a pilot program in FY 2010. DMH partnered with the Department of Health (DOH) Early Childhood Comprehensive System (ECCS) Grant Coordinator to launch an early childhood mental health consultation pilot program in eight (8) Child Development Centers. This project focuses on child and family-centered, and program consultation. The primary goal of child or family-centered consultation is to address an individual child's (and/or family's) difficulties in functioning well in the early childhood setting. The programmatic consultation focuses on improving the overall quality of the program or agency and/or assisting the program to solve a specific issue that affects more than one child, staff member, and/or family.

During the third quarter of FY 2010, services were implemented for children (ages 0 to 5) at 26 centers. This number grew to 27 centers during the fourth quarter. The services are provided to children and families identified through child/family centered consultation at all centers, as well as programmatic consultation to Child Development Center staff. In FY 2011, services will continue to be offered and data reported on measures developed during the project initiation phase.

3. Parent Infant Early Childhood Enhancement Program (P.I.E.C.E.): During FY 2010, DMH began the process of developing the P.I.E.C.E. Program at the Howard Road site. This program will serve primarily children age 5 and under. DMH began accepting limited referrals for this program that will serve up to 60 children. The program is expected to be fully operational by October 1, 2010 and will provide parenting groups, infant observation, play and art therapy, and Parent Child Interaction Therapies.

4. Functional Family Therapy (FFT): Family Functional Therapy (FFT) was selected as an evidence-based practice by the District. In October 2009, DMH awarded a contract to FFT Inc. to provide training and technical assistance services to child-serving Core Service Agencies (CSAs) designated as Choice Providers. Four (4) of the six (6) active Choice Providers began

the initial step of readiness assessment. They include: Family Matters, First Home Care, Hillcrest Children's Center, and MD Family Resource Inc. Three (3) phases were identified: 1) pre-implementation training and consultation (October- July 2010); 2) implementation and assessment training (July 2010); and 3) externship (about 6-8 months after the initial clinical training). Also during FY 2010, DMH initiated the process to amend the mental health rehabilitation services (MHRS) Regulations to include reimbursement for FFT.

5. Transition Age Youth Development Project: The District's Mental Health Block Grant provided the funding that allowed DMH CYSD to begin to address some of the system gaps in service delivery to young adults who are transitioning from child services to adult services and from young adults into adulthood. This project was launched in FY 2010. The activities included: adoption of the Transition to Independence Process (TIP) model; two (2) site visits to programs that implemented this model; survey of DMH MHRS providers about young adults served; focus groups with young adults and providers; and contract to child provider to implement services and supports in accordance with the TIP model

6. Suicide Prevention Grant: The District was awarded a 3-year Substance Abuse and Mental Health Services Administration (SAMHSA) State/Tribal Youth Suicide Prevention Grant (October 1, 2009 - September 30, 2012). The Capital CARES (Citywide Approach to Reduce Risk for and Eliminate Youth Suicide) grant focuses on preventing suicide and suicide behaviors among all youth in the District of Columbia. The activities during FY 2010 include convening the D.C. Youth Suicide Prevention Coalition; hiring a social marketing agency; the approval of four (4) community-based organizations to receive mini-grants; suicide prevention training; focus groups with youth; and disseminating a newsletter.

Child - Legislative initiatives and changes, if any.

C. Child Legislative Initiatives and Changes

Regulations

Child Choice Providers Flexible Spending Local Funds Program: Chapter 22-A D.C. Municipal Regulations (DCMR) Chapter 36. These rules allow Child Choice Providers to bill for non-Medicaid services through DMH's automated billing system, which will enable faster payment, tracking, and auditing of claims.

> Status and FY 2010 Activity: These rules were published as proposed on May 7, 2010, and final rules were published on July 23, 2010.

CBI Level IV – Functional Family Therapy: 22-A D.C. Municipal Regulations (DCMR) Chapter 34. These rules establish standards for Functional Family Therapy (FFT). FFT is an intensive service provided to children, youth and their families to prevent the child or youth's further penetration into the legal system. The rules will allow FFT to be offered to a broad segment of the population when medically necessary using Medicaid, rather than local funds.

> Status and FY 2010 Activity: These rules were developed in consultation with DHCF. Currently, they are at the Executive Office of the Mayor for review after which they will be sent to Office of Legal Counsel for legal certification. They will be published as emergency and proposed rules as soon as possible.

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 new MHRS services including CBI Level IV – Functional Family Therapy. These rules are with DHCF.

> Status and FY 2010 Activity: Proposed draft rules were forwarded to DHCF to establish a rate for CBI level IV – Functional Family Therapy services. DHCF is working with DMH on these rules.

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

D. Child Description of State Agency's Leadership

The DMH Child and Youth Services Division (CYSD) has taken the lead role in establishing a 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.

During FY 2010, CYSD moved forward with developing a 3-5 year comprehensive mental health plan for children and youth. 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 are being included in the process. The four (4) planning phases include: 1) development of process for plan development (establish planning committee, conduct strength and needs assessment); 2) research and strategy development (establish planning task groups, conduct environmental scan of services and supports, develop committee recommendations and strategies for implementation); 3) develop Draft Plan (synthesize task groups findings and recommendations, share draft with System Redesign Work Group); and 4) present Draft Plan to stake holders and finalize Plan (collect feedback and analyze data gathered, revise and finalize Child System Plan).

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 2010, focus areas for child/youth services included:

- moving forward with the Child System Plan development process;
- implementing the Capital CARES (Citywide Approach to Reduce Risk for and Eliminate Youth Suicide) grant project;
- implementing the Early Childhood Mental Health Consultation (Healthy Futures) pilot program;
- implementing the Functional Family Therapy (FFT) contract to provide training and technical assistance services to child-serving Core Service Agencies (CSAs) designated as Choice Providers, and initiating the process to make this service Medicaid reimbursable;
- implementing a Transition Age Youth Service Development Project;
- adopting Psychiatric Residential Treatment Facility (PRTF) criteria for admission, discharge, continued stay, and exclusion proposed by the Sub-committee on Residential Placements and Wraparound Implementation Work Group of the PRTF Residential Commission on Coordination of PRTF/Residential Treatment Center;
- continuing the School Mental Health Program;
- continuing the children's mobile crisis and stabilization services;
- continuing the child wraparound initiative;
- continuing to host the Children's Roundtable; and

- continuing 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.

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 took 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 launched in August 2008. The program will continue in FY 2011.

The DMH continues to host a monthly Children's Round Table, 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 Round Table'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). The name was changed in FY 2010 to the Statewide Commission on Children, Youth and their Families (SCCYF). A 32-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 SCCYF. The DMH, through the former ICSIC, proposed establishing a Unified Residential Treatment Placement Commission (RTPC) to provide a common pathway for placing all District children in PRTFs. During FY 2010, a set of PRTF criteria was proposed that has to be discussed with the leadership of other agencies. DMH adopted the criteria between late March and early April 2010.

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

Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

A. Adult Service System Strengths and Weaknesses

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

1. Adult 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- The DMH Office of Consumer and Family Affairs (OCFA), in collaboration with the D.C. Office of Disability Rights, sponsored the second annual Olmstead Conference on December 18, 2009. The theme was "Social Inclusion and Community Living," and the conference was largely organized, planned and attended by consumers. It was well-received by the approximately 250 people in attendance. Planning has already begun for the third conference that is scheduled for October 21, 2010.

- Peer Transition Specialists- The DMH through the OCFA contracted with 10 consumers to work as Peer Transition Specialists (PTS). Some of the Peer Partners from the DC CSA transition have moved into these new roles. During the FY 2010 third quarter, the PTS worked directly in the new hospital. They participated in the NAMI BRIDGES class to learn about recovery and to learn how to serve as a facilitator for this class. All the PTS were assigned caseloads of 2-3 individuals and began their work by building relationships with the people in care at Saint Elizabeths Hospital. This included attending community meetings, co-facilitating the BRIDGES classes, and attending various meetings with the consumers in care. DMH has obtained an apartment in the community that the PTS will use e to assist individuals in transition with activities of daily living.

- Consumer Satisfaction Measures- The DMH has used several methods to access 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) supporting a peer run advocacy organization to provide peer advocacy services support, information and referrals associated with the consumer grievance process; 2) providing funding to operate a community-based consumer run wellness and resource center for mental health advocacy, work skills training, and leadership development, 3) providing funding to support an International Center for

Clubhouse Development program, 4) implementing the planning process for a Peer Specialist Training and Certification program for consumers to provide Medicaid billable services, and 5) implementing Peer 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 and Promising 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.

2. Adult 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:

- Information Technology: DMH has experienced ongoing challenges related to the development of a viable and accessible Department-wide information system.

- Range of Services: DMH program staff and providers have found that the current services array under the MHRS program is limited in being able to provide flexible services that meet the unique needs of a given consumer. Also, the results of the Annual Community Services Reviews have shown that services are equally provided to persons with the least and the greatest need.

- 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 (the Dixon

Exit Criteria measure), problems tend to be related to service team formation and team functioning.

- Evidence-based Practices: DMH is not able to report on several evidence-based practices that include: family psychoeducational services, illness self-management, medication management, and permanent supportive housing.

- ACT Fidelity Assessments: Twelve (12) ACT teams operated during FY 2010 and the majority were new teams. The fidelity assessments were conducted on 11 teams, as the 12th team started serving consumers after the process was underway. The audit results show that performance improvement strategies need to be implemented in order to bring the teams' total mean score into the acceptable range.

- Older Adult Services: While a significant portion of DMH consumers are age 50 and above, there is no comprehensive strategy to address the special needs of this population.

- Consumer Satisfaction: The 2009 Adult MHSIP Survey findings suggest a differential pattern of satisfaction based on gender, race/ethnicity, and type of service and amount.

In FY 2011, the focus will be on improving the quality of care for consumers in the system by continuing the system redesign planning efforts, and exploring ways to introduce more evidence-based practices as well as best practices into the repertoire of services and interventions.

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.

3. 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.

Information Technology- DMH began to develop a strategy to address the information technology (IT) shortcomings during FY 2008, which included the roll out the Dashboard Technology project. In July 2009, DMH purchased, developed, trained and installed SharePoint, although not at the level envisioned due in part to the loss of a Senior Developer in Information Services. A preliminary IT structure was developed that would create a new Business Intelligence Unit under the Chief Information Officer (CIO). During FY 2009, budgetary constraints did not allow DMH to move forward with implementation of the new structure. While this structure has not been implemented, during FY 2010 DMH began a Departmental initiative to establish an improved centralized, electronic based integrated reporting process.

Range of Services- The current efforts to restructure the District's public mental health delivery system includes expanding community-based clinic services and greater access for uninsured individuals. The larger System Redesign Work Group was divided into four (4) sub-committees (child services, free standing mental health clinics, health information technology, provider restructuring).

Adult Community Services Reviews- The results of the FY 2010 Adult Community Services Reviews show that areas that continue to score low include: social network, education/career preparation, work, and recovery activities. While the overall system performance score was 76%, this does not meet the required 80% performance level established in the Dixon Consent decree.

Evidence-based Practices- DMH is implementing evidenced-based and promising practices related to supported employment, medication algorithms, assertive community treatment, integration of mental health and substance abuse services, and supported housing. DMH is not able to report on evidence-based practices that include family psychoeducational services, illness self-management, medication management, and permanent supportive housing. While DMH staff engage in activities related to these evidence-based practices, specific models are not being implemented and no data is collected.

ACT Fidelity Assessments- During FY 2010, ACT fidelity audits were conducted on 11 ACT teams. The results indicated that two (2) of the 11 ACT teams scored within the acceptable range and two (2) other teams scored very close to this range. While the majority of the ACT teams scored outside of this range, it is noted that most of the teams were new.

Older Adult Services- In mid-August 2010, there were approximately 5,210 adults age 50 and above who had received at least one service through the DMH mental health services rehabilitation (MHRS) program. The service needs of this population 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 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.

Consumer Satisfaction- The 2009 Adult Mental Health Statistics Improvement Program (MHSIP) Survey was conducted in FY 2010**.** The Adult MSHIP findings show gender differences with females reporting significantly less perceived access to services than males; however they reported greater levels of participation in treatment relative to males. There were also race/ethnic differences. African-American consumers reported being significantly less satisfied with services and reported significantly less access to services. The service type and amount were also predictors of perceived satisfaction. The receipt of more ACT service contacts predicted significantly lower ratings of general satisfaction, and a trend towards lower ratings on quality and appropriateness of care. The receipt of more community support service contacts predicted significantly better self-perceived outcomes, and a trend for significantly better self-perceived functioning.

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

4. Adult Plans to Address Unmet Needs

Information Technology Issues- DMH leadership was hopeful that SharePoint (a Microsoft product) could be the vehicle to build a common data platform throughout the Department. Currently, DMH has an active SharePoint site that supports the entire hospital and it is their central portal for all common, shared information (policies, application links, announcements, procedures, video and photo archives, etc.). SharePoint is used in Information Services and other areas of the Department (as management site for tracking software, licenses, remote access, purchases, etc.). During FY 2010, DMH launched an addition to the Information Services site that allows users to request the generation or creation of canned reports. Also, Contracts and Procurement uses SharePoint to track the status of contracts. Information Services leadership remains very interested in expanding the use of SharePoint if the Senior Developer position can be successfully recruited and if the funds can be found in the FY 2010 Budget that would allow for the purchase, development, training and installation of Share Point. It is believed that SharePoint would meet managers' needs through: 1) access to multiple databases; 2) automation of operational workflow; 3) versatility to meet unique team needs; and 4) low IT maintenance once installed.

In addition, during FY 2010 the Reporting Work Group was formed. The core functional areas became the sub-committees or teams and include: 1) Process Team- establish a reporting process that defines request format, report location, report catalogue, and reporting protocols; 2) Requirements Team- determine DMH data reporting requirements, considering internal and external data sources to meet requirements, and coordinate definition of reports; 3) Lexicon Team- develop a compendium of common terminology to be used to request and report data and to communicate business activities within DMH; 4) Code Standardization Team- define and document coding standards to be used in the development of all reports and reporting components; and 5) Reporting Infrastructure- research, define, and develop a centralized easy to use, data delivery system that integrates specified internal and external data sources to provide data that that meets DMH data report requirements. The Reporting Work Group will continue in FY 2011.

Range of Service Issues- The System Redesign Work Group findings and recommendations, once this process is completed, should inform ways to broaden the range of services within the DMH service delivery system. This work group includes consumer, provider, mental health and community-based organizations, and District agencies. During FY 2010, four (4) sub-committees were formed to examine and develop recommendations for the redesign. The sub-committees include: 1) child services (with an emphasis on services to children under age 5); 2) free standing mental health clinics (with an emphasis on co-occurring disorders); 3) health information technology (with an emphasis on high-level needs for the public mental health system); and 4) provider restructuring (with an emphasis on the CSA/sub-provider construct and determining how the provider system will look in the redesign). Each of the sub-committees issued a preliminary report describing the issues and process that would be employed in producing a final report with feedback from the larger group. The planning activities will continue in FY 2011.

Adult Community Services Review Issues- In FY 2009, the DMH Organizational Development Division created the first internal Community Services Review (CSR) Unit. This Unit plays a major role in the formal Dixon CSR reviews by providing logistical support for DMH reviewers

and helping to provide reviewer training. It has also been involved in focused provider reviews aimed at developing targeted practice improvement interventions. DMH has developed an overall systems improvement strategy that includes the following elements: 1) provision of individual feedback sessions in which agencies are presented their disaggregated CSR data and have the opportunity to discuss and clearly identify areas for practice improvement; 2) collection of additional data to gain a better understanding of agency strengths and needs in the areas identified for practice improvement; 3) development of an agency-specific action plan to address areas for practice improvement; and 4) the provision of technical assistance, coaching and identification of resources to support the implementation of an agency-specific action plan.

This approach will be used to address weaknesses identified in both the 2010 adult and child CSRs, as well as in FY 2011 and beyond.

Evidence-based Practices Issues- During FY 2010, DMH had some preliminary discussions about broadening its current repertoire of evidence-based and promising practices to include the models that are not currently being reported (family psychoeducational services, illness self-management, medication management, and permanent supportive housing). This is a complex issue because DMH does not offer these services within the system as a reimbursable service, nor does DMH provide training or technical assistance to support implementation of a specific model. As a first step, during FY 2010 the DMH Housing Division collaborated with a provider agency that is interested in adopting the Permanent Supportive Housing evidence-based model. This agency conducted a presentation on the Permanent Supportive Housing Toolkit at the August 5, 2010 Housing Division staff meeting. These discussions will continue in FY 2011.

Also during FY 2011, DMH will survey agencies to determine those that are providing/and or have an interest in providing the evidence-based practices as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA).

ACT Fidelity Assessment Issues- During FY 2010, DMH began administering the Dartmouth Assertive Community Treatment Scale (DACTS). The results of the fidelity assessment show that only two (2) of the 11 teams surveyed scored within the acceptable range (4-5), while two (2) others came very close to this range. With regard to the results of the fidelity audits, the teams are required to submit a performance improvement plan for any criteria where the score is three (3) or below. They will be monitored for improvement in that area. The audits are an annual process and will continue in FY 2011. The goal in FY 2011 is for at least 50% of the teams' total mean score on the 28-item fidelity scale to be in the acceptable range.

Older Adult Services Issues- While there is a significant number of DMH consumers 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 2011 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. Also, consideration will be given to conducting a training through the DMH Training Institute on older adults with mental health and other issues for the community providers.

Consumer Satisfaction- Several recommendations were made in response to the 2009 Adult MHSIP Survey findings, which indicated different perceptions of satisfaction based on gender, race/ethnic, and service type and amount. Some of the proposed quality improvement activities might include: 1) Gender- training and resource development on assisting male consumers feel comfortable asking questions about their treatment and developing treatment goals, and work with Core Service Agencies (CSAs) to develop strategies that will improve access for women (i.e., including transportation, child care, flexible hours; 2) Race/Ethnicity- for African-Americans an area for practice development includes the development of culturally responsive engagement strategies and implementation guidelines; and 3) Service Type and Amount- provide results to ACT Program Manager for integration into fidelity monitoring quality improvement efforts, specifically assertive engagement component of fidelity scale, and build motivational interviewing concepts into training for ACT teams.

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

5. Adult Recent Significant Achievements

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

- District SSI/SSDI Outreach, Access and Recovery (SOAR) Initiative: DMH engaged in planning activities aimed at improving processing times for SSI and SSDI that included: developing strategies and monitoring process; identifying new trainers to assist consumers apply for SSI and SSDI; participating in the national SOAR Train-the-Trainer training; and identifying a target group for training in Fall 2010.

- ACT Services: An ACT Performance Improvement Plan was developed that included a timeline for completing fidelity assessments; training for ACT staff; the development of reporting processes; and quality improvement activities. FY 2010 was the first time that DMH staff administered the Dartmouth Assertive Community Treatment Scale DACTS).

- Hamlin Street Pilot Project: This 22-unit building is targeted to individuals with mental illness who require a high level of community-based care but are assessed to be able to live independently. This partnership between Four Walls Development, Inc., DMH Housing Division and DMH Assertive Community Treatment (ACT) Program, funded by Mental Health Block Grant funds, completed the pilot phase during FY 2010.

- Housing Improvement Program Initiative: A $1M grant was awarded to Cornerstone (finances supportive housing for people with mental illness in the District) by the Department of Housing and Community Development (DHCD) using DMH capital funds. These funds provide loans and grants for the rehabilitation of units in small multi-family buildings and CRFs that house DMH tenants.

- Memorandum of Agreement (MOA) with the Department of Health Care Finance (DHCF): This MOA allows DMH to authorize individuals residing in Mental Health Community Residence Facilities (MHCRFs) as being eligible for the District's Optional State Supplement Payment (OSP).
- Community Residential Facility Task Force- a planning initiative to develop a service and funding structure to support the delivery of quality care to individuals enrolled in the public mental health system that require placement in community residence facilities (CRFs).

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

6. þÿ A d u l t S t a t e s V i s i o n f o r t h e F u t u r e

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.
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.

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

Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

A. Child Service System Strengths and Weaknesses

The DMH process to further develop the system of care for children, youth and families is ongoing; evidenced by the planning process to develop a 3 -5 year plan that continued during FY 2010. The evolution of this process involves developing partnerships with local, federal and community-based agencies, and the introduction of evidenced-based and other best practices.

1. Child 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:

- Public and Private Collaboration- DMH continues to work collaboratively with the local public and private child-serving agencies (child welfare, juvenile justice, public schools and state education) , as well as the Medicaid department with the common goal of improving the children's mental health service delivery system.

- Early Childhood Mental Health Consultation (Healthy Futures)- During FY 2010, the pilot phase for this program was implemented, which focuses on child and family-centered, and program consultation. The initial plan was to operate in eight (8) Child Development Centers, however by the time the program became operation during the third quarter of FY 2010, services were implemented for children (ages 0 to 5) at 26 centers.

- School Mental Health Program- The DMH School Mental Health Program (SMHP) provides intervention and prevention services in public and charter schools throughout the District. During School Years 2008-2009 and 2009-2010, the SMHP operated in 58 schools (47 public and 11 charter). The DMH Child and Youth Services Division launched the Primary Project in FY 2009 in 12 schools. During FY 2010, this evidence-based practice provided early intervention services to children identified with mild school adjustment issues in kindergarten and first grade in 16 schools. The School Mental Health Crisis Team continues to respond to crises in the D.C. Public Schools.

- Transition Age Youth Development Project- The District's Mental Health Block Grant provided the funding that allowed DMH CYSD to begin to address some of the system gaps in service delivery to young adults who are transitioning from child services to adult services and from young adults into adulthood. This project was launched in FY 2010. The activities included: adoption of the Transition to Independence Process (TIP) model; two (2) site visits to programs that implemented this model; survey of DMH MHRS providers about young adults served; focus groups with young adults and providers; and contract to child provider to implement services and supports in accordance with the TIP model

- Suicide Prevention Grant- The District was awarded a 3-year Substance Abuse and Mental Health Services Administration (SAMHSA) State/Tribal Youth Suicide Prevention Grant (October 1, 2009 - September 30, 2012). The Capital CARES (Citywide Approach to Reduce Risk for and Eliminate Youth Suicide) grant focuses on preventing suicide and suicide behaviors among all youth in the District of Columbia. The activities during FY 2010 include convening the D.C. Youth Suicide Prevention Coalition; hiring a social marketing agency; the approval of four (4) community-based organizations to receive mini-grants; suicide prevention training; focus groups with youth; and disseminating a newsletter.

- Functional Family Therapy (FFT)- During FY 2010, DMH awarded a contract to FFT Inc. to provide training and technical assistance services to child-serving Core Service Agencies (CSAs) designated as Choice Providers. Four (4) of the six (6) Choice Providers began the initial step of readiness assessment. Three (3) training phases were identified. Also during FY 2010, DMH initiated the process to amend the mental health rehabilitation services (MHRS) Regulations to include reimbursement for FFT. DMH forwarded draft rules to the Department of Health Care Finance (DHCF) to establish a rate for CBI Level IV- Functional Family Therapy services.

- Co-Location of Mental Health Staff at Child and Family Services Agency (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, community-based intervention (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) mental health coordinator assigned to the CFSA Child Protective Services (CPS) Unit under the direct supervision of the CFSA BSU.

- Child Welfare Mental Health Needs Assessment- 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 (FY 2009- FY 2011).

- Choice Provider Network- The Choice Provider Network is a designated cohort of mental health rehabilitation services (MHRS) Core Service Agencies (CSAs) with the ability to provide quality, evidence-based, innovative services and interventions to meet the needs of children and their families. CSAs within the Choice Provider Network, serve as a clinical home and baseline for the mental health of children served by the public mental health system. Currently, there are six (6) active CSAs designated as Choice Providers. As of June 30, 2010 over 261 children and youth had been referred, assessed and are receiving ongoing mental health treatment. A Request for Proposal (RFP) has been issued to expand the network.

- DC Choices High–Fidelity Wraparound Project- DMH CYSD in collaboration with CFSA and DYRS developed the Wraparound Initiative, which is operated via contract by DC Choices. The purpose of the contract is 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. As of June 30, 2010, approximately 152 youth with intense emotional and/or behavioral health concerns and their families received services.

- Children's Mobile Crisis Response Team: During FY 2010, Catholic Charities continued to operate the Child and Adolescent Mobile Psychiatric Service (ChAMPS) under contract with DMH. The goal of this service is to provide on-site 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. As of June 30, 2010, ChAMPS received 822 crisis calls and deployed response teams for 444 of them.

- 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. The providers participated in ongoing case consultation and technical assistance from October 2009 until May 2010. Due to a high rate of turnover at the agency level the agencies lost some staff that were trained.

- Establishing a Primary Family-Run Organization- DMH has established a partnership with one (1) Family-Run Organization, Total Family Care Coalition, to ensure that there is a family member as co-trainer in trainings delivered within the DMH System of Care program. The Family-Run Organization provides peer-delivered family support to families enrolled in the Wraparound and Child and Family Team process services 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 Children's System of Care; 3) expand to support and train family advocates for families of children with serious emotional disturbances (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 2010, Total Family Care Coalition, through a contract with the Children and Youth Investment Corporation Trust, provided peer-delivered family support and 1:1 supervision and coaching for children with SED and their families. The DMH Children and Youth Services Division will continue to offer peer-delivered family support services through Total Family Care Coalition for families enrolled in the Wraparound and Child and Family Team process.

