The Children's System of Care Plan
A Comprehensive 3-5 Year Plan for Redesign

DEPARTMENT OF MENTAL HEALTH
Children and Youth Services Division

Acknowledgements

EXECUTIVE SUMMARY

The District of Columbia's public mental health system serves nearly 4,500 children and youth with severe emotional disturbance. Yet, according to national standards, many others are not receiving the help they need. Moreover, children in need often are touched by multiple government agencies with the best intentions but receive inadequate or fragmented treatment—some in institutions far from home and natural supports. In 2010, the Department of Mental Health developed a blueprint for change called The Children's Plan to treat more children and youth, intervene at an earlier age, and to expand services in the community shown to improve functioning in the family, at school and in the community

This first ever comprehensive 5-year plan pinpoints barriers to care, outlines ways to leverage the resources of each child serving government agency, and identifies community-based programs and services known to be successful in expanding access and improving the quality and timeliness of care.

Guided by system of care values and principles, the Children's Plan contains proposed actions that will expand the capacity of evidence-based services that support children and youth and their families within their communities reduce the number of youth in out-of-home residential placements, increase the range of services available to children up to five years of age, and encourage family participation in all levels of the system;

SUMMARY OF RECOMMENDATIONS

1. Expand the range of available mental health services

The provision of a full continuum of services is the backbone of a children's mental health system to avoid crisis, unnecessary psychiatric hospitalizations, and placements in out of home facilities.

Recommendations:

- Expand evidence-based services proven to improve functioning in the home, school and community
- Increase the number of free standing mental health clinics able to provide psychotherapy
- Expand treatment for youth with both mental health and substance abuse disorders
- Establish rates for psychotherapy for fee-for-service children and youth that are comparable to surrounding jurisdictions
- Streamline the licensing process for providers

2. Ensure the quality of mental health services

Consumers have a right to expect culturally competent services that are outcomes-based and family-driven. Barriers that impede access to services must be eliminated and the timeliness and quality of the treatments provided must be improved.

Recommendations

- Ensure that all child mental health providers are using appropriate, standardized tools to ensure the right level of care and measure functional outcomes of the children they are serving.
- Improve the number of children receiving appropriate services within seven days of enrollment
- Ensure that all children receive appropriate follow up services within seven days of discharge from a psychiatric hospitalization
- Assess and track the use of psychotropic medications to ensure children are not improperly medicated and to ensure coordination with other aspects of treatment and intervention.
- Ensure services are family driven, culturally competent, and outcomes-based
- Implement community support worker certification program to increase the quality of the service and the stability of the workforce.
- Develop and implement outcome measures for all services to ensure that quality services are delivered.

3. Improve Access for Children and Families

Too often children go without services or treatment until a crisis arises. Crisis care is extremely disruptive to children and families and also costs the system significantly more than less-intrusive, community-based mental health care. The District children's mental health system is fragmented across multiple agencies, which can result in poorly coordinated care, barriers to access, and persistently low utilization. Further, the bifurcated mental health system of managed care and fee for service in some cases has the unintended consequence of disrupting continuity of care for high-risk children at their most fragile moments.

Recommendations

- Increase the capacity and competencies of community mental health providers that serve children and youth
- Require managed care organizations build system capacity to serve more children and youth
- Produce a comprehensive, mental health services access guide

- Develop and implement a social marketing and public awareness stressing prevention and early intervention

4. Create a strong early identification and prevention system

Nationally, one in five children from birth to age 18 has a diagnosable mental disorder. One in 10 youth has a serious mental health problem that is severe enough to impair how they function at home, school or in the community. Without early screening and treatment, childhood conditions may persist and lead to a cycle of school failure, poor employment opportunities and poverty.

Recommendations

- Adopt early screening as a standard practice with children and youth entering foster care or the juvenile justice system
- Ensure children are screened for mental health in primary care settings.
- Expand services for children five years and younger
- Develop a psychiatric referral protocol for children and youth from primary care providers to mental health providers and ensure coordination of care
- Expand school based mental health services.
- Ensure coordinated mental health services with young children with disabilities to promote the provision of robust, coordinated mental health services.

5. Strengthen community based services to reduce psychiatric residential facility placement and length of stay

Research shows that high quality community-based services have better long-term outcomes for children and youth through their promotion of home/community-based rehabilitation. At the same time, evidence shows that psychiatric residential treatment facilities and residential treatment centers are relatively ineffective long term in treating adolescents or helping them to reintegrate into their communities once they are released.

Recommendations

- Make use of the interagency Sub-Committee on Residential Placements to monitor/streamline the placement based on level of care determination
- Ensure that there are appropriate, community-based programs and services to support youth diverted or returning from residential placements in the community
- Expand the therapeutic foster care network and improve the quality of current services

- Expand the capacity of the community based services like the Wraparound Program

6. Engage with family and youth as partners at all levels of the children's public mental health system

Families and surrogate families of children with severe emotional disturbance should be full participants in all aspects of the planning and delivery of services. To be effective, the delivery of services and treatment for children/youth must be family-driven.

