Dixon Settlement Agreement Quarterly Report – FY 2012 Fourth Quarter
January 15, 2013

Pursuant to the terms of Paragraph 74 of the Settlement Agreement ("SA"), the District reports the following information:

I. Child and Youth Services

a. Community Services Reviews

Goal: 70% performance level for child/youth service reviews

(1) Results of FY 2012 or FY2013 CSRs, as applicable (SA, ¶¶ 55 and 58).

The FY2012 Child/Youth CSR was completed during May of 2012. There were 89 children/youth reviewed, and almost 600 interviews conducted during the reviews. DMH worked closely with the Child and Family Services Agency, and the Court Monitor for the *LaShawn v. Gray* case, the Center for the Study of Social Policy, to jointly review the cases of children served by both systems. The joint reviews provided comprehensive information about children served by both systems, and will serve as a model for ongoing cooperation between the two agencies.

DMH achieved its FY 2012 goal of an overall system performance score of 65% for the FY2012 CSRs. We anticipate achieving a score of 70% system performance by the FY2013 reviews. We achieved a 71% score for consumer status, and a 67% score for consumer progress.

(2) Status of Human Systems and Outcomes ("HSO") consultation (SA, ¶¶ 56 and 57), including:

HSO participated in the FY2012 CSRs by conducting training for targeted providers; providing contracted reviewers; supplying case consultation services; and running the group debriefing sessions. HSO has been responsible for compiling and preparing all data from the CSRs, and has issued a final report on the FY2012 reviews. HSO's contract is being renewed at the completion of the current contract for work on the 2013 CSR, and HSO has also been working to prepare DMH to assume oversight of the reviews after the FY2013 CSR.

The data from the FY2012 CSRs was presented and discussed in detail with focus CSAs during October 2012. This data, in addition to data from prior CSRs, were used to identify target agencies with which the CSR Unit will work during the period leading up

to the 2013 CSRs in May 2013. In addition to the previously identified agencies, agencies new to our system have been targeted for special technical assistance and training. The CSR unit is providing training on the core elements of quality practice, supervisory practices commensurate with practice improvement, and, with HSO, trainings that focus on the weaknesses in clinical case formulation identified from the 2012 CSR data. These trainings began in August 2012 and will continue into the spring. The CSR unit has offered these trainings both through the DMH Training Center, which has enabled the participants to be more varied and promoted inter-system discussion, and at the individual Core Service Agencies.

b. Psychiatric Residential Treatment Facilities ("PRTFs") (SA, ¶ 59)

Goal: Decrease bed days by 30% compared to baseline year (72,687 → 50,880)

PRTF Total Bed Days Baseline Data Baseline Period: 05/01/11 –04/30/12		
Placing Agency	**# Served with SED**	**Total # of Bed Days**
Department of Youth Rehabilitation Services (DYRS)	155	37,999
Child and Family Services Agency (CFSA)	44	17,910
Department of Mental Health (DMH)	14	4,648
Office of the State Superintendent of Education (OSSE)	5	1,811
D.C. Public Schools (DCPS)	13	7,883
HSCSN	9	2,436
Total Bed Days Baseline Number	**240**	**72,687**

c. Reduction PRTF Usage (SA, ¶ 59)

PRTF Bed Days Comparison Period: 05/01/12 –04/30/13[1] (as of 9/30/12)		
Placing Agency	**# Served with SED**	**Total # of Bed Days**
Department of Youth Rehabilitation Services (DYRS)	68	16,905
Child and Family Services Agency (CFSA)	28	6,438
Department of Mental Health (DMH)	11	2,493

[1]The District will report a running total of number of children served with SED in a PRTF and bed days during the comparison period until it is complete. The date of the reporting will also be included in the chart underneath the line describing the baseline period. An example of the language is as follows "Data reported below is as of 12/31/11."

Office of the State Superintendent of Education (OSSE)	4	1,920
D.C. Public Schools (DCPS)	7	5,237
HSCSN	1	355
Total Bed Days (05/01/12 – 09/30/12)	**119**	**33,348***
Total Percentage Reduction from Baseline Number of Bed Days (72,687)		

*Reduction in bed days is on track for meeting the goal of 30% decrease from the baseline.

d. PRTF Discharges and Community Services (SA, ¶ 60)

There were 28 youth discharged from PRTFs during the fourth quarter of FY 12. Three (3) youth were discharged from PRTF and did not spend any time in the community because they went directly into non-community placements (each went to the Youth Services Center) and remained for the duration of the 90-day period. These youths had been discharged on 9/25, 9/28, and 9/28 so the number of days not spent in the community was minimal. There were 25 youth who were discharged and spent time in the community.