- The District of Columbia Children's Round Table (Children's Round Table)- 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, managed care organizations (MCOs), providers, family organizations, community-based organizations and others. During FY 2010, the Children's Round Table met on a monthly basis for the purposes of information sharing and learning about new initiatives within the District's Children's System of Care. Additionally, the Children's Round Table: 1) enhances service coordination and resolves barriers to effective service planning and delivery; 2) affords DMH a very unique feedback opportunity consistent with the established Continuity of Care Guidelines set forth by the Department and the Teaming Formation and Functioning Practice Guidelines; and 3) provides a forum for information sharing about new resources, system transformation efforts, consumer education and outreach efforts.

- Participation in Statewide Commission on Children, Youth and their Families (SCCYF)- The primary strength is the strong interagency collaboration. The SCCYF 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. Also, the SCCYF Action Items and timelines are identified for each agency during the meetings.

2. Child System Weaknesses

- 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.

- Limited Family Involvement at All Levels of the System- There is still a limited focus on family empowerment and utilization of natural supports within the community.

- 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 Education and Outreach to Families- There is a lack of understanding about mental health and continued stigma regarding the use of mental health services.

- Shortage of Psychiatrists- Although there are many child psychiatrists in the Washington D.C. Metropolitan Area (per capita as compared nationally), there is still a shortage of those who are willing to accept Medicaid or work in the public mental health system with children and youth.

- Limited Community-based Early Identification and Intervention Services- The majority of the DMH provider network does not provide a full array of services for very young children.

- Transition Age Youth Services- DMH does not have a comprehensive strategy to address the service needs of young adults who are transitioning from child services to adult services and from young adults into adulthood.

- Community Service Reviews- The annual Child Community Services Reviews (CSR) continue to show problems related to practice issues including service team formation and team functioning.

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.

3. Child Unmet Service Needs

- Limited Culturally and Linguistically Competent Services- The provider network needs to improve its capacity to implement culturally and linguistically responsive practice skills to provide appropriate services to meet the needs of individuals of different cultural groups.

- Transition Age Youth Services- While some child providers serve transition age youth, there is no comprehensive approach that addresses the range of needs of this population (including education, employment, housing, etc.).

- Community Service Reviews- The 2010 Child Community Services Reviews (CSRs) show problems in areas that have scored poorly in the past that include: service team formation, service team functioning, functional assessment, and long-term guiding view.

- Consumer Satisfaction- The 2009 Youth Services Survey for Families (YSS-F) was conducted in FY 2010**.** The YSS-F findings highlight issues related to parental/guardian engagement as children and youth get older; a different pattern of perceived social connectedness for parents/guardians of boys; and a correlation between the level of resource intensity and parents/guardian's perception of access and engagement in services.

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

4. Child Plans to Address Unmet Needs

The Department of Mental Health goal is to continue to remove the existing structural barriers and create a comprehensive System of Care for District children and their families. Some of the strategies related to obtaining this goal include:

- Limited Information Technology Infrastructure to Capture Needed Data to Drive Data Informed Planning and Decision Making- During FY 2010, DMH created a Reporting Work Group to assist with the system-wide data capture and reporting needs. Also, the DMH Applied Research and Evaluation (ARE) Unit assists program managers in increasing the efficiency of data collection and how to use data to improve their program areas.

- Limited Family Involvement- DMH continues to work with the family organization, Total Family Care Coalition (TFCC), to ensure integrated participation of families at all levels of the system. DMH has provided training and technical assistance services to TFCC. These efforts assisted TFCC obtain a contract with the Child and Family Services Agency (CFSA) to provide peer support to parents involved in the child welfare system. TFCC is now involved at most levels within the DMH planning process. This includes being a member a member of the District Children's Round Table, the virtual management steering committee known as the Wraparound Initiative Group, and the Sub-Committee on Residential Placement (WIG/SRP). The Parent Action Group, the Juvenile Justice family organization, has joined both the Children's Round Table and the WIG/SRP group. Both organizations are active participants in the DMH 3-5 year planning process.

- Limited Education and Outreach to Families- During FY 2010, the CYSD Director participated in many community forums to discuss the bifurcated mental health system that exists in the District and how families can best access mental health services. Also, CYSD developed and began distributing a brochure on services for transition age youth during FY 2009. This brochure was updated during FY 2010 and is in its final revision. The development and dissemination of this important resource was made possible by Mental Health Block Grant funds.

- Limited Youth Advocacy and Voice in the System- Total Family Care Coalition, the family run organization, has implemented youth peer support. In addition, DMH engaged a group of youth from Metro Teen/AIDs to participate in the focus groups related to the Transitional Age Youth Development Project. Since full implementation of the Child and Family Team process, youth have been participants in the development of their treatment plan. In FY 2011, DMH will recruit youth to start a District of Columbia chapter of Youth Move. This is a nationally youth advocacy group funded by SAMHSA and currently housed at the National Federation of Families.

- Limited Culturally and Linguistically Competent Services- DMH is working with The Sexual Minority Youth Assistance League (SMYAL), a service organization

dedicated to supporting individuals who are gay, lesbian, bisexual, transgender, and questioning (GLBTQ), to train the Core Service Agencies on addressing the needs of this population. Also, DMH continues to contract for language access for families in need of interpretation services.

- Shortage of Psychiatrists- In FY 2010, DMH established the Child Psychiatrists Practice Group (PPG) at the Howard Road site. The PPG serves District children in need of psychiatric services. It also provides same day services for children experiencing a psychiatric crisis that may not have risen to the level of acuity requiring psychiatric hospitalization.

- Limited Community-based Early Identification and Intervention Services- During FY 2010, DMH developed and implemented the Early Childhood Mental Health Consultation Project. This is a problem-solving and capacity-building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one (1) or more individuals with other areas of expertise-primarily child care, child development, and families or individuals with child care responsibility. The goal of this project is to promote social and emotional development, and transform children's challenging behaviors. The project is operating in 27 child development centers.

  During FY 2010, DMH expanded the Primary Project from 12 to 16 schools. This project is a school-based early detection and prevention program that seeks to prevent serious mental health and behavior control problems among young children (kindergarten to first grade). Also, during FY 2010 DMH began the process of developing the Parent Infant Early Childhood Enhancement Program (P.I.E.C.E.) at the Howard Road site. This program will serve primarily children age 5 and under. DMH began accepting limited referrals for this program that will serve up to 60 children. The program is expected to be fully operational by October 1, 2010 and will provide parenting groups, infant observation, play and art therapy, and Parent Child Interaction Therapies.

- Transition Age Youth Services- The District's Mental Health Block Grant provided the funding that allowed DMH CYSD to begin to address some of the system gaps in service delivery to young adults who are transitioning from child services to adult services and from young adults into adulthood. The Transition Age Youth Development Project was launched in FY 2010. The Transition to Independence Process (TIP) model is the evidence-based practice that DMH has chosen to implement in the District. The project activities included: 1) site visits to programs in Phoenix, AZ and Pittsburgh, PA, to learn about these programs (process, barriers, challenges and successes); 2) data collection from DMH MHRS providers about services for this population; 3) consultant services that included three (3) focus group discussions with young adults, and one (1) with providers in order to develop the Road Map and Curriculum for service providers and young adults; and 4) award of a contract to a child provider for services and supports in accordance with the TIP model.

- Child Community Services Review (CSR)- As an outgrowth of the 2009 CSR review, DMH initiated a process to work with the child/youth providers on the core issues uncovered by the review. One of the first steps was the development of a common practice model for all agencies and staff. The kickoff of these efforts was held in June 2009. The DMH Team Formation and Team Functioning Practice Guidelines was distributed and discussed at the session. Also, there was focus intervention with providers related to areas needing improvement. Two of the larger child/youth providers undertook an intensive staff training and organizational change effort with DMH support. During the 2010 CSR, both providers scored in the 70% range in system performance. DMH has developed an overall systems improvement strategy that includes: 1) provision of individual agency feedback sessions; 2) collection of additional data; 3) development of an agency-specific action plan; and 4) the provision of technical assistance. This process will be used to provide targeted intervention with providers based on the 2010 findings.

- Consumer Satisfaction- One of the findings from the 2009 Youth Services Survey for Families (YSS-F) is that as children get older, parents perceive less involvement in choosing services, goals and involvement in the implementation of care. A recommended approach is to disseminate the findings to CYSD program staff for development of parent/guardian engagement strategies that respect the increasing role of youth involvement in care, while providing new supporting roles for parents/guardians in treatment. Another finding is that parents/guardians of boys perceive significantly less support from providers. The recommendation is to disseminate the results to the family-run organization and System of Care staff to devise advocacy and parent/guardian support strategies for parents/guardians in dealing with common developmental, emotional, and behavioral challenges within boys; and develop evidence-based practice models within these areas. The results also suggest that the more services that are provided Community-based Intervention and Community Support), the more access and support parents/guardians feel in managing their children's behaviors. The recommendations are to conduct additional analyses to control for length of service and determine whether there is an optimal level of resource intensity; and develop a best practice brief and guidelines on family engagement within these service domains.

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

5. Child Recent Significant Achievements

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

- CYSD continued the process of creating a 3-5 year comprehensive mental health plan for children and youth during FY 2010 by creating planning committees that developed draft reports related to: 1) service delivery/early identification/family engagement; 2) accountability and systems integration; and 3) financial strategies and workforce development.

- CYSD launched an Early Childhood Mental Health Consultation Pilot Project (Healthy Futures) for children (0-5) in 27 child development centers in FY 2010.

- The School Mental Health Program launched the Primary Project, an early intervention program to increase school-related competencies for children in kindergarten through grade 1 in FY 2009; and expanded from 12 to 16 schools in FY 2010.

- DMH initiated the process to develop the Parent Infant Early Childhood Enhancement Program (P.I.E.C.E.) at the Howard Road site. This program will serve primarily children 5 years old and under. It will have the capacity to serve up to 60 children and is expected to be fully operational by October 1, 2010. The program will provide parenting groups, infant observation, play and art therapy, and Parent Child Interaction Therapies.

- CYSD launched a Transition Age Youth Development Project to begin to address some of the system gaps in service delivery to young adults who are transitioning from child services to adult services and from young adults into adulthood in FY 2010.

- CYSD initiated the 3-year SAMHSA State/Tribal Youth Suicide Prevention Grant (October 1, 2009 - September 30, 2012) called Capital CARES (Citywide Approach to Reduce Risk for and Eliminate Youth Suicide), which focuses on preventing suicide and suicide behaviors among all youth in the District of Columbia.

- CYSD launched a Functional Family Therapy (FFT) initiative in October 2009 by awarding a contract to FFT Inc. to provide training and technical assistance services to child-serving Core Service Agencies (CSAs) designated as Choice Providers, and started process to amend the mental health rehabilitation services (MHRS) Regulations to include reimbursement for FFT.

- DMH developed draft common standards for all agencies to use in making decisions regarding residential placement in FY 2010.

- DMH implementation of an effective outreach program to homeless children and youth.

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

6. 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. The 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 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.

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

Section III. Performance Goals and Action Plans to Improve the Service System

Adult Plan

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Adult Establishment of System of Care

The Adult Community Service system is comprised of the Mental Health Authority, certified agencies (including the Mental Health Services Division and a group of private non-profit mental health agencies) and Saint Elizabeths Hospital. The Hospital includes individuals in both civil and forensic legal status who receive treatment in intensive or transitional programs based on the required level of care. 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 2011 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.

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.

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 audit process has continued and has shown an overall improvement in Co-Morbidity indicators from the third to the fourth quarter FY 2009 data. This means that the integration of medical and psychiatric information in documentation and treatment planning is gradually improving. During the past 6 to 12 months it has also been noted during the audits that more and more of the information needed has been transferred from the chart to the new AVATAR electronic medical record. This transition has progressed to such a degree that auditors will be trained in AVATAR to conduct all future audits.

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 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.

Integration of Mental Health Services into Primary Care Settings: 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.

Mental Health and Rehabilitation 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 38 MHRS providers in June 2010.

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.

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.

ACT Teams: During FY 2009, seven (7) new ACT teams began delivering services and the three (3) DC CSA teams closed down, requiring the transfer of all consumers from those teams to new teams. In FY 2010, there were 12 ACT teams. The ACT census as of June 30, 2010 was 891. This compares to 613 consumers receiving ACT services in September 2009, and 397 in

September 2008. The breakdown of ACT providers, teams, and the census is presented in the table that follows.

ACT PROVIDERS, TEAMS AND CENSUS

ACT Providers	ACT Teams	ACT Census
Anchor	1	60
Capital Community Services	1	40
Community Connections	3	276
Family Preservation	1	100
Green Door	1	84
Hillcrest	1	63
Pathways DC	4	268
TOTAL	**12**	**891**

ACT Performance Improvement Plan: During the FY 2010, a Performance Improvement plan was developed that included training for ACT staff, the development of reporting processes and quality improvement activities, and a timeline for completing fidelity assessments. An ACT team 2- day Core Training was held in May, June, and September 2009 and in January 2010. 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. DMH has developed the capacity to complete core ACT training utilizing in-house expertise and will offer Core Training to new team members during the FY 2010 fourth quarter.
A Wellness Self Management and Recovery training occurred in February 2010. This is an evidence-based practice that helps people to more effectively manage their mental illness and achieve personal goals. Workshop participants reviewed the nine (9) core skill areas of Wellness Self Management and Recovery and strategies to teach these skills. Wellness Recovery will be implemented broadly on ACT teams in FY 2011.

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. The FY 2010 Team Leader Retreat was held in April 2010. In addition, Team Leaders meet monthly with the DMH ACT Coordinator and Adult Systems of Care Manager to discuss DMH system issues, clarify policies, and provide peer support to each other.

During FY 2010, an internal Fidelity Audit Team was developed. The Adult System of Care Manager and the ACT Coordinator served as the fidelity audit team leaders. Other DMH staff from the Office of Accountability, Provider Relations and Integrated Care served on the audit teams. The Dartmouth Assertive Community Treatment Scale (DACTS), a 28-item fidelity scale, is being used to conduct the audits.

The results of the fidelity assessment show that only two (2) of the 11 teams surveyed scored within the acceptable range (4-5), and two (2) other teams came very close to this range. The ACT Performance Improvement Plan with regard to the fidelity audits, requires the teams to submit a performance improvement plan for any criteria where the score is three (3) or below.

The teams are monitored for improvement in that area. The audits will be conducted annually. The FY 2011 goal is for at least 50% of the teams' total mean score to be in the acceptable range.

Other ACT Goals for FY 2010 and FY 2011: Some of the other ACT goals through FY 2011 include: 1) 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 the 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 Supported Employment Program.

Forensic Services

The Adult System of Care Manager has worked collaboratively with the forensic team to further refine the Sequential Intercept Model. The goal is to provide the earliest possible linkage (or re-linkage) to the mental health system for persons with serious mental illness and/or co-occurring substance abuse who are involved in the criminal justice system. DMH has conceptualized the Sequential Intercept into five (5) levels of mental health intervention. The access points include: pre-booking, post-booking, incarceration, and re-entry from prison or jail.

The First Point of Intercept-Pre-Booking Services: Community crisis services and outreach services are the first point of intercept. They offer an opportunity to identify individuals in need of services before arrest. The Homeless Outreach Program and the Comprehensive Psychiatric Emergency Program (CPEP) have been in existence for a number of years to link individuals with mental illness to mental health services, however DMH has developed two (2) additional services that are also critical aspects of the first point of intercept. These include the mobile crisis services and the District Metropolitan Police Department Crisis Intervention Officer Training.

The Second Point of Intercept-Post-Booking Services: DMH provides three services in the post-booking phase of the Sequential Intercept Model.

- DMH Court Liaison- is responsible for screening individuals and 1) recommending continued follow-up with the D.C. Pretrial Service Agency's Specialized Supervision Unit, 2) making referrals to the Court Urgent Care Clinic for immediate evaluation, or 3) recommending referrals 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.

- Options Program- offers intensive mental health, case management and residential services to defendants with mental health issues who are referred by the Pre-Trial Services Agency.

- Court Urgent Care Clinic- offers mental health assessments, linkages and referrals to DMH mental health providers. This clinic is housed in the D.C. Superior Court Building and is available on a walk-in basis. Court personnel make referrals to the program. Program staff are able to go to the court room and provide assistance upon request. This program is operated under contract with Psychiatric Institute of Washington (PIW).

The Third Point of Intercept-Incarceration: In the District of Columbia, there is one Detention Facility. DMH employs a full-time Jail Liaison with an office at the D.C. Jail who ensures linkage to a mental health provider for all consumers referred by the jail mental health program.

Some individuals are re-linked to DMH mental health providers who have lost track of their consumers and others are linked to the DMH D.C. Linkage Plus program.

The D.C. Linkage Plus (DCLP) program began in 2005. There are currently two (2) mental health providers who provide services as part of this program (Green Door and Volunteers of America). The target population is consumers coming out of jail with serious and persistent mental illness (SPMI).

The two (2) mental health providers have designated liaisons who meet with consumers in the jail within 48 hours of referral to ensure that services will be available to the consumer upon release. There were 270 persons served under the DCLP program from October 2009 – June 2010.

The Fourth Point of Intercept- Re-entry: DMH employs a Re-Entry Coordinator on site at the Project Empowerment Employment program. Mental health screenings and 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. During FY 2009, 309 persons were evaluated and assisted as part of the re-entry program. In FY 2010, through mid-August approximately 624 persons were seen.

The Fifth Point of Intercept - Community Corrections and Community Supports: This phase includes: 1) Outpatient Competency Restoration- DMH Mental Health Services Division (MHSD) has a program to assist individuals deemed not competent to stand trial to become competent; 2) Streicher Cases- DMH Forensic Services has responsibility for monitoring the Periodic Psychiatric Examinations (PPEs) for committed patients; and 3) collaboration with Saint Elizabeths Hospital staff to coordinate efforts and share linkage information for persons in the care of the Hospital.

Co-Occurring Mental Illness and Mental Retardation Services

One of the major cross-agency efforts between DMH and the Department on Disability Services (DDS) has been locating consumers who are developmentally disabled at Saint Elizabeths Hospital (SEH) to the community. During FY 2009, eleven (11) dually diagnosed individuals were moved. The FY 2010, target is 10 additional individuals to be placed by September 30, 2010. These are very challenging placements given the array of services needed. DMH has transferred a total of $500,000 to support services for this group of individuals ($300,000 to DDS and $200,000 to Department of Health Care Finance).

The other major DMH effort for this population is the special team that exists within the Mental Health Services Division (MHSD). This team specializes in services to this dually diagnosed population and has established a good working relationship with DDS. MHSD currently has a total of 124 consumers who are dually diagnosed (MI/MR). Of these, 114 are enrolled in the DDS system. MHSD staff regularly attend cross-agency planning meetings regarding individual consumers.

During FY 2011, DMH plans to meet with new leadership at DDS to explore several issues. These include: 1) whether it is feasible for MHSD to become a provider through the DDS Medicaid waiver program; 2) strengthen the relationships among DMH providers and DDS providers; and 3) explore the potential for DMH to develop specialized crisis/emergency services for the DDS population.

Clubhouse Services

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.

In May 2010, DMH published emergency and proposed rules that will allow a portion of clubhouse services to be reimbursed through Medicaid. Comments were received and the rules revised. A second set of emergency and proposed rules was published on August 20, 2010. DMH is working with the Department on Health Care Finance (DHCF) on this initiative.

Wellness and Resource Center

June 2010 marked the second 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. The Center is open Tuesday 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 activities during FY 2010 included: Double Trouble in Recovery Groups (mental health and addiction issues); Hanover Area Civic Association meetings; workshops on employment; Toastmasters International meeting; free training for Disability Employment Awareness; poetry slam nights; women's Gestalt group; free HIV testing; community voicemail program; fitness classes; Ticket to Work program; computer classes and computer access; library and resource center; referral services; and community outreach and self-advocacy trainings. The Mental Health Day observance focused on issues related to HIV/AIDS.

Court Urgent Care Clinic

June 2010 also marked the second 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.

Within the past year, the part-time psychiatrist staffing the CUCC has expanded to full-time. He is now also available to the Child and Family Court for emergency evaluations. Also, during FY 2010 there have been discussions with the Addiction Prevention and Recovery Administration (APRA) and DMH about creating a fully integrated mental health/drug and alcohol clinic at the Court Urgent Care Clinic.

Employment Services

DMH Supported Employment Program

Supported Employment Program Overview: 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. 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 place 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.

Supported Employment Provider Programs**:** DMH funds six (6) programs to provide evidence-based supported employment services: 1) Anchor Mental Health; 2) Community Connections, Inc.; 3) Deaf Reach, Inc.; 4) Green Door, Inc.; 5) Pathways To Housing, Inc.; and 6) Psychiatric Center Chartered, Inc. The data that follows summarizes program activities and outcomes for the Dixon Court reporting period April 1, 2009 to March31, 2010.

1. Supported Employment Referral Sources

Referral Source	Number of Referrals
DMH Supported Employment Programs	141
Rehabilitation Services Administration	9
Referrals to DMH SE Manager	22
McClendon Center	11
Mayor's Focused Improvement Initiative (FIA)	5
DMH Child & Youth Division	4
Washington Hospital Center	15
DMH Reentry Program	3
DMH Housing Division	5
Volunteers of America	13
Voices of America	14
Total Referrals:	**242**

2. Supported Employment Dixon Criterion

The Dixon Exit Criterion states that 70% of persons referred receive supported employment services within 120 days of a referral. The table that follows shows the overall percentage for the four (4) consecutive reporting quarters was 84.71%.

Reporting Periods	FY09 Quarter 3 4/1/09-6/30/09	FY09 Quarter 4 7/1/09-9/30/09	FY10 Quarter 1 10/1/09-12/31/09	FY10 Quarter 2 1/1/10-3/31/10	Performance
Performance Indicator	82.88%	75.00%	91.11%	100%	84.71%
Numerator: (Referrals who received services within 120 Days)	92	42	41	30	205
Denominator: (Consumers Referred)	111	56	45	30	242
Number of Referrals who did not receive services within 120 Days	19	14	4	0	37

3. Supported Employment Consumer Outcome Data

A successful job placement is defined as a consumer employed for 30 days. The table that follows shows supported employment consumer outcomes for the DMH approved supported employment programs for the Dixon reporting period.

Supported Employment Consumer Outcomes

Supported Employment Program	Number of Consumers Enrolled in Service		Number of Consumers Placed in Competitive Employment		Average Number of Hours Worked Per Week		Average Hourly Wage	
	FY09	FY10	FY09	FY10	FY09	FY10	FY09	FY10
Green Door, Inc.	114	88	57	45	27.7	26.8	$9.76	$9.74
Anchor Mental Health	72	65	33	35	30.0	28.3	$11.25	$10.51
Psychiatric Center Chartered	110	135	72	79	38.7	38.7	$9.82	$9.79
Community Connections	75	75	41	32	20.0	22.0	$9.45	$9.52
Pathways To Housing	54	46	13	7	22.0	33.0	$11.87	$11.79
Deaf Reach, Inc.	44	44	8	7	28.0	28.0	$9.00	$9.00
Total:	**469**	**456**	**224**	**205**	**27.7**	**29.5**	**$10.19**	**$10.05**

4. Consumers Transitioned To Competitive Employment

Several consumers maintained employment for one year or longer and graduated to competitive employment with follow-up supports as needed. The following table shows the number of consumers who have been working one (1) or more years (n = 26 as of March 31, 2010).

Supported Employment Program	One Year of Employment	Two Years of Employment	Three Years of Employment
Psychiatric Center Chartered	0	2	4
Green Door	2	3	4
Community Connections	2	1	1
Anchor Mental Health	2	2	3
Pathways To Housing	0	0	0
Deaf Reach	0	0	0
Total:	**6**	**8**	**12**

5. Supported Employment Performance Measurement

Program fidelity audits are conducted annually to determine if supported employment programs are meeting performance measurements based on DMH Evidence-Based Practice Supported

Employment Policy. The most recent audits were conducted in FY 2009 and results were based on the fidelity assessment rating scale that was revised in 2007 by the creator of the fidelity assessment tool, Dartmouth Psychiatric Research Center. DMH supported employment program staff and a representative from the Rehabilitation Services Administration currently conduct the assessments. DMH will explore whether the Office of Accountability staff can be cross trained to conduct fidelity assessments. The results of the FY 2009 fidelity assessment show that two (2) providers were exemplary, two (2) were good, and two (2) were fair.

Saint Elizabeths Hospital Work Adjustment Training Program (WATP) Transition: DMH continues to restructure the WATP. In FY 2008, a total of 160 consumers were on the program payroll from the DCCSA, Saint Elizabeths Hospital and a private provider. In FY 2009, DMH removed 64 consumers who had not worked one (1) year or more from the program, and converted the Stamp, Green House, and Library programs at Saint Elizabeths Hospital to non-paid pre-vocational programs. Eighteen (18) consumers linked to a private provider were transitioned into that provider's supported employment program. As part of the DC CSA closure, 26 consumers were either enrolled in supported employment programs with private providers, or in collaboration with the Office of Consumers and Family Affairs, were assisted in obtaining part-time positions supporting other DC CSA consumers as they went through the process of selecting new Core Service Agencies (CSAs).

As a result of the restructuring, WATP currently serves 52 consumers. The 37 forensic outpatients have been enrolled in supported employment programs. The programs are helping consumers obtain jobs in the community, as DMH continues to transition these consumers into supported employment.