Recommendations

- Ensure that family members are primary decision-makers on the child/youth/family's treatment team.

- Train parents and caregivers on common psychotropic medication for children, questions to ask your doctor, and other services in addition to medication.
- Increase parent participation as co-trainers in all DMH sponsored trainings.
- Provide technical assistance and coaching to agencies experiencing challenges to engaging families in the treatment planning and delivery process.

7. Enhance cross systems collaboration and data sharing

Often multiple government agencies interact with the same family. Continued collaboration and increased efforts to integrate child serving systems ensure that children and families are served within a seamless system of care.

Recommendations

- Leverage cross-systems governance structures such as the Statewide Commission on Children, Youth and their Families
- Exchange health-related data across systems to ensure appropriate care coordination, and increase provider capacity to collect and report data to inform policy, training, and planning decision-making.
- Create an interagency accountability office to support cross systems implementation of best practices

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Background and Overview:

There has been a twenty year national dialogue on the development of coordinated Systems of Care (SOC) that serve to maintain children within their communities. Jane Knitzer, in her seminal work, Unclaimed Children (1982; 2008),[1] exposed the many deficits of the current children's mental health system in the United States, citing fragmentation and inadequacies and pointing out the system's heavy reliance on placement. In so doing, Knitzer shined a light on the urgent need for states to develop coordinated and integrated mental health services for children and adolescents with severe emotional disturbance (SED). This comprehensive report provided an overview of policy barriers, a discussion of the roles that multiple, child-serving agencies play in the provision of mental health services, an analysis of individual states' regulations regarding the voluntary commitment of children to psychiatric facilities and recommended community-based programs and services known to be successful, along with action steps at the federal, state and local levels. In essence, it laid the groundwork needed to spark a movement of mental health system reform that is steadily growing in strength.

In 1984, responding to the call-to-action put forth by Knitzer, the Child and Adolescent Service System Program (CASSP) began supporting states to develop coordinated "Systems of Care"[2] for youth with serious emotional, socio-emotional and behavioral needs. A System of Care is defined as ". . . an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and their families."[3] Stroul and Friedman (1996) noted that the System of Care movement represents a philosophy about the way in which services should be delivered to children and their families. This System of Care Plan represents the first of its kind for the children and families of the District of Columbia.

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[1] Knitzer, J. (1982; 2008). *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services.* Washington, D.C.: Children's Defense Fund.Latino Needs Assessment (2003). Erie County Department of Health, Buffalo, NY.

[2] Stroul, B.A., & Friedman, R.M. (1986; 1996). *A System of Care for Children and Youth with Severe Emotional Disturbances,* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

[3] Technical Assistance Partnership (no date). "*Systems of Care Home"* Page. Retrieved December 2, 2010 from http://www.tapartnership.org/systemsOfCare.php.

The District of Columbia Children's System of Care Guiding Principles

Although Systems of Care may differ markedly from state to state and between local communities, they share a set of guiding principles at their core. Consistent with the System of Care philosophy as put forth by Stroul and Friedman[4] and adapted for the unique needs of DC's children and families, the following 11 foundational Principles represent the core value system at the heart of DC's System of Care.

1. Family Driven & Youth Guided. A holistic approach that supports and recognizes all family members involved in a youth's care and upbringing, with the end goal of providing services that are successful and meaningful to the youth. Families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children. Youth and families have the right to be empowered, educated, and given a decision-making role. **Youth and families** are full participants in service planning, service delivery as well as the program procedures and policy development governing their care.

2. Individualized & Needs-Based. Services and activities are customized, tailored, and guided by an individualized service plan that is comprehensive and based on the unique needs and strengths of the youth and their family.

3. Array of Services & Supports. A comprehensive network of services and supports are readily accessible to youth and families to address the physical, emotional, social, developmental, and educational needs of youth. Clinically appropriate services exist along a continuum of care from early identification and early intervention through transition to adulthood.

4. High Quality. Service delivery incorporates evidence-based, promising, and best practices in meeting the complex needs of youth and families. The rights of youth and families are protected and effective advocacy efforts are promoted.

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. The DC System of Care will continuously develop the capacity of the community to care for its youth and families, maximizing traditional and natural community resources.

6. Cultural Competence. Policies and service delivery will demonstrate respect for the unique and diverse roles, values, beliefs, race, ethnicity, culture and gender of the youth, family, and their community.

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

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[4] Stroul, B., & Friedman, R. (1986). A system of care for children and youth with severe emotional disturbances (Rev. ed.) Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health. Reprinted.