July 2012: There were three (3) youth discharged. Two (2) youth discharged after having appropriately completed treatment and one youth discharged home after having reached maximum benefit. Each of these three youth was discharged into the community.

August 2012: There were twelve (12) youth discharged. Eleven (11) youth were discharged after having appropriately completed treatment and one youth discharged against medical advice. The 11 youth discharged after appropriately completing treatment all entered the community. The one youth discharged against medical advice entered a non-community placement (the Youth Services Center) for 4 days before being placed into a therapeutic group home.

September 2012: There were thirteen (13) youth discharged. Eleven (11) youth were discharged after having appropriately completed treatment, one absconded, and one was discharged against medical advice. Eight youth were discharged into the community. Five were discharged into non-community placements. Of the five in non-community placements, two entered the community shortly after discharge.

Quarter	Total Number of C/Y Discharged	Avg. LOS (Length of Stay)	Reasons for Discharge	Community-Based Services After Discharge
1QFY12	(29) Discharged	365.15 days	(25) Approximately Completed Treatment (1) Abscondence (3) Discharged but went directly into non-community placements (correctional facility or RTC)	**Billed MHRS Services** CBI Level II: CBI Level I – MST: Med/Som: Community Support: Diagnostic Assessment: Behavioral Health Screening Other **Agency Self-Reported Non-MHRS Services** Mentoring Academic Support Tutoring Job/Work Problem Workforce Development Substance Abuse Counseling
2QFY12	(21) Discharged	305.11 days	(18) Appropriately Completed Treatment (1) PRTF Review Committee denied the LOC (2) Refused to Comply with Treatment	**Billed MHRS Services** CBI Level II: CBI Level I – MST: Med/Som: Community Support: Diagnostic Assessment: Behavioral Health Screening Counseling Onsite Individual Crisis/Emergency Other:[2] **Agency Self-Reported Non-MHRS Services** Mentoring Academic Support Tutoring Workforce Development Substance Abuse Counseling Gang Prevention Individual Therapy (via Sasha Bruce) Intensive Third Party Monitoring Physical Activity Youth Parenting Class
3QFY12	(40) Discharged	292.38 days	(28) Appropriately Completed	**Billed MHRS Services** CBI Level II: CBI Level I – MST:

[2] The District will amend this report to reflect additional services as they are added to the service taxonomy.

			Treatment (1) PRTF Review Committee denied the LOC (6) Refused to Comply with Treatment (1) Reached Maximum Benefit (2) PRTF Unable to Meet Clinical Need (2) Discharge Against Medical Advice	Med/Som: Community Support: Diagnostic Assessment: Counseling Onsite Individual Crisis/Emergency Other:[3] **Agency Self-Reported Non-MHRS Services** Mentoring Academic Support Tutoring Workforce Development Substance Abuse Outpatient Gang Prevention Individual Therapy (via Sasha Bruce) Intensive Third Party Monitoring Summer Youth Employment Parenting Class
4QFY12	(28) Discharged	260.71 days	(24) Appropriately Completed Treatment (1) Abscondence (1) Reached Maximum Benefit (2) Against Medical Advice	**Billed MHRS Services** CBI Level II: CBI Level I – MST: Med/Som: Community Support: Diagnostic Assessment: Counseling Onsite Individual Crisis/Emergency Other:[4] **Agency Self-Reported Non-MHRS Services** Arts Enrichment Educational Support Family Support/Reunification Gang Prevention Individual Therapy Intensive Third Party Monitoring Mentor Physical Activity Substance Abuse Out-patient Tutoring

[3] The District will amend this report to reflect additional services as they are added to the service taxonomy.
[4] The District will amend this report to reflect additional services as they are added to the service taxonomy.

				Workforce Development Youth Parenting Class
1QFY13				
2QFY13				
3QFY13				
4QFY13				

e. PRTF Discharges and Outcomes (SA, ¶ 60)

(1) Narrative summary of outcomes for children/youth discharged from PRTFs during the most recent quarter and for the end of the fiscal year, if applicable.

The services youth received while in the community are listed above in Table d. and show both billed claims received for MHRS services, as well as non-MHRS services which were self-reported by agency staff to DMH. Youth received therapeutic and clinical services as well as academic and professional assistance. There were 8 disruptions. Six were incarceration disruptions, one was a hospitalization disruption, and one was a PRTF disruption. The six Incarceration disruptions were 4 DYRS (occurring on days 56, 59, 83, and 147 after discharge from PRTF) and 2 DYRS/CFSA (occurring on days 87 and 102 after discharge from PRTF) youth. The Hospitalization disruption was a CSS youth (occurring 39 days after discharge from PRTF) and the PRTF disruption was an HSCSN youth (occurring 136 days after discharge from PRTF).