DMH in collaboration with Saint Elizabeths Hospital is finalizing the establishment of a coordinated delivery system for vocational rehabilitation services at the Hospital, which will be an important part of a successful treatment and recovery program. The new vocational rehabilitation services program will be a three-step process consisting of 1) pre-vocational/employment activities such as participation in the Stamp, Horticulture and Library Programs to help develop work readiness skills and abilities; 2) work adjustment training such as working in time-limited part-time housekeeping, clerical, transportation, or facilities management on the grounds of the Hospital to gain work experience, which will facilitate community-based employment; and 3) supported employment where consumers will be enrolled in private provider programs so that upon release from the Hospital they are assisted in obtaining a job in the community and will receive ongoing support to help them successfully maintain employment. The DMH is currently working to identify funding for this initiative for FY 2011.

DMH and RSA Supported Employment Collaboration**:** DMH and Rehabilitation Services Administration (RSA) have entered into a collaborative effort where DMH approved supported employment programs have obtained contracts with RSA to provide evidence-based supported employment services as RSA vendors. The programs will provide the following supported employment services through the contracts: 1) intake and assessment; 2) job development and placement services; 3) individual stabilizations- job coaching; and 4) individual employed- 90 days (programs receive payment for helping a consumer maintain employment for 90 days).

The contracts are human care agreements with a fixed unit price of $65 per hour, which matches the DMH unit price for supported employment and provides consistency across both funding sources. The contracts began October 1, 2010 and DMH supported employment programs have begun providing services under the contracts. These contracts with RSA will allow DMH to expand service capacity by 150 slots.

DMH and Department of Human Services (DHS), Income Maintenance Administration (IMA) Supported Employment Collaboration: DMH and DHS/IMA have agreed to collaborate on the development and provision of evidence-based supported employment services to individuals with serious mental illness who receive Temporary Assistance for Needy Families (TANF). DHS/IMA would provide funding for supported employment services for TANF clients and DMH would distribute the funding to current approved supported employment programs. DMH and DHS/IMA are developing a Memorandum of Agreement (MOA). It is anticipated that the MOA will be completed by the end of FY 2010 or early FY 2011.

Supported Employment Social Marketing: DMH continues to implement a social marketing plan to educate clinicians, case workers and consumers about the availability of supported employment services. The 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 and Employment Specialist 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. Training was provided as follows: 1) Consumer Training conducted September 24, 2009 (12 consumers); 2) Clinician Training conducted April 20, 2010 (11 clinicians); and 3) Consumer Training conducted April 22, 2010 (10 consumers).

Housing Services

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

According to CSH, permanent supportive housing (PSH) 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. DMH provides supportive housing in scattered site housing; consumers are linked to services through a DMH 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, living from place to place without a permanent resident), or in institutions such as Saint Elizabeths Hospital, jail, or living in substandard housing; at the time of referral for DMH housing resources. 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 escalation of housing costs in the District of Columbia is an ongoing challenge for DMH and consumers.

DMH maintains a formal application process, working through Housing Liaisons from the referring Core Service Agency (CSA). Qualified applications are either approved or placed on a waiting list. The DMH Housing Program compiles and distributes a Housing Vacancy list to assist CSAs and consumers in the housing search.

Housing is one of the highest priorities for consumers. The District received a legal opinion from bond counsel regarding the use of capital funds via general revenue bond sales. This legal opinion facilitated the transfer of $14M of DMH capital funds to the Department of Housing and Community Development (DHCD) in 2007. DMH and DHCD have amended their Memorandum of Understanding (MOU) to extend the period to finance and develop 300 affordable housing units from November 2009 to November 2010. DMH has identified funding to continue this initiative in FY 2011.

DMH Affordable Housing Strategy

The DMH strategy is a structured initiative designed to expand supported housing for consumers. It includes the following:

Housing Partnership Model: DMH continually expands utilization of partnerships to better leverage/maximize supported housing resources. Important partnerships have been established and formalized with both public and private housing and related agencies. DMH partners

include: the D.C. Housing Authority, the Department of Housing and Community Development, Corporation for Supportive Housing, Advance Dispute Resolution Service (ADRS), and a network of Mental Health Rehabilitation Services (MHRS) agencies contracted by DMH to provide support, clinical and treatment service that provide major "supports and services" to consumers in supported housing.

Supported Housing Advisory Committee: 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 the Behavioral Health Association, 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, Inc., Community Connections, Green Door and the Office of the Ombudsman.

Housing Liaison Provider Network: Twenty-two (22) core service agencies (CSAs) have designated Housing Liaison representatives to serve as the central point of contact (POC) for accessing DMH housing resources and monitoring consumer stability and tenure 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: 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 D.C. Housing Authority for Federal voucher programs that provide additional housing for consumers.

Supported Housing Programs

The DMH supported housing programs are presented in the tables that follow.

DMH Housing Programs (Summary) **As of June 30, 2010*	**Total Capacity**	**Persons Housed**
DMH Home First and Supported Independent Living Housing	750	710
Supported Independent Living	461	403
Federal Vouchers	374	363
Local Rental Subsidy Program	58	58
Totals	**1643**	**1534**

DMH Housing Programs *As of June 30, 2010*			
DMH HOME FIRST PROGRAM & SIL	**Housing Capacity**	**Persons Housed**	**Vacancies**
DMH Home First- Permanent Supportive Housing Bridge Rental Subsidy Program	750	710	
Supported Independent Living DMH Contract	461	403	
FEDERAL PROGRAMS- DMH HOUSING REFERRALS ONLY	**Housing Capacity**	**Persons Housed**	**Vacancies**
Shelter Plus Care/ DMH Grant	15	14	1
Shelter Plus Care/TCP Grant	144	129	15
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	105	100	5
HUD HCVP Vouchers DMH MOU	30	30	0
TOTAL	**384**	**363**	**21**

Community Residential Facilities

In addition to the supported housing programs, a number of consumers reside in community residential facility (CRF) group homes that are supervised 24-hours per day. There are 225 facility beds under contract with DMH. These providers have 72 additional beds not contracted by DMH. There are 478 facility beds that are independently operated. All of the CRFs are licensed by DMH.

Capital Funds Used to Leverage Other Public Sources of Housing Funds

The DMH MOU with DHCD transferred $14M in capital funds to develop 300 housing units by November 30, 2010. As of June 30, 2010, 248 housing units were 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. Twenty-three (23) are funded to preserve DMH housing stock and were previously. The 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 are scattered sites. As of June 30, 2010, sixty-three (63) of the pipeline units are online and 61 of the units are occupied. Of the remaining pipeline housing units, 32 are scheduled to come online by the end of 2010 and the remaining 26 are scheduled to come online in 2011.

Strengths and Resources of the DMH Supported Housing Program

Supports in the Supported Housing Program: Supports to consumers is the most important factor in the program. The DMH Housing Division provides numerous supports including:
1) MyHouse Housing Mediation to assist consumers in addressing landlord tenant rights and responsibilities; 2) education on how to manage the housing unit and how to be a good neighbor; 3) housing search assistance through Housing Vacancy List; 4) subsidy payments; 5) housing initial and annual inspections; and 6) housing crisis intervention.

Housing Data Base**:** The data base has added 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: These rules are intended to establish standards for various housing processes including the application process, eligibility determination and issuance of subsidies, annual recertification, waiting list, transfers, termination, and due process rights. A third notice of proposed rulemaking was published May 7, 2010. The comments are being reviewed and if no further substantive changes are made, the final rules should be published before the end of FY 2010.

Draft Housing 5-Year Plan: During FY 2010, the Housing Plan development process shifted from focusing solely on DMH efforts to include coordination with and integration of other District housing initiatives. The plan development is in progress and the 5-Year Housing Plan will likely include the period FY 2011 – FY 2016.

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- FY 2010 and funding is proposed for FY 2011.

- 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. ERAP provides emergency assistance to prevent eviction.

Federal Housing Grant Resources

DMH continues to explore ways to augment its supported housing capacity. The Department was one of the agency partners in the D.C. Housing Authority application to HUD for Rental Assistance for the Non-Elderly Persons with Disabilities. The funds will be available in October 2010. The notice of award is pending.

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): During FY 2010, MHBG funds ($380,000) provided bridge subsidies for consumers leaving institutions and transition age youth. Also during FY 2010, the pilot program to house ACT consumers was completed that was funded by MHBG FY 2009 carryover funds.

Shelter Plus Care: 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 a new Shelter Plus Care grant in 2008 that became operational October 1, 2009. As of March 31, 2010 the program housed 14 consumers and is at capacity.

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. This grant program expanded the partnership with the Department on Disability Services, which also works collaboratively with the DMH Integrated Care Division (persons leaving Saint Elizabeths Hospital), and the DMH Mental Health Services Division (community program for persons with MI/DD).

Permanent Supportive Housing Evidence-Based Practice

The DMH Housing Division August 5, 2010 staff meeting included a presentation on the Substance Abuse and Mental Health Services (SAMHSA) Permanent Supportive Housing Toolkit. The presentation was provided by one of the Core Service Agency that has an interest in implementing this model. During FY 2011, DMH will continue this collaboration.

Dixon Housing Exit Criterion

The Dixon Exit housing criterion requires that 70% of adults with serious mental illness receive supported housing services within 45 days of a referral. Since housing placement is the sole measure of supported housing services, it has been difficult for DMH to achieve this measure.

In late October 2009, DMH submitted a request to the Court Monitor to modify this measure. The recommendations include three (3) indicators: 1) housing stability (75% of adults with SMI are able to sustain their housing for 1 year or longer); 2) availability of mental health services and supports (90% of consumers are actively enrolled with a DMH provider or have access to supports and services from a mental health specialist who may not be in the DMH system); and 3) availability of DMH housing resources (20% of SMI population will receive supported housing services controlled by DMH or administered by DMH providers within the reporting period).

In February 2010 Plaintiff's Counsel opposed the modification, and the Court Monitor requested additional information. The discussion on this and other housing issues are ongoing with the Dixon Court Monitor.

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. Recently, the University of the District of Columbia has opened a community college, which provides more educational opportunities for District residents.

DMH Organizational Development Division- In January 2010, the DMH Organizational Development Division was successful in hiring a very experienced Director for the Training Institute. This has accelerated and intensified the overall development of the Training Institute. The Fall 2009 and 2010 (Spring, Summer) courses reflect a broad range of training opportunities for consumers, DMH staff, and community providers. The training includes both basic training (DMH 101: Overview of Services and Supports Offered through the D.C. Department of Mental Health) to more advanced (Using the Ohio Scales to Inform Case Conceptualization and Ongoing Treatment Planning) training. There were approximately 75 course offerings during FY 2010. A list of the trainings is presented in Criterion 5 (Management Systems). As noted under the Adult New Development and Issues section, during FY 2010 a Brown Bag Series was developed for calendar 2010, as well as a 5-session series on Disaster Mental Health.

Substance Abuse Services

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

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

Comprehensive Psychiatric Emergency Program (CPEP)- The Department of Health Addiction Prevention and Recovery Administration (DOH/APRA) has made CPEP a satellite site. This enables CPEP to refer consumers directly to substance use disorder treatment facilities.

Saint Elizabeths Hospital (SEH) 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.

Mental Health Services Division- Substance abuse services are provided through the following programs: deaf and hard of hearing and persons with intellectual disabilities, multicultural, and physician's practice group (PPG).

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 (FY 2010) is the evaluation period. This initiative established 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.

Some of the activities related to achieving co-occurring disorders (COD) competency throughout the system include: 1) all clinical staff and all new employees at SEH are trained in COD, and a standard COD assessment tool is used; 2) a comprehensive training manual was completed during the grant period and five (5) individuals within DMH system can train on the 14 modules; and five (5) providers continue to be designated by DMH as COD competent.

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, pharmacy services provided by the Mental Health Services Division (MHSD), as well as the District's community health system.

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).

Support Services

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 DMH system's planning and delivery efforts for adults and children. The OCFA also serves as the Olmstead and Stigma Coordinator for DMH.

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'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 two (2) consumer-run organizations, the Consumer Action Network (CAN) that operates the peer grievance process, and the Ida Mae Campbell Wellness and Resource Center. It also includes hiring consumers who are assigned to various DMH Authority offices (General Counsel, Accountability, Strategic Planning Policy and Evaluation).

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 and has become an annual event. The second conference was held on December 18, 2009 and the third conference is being planned for October 2010.

DMH has convened a work group to develop a Peer Specialist Program. A training curriculum and supervisory protocol for all peer specialists is being developed. The OCFA is collaborating with the DMH Office of Strategic Planning, Policy and Evaluation to accomplish this task. After rules are developed and the training curriculum and supervisory protocol are finalized, DMH will work with the Department on Health Care Finance (DHC) to obtain Centers for Medicare and Medicaid approval. Once accomplished, this will open up major new opportunities for employment by peer specialists.

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 the areas of need that will be addressed 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 Service 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.
- DMH is committed to expanding the scope of community-based services.
- 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.
- 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. 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

Co-Occurring State Incentive Grant (COSIG): DMH completed the initial four (4) active years of its Substance Abuse and Mental Health Services Administration (SAMHSA) COSIG in August 2009. The final year involved project evaluation activities conducted by George Washington University and ended August 31, 2010. Cross-agency collaboration was established between the DMH and the Department of Health Addiction Prevention and Recovery Administration (APRA) to carry out this project.

Four (4) major objectives were identified with a portfolio of activities clustered under each objective. Some of the project results include the following:

1. System Supports for Integrated Service Delivery- a) developed standards and tested process for DMH and APRA provider agencies to achieve a designation of Co-Occurring Competency, b) collaborated with other DMH, APRA, and District key initiatives (i.e., APRA's Access to Recovery and State Substance Use and Adolescent Care Coordination) for technical assistance and training on co-occurring disorders to homeless services providers), and c) worked with partners to close gap in youth substance use and co-occurring services by developing an 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 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– DMH developed the comprehensive Clinical Competency Certificate Program and Manual for a 72- hour course that awards graduates a "Certificate of Co-Occurring Clinical Competency." There have been 150 mental health and substance use professionals trained to date. Over 50 agencies and more than 350 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. The project also worked 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- DMH worked closely with George Washington University to improve consumer outcomes by developing practice-based evidence of treatment effectiveness within the public behavioral healthcare treatment system. CIOMS, a consumer self-reported outcomes data set collected at the point of service and tracked over time, was tested for usability in DC at COSIG volunteer mental health and addiction treatment agency test sites. Small test groups used the instrument with real time feedback to the treatment team, alerting them to issues that may call for a revision of the treatment plan. Given the results of the small tests of this approach DMH has decided that the CIOMS could have broad benefit for continually improving care and achieving better treatment outcomes. It was determined, however, that to be successful a web-based platform would be required to support the application and make it easily accessible to provider agencies.

Mental Health Consumers with Co-Occurring Substance Use Disorder: The DMH e-Cura system has a quarterly event screen that captures co-occurring (mental health and substance use disorder) services. The provider network reported services include: 1) day treatment; 2) detoxification; 3) diagnostic assessment; 4) integrated treatment; 5) psychiatric inpatient unit; 6) referral; 7) relapse prevention; and 8) screening. The numerator is the number of consumers receiving a co-occurring service and is a unique count per category; however, consumers may be in more than one (1) category. The denominator is the number of consumers receiving at least one mental health rehabilitation service (MHRS) for the reporting period.

The data for the period FY 2007 through August 3, 2010 is presented in the table that follows.

MENTAL HEALTH CONSUMERS WITH CO-OCCURRING SUBSTANCE USE DISORDER

Programs	2007	2008	2009	2010
Day Treatment	271	347	410	390
Detoxification	245	343	346	372
Diagnostic Assessment	2,092	1,234	1,897	2,385
Integrated Treatment	1,562	877	1,223	1,406
Psychiatric Inpatient Unit	191	210	177	204
Referral	662	853	993	967
Relapse Prevention	1,829	1,219	1,573	1,836
Screening	1,787	1,318	1,582	1,968
Unique Consumer Count	**3,728**	**5,296**	**5,831**	**5,485**

Unique consumers per category; consumers may be in more than one (1) category

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 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 2009 through June 2010, the Jordan House beds had an average utilization rate 86.1% and Crossing Place79.4%. The total year-to-date utilization rate is 82.75%.

Peer Transition Specialists: During FY 2010, the Office of Consumer and Family Affairs, Saint Elizabeths Hospital, and the Integrated Care Division collaborated on the implementation of this initiative aimed at helping consumers leave the Hospital. The role of the Peer Transition Specialists (PTS) is to assist individuals in the care of the Hospital, who have been determined ready for discharge, make a smooth transition to community living. Ten (10) PTS were hired and trained during FY 2010. The PTS are able to draw upon lived experiences as well as their training to provide encouragement and support to those who are returning to the community. Some of the consumers who served as Peer Partners during the DC CSA transition are now PTS. This initiative is supported with Olmstead funding.

Use of Local Hospitals for Acute Care: The DMH continues to use local hospitals to provide acute care. During the six-month period of October 2009 through March 2010, there were 40 total acute care admissions to Saint Elizabeths Hospital (SEH); which is the same number of admissions for the previous months of April-September 2009). Also, from October 2009 through March 2010, there were only four (4) occasions when a person was not admitted to an acute hospital due to the lack of an available bed. The United Medical Center (UMC) with 30 available beds averaged 33 acute admissions per/month for this period. Providence Hospital with 15 beds averaged 31 admissions per month. The total number of admissions to SEH for this period was slightly under 21 per month and is very comparable to the prior six (6) months that was 22 admissions per month. The data suggests that the overall management of acute care admissions is in a continued stable pattern. The number of acute care admissions to SEH is probably approaching its low point.

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.

During FY 2010, the DMH Homeless Outreach Program became a part of CPEP joining the other components that includes: 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. Consumers may stay in an EOB for up to 72 hours. The EOB is used for consumers who may need additional time to stabilize before discharge to the community.

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 operates from 9 am – 1:00 am, seven (7) days per week.

The number of consumers served by the Psychiatric Emergency Services from October 2009 through June 2010 is 2,882 (duplicated count). The unduplicated number of consumes served by Mobile Crisis Services is 1,278 and the unduplicated number of consumers served by the Homeless Outreach Team is 1,209.

Integrated Care Division: The DMH Integrated Care Division (ICD) continues to provide intensive care management and care coordination for the most difficult to place persons in the care of Saint Elizabeths Hospital (SEH). ICD is also responsible for tracking and monitoring individuals who are discharged from inpatient settings back to the community. The Washington Hospital Center (New Directions) has been contracted to serve 27 difficult to place individuals coming from SEH. As of July 7, 2010, 27 were enrolled and 16 had been placed in the community.

DMH and New Directions continue to find that it takes 4-6 months of intensive work to actually place individuals, as most have been in the care of SEH for many years. The hope is to increase the capacity of this contract to 30 as of March 2011.

The ICD also assumes the ongoing leadership role for working with the Department on Disability Services (DDS) to place individuals with mental retardation into the community. DMH will transfer $500,000.00 to DDS and the Department of Health Care Finance (DHCF) to support services for 10 individuals to be served through the Medicaid 1915(c) waiver for the developmentally disabled. The goal is to accomplish these placements by September 30, 2010.

The ICD has intensified its efforts to monitor individual Hospital and Core Service Agency (CSA) collaboration for individuals moving from Hospitals to community care. This important in trying to meet the Dixon Exit Criterion for Continuity of Care (adults and children/youth

discharged from inpatient care must be seen in the community within 7 days in a non-emergency outpatient setting). ICD is now tracking this measure (by discharging Hospital) for those who are seen within seven (7) days, within 30 days, after 30 days, or not at all.

On the adult side, ICD began intensive efforts with SEH and Providence Hospital, with United Medical Center expected to come on line in mid-July 2010. The ICD staff started participating in treatment team meetings to help ensure that DMH consumers are appropriately referred and connected to the assigned CSA.

Annual Adult Community Services Reviews

The Year 8 (2010) Adult Community Services Review (CSR) included a total of 85 consumers and was conducted during May 2010. Two-thirds of the cases were reviewed by Human Systems and Outcomes, Inc. (HSO) - affiliated reviewers and one-third by DMH reviewers. HSO has provided a Case Judge since the 2008 review. This individual reviews, all cases reviewed by DMH staff and as many cases as possible reviewed by HSO, in order to ensure inter-rater reliability.

The overall Year 8 (2010) result for consumer status was 80%. This compares favorably to Year 7 (2009) at 74% and Year 6 (2008) also at 74%. The areas of strength included: safety (89%), economic security (79%) and health/physical well-being (80%). The areas that continue to score low included: social network (49%), education/career preparation (49%), work (50%), and recovery activities (60%). These patterns of strengths and weaknesses are very consistent with prior years.

Year 8 (2010) results for the Dixon measure of systems performance was 76%. This also compares favorably to the 70% score for 2009 and 74% for 2008. However, it still does not meet the required 80% performance level. The data for 2010 shows that the larger providers tended to perform very well while the smaller providers scored much lower. DMH intends to use this CSR data to create targeted technical assistance interventions.

Performance Goals, Targets and Action Plans

Criterion 1: FY 2011 Goals, Targets and Action Plans

Goal 1: Improve Continuity of Care

Targets:

1. Establish the percent of adults re-admitted to Saint Elizabeths Hospital within 30 days of discharge at 7.0%.

2. Establish the percent of adults re-admitted to Saint Elizabeths Hospital within 180 days of discharge at 25.0%.

Action Plans:

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, 6) continue the Peer Transition Specialist Project where peers provide encouragement and support to consumers leaving the hospital, and 7) continue to try to reach the Dixon Performance Target that 80% of adults discharged from inpatient care must be seen within seven (7) days in a non-emergency outpatient setting.

DISTRICT OF COLUMBIA
FY 2011 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: Establish the percent of adults re-admitted to Saint Elizabeths Hospital within 30 days of discharge at 7.0% in FY 2011

Performance Indicator Value:

Numerator: Number of adults re-admitted to Saint Elizabeths Hospital within 30 days of discharge in FY 2011

Denominator: Number of adults discharged from Saint Elizabeths Hospital in FY 2011

Sources of Information: Hospital Management Information System (AVATAR)

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

Special Issues: AVATAR was launched in July 2008 and there were data conversion issues. Also, instability of the previous system (STARS) raised questions about data accuracy prior to FY09.

	Name of Performance Indicator: Improve Continuity of Care				
	Population: Adults with mental illness in the District of Columbia			**Criterion 1:** Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator (Value)	8.8%	10.04%	11.36%	7.2%	7.0%
Numerator	85	49	41	24	---
Denominator	962	488	361	333	---

Note: FY10 data is through May 2010.

DISTRICT OF COLUMBIA
FY 2011 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 2: Number of adults re-admitted to Saint Elizabeths Hospital (SEH) within 180 days of discharge

Target: Establish the number of adults re-admitted to SEH within 180 days of discharge at 25.0% in FY 2011

Performance Indicator Value:

Numerator: Number of adults re-admitted to Saint Elizabeths Hospital within 180 days of discharge in FY 2011

Denominator: Number of adults discharged from Saint Elizabeths Hospital in FY 2011

Sources of Information: Hospital Management Information System (AVATAR)

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

Special Issues: AVATAR was launched in July 2008 and there were data conversion issues. Also, instability of the previous system (STARS) raises questions about data accuracy prior to FY09. Data reported for FY10 is for a 6-month period from 10/09-3/10 as the full year is not available.

	Name of Performance Indicator: Improve Continuity of Care				
	Population: Adults with mental illness in the District of Columbia			**Criterion 1:** Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator (Value)	20.27%	23.36%	31.15%	27.5%	25%
Numerator	195	114	57	38	---
Denominator	962	488	183	138	---

Note: FY10 data is for the period 10/1/09-12/31/09.

DISTRICT OF COLUMBIA
FY 2011 STATE PLANNING AND MONITORING
MENTAL HEALTH PERFORMANCE INDICATORS

Name: Improve Continuity of Care

Goal: Increase adults seen in community within 7 days of discharge from inpatient care

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

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Indicator 3: Number of adults receiving a community-based mental health service (other than a crisis service) within 7 days of discharge from an inpatient psychiatric unit

Target: 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

Performance Indicator Value:

Numerator: Number of known adult discharges from inpatient psychiatric unit receiving community services within 7 days of discharge in FY 2011

Denominator: Number of known adult discharges from inpatient psychiatric unit in FY 2011

Sources of Information: e-Cura System, information about discharges provided by local community hospitals and the Department of Health Care Finance.

Special Issues: The DMH request to modify this Dixon exit criteria performance target based on National Committee for Quality Assurance (NCQA) data was denied in FY09. Persons seen within 7 days of discharge from inpatient care include: 34.73% (FY07), 53.5% (FY08), 53.51% (FY09), and 55.56% (FY10). The FY11 target remains at 80%.

Significance: Achievement of the performance target of 80% is required for the District to exit from court oversight of the mental health system.

	Name of Performance Indicator: Improve Continuity of Care				
	Population: Adults with mental illness in the District of Columbia			**Criterion 1:** Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator (Value)	34.73%	53.53%	53.51%	55.56%	80%
Numerator	314	523	396	504	---
Denominator	904	977	740	907	---

Note: FY10 projection based on 7/16/10 data run.

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 2010 (September 30, 2010). This data will be reported in the FY 2010 District of Columbia Community Mental Health Services Progress Implementation Report (submitted to SAMHSA on December 1, 2010) for categories for which there is data in the e-Cura 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 2011.

2. Increase the number of persons receiving evidence-based practices in FY 2011:
   2-1-Continue to try to reach the Dixon Performance Target to provide supported 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 reach 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, and try to reach the Dixon Performance Target to provide ACT services to 85% of persons referred within 45 days of a referral; and 4) maintain the Dixon Performance Target to ensure that 70% of adults with schizophrenia have access to the newer generation antipsychotic medications.

