Department of Mental Health

TRANSMITTAL LETTER

SUBJECT **DMH Policy Statement on Core Values and Practice Principles**		
POLICY NUMBER **DMH Policy 115.3**	**DATE** JUN 0 5 2012	**TL#** 169

Purpose. This is a policy statement that describes the Department of Mental Health's (DMH) service delivery core values and practice principles, and designates procedures toward the integration of the community service reviews (CSR) to the core service agencies (CSAs). CSRs measure the performance of DMH in providing mental health services.

Applicability. Applies to the Department of Mental Health (DMH) certified core service agencies (CSAs), their sub-providers and specialty providers, Saint Elizabeths Hospital (SEH), and the Mental Health Authority (MHA).

Policy Clearance. This policy was cleared through the Senior Deputy Director, Office of Programs and Policy.

Implementation Plans. A plan of action to implement or adhere to a policy must be developed by designated responsible staff. If materials and/or training are required to implement the policy, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible to follow through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work. Implementation of all DMH policies shall begin as soon as possible. Full implementation of this policy shall be completed within sixty (60) days after the date of this policy.

Policy Dissemination and Filing Instructions. Managers/supervisors of DMH and DMH contractors must ensure that staff is informed of this policy. Each staff person who maintains policy manuals must promptly file this policy in Volume II of the **DMH** Policy and Procedures Manual and contractors must ensure that this policy is maintained in accordance with their internal procedures.

*If any DMH policies are referenced in this policy, copies may be obtained via DMH Intranet on the dmhweb or the District Internet at www.dmh.dc.gov Hard copies of DMH policies may be obtained from DMH Policy Support Division by calling (202) 671-4070.

ACTION

REMOVE AND DESTROY	**INSERT**
NONE	**DMH Policy 115.3 DMH Policy Statement on Core Values and Practice Principles**

6/5/12

Stephen T. Baron **Date**
Director, DMH

GOVERNMENT OF THE DISTRICT OF COLUMBIA ★ ★ ★ **DEPARTMENT OF MENTAL HEALTH**	**Policy No.** **115.3**	**Date** JUN 0 5 2012	**Page 1**
	Supersedes **NONE**		

Subject: DMH Policy Statement on Core Values and Practice Principles

1. **Purpose**. This is a policy statement that describes the Department of Mental Health's (DMH) service delivery core values and practice principles, and designates procedures toward the integration of the community service reviews (CSR) to the core service agencies (CSAs). CSRs measure the performance of DMH in providing mental health services.

2. **Applicability**. Applies to the Department of Mental Health (DMH) certified core service agencies (CSAs), their sub-providers and specialty providers, Saint Elizabeths Hospital (SEH), and the Mental Health Authority (MHA).

3. **Authority.** Department of Mental Health Establishment Amendment Act of 2001 and Mental Health Rehabilitation Services (MHRS) Provider Certification Standards.

4. **Definitions**.

4a. Core Service Agency (CSA). A DMH-certified community-based MHRS provider that has entered into a Human Care Agreement with DMH to provide specified MHRS. A CSA shall provide at least one core service directly and may provide up to three core services via contract with a sub-provider or subcontractor. A CSA may provide specialty services directly if certified by DMH as a specialty provider. However, a CSA shall also offer specialty services via an affiliation agreement with all specialty providers.

4b. Community Service Review (CSR). The protocol designed to examine and improve service delivery and performance outcomes.

4c. Family. The primary care-giving unit, including a biological, adoptive or self-created unit of people who may or may not be residing together and consisting of adult(s) and children, with adult(s) performing duties of parenthood for the children. Persons within this unit share bonds, culture, practices and significant relationships. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family.

4d. Key stakeholders. Refers to personal or legal persons or entities that is linked to the child/youth or adult requiring legal representation or chosen by the individual receiving services.

4e. Person(s). Refers to people served by DMH. To be consistent with the Substance Abuse and Mental Health Services Administration's (SAMSHA) strategic initiatives, the people-first language[1] is used in this policy. Persons are referred to as "individuals in care" at Saint Elizabeths Hospital.

[1] People-first language is a form of linguistic prescriptivism in English, aiming to avoid perceived and subconscious dehumanization when discussing people with disabilities, as such forming an aspect of disability etiquette.

4f. Practice. The term practice refers to the collective set of actions used to plan and deliver interventions and supports. Practice takes place in collaboration with the person(s) served and the social and service-related networks and supports available to help meet the person's individualized needs, and is guided by self-determination and consumer choice. The purpose of practice is to help a person or family to achieve an adequate level of:

(1) Well-being (e.g., safety, stability, permanency for dependent children, physical and emotional health);

(2) Daily functioning (e.g., basic tasks involved in daily living, as appropriate to a person's life stage and ability);

(3) Basic supports for daily living (e.g., housing, food, income, health care, child care); and

(4) Fulfillment of key life roles (e.g., a child being a successful student or an adult being a successful parent or employee). Refers to the collective set of actions used to plan and deliver interventions and supports.