8. Integrated Care. Child-serving agencies will systematically coordinate efforts and blend resources to enhance the availability of traditional services, natural supports, and community resources and to avoid duplication of services and gaps in care. Agencies collaborate to ensure appropriate and clear transitions between levels of care and between youth and adult systems of care.

9. Strengths-Based. Assessments comprehensively identify and services build on the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.

10. Outcomes-Based. Goals and objectives identified in the individualized service plan are clearly understood and measurable, with supports and services helping youth to live with their families, achieve success in school, and avoid delinquency. Outcomes are used to drive decisions to further improve services for youth 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 life.

The Planning Process for the District of Columbia System of Care

Through the collaborative efforts of child and youth serving agencies throughout the District of Columbia, the children's mental health system re-design process will create a coordinated System of Care to provide high quality and evidence-based services and supports to children with severe emotional disturbance and their families. DMH and the CYSD made a concerted effort to utilize a ***public health model of mental health*** in the development of the Children's Plan that ". . . focuses not only on traditional areas of diagnosis, treatment and etiology, but also on epidemiologic surveillance of the health of the population at large, health promotion, disease prevention, and access to and evaluation of services."[5]

During FY 2010, the Child and Youth Services Division (CYSD) moved forward with developing a 3-5 year comprehensive mental health plan (SOC) for children and youth. The intent of which was to develop a plan that addresses the entire gamut of child/youth issues and challenges. There were many objectives of this initiative, including: (1) facilitate the continued development and maintenance of formal cross-agency planning and decision-making processes to support the development of the System of Care; (2) reduce the number of youth in out-of-home residential placements; (3) re-invest the dollars saved to expand the capacity of Wraparound and other community-based services that will support families, children and youth

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[5] Last, J. M., & Wallace, R. B. (Eds.). (1992). *Maxcy-Rosenau-Last public health and preventive medicine* (13th ed.).Norwalk, CT: Appleton and Lange as cited in U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999 at 3.

within their communities; (4) increase the array of services available to the 0-5 population; (5) increase family involvement in all levels of the system; and (6) implement an array of Evidence Based Practices (EBPs).

Multiple child-serving agencies, child advocates and children, youth and families were included in the process. The four (4) planning phases included: 1) development of the process for SOC Plan development (establishment of the Children's Planning Committee/ conducted community strength and needs assessment); 2) research and strategy development (established subcommittee workgroups/conducted environmental scan of currently available community services and supports/ developed subcommittee recommendations and strategies for implementation); 3) developed Children's SOC Draft Plan (synthesized task groups' findings and recommendations/shared draft with System Redesign Workgroup); and 4) presented Children's SOC Draft Plan to stake holders and finalized, (i.e. collected feedback, analyzed and synthesized collected data, revised and finalized the Children's System of Care Plan).

The District of Columbia has made considerable strides over the past three (3) years in building the infrastructure and support required to develop a coordinated System of Care. Specifically, all of the major child/youth serving agencies were actively engaged in joint planning and decision-making activities. These agencies include: the Department of Mental Health (DMH); the Child and Family Services Agency (CFSA); the Department of Youth Rehabilitation Services (DYRS); the District of Columbia Public Schools (DCPS); the Department of Health Care Finance (DC's Medicaid Agency); and the Office of the State Superintendent of Education (OSSE). In addition, DMH was pleased to have the participation of the following agencies in the Children's Planning process: the Department of Human Services/Income Maintenance Administration (DHS/IMA); the Department of Health (DOH); the Addiction Prevention and Recovery Administration (APRA); the Children's Law Center; Psychiatric Institute of Washington, Children's National Medical Center, DC Behavioral Health Association, Beacon Health Services; Total Family Care Coalition; Parent Watch; as well as a whole host of representatives from the mental health core service agencies and collaboratives from which invaluable input was garnered (see Acknowledgements for a complete list of participants). Finally, the dedicated commitment from the Executive Office of the Mayor (EOM) proved to be essential to the support and success of this initiative. As a result of the formation of these strong interagency partnerships and collaborative efforts, the District is now well into the process of developing a comprehensive array of community-based services to support children and youth with serious emotional disturbances and their families.

The CYSD has made substantial progress over the last two years towards its mission and is proud to highlight the following accomplishments. Despite these efforts, there is still much work to be done and the CYSD is committed to forging ahead to continue to address existent system gaps

Program Accomplishments

> Early Childhood Mental Health Consultation (Healthy Futures): This initiative began as a pilot program in FY 2010. DMH partnered with the Department of Health to launch an early childhood mental health consultation pilot program in eight 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.

> Parent Infant Early Childhood Enhancement Program (P.I.E.C.E.): During FY 2010, DMH established the P.I.E.C.E. Program at the children's clinic located in the Anacostia neighborhood. This program serves 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.

> 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.

> 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.