DISTRICT OF COLUMBIA
FY 2011 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 2011

Source of Information: ACT Program

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

Special Issues: In FY09, there were 11 ACT teams. As of June FY10 the 12 ACT teams include: Anchor (1), Capital Community Services (1), Community Connections (3), Family Preservation (1), Green Door (1), Hillcrest (1), and Pathways DC (4). The FY11 target is 12 ACT teams.

	Name of Performance Indicator: Improve Access to Evidence-Based Practices				
	Population: Adults with SMI in the District of Columbia			**Criterion 1:** Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator	8	8	11	12	12

DISTRICT OF COLUMBIA
FY 2011 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: Try to reach Dixon Performance Target that 70% of adults with SMI receive supported housing services within 45 days of a referral in FY 2011

Performance Indicator Value:

Numerator: Number of adults receiving supported housing services within 45 days of referral in FY 2011

Denominator: Number of adults referred for supported housing in FY 2011

Source of Information: DMH Authority Housing Division Database

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

Special Issues: In October 2009 DMH requested modifying this measure and recommended 3 indicators of housing stability. In February 2010 Plaintiff's Counsel opposed the modification, and the Court Monitor requested additional information. The discussion of housing issues is ongoing. In FY10, DMH had to stop housing consumers due to lack of funding. The data highlight the difficulty in reaching this exit criterion based solely on housing. FY07- FY09 data show that 12%, 14% and 10% (respectively) were housed in 45 days. FY10 data shows 29%. The target remains at 70%.

	Name of Performance Indicator: Improve Access to Evidence-Based Practices				
	Population: Adults with serious mental illness in the District of Columbia			**Criterion 1:** Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator (Value)	12%	14.4%	10%	29%	70%
Numerator	28	15	6	2	---
Denominator	242	104	61	7	---

Note: FY10 projection through June 30, 2010.

DISTRICT OF COLUMBIA
FY 2011 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 2011

Performance Indicator Value:

Numerator: Number of adults receiving supported employment services within 120 days of referral in FY 2011

Denominator: Number of adults referred for supported employment in FY 2011

Source of Information: DMH Authority Supported Employment Database

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

Special Issues: DMH met this performance target beginning in FY07, however requests to move this measure to inactive status in FY07 and FY08 were denied. Data for FY07-FY10 show the Dixon Performance Target was exceeded (89%, 95%, 90%, 78%, respectively). A Supported Employment Promotion, Outreach and Training Plan has been implemented since FY08 and continued in FY10. The FY11 target remains 70%.

	Name of Performance Indicator: Improve Access to Evidence-Based Practices				
	Population: Adults with serious mental illness in the District of Columbia			**Criterion 1:** Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator (Value)	89%	95%	90%	78%	70%
Numerator	98	77	94	88	---
Denominator	109	81	104	112	---

Note: FY10 projection through June 30, 2010.

DISTRICT OF COLUMBIA
FY 2011 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: Increase to 85% the number of adults with SMI receiving ACT within 45 days of a referral in FY 2011

Performance Indicator Value:

Numerator: Number of adults receiving ACT services within 45 days of referral in FY 2011

Denominator: Number of adults referred for ACT service in FY 2011

Source of Information: e-Cura System

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

Special Issues: In FY07 baseline data was reported to the Court Monitor. The data show that 51.52%, 65.81%, 75.06%, and 62.44% of persons referred received ACT services within 45 days in FY07- FY10. In FY10, training and technical assistance continued to be provided to the ACT teams and fidelity audits were conducted. The FY11 target remains at 85%.

	Name of Performance Indicator: Improve Access to Evidence-Based Practices				
	Population: Adults with serious mental illness in the District of Columbia			**Criterion 1:** Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2010 Target**
Performance Indicator (Value)	51.52%	65.81%	75.06%	62.44%	85%
Numerator	34	77	280	261	---
Denominator	66	117	373	418	---

Note: FY10 projection based on 8/20/10 data run.

DISTRICT OF COLUMBIA
FY 2011 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 with schizophrenia receiving new generation antipsychotic medications in FY 2011

Denominator: Number of adults with schizophrenia in FY 2011

Source of Information: e-Cura 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.

	Name of Performance Indicator: Improve Access to Evidence-Based Practices				
	Population: Adults with serious mental illness in the District of Columbia			**Criterion 1:** Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator (Value)	84.37%	85.6%	87.25%	59.73%	70%
Numerator	2882	3,231	3,839	2,576	---
Denominator	3416	3,771	4,400	4,313	---

Note: FY10 projection based on 8/27/10 data run.

Goal 3: Improve Client Perception of Care

Mental Health Statistics Improvement Program (MHSIP) Surveys

2010 MHSIP Survey- DMH is discussing the execution of the second year option with RightSource, LLC, the contractor that conducted the 2009 MHSIP Survey.

2009 MHSIP Survey- This survey was conducted between October 23, 2009 and February 12, 2010. Random sampling (probability sample) was used with adult consumers who received two (2) or more Mental Health Rehabilitation Services (MHRS) during the period December 1, 2008 through May 31, 2009. In an attempt to mitigate low response rates and inaccurate contact data, oversampling was used. Also, in order to encourage the best possible response rates an incentive ($10.00 gift card) was given. Translation services included bi-lingual Spanish/English surveyors and Language Access Line services were also available.

The mixed methods design included: 1) four (4) attempts by telephone; 2) surveys mailed after four (4) phone call attempts or for anyone with inaccurate phone information (i.e., disconnected, wrong number); and 3) attempted outreach at point of service (but were unable to fully implement prior to survey end date). The Adult MHSIP Survey was implemented by DMH Contractor, RightSource LLC, who employed adult consumer surveyors from the District mental health system.

Sample: The sample overview includes: 1) overall eligible sample 9,085; 2) over-sample 1,345; 3) optimal sample for 95% confidence level (+/- 5) 369; 4) surveys completed 302; 5) overall response rate 22% (number of surveys/over-sample); 6) telephone survey 5% success rate per call (3,286/172); and 6) mail survey 15% success rate per mailing (856 mailed/219 returned to sender/130 surveys).

Demographics: The adult demographics include the following:1) gender (n=290) with 111 males and 179 females; 2) ethnicity (n= 242) with 12 Hispanic and 230 non-Hispanic; 3) race (n= 291) with 245 African-American, 22 Caucasian, 21 Other, and 3 American Indian/Alaska Native; 4) age (n=288) with an age range of 18-78 and the mean = 47.

Survey: The MHSIP Survey consists of 28 items, rated on a 5-point Likert scale ranging from 1 (strongly agree) to 5 (strongly disagree). The seven (7) domains include: 1) Perception of Access; 2) Perception of Quality and Appropriateness; 3) Perception of Outcomes; 4) Perception of Participation in Treatment Planning; 5) General Satisfaction; 6) Social Connectedness; and 7) Functioning.

Positive Responses: The adult consumer percentage of positive responses includes: 1) Overall = 83%; 2) Access = 81%; 3) Quality and Appropriateness = 84%; 4) Outcomes = 72%; 5) Participation in Treatment = 74%; 6) General Satisfaction = 82%; 7) Functioning = 73%; and 8) Social Connectedness = 74%.

Differences by Demographics and Diagnosis: The gender differences show that females reported significantly less perceived access to services than males; however they reported greater levels of participation in treatment relative to males. The race/ethnic differences indicate that Black/African-American consumers reported being significantly less satisfied with services and reported significantly less access to services. The receipt of more ACT service contacts predicted significantly lower ratings of general satisfaction, and a trend towards lower ratings on quality and appropriateness of care. The receipt of more community support service contacts predicted significantly better self-perceived outcomes, and a trend for significantly better self-perceived functioning.

Recommendations for Quality Improvement: The results show a differential pattern of perceived satisfaction based on gender, race/ethnic, and service type and amount. Some of the proposed quality improvement activities for these variables might include: 1) Gender- a. additional item-level analyses to determine which specific aspects of access and treatment participation might be perceived barriers for females versus males in the sample, b. training and resource development on assisting male consumers feel comfortable asking questions about their treatment and developing treatment goals, and c. work with Core Service Agencies (CSAs) to develop strategies that will improve access for women (i.e., including transportation, child care, flexible hours; 2) Race/Ethnicity- a. for African-American consumers an area for practice development includes the development of culturally responsive engagement strategies and implementation guidelines and b. A specific resource for the development of a quality improvement initiative is *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups;* and 3) Service Type and Amount- a. provide results to ACT Program Manager for integration into fidelity monitoring quality improvement efforts, specifically assertive engagement component of fidelity scale, and b. build motivational interviewing concepts into training for ACT teams.

Adult Community Services Reviews

During FY 2010, 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:

DMH established a Community Services Review Unit within the Organizational Development Division, Office Programs and Policy in FY 2009. This Unit performs a major role in the formal Dixon CSR reviews by providing logistical support for DMH reviewers and helping to provide reviewer training. It has also provided focused reviews and created targeted technical assistance interventions to assist the provider network with clinical practice issues.

The Adult 2010 CSR data shows that the larger providers tended to perform very well, whereas the smaller providers' scores were considerably lower. DMH intends to use this CSR data to assist individual providers develop specific interventions to address their issues.

DISTRICT OF COLUMBIA
FY 2011 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 2011

Performance Indicator Value:

Numerator: Number of adults considered having acceptable system performance ratings in FY 2011

Denominator: Number of adult cases surveyed in FY 2011

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. FY07 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 FY08. The FY08 score was 74%, FY09 score 70% and FY10 score 76%. The FY11 target remains at 80%.

	Name of Performance Indicator: Improve Client Perception of Care				
	Population: Adults with mental illness in the District of Columbia			**Criterion 1:** Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**
Performance Indicator	80%	74%	70%	76%	80%
Numerator	45	65	62	65	---
Denominator	56	88	88	85	---

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, 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. It is noted that the System Redesign process will likely influence these definitions. 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;

(c) 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 (1) 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 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.

DMH proposed to reinvest the cost savings from the closure of the DC CSA into a redesign of the public mental health system and launched this planning initiative during FY 2010. The System Redesign Work Group created three (3) sub-committees. These include: 1) child/youth services (emphasis on children under age 5) as well as the need for expressive therapies; 2) free-standing mental health clinics (emphasis on co-occurring disorders); and 3) health information technology (emphasis on high-level needs for the public mental health system). Each subcommittee issued a preliminary report describing the issues and process to produce a final report. During FY 2011 the planning process will continue.

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 6-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 6-month period, one (1) of every five (5) 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 (7) 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 (1) 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.

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. In January 2009, the penetration rate for adults with serious mental illness (Dixon Exit Criterion #8) was achieved and moved to inactive status. In July 2010, the penetration rate for adults (Dixon Exit Criterion #7) was achieved and moved to inactive status.

DMH launched a tool to capture data related to the Dixon Exit Criteria measures in April 2005. 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 has been developed as part of the Data Infrastructure Grant. Also, there have been enhancements to the information system to meet the requirements of Federal grants, HIPAA 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 follows.

DIG Table	Report Data	Enhancements/Reporting
Table 1. Profile of the State Population by Diagnosis	Yes	DMH supplies data for federal reporting. Data are captured by information system.
Table 2. Profile of Clients Served, All Programs by Age, Gender and Race/Ethnicity	Yes	Data elements modified in e-Cura and data are reported for federal purposes.
Table 3 A. Profile of Clients Served in Community Mental Health Settings by Homeless Status	Yes	Operational Definition was developed. Homeless data are currently being reported.
Table 3B. Profile of Clients Served in State Psychiatric Hospitals and Other Inpatient Settings	Yes	The Hospital legacy system stored these data, which are being reported for federal purposes. A new system was implemented in July 2008.

DIG Table	Report Data	Enhancements/Reporting
Table 4. Profile of Adult Clients by Employment Status	Yes	Capturing data every 90 days on persons served in the community mental health setting and employment status over past 90 days
Table 5. Profile of Clients by Type of Funding Support (Medicaid/Non-Medicaid)	Yes	Modifications of information system were required. Incorporation of reporting capacity in new systems achieved.
Table 6. Profile of Client Turnover	Yes	Modification of information system was required and incorporation of capacity in new systems achieved.
Table 7. Profile of State Mental Health Agency Service Expenditures and Sources of Funding	Yes	Analyses conducted of Mental Health Authority data. Data reported for federal purposes.
Table 8. Profile of Community Mental Health Block Grant Expenditures for Non-Direct Service Activities	Yes	Analyses conducted of contract, procurement and budget data. Data reported for federal purposes.
Table 9.Public Mental Health Service System Inventory Checklist	Yes	Analyses are conducted of mental health data and report data.
Table 10. Profile of Agencies Receiving Block Grant Funds Directly from the State Mental Health Authority	Yes	Conduct analyses of Block Grant data and Report Data Years 1-3
Table 11. Summary Profile of Client Evaluation of Care	Yes	Conduct MHSIP survey yearly and provide analyses for report
Developmental Tables		
Table 12. State Mental Health Agency Profile	Yes	Conduct analyses of mental health data, which are currently reported for federal purposes.
Table 14. Profile of Clients Served with Serious Mental Illness and Serious Emotional Disturbance, All Programs by Age, Gender, and Race/Ethnicity	Yes	Reviewed operational definitions and implemented data collection requirements. Data are reported for federal purposes.
Table 15. Profile of Clients' Living Situation in Institutional and Non-Institutional Settings	Yes	Reviewed operational definitions and implemented data collection requirements. Data 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 e-Cura 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	No	At present DMH does track consumers that receiving Family Psychoeducation, Integrated Treatment for Co-occurring Disorders (MH/SA), Illness Self Management and Medication Management.
Table 18. Profile of Adults with	Yes	Reviewed operational definitions and

DIG Table	Report Data	Enhancements/Reporting
Schizophrenia receiving New Generation Medications		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 Juvenile Justice System, and Adults who have had Contact with the Criminal Justice System	Partial	Reviewed operational definitions, assessed methodology for data collection, and modified information systems to capture data. Data collection process needs to be validated. Data are used with caveats. Arrest data for children is currently not available.
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 (changed to Applied Research and Evaluation Unit in FY 2010) 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. The data generated from this process is currently being used to assist in the identification and development of a reporting system.

During FY 2010, a Reporting Work Group was formed to develop a comprehensive, centralized and fully automated data access and delivery system that meets the DMH information needs. Five (5) teams were created consistent with the core functional areas that include: 1) process, 2) requirements, 3) lexicon, 4) code standardization, and 5) reporting infrastructure. The Reporting Work Group incorporated information from the DMH program databases inventory into its process. The Data Requirements Team is using it to collect and update program data to inform reporting requirements. This planning initiative will continue in FY 2011.

Criterion 2: FY 2011 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 2010 (September 30, 2010) and reported in the FY 2010 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) maintain the Dixon Performance Target to increase the number of adults receiving mental health services by 3% of the overall adult population, and 7) maintain the Dixon Performance Target to increase the number of adults with SMI receiving mental health services by 2% of the overall adult population.

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) development of a reporting infrastructure that allows extraction from multiple data sources, and 4) establish and complete the process of linking data information systems within the DMH provider network.

DISTRICT OF COLUMBIA
FY 2011 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: Provide mental health services to 3% of the overall adult population

Performance Indicator Value:

Numerator: Number of adults receiving MHRS in FY 2011

Denominator: Number of adults based on most recent U.S. Census Bureau estimates

Source of Information: e-Cura System

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

Special Issues: The Dixon Performance Target is 3%. FY07 (2.17%) and FY08 (2.49%) data reflects only MHRS. FY09 (3.09%) and FY10 (3.23%) also includes MCOs, School MH, Assessment Center, PRTFs and WRAP services. This performance indicator moved to inactive status in July 2010 but continues to be measured. The FY11 target remains at 3%.

	Name of Performance Indicator: Improve Access to Community-based Mental Health Services				
	Population: Adults with mental illness in the District of Columbia			**Criterion 2:** Mental Health System Data Epidemiology	
(1)	(2)	(3)	(4)	(4)	(5)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator (Value)	2.17%	2.49%	3.09%	3.23%	3%
Numerator	10,123	11,819	15,023	15,690	---
Denominator	466,649	474,572	485,621	485,621	---

Note: FY07-FY10 denominators based on U.S. Census Bureau estimates for the District.

DISTRICT OF COLUMBIA
FY 2011 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: Provide mental health services to adults with SMI to reflect 2% of the overall adult population

Performance Indicator Value:

Numerator: Number of adults with SMI receiving MHRS in FY 2011

Denominator: Number of adults based on most recent U.S. Census Bureau estimates

Source of Information: e-Cura System

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

Special Issues: The Dixon Performance Target is 2%. FY07 (1.83%), FY08 (2.12%) and FY09 (2.51%) data reflects only MHRS. FY10 (2.97)% also includes MCO data. This performance indicator moved to inactive status in January 2009 but continues to be measured. The FY11 target remains at 2%.

	Name of Performance Indicator: Improve Access to Community-based Mental Health Services				
	Population: Adults with SMI in the District of Columbia			**Criterion 2:** Mental Health System Data Epidemiology	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator (Value)	1.83%	2.12%	2.51%	2.97%	2%
Numerator	8,566	10,062	12,178	14,444	---
Denominator	466,649	474,572	485,621	485,621	---

Note: FY07-FY10 denominators based on U.S. Census Bureau estimates for the District.

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

Adult Quantitative Targets

The adult quantitative targets that will be reported include the following National Outcome Measures (NOMs): 1) reduced utilization of psychiatric inpatient beds; 2) use of evidence-based practices; and 3) client perception of care.

The measures that will be reported established under the Dixon Exit Criteria will include the following:

Dixon Exit Criteria	Required Performance Level
Community Services Review	80% System Performance
Penetration Rate Adults	3% of Adult Population
Penetration Rate Adults SMI	2% of Adult Population
Supported Housing	70% Served within 45 days of referral
Supported Employment	70% Served within 120 days of referral
ACT	85% Served within 45 days of referral
Newer Generation Medications	70% of Adults with Schizophrenia
Homeless Engagement	150 Served plus Comprehensive Strategy
Continuity of Care	80% Inpatient Discharges Seen in 7 days in Non-emergency Outpatient Setting

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

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

District of Columbia Homeless Services Initiatives

The DMH Homeless Services strategy was developed in accordance with the overall strategy for ending homelessness that has been developed by the District of Columbia and is subject to change from time to time, based upon the needs of District residents. The Homeless Services policy is guided by the Interagency Council on Homelessness and is defined and coordinated by the District Department of Human Services.

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"), which is chaired by the City Administrator and includes various cabinet agencies directors, including the Director of DMH. 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 detailing the homeless service Continuum of Care, including hypothermia planning. DMH Homeless Services participates in this planning process.

District Department of Human Services: The Department of Human Services (DHS) is the lead agency responsible for the coordination of homeless services in the District, and its policy is informed by the Interagency Council. DHS contracts with The Community Partnership for the Prevention of Homelessness, an independent non-profit corporation to administer the District's Continuum of Care services funded through the U.S. Department of Housing and Urban Development (HUD) on behalf of the city.

As expressed in its "Strategic Action Plan to End Homelessness" (April 2010), DHS has initiated a redesign of the system of care for families and individuals. With this reconfiguration, there is an emphasis on three policy objectives:

1. Reduce the overall number of individuals and families experiencing homelessness.
2. Redesign the Continuum of Care to develop an appropriate mix of services and interim and permanent housing options.
3. Design an evaluation strategy and mechanism to track the District's progress in preventing and reducing homelessness.

This process will include a robust family assessment center, a new individual assessment center, along with new transitional programs to meet specialized needs of families and individuals not

easily met in the emergency shelter environment. DHS will introduce performance-based contracts by tracking benchmarks to ensure accountability.

DHS recently began directly funding the Hypothermia Hotline and transportation services and is shifting funding for street outreach services back to DHS. Current program focus includes Permanent Supportive Housing and Homeless Prevention and Rapid Re-Housing Program.

Permanent Supportive Housing Plan (Housing First): Mayor Adrian Fenty embraced a Permanent Supportive Housing (PSH) initiative to end chronic homelessness, and toward this end, DHS was charged with implementing a person-centric approach to implement this policy. Permanent supportive housing is a "housing first" approach and is 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 this PSH initiative. This is a significant departure from the way the District delivered homeless services in the past. Rather than simply meeting the survival needs of individuals and families through providing blankets and shelter, the agency provides PSH participants with comprehensive case management intended to address the root causes of their homelessness and help them enjoy greater independence in the community.

The PSH Plan targeted 400 of the District's most vulnerable, frequent users in the shelter system over a 6-month period with a goal of decreasing the need for emergency shelter beds and was launched 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 by January 2010, over 638 individuals and 78 families who were homeless have been housed through this initiative. Each housing placement included linkages to DHS contracted case management programs. 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.

On July 23, 2010, Mayor Fenty announced the placement of the 1,000th household since the start of this initiative less than three (3) years ago. PSH data shows a 100% retention rate for families and a 95% rate for individuals, which is 11 percentage points higher than the national average. The success of this locally funded initiative has generated additional resources that have enabled the Housing First Initiative to expand. Along with $10M in local funds, the program received $17.2M in appropriations from President Barack Obama's 2010 federal budget.

Homeless Prevention and Rapid Re-Housing Program: Due to the economic downturn in 2008, President Barak Obama promoted the American Reinvestment and Recovery Act (2009), which included federal funding to the states to prevent families and individuals from becoming homeless and to help those who became homeless to regain housing through one-time, short-term financial supports. DHS and the Department of Housing and Community Development (DHCD) administer the Homeless Prevention and Rapid Re-Housing Program (HPRP). DHS has contracted with four (4) eligibility providers that screen applications for this funding in addition to agencies that will provide case management, housing inspection, and legal assistance. Significantly, HPRP funding has a much higher financial eligibility threshold (50% of Area Mean Income), which empowers the District to assist a larger range of individuals who normally

would have been excluded from traditional programs, such as Emergency Rental Assistance Program (ERAP).

DMH has a Memorandum of Understanding (MOU) with DHS that allows the DMH Homeless Outreach Program (HOP) to do case finding and screening. The individuals are then processed through one of the eligibility centers that includes intake and assistance in obtaining the services for which they qualify.

DMH Homeless Services

DMH is committed to meeting the changing needs of consumers who are chronically or temporarily homeless and have mental illness and directly provides or contracts for a range of appropriate services to address their needs. In conjunction with the other District agencies and homeless service providers, DMH continually assesses the effectiveness of the array of programs and will adapt services to meet program and budgetary imperatives. The DMH Homeless Outreach Team works closely with The Community Partnership for the Prevention of Homelessness (TCP). The data from the TCP January 2010 Point in Time Survey indicate that:

- 6,539 homeless singles and individuals in families were counted in the District of Columbia;
- 2,097 were chronically homeless according to the HUD definition;
- 387 were unsheltered on the night of the survey;
- 6% increase from the 2009 Point in Time Survey (6,228); and
- 1,145 were identified as having a serious and persistent mental illness.

Administrative and Program Changes: During October 2009, DMH moved Homeless Services from the Office of Programs and Policy to the administrative and clinical auspices of the Chief Clinical Officer and, more directly, the DMH Comprehensive Psychiatric Emergency Program (CPEP). Homeless Services is now one of four (4) distinct programs under CPEP: Emergency Psychiatric Services, Extended Observation Beds, Mobile Crisis Services, and Homeless Services. In this process, DMH created a position to coordinate policy for high-risk populations (homeless services, forensic services, and ACT) and transferred the Homeless Outreach Program (HOP) psychiatrist to the Mental Health Services Division Same Day Clinic. The role of the HOP psychiatrist has been assumed by CPEP psychiatrists. A licensed psychiatric nurse practitioner joined HOP in May 2010; however she is serving as a mental health specialist until the District license is obtained.

The DMH Sobering Station ceased operation after FY 2009 due to fiscal restraints impacting all District agencies. In planning for this service change, DMH collaborated with the Department of Health Addiction Prevention and Recovery Administration (APRA) to include this function in their program and budget planning at their Detoxification Facility. However, at the time APRA was in the process of out-sourcing detoxification services to the private sector and currently has no plans to re-start the Sobering Station. Currently, the District is using the detoxification facility for increased capacity to shelter families who are homeless.

During FY 2009, Homeless Services assisted DMH in tracking and coordinating services for consumers who were homeless transition from DMH site-based mental health care to private service providers. Similarly, the team provided assistance to the DMH "SURE" (Service Upon Request Expanded) consumers who were still coming to its "same day service" site for intake. With the transition and closure of DC CSA, this assistance is no longer required.

Homeless Services Activities Programs and Activities: During FY 2010, DMH Homeless Services included the following programs: 1) Homeless Outreach Program; 2) Psychiatry Residency Training Program Placements; and 3) Hermano Pedro Drop-In Center.

1. 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 consumers live on the streets, in abandoned vehicles and buildings, in temporary residences as well as low-barrier shelters and transitional programs. Reunification assistance is provided for individuals stranded in the District who are homeless and mentally ill through a collaborative relationship between HOP, Greyhound, and Travelers' Aid.

HOP also continues to provide community consultation and training to the provider network most closely involved with the homeless population. An important part of this work includes: a) hosting the nationally recognized monthly "Emergency Rounds"; b) hosting the "Hot List" meeting that focuses on high risk consumers; and c) participating in the District Metropolitan Police Department Crisis Intervention Officer training.

The HOP staff includes 10 FTEs with the following funding: Projects for Assistance in Transition from Homelessness (PATH)- three (3) staff; HPRP- two (2) staff; and local funding- five (5) staff. HOP was able to reclaim two (2) lost FTEs through the new HPRP funding. Three (3) staff members are Licensed Independent Clinical Social Workers, one (1) staff member is a Licensed Graduate Social Worker, one (1) staff member has a masters in psychology, and two (2) staff members are in current preparation for the LGSW examination. As noted, a licensed psychiatric nurse practitioner joined the team in May 2010 and two (2) other staff members have doctorate degrees in the humanities and social science.