There were 75 youth in community tenure during Q4: 14 youth from Q2, 37 youth from Q3, and 24 from Q4.

(2) Length of Community Tenure – Community tenure for children/youth is calculated beginning with the date of discharge and continuing up to and including the 180th day after discharge. For purposes of this report, a disruption in community tenure occurs when the child/youth is: incarcerated/detained for 14 days or more; hospitalized (in a psychiatric hospital) for 22 days or more; or re-admitted to a PRTF.

Summary of Community Tenure Data	
Total Youth Monitored in the Community at the beginning of 4Q	*50*
Total Youth Discharged from a PRTF to the Community during FY 12 4Q	*25*
Total Youth Completing Community Tenure	*19*
Total Youth Removed from Community Tenure due to removal from community (re-enrolled in PRTF, incarceration, etc.)	*1 (PRTF)*
Total Youth Being Monitored at the end of the Quarter	*55*
Total Youth Without Disruptions in Community Tenure during FY 12 4Q	*67*
Total Youth With Disruptions in Community Tenure	*8*
Total Possible Maximum Number of Days (Total # of Days Between Date of Discharge for Each Youth to Last Day of Reporting Period)[5]	*7,899*
Actual Number of Days in Community	*6,998*
% of Actual Days of Possible Days in Community	*89%*

Disruption in Community Tenure Data[6]							
Type of Disruption	**Total Applicable**	**<30 Days**	**31-60 Days**	**61-90 Days**	**91-120 Days**	**121-150 Days**	**151-180 Days**
Incarceration More than 14 Days	*6*		*2*	*2*	*1*	*1*	
Hospitalization More than 22 Days	*1*		*1*				
Readmitted to PRTF	*1*					*1*	

[5] DMH will report the total number of days that the children discharged during a quarter could have been in the community. This accounts for the different discharge dates from a PRTF. For example: 20 children are discharged during the first quarter of FY 12 (October 1 – December 31, 2011). A child is discharged on October 3, 2011. The maximum days in the community for that child would be 89 (28 days in October + 30 days in November + 31 days in December). Another child is discharged on December 25, 201 the maximum days in the community for this child would be 6.

[6] Data will be reported cumulatively and will identify each placement disruption throughout the course of the 180 day tracking period. For example, a child who is hospitalized during days 31 – 60 and hospitalized again during days 151 – 180 will be shown in both columns of the chart.

f. Evidenced-Based and Promising Practices (SA, ¶ 61)

Goal 1: Increase number of youth served by EBP's by 20%
Goal 2: Increase number of youth in HFW by 10% in 2012; 20% in 2013

Annual Service Utilization					
Type of Service	**FY 2011 Unduplicated Number of C/Y Served**	**FY 2012 Unduplicated Number of C/Y Served** As of 9/30/12	**FY 2011 - 2012 Percent Increase**	**FY 2013 Unduplicated Number of C/Y Served**	**FY 2012 - 2013 Percent Increase**
FFT	82	224	173%		
MST	129	119	-7.75%		
HFW	211	282	34%		

Service Utilization by Quarter				
Services	**# Served 1Q**	**# Served 2Q**	**# Served 3Q**	**# Served 4Q**
FFT	61	128	173	224
MST	54	71	90	119
HFW	156	231	257	282
Total Served	**271**	**430**	**520**	**625**

In FY12, a total of 119 youth received MST services, less than the 155 target number of youth (20% increase) to be served in accordance with the Settlement Agreement. However, the tremendous increase in FFT during the same period has ensured that children needing intensive services were provided necessary services. Although the population for both MST and FFT can be children with similar issues, MST has stricter requirements for the home environment that is a limitation on the children who can receive MST. MST serves children and youth up to age seventeen who display the most severe and chronic externalizing behaviors, and requires that the child or youth be in a stable home setting with a long-term caregiver. FFT serves children and youth up to eighteen years old who display behaviors ranging from at-risk to severe with the

requirement that the child is in a stable setting with a caregiver willing to participate in the treatment. To that end, far more children and youth met the criteria for FFT, hence the significant overall increase in FFT rather than MST services.

Nonetheless, MST enrollment should increase in FY 13. Youth Villages, the MST provider is expanding its internal staffing capacity from ten therapists to twelve MST therapists to accommodate an average daily census of 50 youth in order to serve 154 youth by the end of the fiscal year. As the average daily census increases, the provider will increase staffing to accommodate the growth. In addition, the MST provider also restructured its referral pre-assessment process by adding two team lead positions to assess all referrals; implemented improved referral data tracking process and participates in weekly referral reviews with DMH. The goal is to improve admission rates in FY13.