The programs below represent the Department of Mental Health's commitment to an interdisciplinary, District-wide approach to child and youth mental health service delivery:

• School Based 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 public schools (47 public and 11 public 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.

• 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) to expand the network was issued in FY10 and awarded to (2) two additional core service agencies (CSAs).

- PRTF Report-Out- The Department of Mental Health in collaboration with the cross-agency subcommittee, Sub-Committees on Residential Placements (SRP) has been meeting since 2008. We have several accomplishments to report. One, a new Department of Health Care Finance Rule enacted in January of 2010 designates DMH as the Level of Care Agent for the all Medicaid Psychiatric Residential Placement which also includes Continuity of Care in Psychiatric Residential Placements for all MCO placed children. Two, as of March 2010, DMH monitors all Child and Family Services Administration, all DMH and all the Manage Care Youth (MCO) youth placed in PRTF. Three, as of April 2010, DMH has adopted and publish its Psychiatric Residential Treatment Criteria and a uniform referral form for use by all child serving agencies seeking a PRTF Level of Care (LOC) from DMH. (Attach). Four, a central data based has been created to store monitoring reports conducted by all the Child Serving Agencies which allows for immediate sharing of information on PRTFs commonly used by all child serving District Agencies.

- 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. 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.

• 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.

Objectives and Goals

Although DMH/CYSD has made substantial progress over the last three years, there is still much work to be done to develop a well-coordinated System of Care within the District of Columbia. Our ongoing objective is to continue to target and remove existing structural barriers and to create a System of Care for District children and their families that is consistent with CYSD's vision, i.e. that children and families will have easy access to a comprehensive array of services and supports, including Evidence Based and Promising Practices, that are organized into a coordinated, seamless, community-based continuum of care, to meet their multiple and changing needs within their own communities. To this end, DMH continues to focus on the following goals:

- Reduce the current reliance on out-of-home and out-of-state (RTC/PRTF) placements for children and youth with serious emotional, socio-emotional and behavioral challenges.
- Focus on strengthening, supporting and engaging families as partners in the provision of mental health treatment as an alternative to child welfare and juvenile justice placements.
- Create a comprehensive array of community-based services that are accessible, available and culturally appropriate that offer opportunities for early identification and intervention of youth at-risk of out-of home placement.
- Implement evidence-based and promising practice models, care coordination, and individualized team-based service planning embedded in strengths-based foci that build resiliency and take into account the cultural strengths of the District's youth and families.

- Maximize the use of Medicaid and other federal funding programs, District funding, and private sector funding to meet the multiple needs of youth with serious emotional, socio-emotional and behavioral challenges and their families, as well as develop strategies to re-invest funds from out-of-home and out-of-state residential placements to community-based services to address long-term sustainability of the System of Care.
- Develop a new management information system (MIS) to enhance existing evaluation activities and to track outcomes at the clinical, program and cross-system levels. DMH's established Research and Clinical Informatics (RCI) Department will take the lead in this area.

The Children and Youth Services Division Description

The Children and Youth Services Division of the Department of Mental Health (CYSD) is responsible for developing an all inclusive system of care for children, adolescents and their families that promotes prevention/early intervention, continuity of care, diversion from the juvenile justice system and community alternatives to out-of-home as well as residential placements. Child and Youth Services within the authority provides direct school based services, court-ordered assessments and oversight of youth placed in Residential Treatment Centers (RTCs).

CYSD Mission
To develop and implement a coordinated system of care that is community-based, culturally and linguistically competent, family-driven, and youth-guided for children, youth and their families.

CYSD Vision
Children and families will have easy access to a comprehensive array of services and supports, including Evidence Based and Promising Practices, that are organized into a coordinated, seamless, community-based continuum of care, to meet their multiple and changing needs within their own communities.

Planning Committee Recommendations

1. Service Delivery

RECOMMENDATION ONE

Improve the array of children's mental health services.

Over the last two years, DMH has significantly improved the continuum of services offered; however, continuous gaps in the array of mental health services for children still remain. The provision of a full continuum of services is the backbone of a children's mental health system; without these services, children will continue to be unnecessarily hospitalized and placed in other residential facilities. Projects that support community-based services, such as the wraparound pilot, can only succeed if there are indeed a full array of services to which to connect children and youth. DMH must place particular emphasis on strengthening the number of evidenced-based services available to children in DC. Evidenced-based practices are models that have been

proven to be effective when delivered with high fidelity to children who meet specific criteria as indicated in the treatment protocol. DMH will develop a clear plan on how to offer these services.