DMH was included in the HPRP funding that led to the MOU with DHS in November 2009 to provide increased outreach and engagement services to individuals who are homeless. This MOU lasts for approximately two (2) years. Three (3) members of the HOP team are working on this initiative and engage consumers on a daily basis at numerous liaison sites throughout the District to screen them for suitability for HPRP. This is in addition to other services in the Continuum of Care including vulnerability surveys for the PSH Program. HOP staff made a special effort to screen families who are homeless and living at the D.C. General Family Shelter.

DMH continues its efforts to work with The Community Partnership for the Prevention of Homelessness (TCP) to track and integrate data using the Homeless Information Management System (HMIS), which is required throughout the District for programs receiving HUD Continuum of Care funding. DMH is currently deliberating how best to increase HOP data capacity while meeting larger agency imperatives for data integrity and integration.

The HOP statistics are based on requirements for the Dixon Exit Criteria for adults and children that include: 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 data related to the Dixon Exit Criteria for the period October 1, 2009 through June 30, 2010 is presented in the table that follows.

Adults (unduplicated count)	1,200
Children (unduplicated count)	52
Adults, Children & Families (face-to-face)	1,951

2. Psychiatry Residency Training- During FY 2009, the HOP psychiatrist served as faculty to the Saint Elizabeths Psychiatry Residency Training Program. This continued through the first quarter of FY 2010, but then that responsibility was assumed by the DMH Chief Clinical Officer and a past director of CPEP currently working in the DMH network of service providers. Third year Residents are placed at a variety of community-based settings (homeless shelters programs, soup kitchens, and street outreach programs) to augment their approaches to serving individuals experiencing homelessness. The available statistics for the Psychiatry Residency Training Program (October 1, 2009- June 30, 2010) show that residents saw 111 different individuals who were homeless.

In the past there has been at least one 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.

3. Hermano Pedro Drop-In Center- This program operates under a contract with the Anchor Mental Health Association and began in December 2007. It continued during in FY 2010. 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 data for the period October 1, 2009 through June 30, 2010 include the following:

Total Unduplicated Consumers	716
Total Face-to-Face Contacts/Sessions	1,448

DMH Initiatives Affecting Homeless Services: These initiatives include adult Mobile Crisis Services, Focused Improvement Areas, and relationship with The Community Partnership for the Prevention of Homelessness.

1. 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 individuals and families who are chronically homeless.

2. Focused Improvement Areas (FIA). During FY 2010, 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. During FY 2009, the DMH Homeless Outreach Program actively participated in this work, however during FY 2010 DMH responsibilities shifted to the Mobile Crisis Services.

3. Contract with and Letter of Agreement Revision with The Community Partnership for the Prevention of Homelessness (TCP). During FY 2009, DMH became the state recipient of Shelter Plus Care (SPC) funding to provide housing and services for single adults experiencing homelessness and mental illness. Toward this end, DMH contracted with TCP to administer the DMH SPC program.

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 (SPC) Program Coordinator, Director of Federal Programs and Director of Clinical Services. This process continued during FY 2010.

DISTRICT OF COLUMBIA
FY 2011 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 2011

Source: 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. Third and fourth quarter data is for FY09. DMH validated the homeless metric and revised the Homeless Strategy. In FY09 the Court Monitor placed this performance measure in inactive status but it still needs to be monitored. The FY11 target remains at 150.

Name of Performance Indicator: Improve Services for Homeless Populations					
Population: Adults with SMI in the District of Columbia			**Criterion 4:** Targeted Services to Rural and Homeless Populations and Older Adults		
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2009 3rd Quarter**	**FY 2009 4th Quarter**	**FY 2010 1st Quarter**	**FY 2010 2nd Quarter**	**FY 2011 Target**
Performance Indicator	ACT =179 CS = 36 Total =215	204 37 241	208 39 247	241 36 277	150

Note: FY10 data is based on Dixon Court reporting period (4/1/09-3/31/10).The requirement is that the average across 4 consecutive quarters equals or is greater than the target 150. The average is 245. Data assumptions: 1) almost every person who entered Pathways was homeless, and 2) all the persons receiving ACT and Community Support are SMI.

DISTRICT OF COLUMBIA
FY 2011 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 400 adults with SMI who are homeless quarterly in FY 2011

Source: 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 400 per quarter in FY 2011.

Name of Performance Indicator: Improve Services for Homeless Populations					
Population: Adults with SMI in the District of Columbia				**Criterion 4:** Targeted Services to Rural and Homeless Populations and Older Adults	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2010 1st Quarter**	**FY 2010 2nd Quarter**	**FY 2010 3rd Quarter**	**FY 2010 4th Quarter**	**FY 2011 Target Per Quarter**
Performance Indicator	902	459	438	---	400

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

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

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

Older Adults

Community Focus on Older Adult Issues- During FY 2008 and FY 2009, one of the areas of focus for older adults in the District was on hoarding behavior. A faculty member in The Catholic University School of Social Work 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.

In June 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 DMH Mobile Crisis Services (MCS) responds regularly to hoarding cases. In FY 2011, MCS plans to specifically track the number of hoarding cases to which a response is provided.

The Office on Aging Senior Service Network agencies conduct workshops on various topics annually. Also, Howard University School of Social Work Gerontology Center provides training for network agencies and others on various topics for professional development and training. The training during FY 2010 addressed the following issues: 1) Aging and Sexuality; 2) Spirituality and Aging; 3) Civic Engagement; 4) Support Groups; 5) Coping with Stress through Humor Exercise and Fun; 6) Grand-Parenting Today: The New Reality; 7) Ethics and Caregiving; and 8) Creative Expressions Across Generations.

DMH and the Office on Aging have had preliminary discussions about staff development and training related to mental health consumers. This issue will be explored more fully during FY 2011. Also, the D.C. State Mental Health Planning Council recommended setting aside funding in the FY 2011 Mental Health Block Grant to fund an Older Adult Initiative.

Mental Health Consumers Entering and Leaving Nursing Home Care- 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. During FY 2010, DMH was asked increasingly more to assist nursing homes find appropriate community resources for persons with mental health histories who no longer need that level of care.

Services for Older Adults- DMH older adult consumers who are outpatients receive mental health rehabilitation services (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.
The number of adults age 50 and over who received at least one (1) service through the DMH MHRS program by mid-August 2010, is 5,210. While a significant number of older adults are served by the provider network, there is no comprehensive service strategy for this population. The service needs of this population 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 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.

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 2011 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. Also, consideration will be given to conducting training through the DMH Training Institute on older adults with mental health and other issues for the community providers and other agencies.

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

Resources for Adult Providers

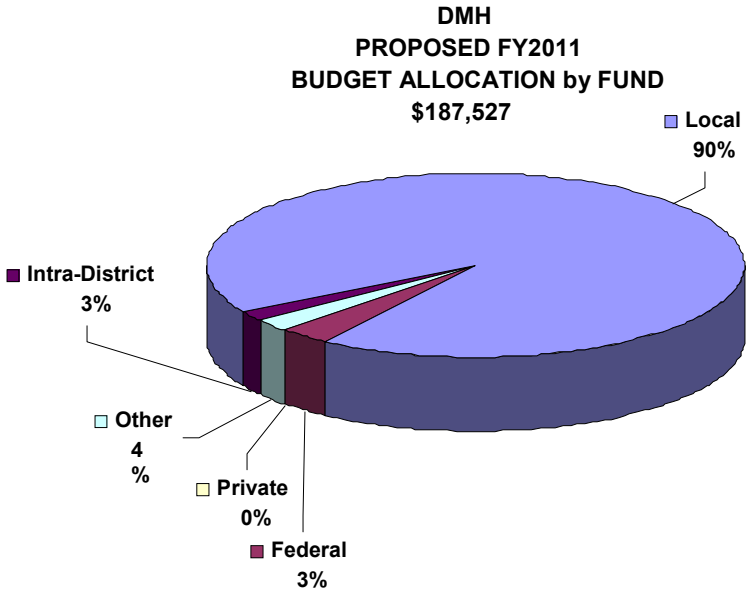
Criterion 5: Management Systems

Financial Structure

The approved DMH FY 2011 Budget is $187,527,163.48. The breakdown of the FY 2011 Budget by program budget category is as follows:

Mental Health Authority	8,813,041	4.70%
Division of Mental Health Services and Supports	57,174,126	30.50%
Saint Elizabeths Hospital	81,349,990	43.40%
Mental Health Financing/Fee for Service	20,055,664	10.70%
	$187,527,163	**100%**

Revenue to support the budget comes from four major revenue sources. **Local** funds are the largest funding source and accounts for $168,451,364 or 89.83% of the FY 2011 Budget.



Federal is the second greatest funding source of the FY 2011 budget at $6,001,874 or 3.20% of the total. **Special Revenue (Other)** funds total $4,627,521 or 2.47% of the FY 2011 Budget. **Special Revenue (Other)** funds total $4,627,521 or 2.47% of the FY 2011 Budget. Private funds total $117,243.00 or 0.06%. Finally, the **Intra District** Funds total $8,329,161 or 4.44% of the FY 2011 Budget.

Information Technology Services

At the end of FY 2008 into FY 2009, the legacy hospital patient accounts system was replaced by the purchase of a new state-of-the-art Hospital Information System. The new system, AVATAR, helped to consolidate many dissimilar systems in preparation for the new Saint Elizabeths Hospital facility that began occupancy in 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 e-Cura system (claims management) and other information system applications that comprise the DMH Information Technology System (IT). The DMH IT 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 e-Cura, Anasazi (a Client Data System for the Mental Health Services Division), and many small-specialized databases that can be accessed on the network or across the Internet. This provides the capability to record data on defined and specified measures included in the system. The new DMH IT 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 e-Cura tracks and pays providers based upon services rendered and coordinates Medicaid reimbursement through the Department of Health Care Finance.

The e-Cura tracks outpatient services provided by public and private community agencies. Each provider qualified/certified to provide mental health services to DMH has a contract that specifies an agreed upon dollar value, provider demographic data, and rates for services provided. The e-Cura validates Medicaid eligibility by matching claims 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 e-Cura 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 e-Cura is accessible via the Internet portal by authorized users and is administered by the DMH IT with claims and appeals processing supported by a finance team.

The system serves as the driving force for centralized claims processing, enrollment, eligibility, 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 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 IT 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 e-Cura applications to more effectively meet Departmental requirements. This has included implementation of a Comprehensive Clinical Module in the Anasazi application (2007) and the implementation of the Accounts Receivable Module in the e-Cura application (2009), which facilitated improved revenue management. Further, the e-Cura application is being enhanced to include greater transparency and a more flexible service authorization process to minimize data entry errors.

Phase 1 of the AVATAR system, which includes Admission, Census, Treatment Mall, Discharge, Pharmacy and Lab was completed in July 2008. Phase 2, which captures clinical information is currently underway and is 85% complete. AVATAR billing is expected to go live by July 2010.

Additionally, in FY 2008, DMH IT implemented the Accounts Receivable (AR) Module in the e-Cura application. This functionality allows e-Cura to automatically post and reconcile payments and report AR information. The DMH IT 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. 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. 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 IT system. A preliminary IT structure was developed that was 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. While the structure has not been implemented, during FY 2010 DMH IT began chairing a Departmental initiative to establish an improved centralized, electronic based integrated reporting process that will be available to internal and external stakeholders and provide consistent accurate data from a single source based in Dashboard, SharePoint and MS-Reporting Services technologies.

The DMH IT plans included, by the end of FY 2008 and into FY 2009, the installation of the latest version of the e-Cura software to improve the authorization process and to also reconfigure the e-Cura 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. During the first quarter of FY 2010, DMH IT successfully implemented Retro-eligibility processing that allows the e-Cura application to reflect proper eligibility throughout the enrollment, authorization, claims and remittance processes.

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

Filling Vacancies in FY 2010: Critical vacancies/positions filled in FY 2010 (October 1, 2009 through June 30, 2009) include the following:

- Social Worker (7)
- Clinical Psychologist (2)
- Chief Nursing Executive (1)
- Psychiatric Nurse (11)
- Recreation Therapist (1)
- Forensic Psych. Technician (1)
- Behavioral Support Technician (2)
- Director of Performance Improvement (1)
- Director of Facilities and Security (1)
- Director of Consumer Affairs (1)
- Training Instructor (1)
- Early Childhood Clinical Specialist (4)
- Project Coordinator (1)
- Homeless Services Coordinator (1)
- Manager, Homeless Services Clinician and Educator Program (1)
- Care Manager (1)
- Supervisory Information Technology Specialist (2)
- Program Analyst (1)

- Training Institute Manager (1)

During the fourth quarter of FY 2010, it is expected that additional key/critical positions will be filled. This will include the following positions:

- Social Worker (2)
- Nurse Practitioner (3)
- Nurse Consultant (1)
- Incident Review Specialist (1)
- Medical Officer (Psychiatry) (3)
- Behavioral Support Technician (1)
- Behavioral Support Data Analyst (1)
- Psychiatric Nursing Assistant (6)
- Psychiatric Nurse (5)
- Mental Health Specialist (2)
- School Primary Project Manager (1)

Human Resources Activities in FY 2010: A number of significant human resource development activities were undertaken during FY 2010. These include:

- Completion of the first cycle of the new e-Performance System for all DMH employees
- Management of Reduction-in-Force (RIF) for DMH employees
- Managed regulatory ARPP/DEP activities
- Management of Early Out and Retirement Incentive Program for DMH
- Attended Career Fairs for Nursing
- Conducted RIF counseling sessions for affected employees
- Planned a 6-week Mayor's Summer Youth Program for DMH
- Management of the implementation of the DMH Alternative Work Schedule Program for Saint Elizabeths Hospital (SEH) employees
- Active Participation in the City-Wide Job Fairs
- Implementation of the DMH transition to the Employee Self Service PeopleSoft Module for time entry including Electronic Time Reporting System-E-Time
- Reclassification of FPT/PNA/MHC positions to Recovery Assistant Positions
- Movement to new hospital and transitioning SEH OPFs from 64 New York Avenue office to SEH
- Conducted Benefits Entitlement Information Sessions for DMH employees
- In conjunction with the D.C. Office of Labor Relations, engaged in bargaining with four (4) DMH unions for re-openers of contracts
- Management of the Mandatory Drug and Alcohol Testing Program for DMH employees serving children and youth
- Completed work with KPMG as they reviewed and documented HR business processes
- Actively participated in the District's Classification and Compensation Reform Project as subject matter experts and human resources experts

Planned Activities for the Fourth Quarter FY 2010: Some of the activities planned by the end of FY 2010 include:

- Complete Reduction-in-Force activity work
- Conduct ARPP/DEP regulatory activities

- Continue recruitment for identified key/critical positions
- Manage the completion of the second e-Performance cycle for DMH
- Continue Random and Periodic Drug and Alcohol Testing
- Coordinate move to PeopleSoft 9.0 at DMH
- Continue to actively participate in the District's Classification and Compensation Reform Project
- Manage Mayor's Summer Youth Program for DMH

DMH Training Institute

The DMH Training Institute has evolved into a primary mental health workforce development training and community education medium for District agencies, human services providers, consumers, family members, and community residents. The Institute's training series provides 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 credit for several disciplines.

At the end of FY 2009 and during FY 2010, the Training Institute hosted a wide range of training activities for providers, DMH staff, and consumers. These trainings include:

Fall 2009 Training

- DMH 101: Overview of Services and Support offered through the DC DMH
- ACT 101 Core Training: An Overview
- System of Care Basic Training
- Service Authorization for Clinicians and Direct Service Staff
- Community-Based Intervention (CBI)
- Equal Employment Opportunity: Employee Rights & Responsibilities under the District of Columbia Human Rights Act of 1977
- How to Get and Keep a Job through a Program Called Supported Employment
- Meeting the Mental Health Needs of Youth Receiving Residential Treatment
- Effective Comprehensive Treatment and Medication Management for Consumers with Schizophrenia Spectrum Disorders: Tool and Resources to Impact Practice Development
- Conflict Management and Coaching for Mental Health Providers
- Compliance Training for Providers
- Transgender Cultural Competency
- LOCUS Train-the-Trainer
- Negotiation Skills for Consumers
- Conflict Management and Coaching for Mental Health Providers
- Intensive Home and Community Based Service (IHCBS) Philosophy; Strength-based Engagement, Assessment, and Treatment Planning
- Effective Management of Severe Behaviors & Collaborating with Schools
- CBI Booster Training III: Intersystem Collaboration, Strengths and Culture, Discovery, and Family Systems
- Teaming Formation and Functioning Practice Guidelines Protocol

- Whole Health Training for Peer Specialists
- Compliance and Mental Health: Understanding and Evaluating Audit Risk
- Medical Record Documentation in Mental Health
- Second Annual Olmstead Conference: Social Inclusion- "What it is and How to Achieve it!"
- The Aftermath of Tragedy: Grief and Trauma
- Medical Record Documentation in Mental Health

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 under-way. DMH completed its intensive train-the-trainer phase in November 2008 and went live with its new web-based application on February 1, 2009. DMH developed a training of trainers (TOT) curriculum, and offered bi-weekly trainings on the CALOCUS and LOCUS TOT from March through June 2009. Subsequent trainings have been offered on a quarterly basis or as needed.

Winter, Spring and Summer 2010 Training

- Implementing Wellness in Daily ACT Practice
- Community Service Reviewer (CSR): Child Reviewer & Refresher Trainings
- Community Service Reviewer (CSR): Adult Reviewer & Refresher Trainings
- Assertive Community Treatment (ACT) 101
- CBI: IHCBS Service Philosophy, Parent Engagement and Respect
- IHCBS Philosophy: Strength-based Engagement, Assessment, and Treatment Planning
- CBI: Cultural Competency and Family Systems
- Using the Ohio Scales to Inform Case Conceptualization and Ongoing Treatment Planning
- Leveraging Diversity and Building Inclusion in a Changing Workforce
- DMH 101: Overview of Services and Supports Offered Through the DC Department of Mental Health
- Deaf Culture Sensitivity Training
- Meeting the Mental Health Needs of Youth Receiving Residential Treatment
- Service Authorization for Clinicians and Direct Service Staff
- Community-Based Intervention (CBI)
- Teaming Formation and Functioning Practice Guidelines Protocol
- LOCUS Train-the-Trainer
- CALOCUS Train-the-Trainer
- System-of-Care Basic Training
- Creating Cultures of Trauma Informed Care
- Supported Employment Training for Clinical Professionals
- Understanding and Enhancing Cultural Competence in Disaster Mental Health Response
- How to Get and Keep a Job through a Program Called Supported Employment
- Equal Employment Opportunity: Employee Rights & Responsibilities under the District of Columbia Human Rights Act of 1977
- Conflict Management and Coaching for Mental Health Providers
- DMH Access to Services
- Annual Compliance Trainings

- Leveraging Diversity and Building Inclusion in a Changing Workforce
- Essentials of Disaster Mental Health
- Psychological First Aid
- Working with Adult Survivors of Trauma: Key Concepts in Understanding Trauma Dynamics
- Introduction to Co-Occurring Disorders
- Staff Support Training in Trauma-Informed Care
- How to Talk the Talk: What You Need to Know about Teen Dating Violence
- Co-Occurring Disorders: Stages of Change
- The Trauma Recovery and Empowerment Profile (TREP)
- Officer/Agent Certification Program
- Dynamics of Teen Dating Violence in a Clinical Setting
- Advanced Psychological First Aid
- Nonviolent Crisis Intervention (NCI)
- Grief, Loss, Suicide in the Wake of Disasters
- Ethical and Legal Issues in Disaster Mental Health
- Logic Modeling Your Way to Program Improvement: Developing a Framework for Planning and Evaluation
- URS and the NOMS
- National Datasets on Mental Health: What do They Track and How Can It be Useful in Program Management?
- The Use of Mixed Methods Research in System Reform
- Improving Public Mental Health through GIS
- Jail Diversion Models and Strategies
- Is Your Program Co-Occurring Competent?
- Putting Together a Successful Presentation through the Training Institute

Upcoming projects for the DMH Training Institute include the launch of the Clinical Supervision Initiative and continuation of the Co-Occurring Disorders Clinical Competency (COSIG) certification in Fall 2010.

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. This process continued in FY 2010.

DISTRICT OF COLUMBIA
FY 2011 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 2011

Denominator: Total mental health expenditures in FY 2011

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 FY06. 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 recommended that this Exit Criterion move to inactive status. FY07 data show a rate of 59% and FY08 data 61%. FY09 data is pending analysis related to Dixon Exit Criterion 18. This criterion will continue to be measured and remains at 60%.

	Name of Performance Indicator: Increase Resources Directed Toward Community Services				
	Population: Recipients of community-based mental health services		**Criterion 5:** Management Systems		
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator (Value)	59%	61%	56%	54%	60%
Numerator	$144,494,336.96	$138,556,904.35	$129,595,365	$111,723,758	---
Denominator	$244,341,952.92	$227,428,073.29	$231,705,365	$206,575,758	---

Note: FY10 projection based on August 2010 data.

DISTRICT OF COLUMBIA
FY 2011 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 2011

Denominator: MHRS billings in FY 2011

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 Criterion move to inactive status in FY08. This criterion continues to be measured for future reporting periods.

	Name of Performance Indicator: Increase Resources Directed Toward Community Services				
	Population: Recipients of community-based mental health services			**Criterion 5:** Management Systems	
(1)	(2)	(3)	(4)	(4)	(5)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator (Value)	47%	50.63%	51.3%	50.3%	49%
Numerator	$16,919,968	$28,437,143	$33,540,698	$27,551,416	---
Denominator	$35,827,490	$56,168,040	$65,320,913	$54,774,187	---

FY08 and FY09 awaiting completion of Revenue billing; FY10 reported through August 2010.

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

Adult Emergency Service Provider Training

Disaster Mental Health Series

To help improve the District of Columbia's preparedness for immediate and long-term disaster response, the Training Institute launched a five session Disaster Mental Health training series in Spring 2010. Target audience for the series includes the staff of DMH, its provider network, response partners and volunteers.

Essential Concepts in Disaster Mental Health: This module provides an introduction and overview to the field of disaster mental health. Specific topics include the history and nature of crisis intervention, crisis intervention versus counseling and psychotherapy, origins of the field of disaster mental health, historical hallmarks of the field, a model of human resilience, the integrated disaster mental health continuum of care, key elements of crisis leadership, and an overview of incident command.

Psychological First Aid (PFA): In this module, participants will be trained in the application of an evidenced-based model of PFA. Specific topics include a definition of PFA, PFA versus crisis intervention, PFA versus "debriefing," the history of PFA, research findings on PFA, the core competencies of PFA, a model of PFA, the mechanisms of action in PFA, practice in the application of PFA.

Advanced Psychological First Aid (PFA): Psychological first aid (PFA) was initially developed to be employed by non-mental health interventionists as a means of providing extended mental health support in times of crisis and disaster. Advanced PFA is a continuation of the basic PFA course. It is designed to extend the fundamental concepts of PFA to more advanced applications, especially suited for use those with prior familiarity with PFA and/or core mental health functions. The fundamental practices of triage and mitigational intervention will be discussed as they may be applied in individual and group settings. Participants will gain practice in triage and intervention with individuals and groups (both large and small). The specific application of PFA to issues of suicide, traumatic grief, disaster will be discussed.

Grief, Loss, Suicide in the Wake of Disasters: The module provides an introduction to the concept of grief, grief related to disasters, and traumatic grief. Specific topics include the nature of loss and grief, dynamics of traumatic grief, human resilience in the wake of loss, adaptive versus maladaptive grief reactions, crisis intervention with grief, suicide intervention in the wake of disasters and traumatic loss.

Ethical and Legal Issues in Disaster Mental Health: The module provides an overview of common ethical and legal issues that may be associated with disaster response. Confidentiality, duty to warn, psychotherapy versus crisis intervention, training and ethical practice, and standard of care are topics that will be covered.

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. Two hundred thirty-eight (238) cadets were trained in FY 2009 and during FY 2010 (to date) 81 have been trained.

2. In-service Training: This mandatory training offers both web-based and face-to-face mental health training based on the recruit curriculum and was implemented in 2009 for all MPDC 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:

- 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. Sixty-one (61) officers successfully completed the 40-hour program in FY 2009 and 93 completed it as of May 2010.

- 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.

Office of Unified Communications Training: In order to ensure that the trained Crisis Intervention Officers (CIOs) are sent to the mental health calls, DMH developed and implemented the first training for call takers (911) and dispatchers. The training was conducted on August 23, 2010. The trainers included the DMH Director of Organizational Development, the DMH Training Institute Manager, and a representative from the Office of Unified Communications (OUC).

The training included two (2) modules, reviewing the CIO program and roles and responsibilities for dispatchers and call takers. The OUC representative has continued training with the modules at each of the roll calls, and has plans to implement the training at least twice at each roll call to ensure all call takers and dispatchers are reached. It is anticipated that all relevant OUC staff will be trained prior to the next CIO training scheduled for the week of September 13-17, 2010.

Coordinator Training: On September 8, 2010, DMH will conduct a one-day training for the CIO Coordinators (overnight Watch Commanders). These individuals supervise the CIOs when they respond to a call in the field. The training will focus on the CIO process.