II. Supported Housing

a. Supported Housing Capacity (SA, ¶¶ 62, 63, and 64)

Goal: Increase available vouchers and capital units by 300 (1,396 → 1,696)

Supported Housing Capacity					
Program	**Baseline Capacity (As of 09/30/11)**	**Capacity Quarter 1**	**Capacity Quarter 2**	**Capacity Quarter 3**	**Capacity Quarter 4**
Home First Subsidy (HFS)	**653**	657	706	739	786[7]
Local Rent Subsidy Program (LRSP)	**93**	93	93	93	93
Shelter Plus Care (SPC)	**159**	159	159	159	159
Federal Vouchers (Project- and Tenant-Based)	**436**	436	436	436	436
Sub-Total	**1,341**	**1,345**	**1,394**	**1,427**	**1,474**
Capital-Funded Units	**55**	35	28	28	28
Grand Total	**1,396**	**1,380**	**1,422**	**1,455**	**1,502**

[7] This number includes eighty-three (83) consumers who were issued subsidy awards in FY12-2Q, 3Q, and 4Q and had not yet leased up by the end of FY2012 4Q (09/30/12).

b. Supported Housing Rules Status (SA, ¶ 65)

Provide narrative of status of Supported Housing rules, including priority populations. Attach draft/final rules as applicable.

The Housing Rules have been reviewed internally with the Office of the General Counsel and are being published for external review.

The Housing Rules include language regarding priority populations where the Consumer is:

1. Pending discharge from Saint Elizabeths Hospital
2. Homeless consumers
3. Moving from a more-restrictive living situation, e.g. nursing homes to the community.

c. Enforcement of Supported Housing Rules (SA, ¶ 65)

(1) Demonstrate that the Supported Housing rules are communicated to providers and that they are being enforced.

Once the Housing Rules have been finalized, they will be disseminated to the providers and other housing stakeholders. DMH has monthly Housing Liaison and Clinical Director meetings where housing issues are discussed and information is exchanged. Additionally, DMH offers quarterly 'Housing 101' training through the DMH Training Institute for all CSA employees and housing stakeholders. There were fifty (50) attendees at the April 2012 Housing training session; fifteen (15) attendees at the July 2012 Housing training session; and eighteen (18) attendees at the October 2012 training session. The next 'Housing 101' training session is scheduled for January 2013.

(2) Demonstrate that available housing is assigned according to the priority populations in accordance with the Supported Housing rules. [Use table below in addition to any relevant narrative].

Consumers on the Housing Waiting List are candidates for housing opportunities as housing opportunities arise. Consumers in priority categories will be selected first for housing opportunities, followed by consumers on the Housing Waiting List, ordered by longest wait time to shortest wait time.

Priority Population Category	# Applied or Referred to SH	# Placed in SH 1Q	# Placed in SH 2Q	# Placed in SH 3Q	# Placed in SH 4Q
SEH Discharge	**1**	**1**	**0**	**0**	**9**
Homeless w/SMI	**145**	**12**	**14**	**33**	**39**
Consumer w/SMI Transfer to Less Restrictive Setting	**1**	**6**	**2**	**4**	**4**
Other	**39**	**1**	**1**	**6**	**66**
Total	**186**	**20**	**17**	**43**	**118**

Housing opportunities, including Home First Program subsidies, are awarded first to consumers in priority categories. When the number of remaining housing opportunities exceeds the number of consumers in priority populations who are ready for independent living, consumers in other living situations such as Treatment Facilities, and consumers residing temporarily with family and friends, will be offered a housing subsidy, beginning with those consumers with the longest tenure on the Housing Waiting List.

d. **Supported Housing Strategic Plan (SA, ¶ 66)**

Provide narrative of status of strategic plan, including efforts to consult with consumers and consumer advocates. Attach draft/final plan as applicable.

The DMH Supportive Housing Strategic Plan was finalized September 27, 2012. It is available for review at the following link:

http://dmh1.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Dixon%20Settlement%20Agreement%20Housing%20Plan%20September%202012.pdf

III. Supported Employment Services

a. Methodology to Assess Need (SA, ¶ 67)

Provide narrative of status of the development of an objective methodology to assess the need for supported employment services. Describe how DMH is implementing this methodology and enforcing compliance.