Services:

1. Outpatient clinics that provide psychotherapy
   a. Increase the number of free standing providers able to provide psychotherapy through the following strategic steps:
      i. Establish the number of children in need of this service
      ii. Explore regulations for provider certification
      iii. Work with the Department of Health Care Finance to establish rates for psychotherapy for fee-for-service children and youth
      iv. Engage Choice Provider Network in discussions to strategize methods for obtaining certification to become a free standing clinic
      v. Identify and address all barriers to implementation
      vi. Provide ongoing support as needed

   b. Identify Choice Provider (s) interested in providing specialized, community-based services for sex offending children and youth through the following strategies:
      i. Explore and establish standards around provider certification for the aforementioned services
      ii. Identify and allocate local funds for the delivery of the aforementioned services
      iii. Identify providers interested in providing these specialty services and engage in discussions re: strategies for implementation

2. Integrated Mental Health/Substance Abuse services for youth with co-occurring disorders
   a. Assess the needs and capacity of DMH providers to serve youth with co-occurring disorders.
   b. Based on evaluation outcomes of capacity analysis (above), partner with APRA to expand services as needed
   c. Develop protocol for direct mental health referrals to APRA/substance abuse services
   d. Cross-train mental health and school-based clinicians to screen and refer to substance abuse services/APRA

3. Mental Health Services for children birth to five years old
   a. Expand system capacity by increasing the core competencies of Core Service Agencies (CSAs) to provide these services through the provision of:
      i. Develop guidelines for implementing identified services
      ii. Provide training and technical assistance
      iii. Provide utilization monitoring and ongoing support to CSAs in the delivery of these services.
      iv. Develop evaluation protocol to measure outcomes

4. Day Treatment

    a. Expand system capacity to meet the day treatment needs of youth between the ages of 5 and 12
    b. Develop system capacity to meet the needs of youth between the ages of 12 and 21
    c. Develop system capacity to meet the needs of youth with developmental disabilities (DD) between the ages of 5 and 21
    d. For a, b and c (above) the following strategies will be employed:
        i. Meet with all CSAs and HSCSN to explore strategies and assess barriers to the expansion of day treatment services to the aforementioned youth populations
        ii. Develop specific strategies to address identified barriers
        iii. Work with interested providers to develop an implementation plan for day treatment programs and provide ongoing technical support as needed
        iv. Identify and address barriers to funding

5. Intensive Day Treatment Programs
    a. Develop system capacity to provide intensive day treatment to youth population through the following strategic steps:
        i. Meet with all CSAs and HSCSN to explore strategies and assess barriers to the development of intensive day treatment programs
        ii. Develop specific strategies to address identified barriers
        iii. Work with interested providers to develop an implementation plan for intensive day treatment programs and provide ongoing support as needed
        iv. Identify and address barriers to funding

6. Psychiatric Residential Crisis Stabilization Unit within the District of Columbia
    a. Establish that this unit will be **short-term only**, for stays up to 90 days maximum
    b. Develop a committee to focus specifically on identifying an agency interested in developing a crisis stabilization unit (above) in the District
    c. Open an informational bidding process for all interested agencies

7. Respite care
    a. Assess current system capacity and community need for respite care
    b. Explore other systems currently providing respite care, e.g. CFSA, DYRS, and other states
    c. Develop utilization criteria
    d. Develop funding strategies

RECOMMENDATION TWO

Develop and/or expand the array of Evidence-Based Practices (EBPs) offered in the District of Columbia.

Evidence-based practices (EBPs) are widely known to produce positive, reliable outcomes through their application in the treatment of specific mental illnesses when delivered with high fidelity. The Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes the need for mental health agencies to identify and implement Evidence Based

Practices to address the performance gap that currently exists between what services are known to produce intended results and what services are currently being delivered.[6] Although the quality of those services may be good, it is widely accepted that the use of EBPs will improve the overall quality of services in any given mental health system.[7] While the District currently offers some EBPs for children, such as Multisystemic Therapy (MST), Wraparound and Early Childhood Mental Health Consultation, it lacks an array, adequate in both number and variety, to meet the complex needs of DC's children, youth and families. Trends in the research indicate that many of DCs kids, like those of other urban areas, may be exposed to multiple risk factors each day that may predispose them to developing mental health disorders. These risk factors include: prenatal damage from exposure to alcohol, illegal drugs, and tobacco; low birth weight; difficult temperament or an inherited predisposition to a mental disorder, as well as external risk factors including exposure to: poverty, deprivation, abuse and neglect, unsatisfactory relationships, parental mental health disorder or traumatic events.[8] Additionally, a number of community characteristics have been shown to contribute to the development of metal disorders for children/youth residing in urban areas: residential instability, poor public services, limited social networks, and community violence. These characteristics have been shown to undermine positive parental behaviors and healthy child development, ultimately leading to the development of emotional problems,[9] such as: depression and anxiety disorders, post-traumatic stress disorder, attention deficit hyperactivity disorder and other behavioral disorders. For these reasons, the committee recommends that the following EBPs, which target the aforementioned disorders and others, be implemented and delivered through the mental health agencies under DMH's oversight.