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

Adult and Child 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 2011 Block Grant. A total of 22 projects were submitted in response to the Request for Projects: one (1) was submitted by a consumer organization; four (4) by youth organizations; two (2) by family and child organizations; one (1) by an adult/child/family advocacy organization; one (1) by an adult family member organization; one (1) by a community human services organization; one (1) by an ethnic community organization; one (1) by an organization that uses the arts and culture to address community needs; one (1) by a community health organization; two (2) by health and fitness organizations; one (1) by a provider association; three (3) by DMH provider agencies; and three (3) by DMH programs.

The D.C. State Mental Health Planning Council recommended funding 10 projects, one (1) planning initiative, and the Planning Council. The DMH Director reviewed and approved the recommendations.

The FY 2011 Block Grant award is based on the federal allocation. The breakdown is as follows:

FY 2011 Award:	**$772, 964.00**
Administrative Fee (5%):	**$38,648.20**
Funds for Projects:	**$734,315.80**

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	Implement activities related to the District's Mental Health Block Grant	**$25,000.00**
Non-DMH Projects				
Older Adults	SOME (So Others Might Eat)	Building Stronger Community for Low-Income Seniors through Providing Mental Health Care In-Home and On-Site	Address mental health needs of older adults in SOME's Elderly Services Programs.	**$9,860.00**
Adult	The Spoken Word	Lens & Pens Creative Expression Project	Use of artistic disciplines poetry, painting, photography in the recovery process and foster community reintegration.	**$11,799.00**
Adult	FamilyLinks Outreach	FamilyLinks Outreach	Provide a weekend	**$20,000.00**

Type of Project	Organization	Project Name	Purpose	Amount
	Center, Inc.	Center	socialization program including workshops, social, recreational activities, and meal.	
Youth	Metro TeenAIDS	Learning and Incorporating Risk Management Around HIV/STI and Teen Pregnancy	Provide SED and/or SMI youth with skills, information, resources and confidence to understand personal risks for acquiring HIV/STI and/or facing and unplanned pregnancy	**$9,905.00**
Youth and Families	Family Voices of the District of Columbia	"FIT–N-FUN: A Wellness Intervention for Special Youth"	Provide support services for SED children/youth with co-morbid health issues	**$15,000.00**
Youth	Raising Expectations Inc.	"Cooking and Dancing with Flava!"	Combines resiliency principles with culinary arts and dance to promote wellness	**$16,721.25**
Youth	Time Dollar Youth Court, Inc.	Youth Court Boy's Focus Group	Support services for male youth who have experienced trauma	**$20,000.00**
Youth and Families	National Association on Teen Fitness and Exercise	Family Learning, Nutrition and Fitness Program	Provide support services for families with children diagnosed with ADHD who are also obese or at risk of becoming obese	**$20,000.00**
DMH Projects				
Child	Department of Mental Health	Child and Youth Services Division	Implement practices in the development project that focus on the Transition to Independence (TIP) model.	**$200,000.00**
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.	**$380,000.00**
Set-Aside Funds				
Older Adults	D.C. State Mental Health Planning Council, DMH, D.C. Office on Aging	Older Adults Initiative	Develop planning initiative to address specific needs of older adults in DMH service system	**$6,030.55**

Table C. MHBG Funding for Transformation Activities

State: District of Columbia

	Column 1	Column 2	
	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the *actual* **or** *estimated* amount of MHBG funding that will be used to support this transformation goal in FY2011	
		Actual	**Estimated**
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	☑	81,626.25	
GOAL 2: Mental Health Care is Consumer and Family Driven	☑	621,659	
GOAL 3: Disparities in Mental Health Services are Eliminated	☑	6,030.55	
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	☐		
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	☐		
GOAL 6: Technology Is Used to Access Mental Health Care and Information	☐		
Total MHBG Funds	N/A	709,315.80	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.

For each mental health transformation goal provided in Table C, breifly 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

The majority of the non-DMH FY 2011 Mental Health Block Grant funded projects will address mental health and primary health issues. These include the following:

Metro TeenAIDS ($9,905.00): This project, "Learning and Incorporating Risk Management Around HIV/STI and Teen Pregnancy," proposes to conduct a series of trainings for youth (16-25) living with serious emotional disturbances and/or serious mental illness and the adult professionals who serve them in the DMH service delivery system. The approach with involve engaging youth in community and educational setting, and engaging youth-serving professionals through the DMH Training Institute.

Family Voices of the District of Columbia ($15,000.00): This project, "FIT–N-FUN: A Wellness Intervention for Special Youth," addresses the needs of children and youth with serious emotional disturbances and co-morbid issues with a primary focus on obesity (to include risk for diabetes and high cholesterol). The program will also benefit parents/care givers through learning opportunities related to nutrition, stress reduction, and how to encourage their children. Family members will also have the opportunity to participate in the scheduled fitness activities.

Raising Expectations, Inc. ($16,721.25): This project, "Cooking and Dancing with Flava!;" combines resiliency principles with culinary arts and dance to promote wellness. Youth (ages 10-18) with serious emotional disturbances will participate in workshops and arts apprenticeships including cooking and dance classes. The project promotes mental health and physical health through nutritious foods and healthier eating habits and physical fitness activities.

Time Dollar Youth Court, Inc. ($20,000.00): This project, "Youth Court Boy's Focus Group," diverts first-time male offenders ages 12-17 from the juvenile justice system. The Focus Group provides the skills needed to reduce negative behavior, due to exposure to violence at a young age, and educate the youth on making healthy decisions behaviorally, physically, and mentally. It also works with the youth on physical activity (exercise) and nutrition (healthy eating).

National Association on Teen Fitness and Exercise ($20,000.00): This project, "Family Learning, Nutrition and Fitness Program," provides children diagnosed with ADHD information about the importance of exercise and eating right in preventing obesity as well as how they can use exercise and yoga to improve their behaviors related to ADHD. It will also teach parents/guardians about the impact that nutrition and exercise have on their children's behavior and teaches them ways to improve their family's nutritional intake and physical activity.

The FY 2011 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: 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 2011Mental Health Block Grant funded projects are related to consumer and family driven initiatives. These include:

The Spoken Word ($11,799.00): This project, "Lens and Pens Creative Expression," uses the artistic disciplines (poetry, painting, photography), as well as display of consumers' artwork in the recovery process to foster community reintegration. This project includes forensic outpatients and inpatients.

SOME (So Others Might Eat)/($9,860.00): This project, "Building Stronger Community for Low-Income Seniors through Providing Mental Health Care In-Home and On-Site," is an outgrowth of this organization's work with seniors in a day program and shelter for abused elderly. In order to address the mental health needs of these older adults, individual and group psychotherapy services will be provided in-home and on-site

FamilyLinks Outreach Center, Inc. ($20,000.00): This project, "FamilyLinks Outreach Center," 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.

DMH Child and Youth Services Division ($200,000.00): This project, "District Youth and Young Adults Transition to Independence (TIP) System Implementation," is intended to put in place the practices developed during the planning phase (specialized supports and services for young adults and training on the Roadmap and Curriculum).

DMH Housing Division Project ($380,000.00): This project, "Permanent Supportive Housing for Special Populations," provides housing services for transition age youth, persons leaving jail, and those who require intensive services (ACT consumers) in order to live in the community.

The projects previously described under Goal 1, are also consumer and family driven. These include:

- Metro TeenAIDS ($9,905.00)-"Learning and Incorporating Risk Management Around HIV/STI and Teen Pregnancy;"
- Family Voices of the District of Columbia ($15,000.00)- "FIT–N-FUN: A Wellness Intervention for Special Youth;"
- Raising Expectations, Inc. ($16,721.25)- "Cooking and Dancing with Flava!;"
- Time Dollar Youth Court, Inc. ($20,000.00)- "Youth Court Boy's Focus Group;" and
- National Association on Teen Fitness and Exercise ($20,000.00)- "Family Learning, Nutrition and Fitness Program."

Goal 3: Disparities in Mental Health Services are Eliminated

SOME (So Others Might Eat)/($9,860.00): This project, "Building Stronger Community for Low-Income Seniors through Providing Mental Health Care In-Home and On-Site," is an outgrowth of this organization's work with seniors in a day program and shelter for abused elderly. They have found that seniors require specialized care due to issues such as trauma, loss of loved ones and material gain, lack of resources, and isolation. These seniors also experience grief, depression and anxiety and, for those homebound, the inability to leave one's home to gain mental health services leaves these older adults to suffer in isolation. This project will allow individual and group psychotherapy services to be provided in-home and on-site.

Older Adults Initiative ($6,030.55): The D.C. State Mental Health Planning Council proposed that any funds that remained once project funding decisions were made; should be used to plan an Older Adults Initiative. This is a population for which DMH has not articulated a service strategy to meet specific needs. The Planning Council would like to participate in this planning initiative with the DMH Adult Services Division and the District's Office on Aging.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	11,819	15,023	15,690	16,000
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: The number of adults receiving mental health services during the reporting period.

Measure: The number of adults based on most recent U.S. Census Burea estimates for the District of Columbia.

Sources of Information: e-Cura System and Department of Health Care Finance data.

Special Issues: The Dixon Performance Target is 3%. FY07 and FY08 data reflects only MHRS. FY09 and FY10 data also includes MCOs, School Mental Health Program, Assessment Center, PRTFs and Wraparound services. This performance indicator moved to inactive status in July 2010 but continues to be measured. The FY11 target remains at 3%.

Significance: Required to exit from Court Oversight.

Action Plan: Continue to include adult mental health services data from a variety of service providers.

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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	10.04	11.36	7.20	7
Numerator	49	41	--	--
Denominator	488	361	--	--

Table Descriptors:

Goal: To improve continuity of care.

Target: Establish the percent of adults re-admitted to Saint Elizabeths Hospital within 30 days of discharge at 7.0%.

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 (AVATAR).

Special Issues: AVATAR was launched in July 2008 and there were data conversion issues. Also, instability of the previous system (STARS) raised questions about data accuracy prior to FY09.

Significance: Achievement of this performance measure will facilitate the reduction in the size of the public hospital to 293. The average end of month census for July 2010 was 308. The plan is to reduce the census by reducing short term admissions, which 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: 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.

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)	
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	
Performance Indicator	23.36	31.15	27.50	25	
Numerator	114	57	--	--	
Denominator	488	183	--	--	--

Table Descriptors:

Goal: Improve Continuity of Care

Target: Establish the number of adults re-admitted to SEH within 180 days of discharge at 25.0%.

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 (AVATAR).

Special Issues: AVATAR was launched in July 2008 and there were data conversion issues. Also, instability of the previous system (STARS) raised questions about data accuracy prior to FY09.

Significance: Achievement of this performance measure will facilitate the reduction in the size of the public hospital to 293. The average end of month census for July 2010 was 308. The plan is to reduce the census to by reducing short term admissions, which 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: 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.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	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, e-Cura System and program databases.

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 conduct fidelity audits of the ACT teams in FY 2011.

2. Increase the number of persons receiving evidence-based practices in FY 2011:

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: 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) review and determine action needed based on the FY 2010 evaluation of 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)	
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	
Performance Indicator	14.42	9.84	29	70	
Numerator	15	6	--	--	
Denominator	104	61	--	--	--

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: Aduls 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: In October 2009 DMH requested modifying this measure and recommended 3 indicators of housing stability. In February 2010 Plaintiff's Counsel opposed the modification, and the Court Monitor requested additional information. The discussion of housing issues is ongoing. In FY10, DMH had to stop housing consumers due to lack of funding. The data highlight the difficulty in reaching this exit criterion based solely on housing. FY07- FY09 data show that 12%, 14% and 10% (respectively) were housed in 45 days. FY10 data shows 29%. The target remains at 70%.

Significance: 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 2011, DMH will continue to provide housing and support services to consumers most in need. DMH will also continue its partnerships with the DC Housing Authority, Department of Housing and Community Development, and The Community Partnership for the Prevention of Homelessness to secure addition subsidies and develop additional housing units. DMH will also continue discussions with the Dixon Court Monitor regarding this performance measure.

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)	
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	
Performance Indicator	95.06	90.38	78	70	
Numerator	77	94	--	--	
Denominator	81	104	--	--	--

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: Program database and e-Cura Event Screen.

Special Issues: DMH met this performance target beginning in FY07, however requests to move this measure to inactive status in FY07 and FY08 were denied. Data for FY07-FY10 show the Dixon Performance Target was exceeded (89%, 95%, 90%, 78%, respectively). A Supported Employment Promotion, Outreach and Training Plan has been implemented since FY08 and continued in FY10. The FY11 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 2011, DMH will continue to focus on building service capacity. DMH will continue to implement its partnership with the Rehabilitation Services Administration, Annual Employer Orientation and Training and the Supported Employment Promotion, Outreach and Training Plan. The latter activity is designed 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 2011, 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. 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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	65.81	75.07	62.44	85
Numerator	77	280	--	--
Denominator	117	373	--	--

Table Descriptors:

Goal: Improve access to evidence-based pratices.

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: e-Cura System.

Special Issues: In FY07 baseline data was reported to the Court Monitor. The data show that 51.52%, 65.81%, 75.06%, and 62.44% of persons referred received ACT services within 45 days in FY07- FY10 (respectively). In FY10, training and technical assistance continued to be provided to the ACT teams and fidelity audits were conducted. The FY11 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: 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. 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)	
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	
Performance Indicator	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)	
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	
Performance Indicator	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: See Criterion 1 for the data table for Mental Health Consumers with Co-Occurring Substance Use Disorder. The DMH e-Cura System has a quarterly event screen that captures co-occurring (mental health and substance use disorder) services. The provider network reports services that include: 1) day treatment; 2) detoxification; 3) diagnostic assessment;
4) integrated treatment; 5) psychiatric inpatient unit; 6) referral; 7) relapse prevention; and 8) screening. The numerator is the number of consumers receiving a co-occurring service and is a unique count per category; however, consumers may be in more than one (1) category. The denominator is the number of consumers receiving at least one mental health rehabilitation service (MHRS) for the reporting period. The data that was reported for Integrated Treatment only includes: 1,562 (2007); 877 (2008); 1,223 (2009); and 1,406 (through August 3, 2010).

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)	
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	
Performance Indicator	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)	
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	
Performance Indicator	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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	73.86	70.45	76	80
Numerator	65	62	--	--
Denominator	88	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 2011. 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 scores for FY 2008- FY 2010 were 74%, 70%, and 76%, respectively. The FY 2011 target remains at 80%.

Significance: Achievement of 80% systems performance is required to exit from federal Court Oversight.

Action Plan: DMH established a Community Services Review Unit within the Organizational Development Division, Office Programs and Policy in FY 2009. This Unit performs a major role in the formal Dixon CSR reviews by providing logistical support for DMH reviewers and helping to provide reviewer training. It has also provided focused reviews and created targeted technical assistance interventions to assist the provider network with clinical practice issues.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	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)	
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	
Performance Indicator	78.83	77.08	85	N/A	
Numerator	633	222	--	--	
Denominator	803	288	--	--	--

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 Survey report positively on social connectedness questions.

Measure: Number of adult consumers responding to MHSIP Survey.

Sources of Information: MHSIP Survey.

Special Issues: A long-standing issue with the administration of the MHSIP Survey has been low consumer participation. In order to address these issues the FY 2009 MHSIP Survey used a mixed methods design that included: 1) four (4) attempts by telephone;
2) surveys mailed after four (4) phone call attempts or for anyone with inaccurate phone information (i.e., disconnected, wrong number); and 3) attempted outreach at point of service (but were unable to fully implement prior to survey end date). The MHSIP Survey was implemented by DMH Contractor, RightSource LLC, who employed adult consumer surveyors from the District mental health system. Also, since the FY 2009 MHSIP Survey was conducted during FY 2010, the FY 2010 survey will be conducted during FY 2011.

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 FY 2010 MHSHIP Survey will be conducted during FY 2011.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	76.12	78.35	85	N/A
Numerator	612	228	--	--
Denominator	804	291	--	--

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 Survey report positively on level of functioning questions.

Measure: Number of adult consumers responding to MHSIP survey.

Sources of Information: MHSIP Survey.

Special Issues: A long-standing issue with the administration of the MHSIP Survey has been low consumer participation. In order to address these issues the FY 2009 MHSIP Survey used a mixed methods design that included: 1) four (4) attempts by telephone;
2) surveys mailed after four (4) phone call attempts or for anyone with inaccurate phone information (i.e., disconnected, wrong number); and 3) attempted outreach at point of service (but were unable to fully implement prior to survey end date). The MHSIP Survey was implemented by DMH Contractor, RightSource LLC, who employed adult consumer surveyors from the District mental health system. Also, since the FY 2009 MHSIP Survey was conducted during FY 2010, the FY 2010 survey will be conducted during FY 2011.

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 FY 2010 MHSHIP Survey will be conducted during FY 2011.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: ACT Teams

(1)	(2)	(3)	(4)	(5)	
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	
Performance Indicator	8	11	12	12	
Numerator	N/A	N/A	--	--	
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: Improve access to evidence-based practices.

Target: Maintain the 12 ACT teams in FY 2011.

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: In FY 2009, there were 11 ACT teams. As of June FY 2010 the 12 ACT teams include: Anchor Mental Health (1), Capital Community Services (1), Community Connections (3), Family Preservation (1), Green Door (1), Hillcrest (1), and Pathways DC (4). The FY 2011 target is 12 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. 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 2011, 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. 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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	85.60	87.25	59.73	70
Numerator	3,231	3,839	--	--
Denominator	3,771	4,400	--	--

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 adults with schizophrenia receiving new generation antipsychotic medications.

Measure: Number of adults with schizophrenia living in the District of Columbia.

Sources of Information: e-Cura System.

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 2011 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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	53.53	53.51	55.56	80
Numerator	523	396	--	--
Denominator	977	740	--	--

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: e-Cura System and information about discharges provided by local community hospitals and the Department of Health Care Finance.

Special Issues: The DMH request to modify this Dixon exit criteria performance target based on National Committee for Quality Assurance (NCQA) data was denied in FY 2009. Persons seen within 7 days of discharge from inpatient care include: 34.73% (FY 2007), 53.5% (FY 2008), 53.51% (FY 2009), and 55.56% (FY 2010). The FY 2011 target remains at 80%.

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.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Supported Housing Services

(1)	(2)	(3)	(4)	(5)	
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	
Performance Indicator	14.40	10	29	70	
Numerator	15	6	--	--	
Denominator	104	61	--	--	--

Table Descriptors:

Goal: Increase number of adults receiving supported housing services.

Target: Try to reach the Dixon Performance Target that 70% of adults with SMI receive supported housing services within 45 days of a referral.

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

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

Indicator: Number of adults receiving supported housing services within 45 days of a referral.

Measure: Number of adults referred for supported housing.

Sources of Information: DMH Authority Housing Division Database.

Special Issues: In October 2009 DMH requested modifying this measure and recommended 3 indicators of housing stability. In February 2010 Plaintiff's Counsel opposed the modification, and the Court Monitor requested additional information. The discussion of housing issues is ongoing. In FY10, DMH had to stop housing consumers due to lack of funding. The data highlight the difficulty in reaching this exit criterion based solely on housing. FY07- FY09 data show that 12%, 14% and 10% (respectively) were housed in 45 days. FY10 data shows 29%. The target remains at 70%.

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

Action Plan: DMH will continue its partnerships with the D.C. Housing Authority, the Department of Housing and Community Development, and The Community Partnership for the Prevention of Homelessness to acquire vouchers and develop affordable housing for consumers.

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

Section III. Performance Goals and Action Plans to Improve the Service System

Child Plan

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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.

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 assumed responsibility for the Psychoeducation, Therapeutic Nursery and Healthy Start programs, formerly operated by the DC CSA. However, only the Healthy Start program remains, as the other two (2) programs ended by June 2010. 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:

- Early Childhood Mental Health Consultation Project,
- Transition Age Youth Development Project,
- Family Functional Therapy Initiative,
- Suicide Prevention Project, and
- Expansion of the School Mental Health Program.

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 (special education, oversight for policy and resources), and the District of Columbia Public School System (education), as well as the charter schools to provide needed mental health 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

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 the 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; 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-day-a-week telephone hotline and service hub operated by DMH Care Coordination Division.

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. 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, DMH CYSD began working on a transition age youth initiative. This initiative will focus on education, employment, and housing. During FY 2010, Mental Health Block Grant funds supported the Transition Age Youth Service Development Project. The Transition to Independence Process (TIP) model is the evidence-based practice that DMH has chosen to implement in the District. The transition domains include education, employment, living situation, and community life.

During FY 2010, the CYSD Program Manager overseeing the Transition Age Youth Service Development Project explored employment opportunities available for this population. She also attended the Interagency Work Group on youth employment. The participating agencies include: Department on Disability Services/Rehabilitation Services Administration; Department of Employments Services; D.C. Public Schools; Department of Human Services; Department of Youth Rehabilitation Services; and the Department of Mental Health.

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.

During FY 2010, a community residential facility (CRF) operated that housed females ages 18-25, which is within the transition age youth range. Also, DMH participated in preliminary discussions with the CRF operator about the possibility of opening a CRF for males.

The FY 2007 funding proposal from the DMH Housing Division for Mental Health Block Grant funds, included youth leaving residential treatment centers (RTCs) among the populations for which housing subsidies would be provided to facilitate community re-integration. The subsequent proposals (FY 2008- FY 2011) have included transition age youth as part of the target population.

Educational Services

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.
- Teaming Formation and Functioning Practice Guidelines Protocol.

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 and Adolescent Level of Care Utilization System (LOCUS/CALOCUS) train-the-trainer initiative
- Community Service Review (CSR) Child Review Training

Other training conducted during FY 2010 includes the following:

- Intensive Home and Community Based Service (IHCBS) Philosophy; Strength-based Engagement, Assessment, and Treatment Planning
- Effective management of Severe Behaviors and Collaborating with Schools

- CBI Booster Training III: Intersystem Collaboration, Strengths and Culture, Discovery, and Family Systems
- CBI: IHCBS Service Philosophy, Parent Engagement and Respect
- CBI: Cultural Competency and Family Systems
- Using the Ohio Scales to Inform Case Conceptualization and Ongoing Treatment Planning
- How to Talk the Talk: What You Need to Know about Teen Dating Violence
- Dynamics of Teen Dating Violence in a Clinical Setting

Substance Abuse Services

Child and youth service providers were 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. 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. The Total Family Care Coalition, which provides traditional and non-traditional supports and services to children and their families has six (6) peer parents. 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. On March 9, 2010 DMH submitted a letter requesting inactive monitoring status based upon compliance with the performance target. The request was approved by the Court Monitor via letter dated May 7, 2010.

2. Seventy-five percent (75%) of children/youth with SED should receive services in a natural setting (i.e., schools). A letter from DMH requesting inactive monitoring status based upon compliance with the performance target was submitted March 9, 2010. A meeting with the Court Monitor and plaintiffs' counsel was held on July 16, 2010 that resulted in additional data requests about the categories of surrogate home. The inactive monitoring status request remains pending as of the date of this application.

Services in Collaboration with School System under Individuals with Disabilities Education ACT (IDEA)

The former D.C. Community Services Agency (DC CSA) operated two (2) psychoeducational programs with support from the D.C. Public Schools (DCPS). They included: 1) the Therapeutic Nursery served children ages 3-5, and 2) the Psychoeducation Program served children ages 6-12. These programs were transferred to the Child and Youth Services Division in FY 2010; however they ended by June 2010.

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. Seven (7) 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 were actively involved in this process. Some of the youth initiatives 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.

Other Activities Leading to Reduction of Hospitalization

DMH contracts with Children's National Medical Center (CNMC) to provide ER services to District children and adolescents. 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. In FY 2010, four (4) crisis/respite beds were available to the team as an alternative, when appropriate, to acute psychiatric hospitalization. However, due to under-utilization, the beds will not be available in FY 2011. One of the goals of this 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 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.

Annual Child Community Services Reviews

The Year 8 (2010) Child Community Services Review (CSR) included 76 cases as the final sample. The review was conducted during March 2010. Human Systems and Outcomes, Inc. (HSO) - affiliated reviewers conducted 52 reviews and DMH specially-trained staff completed 24. HSO has provided a Case Judge since the 2008 review. The Case Judge reviews, all cases reviewed by DMH staff and as many cases as possible reviewed by HSO, in order to ensure inter-rater reliability.

Year Eight (2010) results show a pattern very consistent with prior years. The overall status of acceptable reviews in terms of child/youth status was 70%. This is lower but in the range of previous years that show 77% (2009) and 78% (2008). Areas that scored well were safety of the child (83%), and physical wellbeing (88%). Lower-scoring areas included stability (58%), functional status (59%), academic status (58%), and responsible social behavior (58%).

The Dixon criterion measures how well the system performs with a required acceptable level of 80%. For FY 2010, the overall systems performance was 49%. This score is also very consistent with prior years including 36% (2008), and 48% (2009). Areas that have scored poorly in the past continue to lag well below expectations and include: service team formation (45%), service team functioning (33%); functional assessment (39%) and; long-term guiding view (32%).

One of the encouraging aspects of the 2010 results for children/youth is that the intensive follow-up work from the 2009 CSR review resulted in higher system performance. Two (2) of the larger child/youth providers undertook an intensive staff training and organizational change effort (with DMH support) following the 2009 review. Both providers scored in the 70% range on systems performance in 2010.

Performance Goals, Targets and Action Plans

Criterion 1: FY 2011 Goals, Targets and Action Plans

Goal 1: Improve Continuity of Care

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.

Action Plans:

The DMH refers children to two (2) facilities for inpatient care (National Children's Medical Center and Psychiatric Institute of Washington). During FY 2007- FY 2010, 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 2011.