4g. Recovery. Is learning, developing, and maintaining coping skills to manage living.

4h. Significant others. Persons/entities that are chosen by the individual receiving services that has impact on their life and services.

5. **Policy**.

5a. In order improve the performance of the public mental health system, DMH services shall be guided by the following core values and practice principles in service delivery:

(1) Person and Family Driven.
   a. The person has the primary decision-making role in their services and goals.
   b. Everyone who impacts the person's life, within his/her preferences, is encouraged to participate toward services that are successful and meaningful.

(2) Individualized & Needs-Based. Services and activities are guided by an individualized service plan that is comprehensive, tailored to the person's unique needs, strengths and preferences or, in the case of children/youth, with considerations to the preferences of family or key stakeholders, as applicable.

(3) Array of Services & Supports.
   a. A comprehensive network of services and supports are accessible to address the physical, emotional, social, developmental, and educational needs of each person.
   b. Clinically appropriate services exist along a continuum of care from early childhood through adulthood.

(4) High Quality.
   a. Service delivery incorporates evidence-based, promising, and best practices in meeting the complex needs of the individual.
   b. Practitioners are well-qualified to deliver services that are effective, timely and consistent.

(5) Community-Based. Community-based service options are fully explored so that services and supports take place in the most inclusive, normative, and least restrictive setting possible, maximizing traditional and natural community resources.

(6) Culturally and Linguistically Responsive. Policies and service delivery demonstrate respect for the unique and diverse roles, age, race, ethnicity, background, gender or gender identity, language, values and beliefs of the person and his/her community.

(7) Early Identification & Intervention. Early identification and intervention is promoted to identify and address social, emotional, physical, educational and emerging needs to enhance the likelihood of improved outcomes, prevent harm and lessen the need for more intensive and restrictive services as adolescents, young adults and older adults.

(8) Integrated Care.

a. CSAs and all providers systematically coordinate efforts and blend resources to enhance the availability of traditional services and community resources, to build natural and social supports, and avoid duplication of services and gaps in care.
b. Agencies collaborate to ensure appropriate and clear transitions between levels of care and between youth and adult services.

(9) Strengths-Based. Assessments comprehensively identify, and services build on the capabilities, knowledge, skills, and assets of the person served, significant others, their community and other team members.

(10) Outcomes-Based.

a. Goals and objectives identified in the individualized treatment plan are clearly understood and measurable, with supports and services helping the person to safely live in the community, achieve success developing needed skills and capacities and avoid legal entanglements.
b. Outcomes are used to drive decisions to further improve services for the person served at the system and practice level.

(11) Least Restrictive. Services and supports are provided in the most inclusive, normative and least restrictive setting possible, to increase the likelihood of successful integration into family, home and community.

5b. The Community Service Reviews (CSR) shall be used assess and monitor the degree to which practice principles are integrated into practice.

5c. The CSR shall be integrated in the CSA's service delivery core values and practices.

5d. The CSR results shall be utilized in the continuous quality improvement processes of the DMH public mental health system.

6. **Basic Functions of Quality Practice**.

The DC Department of Mental Health's practice framework is set forth in the following basic functions of quality practice and probes:

6a. Engaging Service Partners.

(1) Does the person have a trust-based, meaningful working relationship with family, key stakeholders and service providers?
(2) Is teamwork building unity of effort among service providers for the person and significant others?
(3) Are efforts made to identify and secure resources and supports that will assist the person reach his/her goals?

6b. Assessing and Understanding the Situation.
(1) Do all involved understand the person, family/significant others' situation well enough to make a positive difference, prevent harm, and work as a team in collaboration with him/her, family and significant others?
(2) Are strengths and needs identified and understood?
(3) Is there a clear understanding of what things must change for the person family/significant others to get better, do better, and stay better?
(4) Are the appropriate people on the treatment team?

6c. Planning Positive Life- Changing Interventions.
(1) Is service planning an ongoing process, reflective of the current situation, involving the necessary partners and helping to achieve desired outcomes for the person(s) served?
(2) Are intervention outcomes clear and agreed upon by the person, his/her family/significant others and providers?
(3) Are strategies planned and sufficiently organized to account for transitions, crises and discharge, and to achieve each outcome?

6d. Implementing Services.
(1) Are services appropriate to meet near-term needs and sufficient for implementing strategies to achieve planned outcomes?
(2) Is the coordination and delivery of services timely, competent, and consistent in order to provide for adequate implementation of all agreed on services?