Strategies/Activities:

1. DMH will employ the following strategies to effectively implement the EBPs listed below that have been identified as necessary and appropriate for DC's population of children and youth:

   a. Establish the number of children in need of EBPs and develop a plan to meet the capacity

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[6] Substance Abuse and Mental Health Services Administration. *Assertive Community Treatment: How to Use the Evidence-Based Practice KITs.* DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, (2008) 1, 2.

[7] Samuels, J., Schudrich, W., & Altschul, D. (2009). *Toolkit for modifying evidence-based practice to increase cultural competence.* Orangeburg, NY: Research Foundation for Mental Health.

[8] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. Chpt. 3, see "Risk Factors."

[9] National Institute Of Mental Health. (2001). *Blueprint For Change. Research On Child And Adolescent Mental Health: Report Of The National Advisory Mental Health Council's Workgroup On Child And Adolescent Mental Health Intervention Development And Deployment*. Washington, DC: U.S. Department Of Health And Human Services.

b. Create rules to integrate each EBP within the current Mental Health Rehabilitative Services System (MHRS) or the free-standing clinic option.
c. Partner with the Department of Health Care Finance (DHCF/Medicaid) to integrate codes within the State Plan in order to obtain/maximize Medicaid funding for each identified EBP.
d. Create a management system to monitor utilization and evaluate outcomes of the implementation of each EBP.
e. Manage and monitor implementation process and evaluate program outcomes on an ongoing basis, addressing and correcting program flaws as they arise.
f. Provide ongoing support, i.e. ongoing training/technical support, as needed to Core Services Agencies (CSAs) based on continuous dialogue and feedback from same.

Evidence-Based Practices:
- Trauma-focused cognitive behavioral therapy (TF-CBT)
- Functional Family Therapy (FFT)
- Parent Child Interaction Therapy (PCIT)
- Child-Parent Psychotherapy for Family Violence (CPP-FV)
- Multisystemic Therapy (MST)
- Transition to Independence Process (TIP)

RECOMMENDATION THREE

Ensure that all children receive services through a specified practice model, emphasizing a coordinated and integrated process that reflects team formation and team functioning.

The purpose of the team formation and team functioning guidelines is to ensure that all children/youth (aged 6-21) who are enrolled in public mental health services in the District of Columbia receive coordinated services that reflect the knowledge and participation of all involved in the child/youth's life.

For the past seven years the Department of Mental Health has contracted with Human Services Organization (HSO) to conduct Community Service Reviews (CSR) on a random sample of youth served by DMH directly or by its contracted private providers. The CSR review is comprised of a comprehensive review of each case in the sample. The review process involves (1) a HSO certified reviewer meeting with staff from any and all agencies (mental health community support worker, psychiatrist, school staff, foster care worker, parent/guardian and others that maybe involved with the youngster) (2) the reviewer writes and compiles documentation on the case and scores both the youth's performance on a number of variables as well as the system's performance. The District of Columbia's System of Care (SOC) for children and youth has consistently scored low on both measures. When the low scores are further evaluated they indicate very poor team formation and team functioning among those responsible for providing services to the child/youth and his/her family. The reviews indicate that all professionals involved in the child's care are neither communication nor collaborating thus leading to treatment decisions being made in a vacuum. If the District's system is to become a high performing System of Care, practice must routinely incorporate collaborative

efforts on the parts of all involved stakeholders as well as family members, i.e. "the team," and must be led by the lead community support worker of the clinical home, operating under strong, qualitative supervision. Treatment decisions must always be child/youth and family-driven, consistent with best practice standards and DMH's guiding principles for care.

The goal of team formation and functioning is to ensure that various individuals involved with the child/youth and family are informed and working collaboratively and that information on a case is gathered from each and every person with knowledge of the child/youth and family and used to inform treatment planning and service delivery.

Strategies/Activities

1. DMH will develop and distribute a system-wide practice model, defined as a model that guides the practice of mental health professionals around planning, providing and evaluating treatment, within six months of the publication of this plan (FY11).
2. DMH will provide system-wide technical assistance and coaching on the implementation of the aforementioned practice model, with particular emphasis on team formation and functioning, as defined through the Team Formation and Functioning Practice Guidelines Protocol drafted by DMH (see Addendum 1).
3. DMH will continue to monitor and evaluate adherence to the Team Guidelines Protocol through periodic, targeted case reviews conducted by the DMH Community Services Review Department, in accordance with the DMH Community Services Review Protocol.

RECOMMENDATION FOUR

Improve the quality of children's mental health services.

The quality of services in the District needs improvement. The timeliness of initial assessments and the subsequent delivery of recommended services are sometimes delayed. Assessments may not always be comprehensive enough to develop appropriate and individualized treatment plans. Some children, after being discharged from the hospital, may not receive follow up services within a reasonable timeframe, i.e. within 7 days, if at all. Barriers that impede access to services must be eliminated and the quality of the treatments provided must be improved. Consumers have a right to expect culturally competent services that are outcomes-based and family-driven, but are not all currently receiving this standard of care.