DISTRICT OF COLUMBIA
FY 2011 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)

Name: Improve Continuity of Care

Goal: Decrease number of children/youth re-admitted to inpatient care within 30 days

NOM: Reduced Utilization of Psychiatric Inpatient Beds

Population: Children/youth with SED living in the District of Columbia

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Indicator 1: Number of children/youth re-admitted to inpatient care within 30 days of discharge

Target: Establish percent of children/youth re-admitted to inpatient care within 30 days at 8.0% in FY 2011

Performance Indicator Value:

Numerator: Number of children/youth re-admitted to inpatient care within 30 days of discharge in FY 2011

Denominator: Number of children/youth discharged from inpatient care in FY 2011

Sources of Information: e-Cura System, information about discharges provided by local community hospitals and the Department of Health Care Finance.

Significance: National Outcome Measure and related to Court oversight

Special Issues: Data integrity issues in FY07. Analysis in FY08 based on 2 hospitals versus 3 in FY07. Data for FY09 revised to reflect that FY09 and FY10 data is based on 12 area hospitals not just those that DMH contracts with, as reported in previous years. A discharge during FY09 and FY10 for children/youth (age 0-17) for the12 providers is considered in this analysis.

	Name of Performance Indicator: Improve Continuity of Care				
	Population: Children with SED in the District of Columbia			**Criterion 1:** Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator (Value)	22.81%	2.56%	6.47%	9.31%	8.0%
Numerator	13	2	27	37	---
Denominator	57	78	417	397	---

Note: FY10 data is through August 4, 2010.

DISTRICT OF COLUMBIA
FY 2011 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)

Name: Improve Continuity of Care

Goal: Decrease number of children/youth re-admitted to inpatient care within 180 days

NOM: Reduced Utilization of Psychiatric Inpatient Beds

Population: Children/youth with SED living in the District of Columbia

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Indicator 1: Number of children/youth re-admitted to inpatient care within 180 days of discharge

Target: Establish percent of children/youth re-admitted to inpatient care within 180 days at 22.0% in FY 2011

Performance Indicator Value:

Numerator: Number of children/youth re-admitted to inpatient care within 180 days of discharge in FY 2011

Denominator: Number of children/youth discharged from inpatient care in FY 2011

Sources of Information: e-Cura System, information about discharges provided by local community hospitals and the Department of Health Care Finance.

Significance: National Outcome Measure and related to Court oversight

Special Issues: In FY07 data integrity issues, in FY08 analysis based on 2 hospitals versus 3 for FY07, and FY09 data revised to reflect that FY09 and FY10 data is based on 12 area hospitals. A discharge during FY09 and FY10 for children/youth (age 0-17) for the12 providers is considered in this analysis.

	Name of Performance Indicator: Improve Continuity of Care				
	Population: Children with SED in the District of Columbia			**Criterion 1:** Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator (Value)	12.28%	6.84%	21.82%	21.15%	22.0%
Numerator	7	5	91	84	---
Denominator	57	73	417	397	---

Note: FY10 data is through August 4, 2010.

DISTRICT OF COLUMBIA
FY 2011 STATE PLANNING AND MONITORING
MENTAL HEALTH PERFORMANCE INDICATORS

Name: Improve Continuity of Care

Goal: Increase children/youth seen in community within 7 days of discharge from inpatient care

Population: Children/youth with SED living in the District of Columbia

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Indicator 3: Number of children/youth receiving a community-based mental health service (other than a crisis service) within 7 days of discharge from inpatient care

Target: 80% of children/youth receive a community-based mental health service (other than a crisis service) within 7 days of discharge from inpatient care

Performance Indicator Value:

Numerator: Number of known children/youth discharges from inpatient care receiving community services within 7 days of discharge in FY 2011

Denominator: Number of known children/youth discharges from inpatient psychiatric unit in FY 2011

Sources of Information: e-Cura System, information about discharges provided by local community hospitals and the Department of Health Care Finance.

Special Issues: The DMH request to modify this Dixon exit criteria performance target based on National Committee for Quality Assurance (NCQA) data was denied in FY09. Children/youth seen within 7 days of discharge from inpatient care include: 33.65% (FY07), 38.19% (FY08), 33.01% (FY09), and 48.95% (FY10). The FY11 target remains at 80%.

Significance: Achievement of the performance target of 80% is required for the District to exit from court oversight of the mental health system.

	Name of Performance Indicator: Improve Continuity of Care				
	Population: Children/youth with SED in the District of Columbia			**Criterion 1:** Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator (Value)	33.65%	38.19%	33.01%	48.95%	80%
Numerator	69	76	140	187	---
Denominator	205	199	424	382	---

Note: FY10 data is based on Dixon reporting period (April 2009 through March 31, 2010) extracted 7/13/10.

Goal 2: Improve Client Perception of Care

Mental Health Statistics Improvement Program (MHSIP) Surveys

2010 MHSIP Survey- DMH is discussing the execution of the second year option with RightSource, LLC, the contractor that conducted the 2009 MHSIP Survey.

2009 MHSIP Survey- The Youth Services Survey for Families (YSS-F) was conducted between October 23, 2009 and February 12, 2010. Random sampling (probability sample) was used with consumers or their families who received two (2) or more Mental Health Rehabilitation Services (MHRS) during the period December 1, 2008 through May 31, 2009. In an attempt to mitigate low response rates and inaccurate contact data, oversampling was used. Also, in order to encourage the best possible response rates an incentive ($10.00 gift card) was given. Translation services included bi-lingual Spanish/English surveyors and Language Access Line services were also available.

The mixed methods design included: 1) four (4) attempts by telephone; 2) surveys mailed after four (4) phone call attempts or for anyone with inaccurate phone information (i.e., disconnected, wrong number); and 3) attempted outreach at point of service (but were unable to fully implement prior to survey end date). The YSS-F Survey was implemented by DMH Contractor, RightSource LLC, who employed adult consumer surveyors from the District mental health system.

Sample: The sample overview includes: 1) overall eligible sample 2,148; 2) over-sample 1,196; 3) optimal sample for 95% confidence level (+/- 5) 326; 4) surveys completed 254; 5) overall response rate 21% (number of surveys/over-sample); 6) telephone survey 17% success rate per call (1,163/201); and 6) mail survey 12% success rate per mailing (453 mailed/78 returned to sender/53 surveys).

Demographics: The child demographics include the following:1) gender (n=252) with 155 males and 97 females; 2) ethnicity (n= 250) with 20 Hispanic and 230 non-Hispanic; 3) race (n= 250) with 228 African-American, 16 Other, 5 Caucasian, and 1 Asian; 4) age (n=236) with an age range of 5-18 and the mean = 12.

Survey: The YSS-F Survey consists of seven (7) domains that include: 1) Perception of Access to Services; 2) Satisfaction with Services; 3) Perception of Positive Outcomes of Services; 4) Perception of Participation in Treatment Planning; 5) Perception of Cultural Sensitivity; 6) Social Connectedness; and 7) Functioning.

Positive Responses: The parent/guardian percentage of positive responses includes: 1) Overall = 76%; 2) Access = 72%; 3) Satisfaction with Services = 71%; 4) Outcomes = 58%; 5) Participation in Treatment = 84%; 6) Cultural Sensitivity = 87%; 7) Social Connectedness = 83%; and 8) Functioning = 59%.

Differences by Demographics and Diagnosis: Parents/guardians of males reported significantly less social connectedness (i.e., perceived provider support), relative to parents/guardians of

females. Age significantly predicted parental/guardian ratings on participation in treatment such that older age predicted less perceived choice of services, treatment goals, and involvement in treatment. Diagnostic differences accounted for variation in the survey when taken as a whole but not for individual domains.

The receipt of more Community Based Intervention (CBI) service contacts was highly predictive of greater parental/guardian perceptions of access to care, and a trend was observed for more positive ratings of social connectedness. The receipt of more Community Support service contacts was also highly predictive of greater perceived access, and a trend for greater social connectedness also emerged. The receipt of more Medication/Somatic was also predictive of a trend for greater social connectedness.

Recommendations for Quality Improvement: The results show that as children get older, parents/guardians perceive less involvement in choosing services, goals and involvement in the implementation of care. It was recommended that the findings be disseminated to CYSD program staff for development of parent/guardian engagement strategies that respect the increasing role of youth involvement in care, but provide new supporting roles for parents/guardians in treatment.

Parents/guardians of boys perceive significantly less social connectedness (i.e. support from providers) in the receipt of services. The recommendations include: 1) additional item-level analyses to determine which specific aspects of social connectedness might distinguish parents/guardians of girls from parents/guardians of boys; and 2) disseminate the results to the family-run organization and System of Care staff to devise advocacy and parent/guardian support strategies for parents/guardians in dealing with common developmental, emotional, and behavioral challenges within boys; and to develop evidence-based practice models within these areas.

Community-Based Intervention (CBI) and Community Support provide a gateway for parents/guardians to access and engage in services. The recommendations include: 1) conduct additional analyses to control for length of service, and determine whether there is an optimal level of resource intensity for the provision of CBI and Community Support; and 2) Since the findings suggest that the more services that are provided the more access and support parents/guardians feel in managing their children's behaviors- develop a best practice brief and guidelines on family engagement within these service domains.

Child Community Services Reviews

During FY 2010, the Annual Community Services Review (CSR) was conducted. The target reported here is related to the Child CSR process.

Target:

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

Action Plans:

DMH established a Community Services Review Unit within the Organizational Development Division, Office Programs and Policy in FY 2009. This Unit performs a major role in the formal Dixon CSR reviews by providing logistical support for DMH reviewers and helping to provide reviewer training. It has also provided focused reviews and created targeted technical assistance interventions to assist the provider network with clinical practice issues.

The Child 2010 CSR data shows that the intensive follow-up work from the 2009 CSR review resulted in higher system performance. Two (2) of the larger child/youth providers undertook an intensive staff training and organizational change effort (with DMH support) following the 2009 review. Both providers scored in the 70% range on systems performance in 2010. DMH will use the 2010 results to guide targeted intervention with providers whose scores are lower than expectation.

DISTRICT OF COLUMBIA
FY 2011 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)

Name: Improve Client Perception of Care

Goal: Improve system performance ratings on Child Community Services Review (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: Children with SED 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 Child CSR in FY 2011

Performance Indicator Value:

Numerator: Number of children considered having acceptable system performance ratings in FY 2011

Denominator: Number of child cases surveyed in FY 2011

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. FY07 data show an acceptable level of system performance was rated at 48%. The FY08 score was 36%, FY09 score 48% and FY10 score 49%. The FY11 target remains at 80%.

	Name of Performance Indicator: Improve Client Perception of Care				
	Population: Children with SED in the District of Columbia			**Criterion 1:** Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2011 Target**
Performance Indicator	48%	36%	48%	49%	80%
Numerator	25	26	29	37	---
Denominator	52	73	60	76	---

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 2010 (September 30, 2010). This data will be reported in the FY 2010 District of Columbia Community Mental Health Services Progress Implementation Report (submitted to SAMHSA on December 1, 2010) for categories for which there is data in the e-Cura System.

Targets:

1. Maintain the children and youth who receive therapeutic foster care at 25% of the foster care population in FY 2011.

2. Maintain the children and youth who receive Multi-Systemic Therapy at 3.5% of the children who receive at least mental health rehabilitation service in FY 2011.

Action Plans:

DMH has made the development of evidence-based practices a focal point for the reformed mental health system. In this regard, DMH has incorporated evidence-based and promising practices in a number of child and youth initiatives. This includes but is not limited to the school mental health curriculum, suicide prevention curriculum, wraparound services, MST, and Functional Family Therapy (FFT) training.

DMH, through its partnership with CFSA, will continue to advocate for increased Therapeutic Foster Care placements for children and youth who require intensive services to remain in the community. The Department will also continue to make Multi-Systemic Therapy available in fidelity to the model.

DISTRICT OF COLUMBIA
FY 2011 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)

Name: Improve Access to Evidence-Based Practices

Goal: Improve community-based services and supports available to children/youth with more complex needs and divert them from more restrictive levels of care

NOM: Increased Evidence-Based Practices

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

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

Target: Maintain children/youth who receive Therapeutic Foster Care at 25% in FY 2011

Performance Indicator Value:

Numerator: Number of children/youth receiving Therapeutic Foster Care

Denominator: Number of children/youth in foster care

Source of Information: Child and Family Services Agency (CFSA) FACES- electronic records database

Significance: Therapeutic Foster Care is aimed at maintaining children/youth in their communities versus more restrictive levels of care

Special Issues: This is a child welfare system goal and outcome. The FY11 target remains at 25%.

	Name of Performance Indicator: Improve Access to Evidence-based Practices				
	Population: Children with SED in the District of Columbia			**Criterion 1:** Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator	25.32%	24.61%	25%	24.26%	25%
Numerator	568	555	538	514	---
Denominator	2,243	2,255	2,144	2,119	---

Note: FY10 data through July 31, 2010

DISTRICT OF COLUMBIA
FY 2011 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)

Name: Improve Access to Evidence-Based Practices

Goal: Improve range of services available to children/youth divert them from psychiatric residential treatment facility (PRTF) placement

NOM: Increased Evidence-Based Practices

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

Population: Children and youth at risk of admission to a PRTF

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Target: Maintain children/youth who receive Multi-Systemic Therapy (MST) at 3.5% in FY 2011

Performance Indicator Value:

Numerator: Number of children and youth who receive MST

Denominator: Number of children and youth who receive at least one (1) MHRS

Source of Information: e-Cura – Medicaid Claims

Significance: One of the evidence-based practices that provides alternatives to PRTF placement and includes children/youth also involved in the child welfare and juvenile justice systems.

Special Issues: Youth Villages is the only MST provider.

	Name of Performance Indicator: Improve Access to Evidence-based Practices				
	Population: Children with SED in the District of Columbia			**Criterion 1:** Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator	4.22%	4.25%	3.68%	2.91%	3.5%
Numerator	129	136	134	105	---
Denominator	3,055	3,200	3,635	3,603	---

Note: FY10 data through August 27, 2010

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

DMH has continued to experience challenges in both data gathering and reporting with regard to children's services and 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. 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 work group 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 inventoried the various program databases and this information is being used by the Reporting Work Group that was created in FY 2010. Also during FY 2010, RCI changed its name to the Applied Research and Evaluation (ARE) Unit. This Unit works closely with the DMH Child and Youth Services Division (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. As of July 31, 2010, the DMH Mental Health Services Division (formerly DC CSA) clients between the ages of 0- 5 account for approximately 8% of its population, clients between the ages of 6-12 account for approximately 50% of its population, and clients between the ages of 13-17 account for approximately 42%.

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, results 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 that 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. It is noted that the System Redesign process will likely influence these definitions.

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 August 2010, 57% of the 37 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. DMH will continue during FY 2011 to try to populate child/youth data for all the required tables.

District Estimates of Need for Mental Health Services Table

Estimates of Serious Emotional Disturbance (SED) for Washington DC, Total for 2000									
	Total Population (HH, Inst. & Group)			Household Population			Households <100% poverty		
Youth	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Youth total	8963	114992	7.79	8773	113428	7.73	3604	36042	10.00
Age	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
Gender	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
Ethnicity	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
Poverty level	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
Residence	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

Criterion 2: FY 2011 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 2010 (September 30, 2010) and reported in the FY 2010 Progress Implementation Report. The assumption is that by increasing access to services for children and children with SED, 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 children and children with SED receiving mental health services.

Targets:

1. Increase the number of children receiving mental health services by 5% of the District Census for children.

2. Increase the number of children with SED receiving mental health services by 3% of the District Census for children.

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) reach the Dixon Performance Target to increase the number of children receiving mental health services by 5% of the overall child population, and 7) maintain the Dixon Performance Target to increase the number of children with SED receiving mental health services by 3% of the overall child population.

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) development of a reporting infrastructure that allows extraction from multiple data sources, and 4) establish and complete the process of linking data information systems within the DMH provider network.

DISTRICT OF COLUMBIA
FY 2011 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)

Name: Improve Access to Community-based Mental Health Services

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

NOM: Increased Access to Services

Population: Children with Mental Health Issues in the District of Columbia

Criterion 2: Mental Health System Data Epidemiology

Target: Provide mental health services to 5% of the overall child population

Performance Indicator Value:

Numerator: Number of children receiving MHRS in FY 2011

Denominator: Number of children based on most recent U.S. Census Bureau estimates

Source of Information: e-Cura System

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

Special Issues: The Dixon Performance Target is 5%. FY07 (2.61%) and FY08 (2.73%) data reflects only MHRS. FY09 (4.94%) and FY10 (4.77%) also includes Medicaid MCOs, School Mental Health, Assessment Center, PRTFs and Wraparound services. The FY11 target remains at 5%.

	Name of Performance Indicator: Improve Access to Community-based Mental Health Services				
	Population: Children with mental health issues in the District of Columbia			**Criterion 2:** Mental Health System Data Epidemiology	
(1)	(2)	(3)	(4)	(4)	(5)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator (Value)	2.61%	2.73%	4.94%	4.77%	5%
Numerator	2,963	3,061	5, 639	5,434	---
Denominator	113,720	112,016	114,036	114, 036	---

Note: FY07-FY10 denominators based on U.S. Census Bureau estimates for the District.

DISTRICT OF COLUMBIA
FY 2011 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)

Name: Improve Access to Community-based Mental Health Services

Goal: Increase number of children with SED receiving mental health rehabilitation services (MHRS)

NOM: Increased Access to Services

Population: Children with SED in the District of Columbia

Criterion 2: Mental Health System Data Epidemiology

Target: Provide mental health services to children with SED to reflect 3% of the overall child population

Performance Indicator Value:

Numerator: Number of children with SED receiving MHRS in FY 2011

Denominator: Number of children based on most recent U.S. Census Bureau estimates

Source of Information: e-Cura System

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

Special Issues: The Dixon Performance Target is 3%. FY07 (1.59%) and FY08 (1.71%) data reflects only MHRS. FY09 (3.45%) and data FY10 (3.16%) also includes MCO data. This performance indicator moved to inactive status in July 2010 but continues to be measured. The FY11 target remains at 3%.

	Name of Performance Indicator: Improve Access to Community-based Mental Health Services				
	Population: Children with SED in the District of Columbia			**Criterion 2:** Mental Health System Data Epidemiology	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Actual**	**FY 2010 Projected**	**FY 2011 Target**
Performance Indicator (Value)	1.59%	1.71%	3.45%	3.16%	3%
Numerator	1,812	1,920	3,935	3,610	---
Denominator	113,720	112,016	114, 036	114, 036	---

Note: FY07-FY10 denominators based on U.S. Census Bureau estimates for the District

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

Child Quantitative Targets

The child quantitative targets that will be reported include the following National Outcome Measures (NOMs): 1) reduced utilization of psychiatric inpatient beds, 2) use of evidence-based practices, and 3) client perception of care.

The measures that will be reported established under the Dixon Exit Criteria will include the following:

Dixon Exit Criteria	Required Performance Level
Community Services Review	80% System Performance
Penetration Rate Children (0-17)	5% of Child Population
Penetration Rate Children SED	3% of Child Population
Continuity of Care	80% Inpatient Discharges Seen in 7 days in Non-emergency Outpatient Setting

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 (special 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 Round Table (Children's Round Table): 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 Round Table was organized in FY 2005. Meetings are held monthly. There is representation from CFSA, DYRS, DCPS, OSSE, legal services, Court Social Services, Medicaid managed care organizations (MCOs), providers, family organizations, community-based organizations and others**.**

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 Round Table 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 Collaboratives provide Child and Family Team (CFT) Facilitation, Care Coordination, and Family Support services in two (2) wards (Georgia Avenue-Ward 4/5 and Far Southeast-Ward 8). The CFT Facilitators/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 partner with the Core Service Agency (CSA) to provide technical assistance to the identified CSA Team Leader so that the facilitation and care coordination can be transitioned to the CSA for continuity of care.

DMH Participation in Statewide Commission on Children, Youth and their Families (SCCYF): A 32-member Commission aligned around six (6) city-wide goals, which outline the District of Columbia's commitment that children and youth make successful transitions from birth to adulthood. SCCYF 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. During FY 2010, another 10 slots were added bringing the total to 144 The processes and outcomes for the 144 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) DMH contracted child mobile crisis and stabilization services; 2) co-location of a six (6) member team of Mental Health staff at CFSA; and 3) 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. In June 2009, RTC Reinvestment Clinical Coordinators began 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.

School Mental Health Program

The School Mental Health Program (SMHP) continues to be a critical component of the overall Child and Youth Services Division of DMH. In the past year, the SMHP provided on-site services in 58 different schools (48 D.C. Public Schools and 10 Charter Schools). The legislative requirement to expand into 10 additional schools in FY 2008/2009 – without any additional staff – required the development of a 2-tiered staffing model. Tier 1 schools have a full-time clinician and Tier 2 schools have a part-time clinician (20 hours/week). During the 2008/2009 School Year, there were 37 Tier 1 schools and 21 Tier 2. DMH evaluations of the Tier 1 vs. Tier 2 schools indicates that, while there are some differences in specific services provided, the overall service delivery pattern for Tier 1 vs. Tier 2 was not discernibly different. This same model was continued for the 2009/2010 School Year. Overall referrals for service in the 58 schools appear to be pretty consistent from 2008/2009 to 2009/2010. Areas of notable services growth are in individual sessions – which grew from 3,736 (2008/2009) to 5,592 (2009/2010) for the comparable September-March period; this major growth is also seen in family therapy (53% increase). The SMHP staff continues to provide a wide array of interventions, including prevention services, training presentations, parent consultations, teacher consultations and classroom observations.

The SMHP continues to measure clinical outcomes and services satisfaction through the use of standardized scales. The Ohio Scales Problem Severity Score from Intake to Discharge has been used for several years. It measures problem severity from intake to discharge for all three (3) cohorts of youth, parent and worker. The SMHP also measures satisfaction from a range of school-based customers – including school administrators, teachers, parents, school nurses and children/youth who received services. There are consistently high scores from all groups.

FY 2009 marked the beginnings of DMH efforts to bill for eligible treatment services for children/youth who are enrolled through the District's Managed Care Organizations (MCOs). This has created significant changes in the SMHP – in that clinical staff must now provide a diagnosis and meet productivity standards for billable units. This has created a level of tension with staff, schools and parents – which is still in the process of being understood and hopefully resolved. Due to delays in working out all the billing issues, it appears that the amount collected for School Year 2009/2010 will be significantly less than the $500,000 which was originally projected; as of the end of March 2010, there were $117,000 in payables for the September 2009-March 2010 period. All indications are that there is significant work still to be done in implementing the billing component for SMHP.

During FY 2009, DMH received a one-year grant via the Deputy Mayor of Education to implement a new program, the Primary Project. This prevention and early intervention effort provides early intervention services to children identified with mild school adjustment issues; the target group is kindergarten through first grade. By the use of specific screening tools, identified children (with parental consent) are paired with specially trained Child Associates.

Over a period of 12-15 sessions, the child-led play interventions are intended to improve child/youth readiness for learning. During its first year, 164 students participated – with positive results on all measured domains. The success of year one prompted continued funding for FY 2010 – with expansion from the original 12 schools to 16.

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 and Technical Assistance for DYRS Program and Management Staff: The DMH System of Care (SOC) component, in collaboration with other Child and Youth Services Division programs, provide training and technical assistance to DYRS staff and their management, on an as needed basis, regarding the following issues: 1) wraparound services; 2) SOC framework and philosophy; 3) request for a review for PRTF Level of Care process; and 4) effective cross agency collaboration.

  During FY 2010, the DMH SOC Practice Manager and the DYRS Manager that oversees the Youth Family Team Meeting (YFTM) process for DYRS committed youth and their families, have been meeting to integrate both family teaming processes and work to ensure that the YFTM practice is in line with the essential steps of the DMH SOC Child and Family Team process. The purpose is to ensure consistency when there is a team-based referral for a request to review for medical necessity for PRTF Level of Care. The two (2) most critical areas to ensure consistency is the engagement of the youth and family in the care planning process and evaluation of their in-home and community-based plan as it relates to producing positive outcomes. This cross training between DMH and DYRS will continue as well as the strategy to further integrate these models so that families will receive the same family-driven and youth-guided collaborative team-based approach to support and service planning.

- Working with DHCF to Optimize Medicaid Funding for CSAs to Provide Services in DYRS Detention Facilities for Youth Awaiting Placement: A work group commissioned by the Children's Round Table 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. 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 their 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. As of June 30, 2010, a total of 651 evaluations were performed at 90% compliance with the Jerry M Cases mandated turnaround time of 15 days.

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) continued this effort in FY 2010.

Health - 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.

Mental Health Services

Mobile Crisis Services: The DMH 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. During FY 2010, four (4) crisis/respite beds were available to the team as an alternative, when appropriate, to acute psychiatric hospitalization. One of the goals of this 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.

Early Childhood Mental Health Consultation- "Healthy Futures": This pilot program began during FY 2010. DMH is working with the Department of Health (DOH) Early Childhood Comprehensive System (ECCS) Grant Coordinator to launch an early childhood mental health

consultation pilot program. There are three (3) components/phases of a system of care for early childhood mental health: 1) prevention; 2) early intervention; and 3) treatment. This pilot project focuses on child-centered, family-centered, and program consultation. The primary goal of child-centered or family-centered consultation is to address an individual child's (and/or family's) difficulties in functioning well in the early childhood setting. The programmatic consultation focuses on improving the overall quality of the program or agency and/or assisting the program to solve a specific issue that affects more than one (1) child, staff member, and/or family.