DMH has revised its Supported Employment Policy (*see* DMH Policy# 508.1A, Evidence Based Supported Employment Services, issued February 28, 2012) to require every CSA to assess all adult consumers with a Serious Mental Illness (SMI) or Axis II Personality Disorder for interest and eligibility in supported employment. If an interested person is eligible, the CSA is required to refer the individual to a Supported Employment Program. The CSA must complete an electronic performance event screen for each individual when completing the 180-day treatment plan (or more often when necessary) to confirm that consumers have been assessed, offered and referred for supported employment services authorization. DMH monitors the performance event screen data to insure that CSA's complete the process and offer the service. A centralized waitlist has been created at DMH for those individuals waiting for an available opening at a Supported Employment provider.

b. Assessment and Referral (SA, ¶¶ 67 and 68)

Goal: 60% of those eligible are referred to SES

Assessment and Referral for Supported Employment Services ("SES") Measurement Period: April 1, 2012 through September 30, 2013						
	3QFY12	**4QFY12**	**1QFY13**	**2QFY13**	**3QFY13**	**4QFY13**
Total # w/SMI Assessed and Need SES	**1,550**	**1,557**				
Of those Assessed, Total # Referred to SES	249	262				
Percentage Referred to SES Services	16%	17%				

c. Service Delivery (SA, ¶ 69)

Delivery of Supported Employment Services					
	1QFY12	**2QFY12**	**3QFY12**	**4QFY12**	**Total for FY 2012**
Total Unduplicated Count of Adults with SMI who Received at Least One SES	**378**	**190**	**104**	**85**	**757**
Percentage Increase Over FY 2012 Baseline (761):					-.52%

***These numbers are of individuals per quarter who did not receive services in the previous quarter.**

Note: all Supported Employment services are transferring under each provider's Human care Agreement with DMH, rather than having individual contracts specifically for supported employment services. This change allows the providers greater flexibility as their reimbursement for supported employment services can be integrated into the larger MHRS reimbursement accounts. Additionally, DMH is working with the new leadership at the Rehabilitation Services Administration (RSA) to refine the working relationship and process between providers and RSA for the benefit of consumers, and to streamline the reimbursement process. Finally, DMH has been able to secure additional funding for FY 13 supported employment services. With these initiatives, DMH expects to be able to meet its FY13 obligations under the Settlement Agreement.

Continuity of Care

d. Continuity of Care Delivery (SA, ¶¶ 70 and 71)

Goal 1: 70% of consumers get at least one non-crisis service in a non-emergency setting within (7) days;
Goal 2: 80% of consumers get at least one non-crisis service in a non-emergency setting within (30) days

Continuity of Care – Adults					
	1QFY12	2QFY12	3QFY12	4QFY12	Total for FY 2012
Total Number of Adults Discharged	253	285	302	289	1,129
Number of Adults Receiving a Community Based Service within 7 days of Discharge	187	212	206	200	805
Percentage Receiving Service w/in 7 Days of Discharge	73.9 %	74.4%	68.2%	69.2%	71.3%
Number of Adults Receiving a Community Service within 30 days of Discharge	206	238	237	231	912
Percentage Receiving Service w/in30 Days of Discharge	81.4 %	83.5%	78.5%	79.9%	80.8 %

Continuity of Care – Children and Youth					
	1QFY12	2QFY12	3QFY12	4QFY12	Total for FY 2012
Total Number of C/Y Discharged	153	132	135	118	538
Number of C/Y Receiving a Community Based Service within 7 days of Discharge	95	83	76	74	328
Percentage Receiving Service w/in 7 Days of Discharge	62.1 %	62.9%	56.3%	62.7%	61 %
Number of C/Y Receiving a Community Service within 30 days of Discharge	120	115	100	92	427
Percentage Receiving Service w/in 30 Days of Discharge	78.4 %	87.1%	74.1%	78%	79.4 %

e. Performance Standards (SA, ¶ 73)

Continuity of Care outcome reporting continues to improve. DMH received billing data from the Department of Health Care Finance (DHCF) regarding non-MHRS Medicaid qualifying services and has incorporated the information into the table as reflected above.

Continuity of Care percentages for children have improved consistently since a child/youth care manager was added to the Integrated Care staff. Consumers seen within 30 days post discharge percentages have risen to compliance faster than seen within 7 days due to a number of factors including the fact that children are dependent on adults to ensure they keep an appointment. As many children/youth are multi-system involved, communication to ensure all parties are aware of appointments, and that a clearly designated responsible adult is tasked with helping the child/youth keep the appointment is essential.

DMH continues to work with the CSAs to ensure they are coordinating the communication, and taking a lead role in assisting families to ensure that post discharge appointments are kept. The ICD care managers also encourages the CSAs to present to the hospital on the day of discharge thus increasing the seen within 7 days outcome. DMH will continue to work with the providers to improve the children's services and, at a minimum, maintain the adult services.