Ranking among these concerns is the potential over-medication or improper medication administration of children with mental illness, particularly children on Medicaid. Use of psychotropic medications is one of many treatment options that should be considered in treating a child with mental health problems. The effects and side effects of medications should be assessed and tracked by the treating clinician and, subsequently, used to inform ongoing treatment. Use of medication should be coordinated with other aspects of treatment and intervention. National research reveals that children covered under Medicaid are prescribed antipsychotic medication at a rate four times higher than children with private insurance. Children on Medicaid are also more likely to receive drugs for less severe conditions than

middle-class children.[10] Here in DC, the 2009 Consumer Service Review found that 53% of children whose cases were reviewed were prescribed one or more psychotropic medications.[11] In 31% of these cases, the person reviewing the case did not find the medication management to be acceptable.[12] Children may be inappropriately medicated for a variety of reasons: psychiatrists may be making decisions without the benefit of having all pertinent information due to inadequate team functioning that would bear comprehensive patient information, pressure or because alternative services are not available and medication becomes the default treatment option.

Reasons currently abound to explain why children may be inappropriately medicated. Many of these reasons illuminate the inherent, systemic disincentive for best practice standards. For example, psychiatrists may prescribe medications without having a comprehensive patient history/assessment and/or current status report. There may be inadequate communication patterns between treatment team members stemming from dysfunctional team formation and functioning (previously discussed herein). Psychiatrists may be dealing with pressures from school personnel and, consequently, from family members to medicate a child to address problem behaviors when risk of suspension/expulsion looms. Or needed resources to support alternative, non-medication related treatments are lacking. Yet, the predominant factor in the decision to medicate likely results from the pressure of a system that prioritizes and thus demands billing and productivity requirements over safe, standard practices.

Strategies/Activities

1. DMH will ensure that all child mental health providers within its oversight are using appropriate, standardized tools to measure the functional outcomes of the children they are serving.
   a. DMH will select a tool that all DMH child-serving providers must use to measure outcomes, such as: the Child and Adolescent Functioning Assessment Scale (CAFAS),[13] Child and Adolescent Needs/Strengths Assessment (CANS) or the Child Behavior Check List (CBCL). DMH should also consider selecting the Child Global Assessment of Functioning (GAF) tool used in Consumer Service Reviews (required by Dixon) to consider the functional status of each child.[14]
   b. DMH will work engage agency partners in a dialogue to advocate for the adoption of the selected tool as a city-wide initiative.

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[10] Duff Wilson, *Poor Children Likelier to Get Antipsychotics*, New York Times, Dec. 11, 2009.

[11] Human Systems and Outcomes Inc., *2009 Report on Children and Youth Served by the District of Columbia Department of Mental Health,* May 2009 at 20.

[12] Human Systems and Outcomes Inc., *2009 Report on Children and Youth Served by the District of Columbia Department of Mental Health,* May 2009 at 42.

[13] Mental Health Statistics Improvement Program, Child and Adolescent Functional Assessment Scale. www.mhsip.org. See also Christine M. Walrath, David S. Mandell and Philip J. Leaf, *Responses of Children With Different Intake Profiles to Mental Health Treatment,* Psychiatric Services, Vol. 52, No. 2 (Feb. 2001) 196, 198.

[14] Human Systems and Outcomes Inc., *2009 Report on Children and Youth Served by the District of Columbia Department of Mental Health,* May 2009 at 17.

c. DMH will provide the necessary training to all DMH provider staff to utilize this tool.
d. DMH will develop and publish a timeline for development of/selection of this tool and implementation of this recommendation.

2. DMH will ensure that psychiatric services are performed within recommended, best-practice standards.
   a. DMH's child psychiatrists will do an annual analysis of a sample of cases from various child-serving providers to evaluate if, given the child's history, reported symptoms, diagnosis, and current reported behaviors, the child is being prescribed an appropriate medication regimen or not. The psychiatrists will also evaluate whether or not all other appropriate services and interventions, or combinations thereof, were considered and/or implemented before medication was initiated or continued. The psychiatrist will write a report detailing his or her findings. The report will include recommendations for how medication management for children should be improved district-wide.
   b. DMH will ensure that providers are fully informed regarding the process of obtaining informed consent for decisions regarding treatment, especially as it relates to children in the child welfare system.
   c. DMH will produce a written guide for parents/caregivers on psychotropic medication for children (basic information about common medications; questions to ask your doctor; other services to consider in addition to medication).

RECOMMENDATION FIVE

Reduce the number of youth being admitted to Psychiatric Residential Facilities (PRTF) and decrease the length of stay for youth for which PRTF placement is determined to be clinically/medically necessary.