The pilot program is funded to provide services for children (ages 0 to 5) currently at 27 centers, 16 are funded by the Statewide Commission on Children, Youth and Families (SCCYF) and the Community Mental Health Services Block Grant funding, and an additional 11 sites that are funded by Project Launch, a SAMHSA grant that DOH received and is partnering with DMH to implement additional early childhood mental health consultation services as a part of the grant. Services will continue to be provided to children and families identified through child/family centered consultation at all of the 27 centers as well as programmatic consultation to Child Development Center staff.

The Healthy Futures program is staffed by four (4) early childhood mental health specialists and one (1) early childhood mental health manager. It was determined that in order to meet the program's unique clinical supervision needs that require expertise in early childhood mental health, the Supervisory Psychologist in the SMHP will now include the clinical supervision of the four (4) early childhood mental health specialists as part of her job duties. Administrative supervision and management of the program will continue to be done by the Clinical Program Administrator for Prevention and Early Intervention Programs, with some assistance from the Project Launch Local Child Wellness Coordinator for the Project Launch sites. Funding for a second year of Early Childhood Mental Health Consultation was put in the SCCYF budget for FY 2011.

Parent Infant Early Childhood Enhancement Program (P.I.E.C.E.): During FY 2010, DMH began the process of developing the P.I.E.C.E. Program at the Howard Road site. This program will serve primarily children age 5 and under. DMH began accepting limited referrals for this program that will serve up to 60 children. The program is expected to be fully operational by October 1, 2010 and will provide parenting groups, infant observation, play and art therapy, and Parent Child Interaction Therapies.

Youth Suicide Prevention: The District was awarded a 3-year SAMHSA State/Tribal Youth Suicide Prevention Grant (October 1, 2009 - September 30, 2012). The Capital CARES (Citywide Approach to Reduce Risk for and Eliminate Youth Suicide) grant focuses on preventing suicide and suicide behaviors among all youth in the District of Columbia. The goals include: 1) create citywide infrastructure of linked supports for suicide prevention; 2) increase awareness of extent of the problem, signs and symptoms, and appropriate response for suicide risk, including related risk factors for suicide (e.g., violence exposure, gang involvement, unprotected sex, HIV/AIDS exposure, substance abuse); 3) build capacity of agencies and gatekeepers to identify and link youth at risk for suicide to services; 4) build capacity of agencies and providers to care for youth at risk before and during a suicidal crisis; 5) reduce suicide attempts by District youth; and 6) suicide reporting and data collection for the District will be accurate, comprehensive, and up to date.

The activities during FY 2010 include:

- Convening the District of Columbia Youth Suicide Prevention Coalition;
- Hiring a social marketing agency;
- The approval of four (4) community-based organizations to receive mini-grants (Martha's Table, The Preparatory School of DC, Asian American LEAD, and ROOTS, Inc.);
- Train-the-Trainer Question, Persuade and Refer (QPR) suicide prevention training (for professions that include schools, mental health, law enforcement, substance abuse);
- Focus groups with youth; and
- Disseminating a newsletter.

The activities during the Fall 2010 will include:

- The D.C. Out of the Darkness Community Walk- supporting the American Foundation for Suicide Prevention (AFSP) will take place at sunset on the National Mall on November 6, 2010. The District's Capital CARES grant will support this event.

- A training on "Suicide Risk Assessment and Treatment Planning for At Risk Adolescents"- by an Assistant Professor at George Washington University whose research interests include the cultural factors in suicidal behaviors in adolescents and adults on December 3, 2010 at DMH.

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

Child Geographic Area Definition

Services are provided throughout the District of Columbia. The Child and Adolescent Mobile Psychiatric Service (ChAMPS) also service children enrolled þÿ i n t h e D i s t r i c t s f o s t e r c a r e s y s t e m r e s programs located in Maryland and Virginia.

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

The DMH Homeless Outreach Program 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 National Medical Center, 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 Dixon Court Monitor approved this Exit Criterion in the January 2010 Report to the Court; it is now in inactive monitoring status.

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

Child Rural Area Services

The District of Columbia is an urban area. There are no services provided to individuals in rural areas.

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 2011 funding for mental health services.

Other planned financial resources for Child and Youth Services Division Programs include the following:

Initiative/Serice	Agency/Source	Amount
Choice Provider Contracts, Evidence-Based Practices Training, Flexible Funding	Child and Family Services Agency (CFSA)	**$2.5M**
Wraparound Services	CFSA	**$463,414.00**
	Department of Youth Rehabilitation Services (DYRS)	**$231,707.00**
Early Childhood MH Consultation	Statewide Commission on Children, Youth and Families (SCCYF)	**$175,000.00**
Early Childhood MH Consultation, Primary Project, Incredible Years Curriclum	Department of Health (DOH)	Funding amount TBD

Information Technology Services

See Adult Plan – Resources for Providers - Information Systems for details about information systems for child and youth services.

Human Resource Development Issues

The Child and Youth Services Division human resources for implementing child/youth initiatives are listed below.

Office of the Director

- Director of Child and Youth Services Division
- Community Liaison/Early Childhood Coordinator
- Program Assistant
- Program Budget Specialist

Child and Youth Clinical Practice

- CFSA Mental Health Program Manager
- Home and Community Based Coordinator

- Licensed Clinical Psychologist
- Mental Health Coordinator

System of Care Services Coordination
- System of Care Practice Manager
- Technical Assistant Coordinator for Practice Improvement (2)

The Parent Infant Early Childhood Enhancement Program (P.I.E.C.E.)
- Program Manager (LICSW)
- Social Workers (3) (2 LICSWs and 1 LGSW)
- Psychologist (1)
- Art Therapist/Mental Health Counselor (1)
- Mental Health Specialist (2)
- Program Assistant (1)
- Education Technician/Receptionist (1)
- Child Psychiatrists (4)

Prevention and Early Intervention Programs
- Clinical Program Administrator, Prevention & Early Intervention Programs
- Program Specialist
- School Mental Health Program (48 School Clinicians)
- Early Childhood Mental Health Consultation Project (One (1) Supervisory Psychologist and 4 Clinical Specialists)
- Capital CARES (Suicide Grant)- Project Director and one (1) staff

RTC Re-investment Program:
- RTC Re-investment Program Administrator
- Clinical Program Manager (Licensed Psychologist)
- Residential Clinical Supervisor (Licensed Social Worker)
- Residential Coordinators (4)
- Program Specialist
- Program/Data Specialist

Assessment Center:
- Administrator/Contracting Officer Technical Representative (COTR)
- Coordinator
- Social Workers (2)
- Mental Health Specialist
- Program Support Specialist
- Contract Evaluators (12) including Psychologists, Psychiatrists and one (1) Social Worker

DMH Training Institute and Training for Child Mental Health Services Providers

The DMH Training Institute provides education and training services on a variety of issues related to child and youth System 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.

- Teaming Formation and Functioning Practice Guidelines Protocol.

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 and Adolescent Level of Care Utilization System (LOCUS/CALOCUS) train-the-trainer initiative

- Community Service Review (CSR) Child Review Training

Other training conducted during FY 2010 includes the following:

- Intensive Home and Community Based Service (IHCBS) Philosophy; Strength-based Engagement, Assessment, and Treatment Planning
- Effective management of Severe Behaviors and Collaborating with Schools
- CBI Booster Training III: Intersystem Collaboration, Strengths and Culture, Discovery, and Family Systems
- CBI: IHCBS Service Philosophy, Parent Engagement and Respect
- CBI: Cultural Competency and Family Systems
- Using the Ohio Scales to Inform Case Conceptualization and Ongoing Treatment Planning
- How to Talk the Talk: What You Need to Know about Teen Dating Violence
- Dynamics of Teen Dating Violence in a Clinical Setting

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

Child Emergency Service Provider Training

þÿ S e e A d u l t P l a n E m e r g e n c y S e r v i c e P r o v i
the Disaster Mental Health Training series and the Crisis Intervention
Collaborative with the District Metropolitan Police Department (MPD).

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

Child Grant Expenditure Manner

See Adult Plan - Adult and Child Grant Expenditure Manner regarding the allocation of FY 2011 Community Mental Health Services 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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	3,061	5,639	5,434	5,500
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: Children with mental health issues in the District of Columbia.

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

Indicator: Number of children/youth receiving mental health services during the reporting period.

Measure: The total child and youth population in the District for the reporting period.

Sources of Information: e-Cura System and Department of Health Care Finance data.

Special Issues: The Dixon Performance Target is 5%. FY 2007 and FY 2008 data reflected only mental health rehabilitation services (MHRS). FY 2009 and FY 2010 data also includes Medicaid MCOs, School Mental Health Program, Assessment Center, Psychiatric Residential Treatment Facilities (PRTFs) and Wraparound services. The FY 2011 target remains at 5%.

Significance: Required to exit from Court Oversight.

Action Plan: Continue to include child and youth mental health services data from a variety of service providers.

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)	
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	
Performance Indicator	2.56	6.47	9.31	8	
Numerator	2	27	--	--	
Denominator	78	417	--	--	--

Table Descriptors:

Goal: Improve continuity of care.

Target: Establish number of children/youth re-admitted to inpatient care within 30 days of discharge at 8.0%.

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 during reporting period.

Measure: Number of children/youth discharged from inpatient care during reporting period.

Sources of Information: e-Cura System and Department of Health Care Finance data.

Special Issues: There were data integrity issues in FY 2007. Analysis in FY 2008 was based on 2 hospitals versus 3 in FY 2007. Data for
FY 2009 was revised to reflect that FY 2009 and FY 2010 data is based on 12 area hospitals not just those that DMH contracts with, as reported in previous years. A discharge during FY 2009 and FY 2010 for children/youth (age 0-17) for the 12 providers is considered in this analysis.

Significance: This is a National Outcome Measure (NOM).

Action Plan: During FY 2007- FY 2010 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 2011.

Transformation Activities: ☐

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

(1)	(2)	(3)	(4)	(5)	
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	
Performance Indicator	6.85	21.82	21.15	22	
Numerator	5	91	--	--	
Denominator	73	417	--	--	--

Table Descriptors:

Goal: Improve continuity of care.

Target: Establish number of children/youth re-admitted to inpatient care within 180 days of discharge at 22.0%.

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 180 days of discharge during the reporting period.

Measure: Number of children/youth discharged from inpatient care during the reporting period.

Sources of Information: e-Cura System and Department of Health Care Finance data.

Special Issues: In FY 2007 there were data integrity issues. In FY 2008 analysis was based on 2 hospitals versus 3 for FY 2007. In FY 2009 the data was revised to reflect that FY 2009 and FY 2010 data is based on 12 area hospitals. A discharge during FY 2009 and FY 2010 for children/youth (age 0-17) for the12 providers is considered in this analysis.

Significance: This is a National Outcome Measure (NOM).

Action Plan: During FY 2007- FY 2010, 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 2011.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	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)	
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	
Performance Indicator	24.61	25.09	24.26	25	
Numerator	555	538	--	--	
Denominator	2,255	2,144	--	--	--

Table Descriptors:

Goal: Improve community-based services and supports available to children/youth with more complex needs and divert them from more restrictive levels of care.

Target: Maintain the children and youth who receive therapeutic foster care at 25% in FY 2011.

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: The number of children/youth receiving therapeutic foster care for the reporting period.

Measure: The 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. The FY 2011 target remains at 25%.

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 PTRFs.

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.

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	4,533.33	3.69	2.91	3.50
Numerator	136	134	--	--
Denominator	3	3,635	--	--

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 2011 target is 3.5%.

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: The number of children and youth who receive MST.

Measure: The number of children and youth who receive at least one MHRS.

Sources of Information: e-Cura 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)	
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	
Performance Indicator	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: During FY 2010 DMH contracted with Functional Family Therapy, lmc (FFT, lnc.) to begin to provide training and technical assistance to the child providers to implement this model. This process will continue in FY 2011.

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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	35.62	48.33	49	80
Numerator	26	29	--	--
Denominator	73	60	--	--

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 2010, the performance was 48%, 36%, 48% and 49%, respectively. Longstanding issues include lack of effective team formation and team functioning. The target for existing active monitoring for this exit criterion is 80% system performance and will remain at 80% for FY 2011.

Significance: Achievement of 80% system performance is required by the terms of the Dixon consent order to exit from federal Court Oversight.

Action Plan: DMH established a Community Services Review Unit within the Organizational Development Division, Office Programs and Policy in FY 2009. This Unit performs a major role in the formal Dixon CSR reviews by providing logistical support for DMH reviewers and helping to provide reviewer training. It has also provided focused reviews and created targeted technical assistance interventions to assist the provider network with clinical practice issues.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

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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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	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)	
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target	
Performance Indicator	92.30	89.37	85	N/A	
Numerator	683	227	--	--	
Denominator	740	254	--	--	--

Table Descriptors:

Goal: To improve child social supports/social connectedness.

Target: Increase social connectedness at 85%.

Population: Children and youth with mental health issues in the District of Columbia.

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

Indicator: Youth Services Survey for Families.

Measure:

Sources of Information: Youth Services Survey for Families (YSS-F).

Special Issues: The FY 2009 YSS-F was conducted during FY 2010 and the FY 2010 YSS-F will be conducted during FY 2011. No FY 2011 target is set.

Significance: This is a federal reporting requirement for the Data Infrastructure Grant(DIG) and the Mental Health Block Grant.

Action Plan: DMH will conduct the FY 2010 YSS-F during FY 2011.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	72.86	73.23	75	N/A
Numerator	674	186	--	--
Denominator	925	254	--	--

Table Descriptors:

Goal: To improve child outcomes by improving functioning.

Target: Maintain level of functioning at 75%.

Population: Children and youth with mental health issues 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: Youth Services Survey for Families.

Measure:

Sources of Information: Youth Services Survey for Families (YSS-F).

Special Issues: The FY 2009 YSS-F was conducted during FY 2010 and the FY 2010 YSS-F will be conducted during FY 2011. No target is set for FY 2011.

Significance: This is a federal reporting requirement for the Data Infrastructure Grant (DIG) and the Mental Health Block Grant.

Action Plan: DMH will conduct the FY 2010 YSS-F during FY 2011.

Upload Planning Council Letter for the Plan

DISTRICT OF COLUMBIA
STATE MENTAL HEALTH PLANNING COUNCIL

August 28, 2010

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 2011 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) are innovative including use of evidence-based, best and/or promising practices; 3) identify measurable results; 4) describe consumer outcomes; and 5) are 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.

DMH Noteworthy Initiatives

There are a number of noteworthy DMH initiatives that are department-wide and address the adult and child systems of care. These include but are not limited to the initiatives that follow.

> Departmental Initiatives: The system-wide noteworthy initiatives include: 1) the annual Olmstead Conference held in collaboration with the D.C. Office of Disability Rights (second annual conference focused on social inclusion); 2) consumer oriented initiatives such as the planning process to create a Peer Specialist Certification program, Peer Transition Specialist who assist persons leaving the hospital with community reintegration, and funding consumer run organizations to provide advocacy, obtain consumer feedback, provide training and outreach to consumers, and to operate a self-

help center; 3) expanding the Crisis Intervention Collaborative so that not only police officers are trained to interact positively with persons with mental illnesses but training is also provided on this initiative to 911 call takers, dispatchers and coordinators; and 4) the System Redesign planning process that includes issues related to children, co-occurring disorders, and provider restructuring.

Adult System: The adult system of care noteworthy initiatives include: 1) the work of the Integrated Care Division on behalf or individuals leaving the hospital and/or in the community who require intensive care management to remain in the community; 2) the Mobile Crisis Services Homicide Survivor Response Project in collaboration with the Office of Victim Services and the Police Department that will ensure the availability of mental health assistance for homicide survivors; and 3) creating a Quality Improvement Plan for assertive community treatment (ACT) services including conducting fidelity assessments.

Child System: The child system of care noteworthy initiatives include: 1) the Early Childhood Mental Health Consultation Project that focuses on child and family-centered, and program consultation, which received some funding from the FY 2010 Mental Health Block Grant; 2) establishment of the Parent Infant Early Childhood Enhancement Program (P.I.E.C.E.) that will primarily serve children age 5 and under beginning in FY 2011; 3) expansion of the Primary Project that serves children with mild school adjustment issues in kindergarten through first grade; 4) implementation of the Transition Age Youth Development Project that adopted the Transition to Independence Process (TIP) model an evidence-based practice, which was funded by FY 2009 Mental Health Block Grant funds; and 5) implementation of Capital CARES (Citywide Approach to Reduce Risk for and Eliminate Youth Suicide) grant that focuses on preventing suicide and suicide behaviors among all District youth.

Status of Concerns in the FY 2010 Mental Health Block Grant

Some of the concerns our Council raised related to the FY 2010 Mental Health Block Grant have been addressed.

Displacement of Parent Group: The Family Alliance and Children and Adults with Attention Deficit Disorders (CHAD) met twice a month at one of the former DC CSA facilities. The displacement of the parent group resulted from the closure of DC CSA. Our Council recommended that DMH provide assistance related to re-location of the parent group meeting. DMH identified a meeting space at the Mental Health Services Division's 35 K Street location.

Monitoring of DC CSA Transition: Our Council's concerns included the process for addressing issues when the consumer expressed dissatisfaction with the new provider and the types of post-transfer variables that might be assessed that signal a red flag and those that indicate positive adjustment. The DMH Office of Accountability gave a presentation to our Council on the overall functions and responsibilities of this office that included monitoring the DC CSA transition. The consumer satisfaction survey and continuity of

care monitoring have largely shown positive results. The monitoring process will continue for one full year post transition ending in Spring 2011.

Transition Age Youth and Older Adults: Our Council has long believed that services for transition age youth and older adults represent two (2) major service system gaps due primarily to the lack of a conceptual framework that addresses the service needs of these populations. To this end, our Council put forth a series of questions for consideration in developing a clearly articulated service strategy for addressing the needs of both transition age youth and older adults. With regard to youth transitioning to adulthood, the Transition Age Youth Service Development Project adopted the TIP model as a conceptual framework and developed a Road Map and Curriculum. With regard to older adults, there does not appear to be any activities related to this issue during FY 2010.

Housing for Mental Health Consumers: Our Council's primary concern was how the DMH housing initiatives 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 recommended a strategy for developing a 5-year Housing Plan The DMH Housing Consultant (Director Mid-Atlantic Corporation Supportive Housing) and a DMH Housing Division staff conducted a presentation for our Council that included District-wide initiatives. During FY 2010, the Housing Plan development process shifted from solely focusing on DMH efforts to include coordination with and integration of District housing initiatives. The plan development is in progress and the 5-Year Housing Plan will likely include the period FY 2011 – FY 2016.

Issues Related to FY 2011 Mental Health Block Grant

The Council would like to point out several issues related to the FY 2011 Mental Health Block Grant.

Transition Age Youth: DMH conducted the development phase of this initiative during FY 2010 and will receive FY 2011 Mental Health Block Grant funds for continued implementation. It is unclear how this initiative will become fully integrated into the service delivery system. Our Council recommends that this issue be addressed during FY 2011.

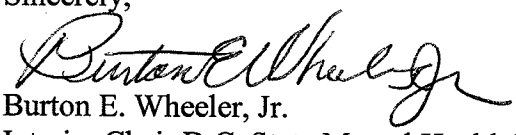
Older Adults: There appears to have been no activities during FY 2010 that would move DMH closer to articulating a service strategy for older adults. Our Council would like to reiterate the questions that were raised last year that might be helpful to this process: What is currently known about older adults? 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?

Funds have been set-aside in the FY 2011 Mental Health Block Grant to begin the process of developing an Older Adult Initiative. Our Council would like to help DMH move this process forward.

System Re-Design: The four (4) sub-committees are identified (child issues, free standing mental health clinics, health information technology, provider restructuring) and it is noted that preliminary reports have been developed. Our Council would like to recommend: 1) that transition age youth and older adults are identified among priority populations that are addressed in the System Redesign Plan, and 2) that a public review and comment period be built into the process before the System Redesign Plan is finalized.

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

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	K. Martin
Affordable Behavioral Consultants	Ms. Christine Williams	1400 Mercantile Lane Suite 206 3005 Bladensburg Rd, NE	Largo Wash	MD DC	20774 20018	301-386-7722 202-636-4520 Christine.Williams@abccares.net	K. Martin
*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	Jeffery Peterson	4801 Sergeant Road, NE	Wash.	DC	20017	832-7343 Ext.307 PetersonJ @boystown.org	K. Martin
CARECO	Dr. Lynda Richard	6323 Georgia Avenue, NW Suite 206	Wash.	DC	20011	202-722-1397 LyndaRichard@carecogroup.com.	J. Alleyne
	Corporate Office	8555 16th St., Suite 240	SS	MD	20910	301-565-9400	
*Capital Community Services, LLC	Mr. Carroll Parks	1310 Southern Avenue, SE	Wash.	DC	20020	202-574-5444 Cparks@unitedpsych.com	K. Martin
*Community Action Group	Ms. Janice Gordan	3325 13th 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 Hbergman@CCDC1.org	V. Hamilton
CPEP	Ms. Cynthia Holloway	1905 E Street, SE	Wash.	DC	20003	202-673-9319 Cynthia.holloway@dc.gov	K. Martin
Deaf-Reach	Ms. Sara Brown	3521 12th St. NE	Wash.	DC	20017	202-832-6681 browns@deaf-reach.org	T. Crews
*Family Matters of Greater Washington	Ms.Tonya Jackson Smallwood	1509 16th Street, NW	Wash.	DC	20036	202-289-1510 TSmallwood@familymattersdc.org	T. Crews
*Family Preservation	Mr. Rick Smith	810 Potomac Avenue, SE	Wash.	DC	20003	540-761-7999 rsmith@fpscorp.com 202-543-0387 DC Office	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	*CEO*	*Street*	*City*	*State*	*Zip*	*Phone/email*	*Provider Relations*
*First Home Care Corporation	Ms. Rose Bruzzo	1012 14th St., NW, #1400	Wash.	DC	20005	202-737-2554 Rose.bruzzo@psysolutions.com	T. Crews
*Green Door	Ms. Judith Johnson	1221 Taylor St., NW	Wash.	DC	20011	202-464-9200 Judith.Johnson@greendoor.org	K. Martin
*Hillcrest Children's Center	Ms. Juanita Price	1408 U Street, NW Suite 8	Wash.	DC	20009	202-232-6100 ext 12 JPrice@hillcrest-dc.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 211	Wash.	DC	20012	202-291-0951 Rhonda.baskerville@LAUNCH4change.com	T. Crews
*Latin American Youth Center	Mr. Carlos Vera	1419 Columbia Rd., NW	Wash.	DC	20009	202-319-2225 carlos@layc-dc.org	J. Alleyne
*Life Stride, Inc.	Ms. Joyce L. Drumming	3005 Bladensburg Rd. NE	Wash.	DC	20018	202-635-2320 jdrumming@earthlink.net	K. Martin
*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 Dr. Beth Crawford	6192 Oxon Hill Road(suite 202) 903 Brightseat Rd.	Oxon Hill MD Landover MD		20745 20785	301-567-8311-301-333-2980 lbivins@mfrinconline.com/bcrawford@mfrinconline.com	J. Alleyne
*McClendon Center	Mr. Dennis Hobb	1313 New York Ave., NW	Wash.	DC	20005	202-737-6191 202-745-0073 dhobb@Mcclendoncenter.org	J. Alleyne
*Mental Health Services Division	Ms.. Theresa Donaldson Ms. Alexis Haynes	35 K Street, NE	Wash.	DC	20002	202-442-4876 Theresa. Donaldson@dc.gov 202-671-3155 Alexis.Haynes@dc.gov	V. Hamilton
*Neighbors Consejo	Ms. Judy Diaz	3118 16th 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
*PSI	Ms. Elizabeth Abramowitz	770 M Street, SE	Wash.	DC	20003	202-547-3870 -301-654-3903 eabramowitz@psifamilyservices.com	K. Martin
*Psychiatric Center Chartered	Ms. Eliere Hall	3001 Bladensburg Rd. NE	Wash.	DC	20018	202-635-3577 ehall@psych-center.com	K. Martin

MHRS Provider	*CEO*	*Street*	*City*	*State*	*Zip*	*Phone/Email*	*Provider Relations*
*Progressive Life	Dr. Laurence Jackson	1704 17th Street. , NE	Wash	DC	20002	202-842-2016 ljackson@plcntu.org	J. Alleyne
*Scruples Corporation	Ms. Sharon Yorke-Cyrus	2811 Pennsylvania Ave., SE	Wash.	DC	20020	202-581-2457or 2455 sharon.cyrus@scruplescorporation.org	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 tpatterson@uhmsdc.com	J. Alleyne
*Volunteers of America Chesapeake	Ms. Kyoko Queen	7901 Annapolis Road 1330 New Hampshire, Ave. Suite 4B	Lanham Wash	MD DC	20706 20009	301-459-2020 202 -223-9630 kqueen@voaches.org	K. Martin
Wade & Wade	Ms. Zenobia Wade	3005 Bladensburg Rd., NE Unit 102	Wash.	DC	20018	202-269-3506 or 202-607-6769 zwade1@aol.com	J. Alleyne
*Washington Hospital Center	Mr. Oliver Russell	216 Michigan Ave., NE	Wash.	DC	20017	202-877-6402 oliver.russell@medstar.net	J. Alleyne
Woodley House Inc.	Mr. Gary Fyre	1221 Taylor Street, NW	Wash.	DC	20011	202-328-4069 gfrye@woodleyhouse.org	K. Martin
Youth Villages	Mr. Paul Enderson Ms. Lily Sojourner	2020 North 14th Street	Arlington	VA	22201	865-560-2548 -703-516-6950 paul.enderson@youthvillages.org Lily.sojourner@youthvillages.org	T. Crews

Updated 8/23/10

Child/Youth Serving Agencies

*** CSAs**