6e. Getting and Using Results.
(1) Are current efforts leading to positive results?
(2) Is knowledge gained through experience being used to refine strategies, solve problems, and to help achieve planned outcomes?
(3) Do those served report that their well-being, daily functioning, and satisfaction are improving?

7. **Responsibilities.** To support the integration of the core values and practice principles in the CSA's service delivery,

7a. DMH shall:

(1) Develop specific service practice guidelines, training and technical support to enhance practice.

(2) Develop strategies to acknowledge mental health providers that develop strong internal practice development activities including integration of the CSR process.

(3) Measure the consistency of the occurrence of functions of practice with individuals receiving services using multiple coordinated activities and strategies implemented through MHA offices as follows:

a. Office of Accountability:
   i. Develop quality initiatives to support integration of CSR content and process.
   ii. Coordinate CSR reviews with existing auditing/review activities.
   iii. Integrate reporting of CSR data into existing quality improvement, accountability and management activities and reports.

b. Provider Relations:
   i. Collaborate with Office of Programs and Policy to provide coaching and resources on practice development.
   ii. Communicate issues, developments and needs related to the integration of the cover values and practice principles and CSR indicators.

c. Child and Youth Services and Adult Services Divisions:
   i. Develop and implement coordinated strategy with Provider Relations to implement practice improvement activities with low-performing agencies.
   ii. Integrate CSR implementation into program management, quality improvement activities, and strategic goals.
   iii. Provide Technical Assistance (TA)/coaching on practice principles related to CSR process.

d. Organizational Development within the Office of Programs and Policy:
   i. Provide internal and external training and case consultation on CSR process, implementation and integration.
   ii. Collect, synthesize and disseminate CSR data in coordination with existing agency quality improvement activities.
   iii. Collaborate with OPP leadership to provide coaching and resources on practice development.
   iv. Identify and train local CSR reviewers.
   v. Develop and conduct CSR Train-the-Trainer for key staff and community reviewers on CSR review and case consultation.
   vi. Develop 4-6 scenarios about persons receiving services for use in training.
   vii. Provide planning, logistical and review supports on a time limited basis;
   viii. Analyze psychometrics of existing CSR data, and revise and abbreviate adult and child protocols.
   ix. Conduct agency-based pilot of revised and abbreviated CSR protocols.
   x. Coordinate with CSR unit to develop and implement agency-based implementation training.
   xi. Provide on-going consultation support for development of practice guidelines, training, case consultation, and agency-based implementation of CSR process.
   xii. Provide logistical support for child annual CSR reviews.
   xiii. Participate in CSR review training
   xiv. Participate in CSR Technical Assistance
   xv. Recruit and provide community lead reviewers, including family partners.

7b. The CSA shall:

(1) Develop an agency mission statement that incorporates key aspects of agency practice principles.

(2) Designate champions of practice who will oversee integration (may be an already functioning clinical practice group, quality assurance person, or may be a newly identified practice leader).

(3) Develop and implement practice principles that are consistent with this DMH policy.

(4) Align policies with DMH practice principles on engagement, teaming, communication, assessment, treatment planning, and assessing the efficacy of practice provision and outcomes.

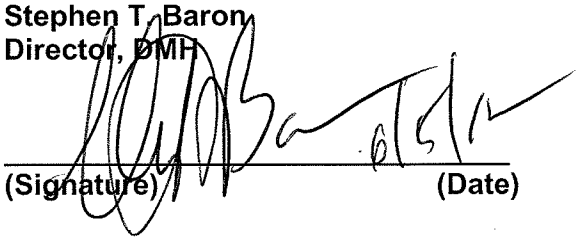
(5) Distinguish procedural, compliance-driven from administrative supervisory functions that is targeted at quality of clinical care.

(6) Enhance supervisory policies that
   a. Address supervisee's abilities to implement practice guidelines;
   b. Facilitate face-to-face supervisory meetings held at least once a month.
   c. Address internal sporadic reviews that are independent of supervision.

(7) Institute a tool for reviewing quality of services for individuals served that meet the following criteria:
   a. Consistent with CSA and DMH practice principles.
   b. Has shared agency vocabulary about the person and their services;
   c. Does not rely solely on what has been documented about the person receiving services (e.g., their diagnosis, treatment history; etc.)
   d. Is standardized and flexible enough for comparison across the service providers;
   e. Is useful for achieving and monitoring supervisory goals and supervisee performance
   f. Promotes orderly and concise sharing of information about the person and his/her services for discussion.

Approved By:

Stephen T. Baron
Director, DMH



(Signature) **(Date)**