As of November, 2010, there are some 300 District youth residing in psychiatric residential treatment facilities. Currently, DC does not have one streamlined process through which children are placed in these facilities; placement determinations are made and executed by several different DC agencies; namely, DMH (includes DHCF/Medicaid), CFSA, DYRS and DCPS/OSSE, thus making the process disjointed and uncoordinated. Until recently, each agency placed children based on their own criteria and did not consult with DMH about these placements. In April of 2008, the former DC Interagency Collaboration and Services Integration Commission (ICSIC) launched a Sub-Committee on Residential Placements and this group has done significant work to streamline the residential placement process. However, major work remains to be done.

It is extremely detrimental and damaging for children to be institutionalized. At the time of this report, all District youth are placed in PRTFs located outside the District with the majority of those facilities being more than 50 miles away. This is due to a lack of appropriate or available in-state, residential resources; a poor mode of treatment and rehabilitation to begin with. This deficit results in the child/youth being separated from his/her home and natural communities, not to mention the long-term harm resulting from protracted separation from his/her family.

Evidence shows that this isolation impedes youths' clinical treatment and their quality of life.[15] Perhaps most importantly, research shows that PRTFs and RTCs are relatively ineffective in treating adolescents[16] or helping them to reintegrate into their communities once they are released. RTCs are also extremely expensive, costing approximately $300 a day. According to the DC City Administrator, the District spends approximately $61 million per year on RTC placements in both local and federal funds.[17] This money could be better spent on the improvement of existing community-based services and the development of additional, high quality programs; all of which show better long-term outcomes for children and youth through their promotion of home/community-based rehabilitation. This is a significant difference as the child/youth therefore develops the skills needed to function effectively in the community vs. in an institution and is able to improve or develop stronger relationships with family and community members, thus creating a strong supportive network from which to launch.

Strategies/Activities

1. Continue to convene interagency, residential placement workgroup and develop written protocol and guidance around PRTF placement decisions for the District of Columbia
   a. DMH recommends that all PRTF placement decisions are made by one, interagency team, creating a "single point of entry" for PRTF, level of care (LOC) determinations for the District
      i. Determine the most appropriate method by which to formalize this role, e.g. through: the development of a rule, legislation, mayoral order, etc.
2. Ensure that there are appropriate, community-based programs and services to support youth diverted from residential placements in the community
3. Ensure that money saved by diverting youth from residential placements is re-invested in community based mental health services
4. Expand the therapeutic foster care network and improve the quality of the current service
   a. Initiate a discussion with CFSA leadership to develop a formalized role for DMH to partner with CFSA to develop: a clear definition of TFC and TFC guidelines, as well as a framework for providing ongoing training and technical support. Propose the following strategies:
      i. Clearly define therapeutic foster care, i.e. high quality, therapeutic, extensive pre-service and ongoing training supervision and supports, full-time commitment from foster parents
      ii. Partner with CFSA to develop standards and practice protocol for therapeutic foster care
      iii. Provide coaching and specialized training to therapeutic foster care staff, parents and families to best meet the needs of children receiving this service
      iv. Provide ongoing system support to CFSA
      v. Work with CFSA to develop strategies to expand this service beyond CFSA involved consumers, to all children in the District in need

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[15] University Legal Services, Inc. *Out of State, Out of Mind: The Hidden Lives of D.C. Youth in Residential Treatment Centers* (June 22, 2009) at 7.
[16] U.S. Department of Health & Human Services, M*ental Health: A Report of the Surgeon General.*
[17] University Legal Services, Inc. *Out of State, Out of Mind: The Hidden Lives of D.C. Youth in Residential Treatment Centers* (June 22, 2009) at 11.

5. Expand the capacity of the current Wraparound Pilot Program
    a. DMH will ensure the system-wide implementation of the Evidence-Based Practice, Wraparound, a high-fidelity teaming practice model, within the next year (FY11) to children/youth who meet program criteria.
    b. DMH will provide Wraparound training to all relevant, program staff and will continue to provide ongoing training at regular intervals to ensure all new staff is appropriately trained and prepared to implement the model to its fidelity.
    c. DMH will work with CFSA and DYRS to coordinate how these new mental health led teams will integrate with already existing CFSA and DYRS team-based models. DMH will initiate joint policies (or MOUs, if necessary) to clarify how the agencies will work together to ensure efficiency and to remove the burden of families having to be involved in various, concurrent teaming processes.
    d. DMH will work with DHCF to develop and issue a strategic funding plan for the expansion of Wraparound within the next year (FY11).
    e. Explore all feasible Medicaid funding options, including Medicaid 1915(c) and 1115(c) waivers
    f. Explore the possibility of reallocating local dollars to fund the program expansion.
    g. The plan for this initiative will be shared with relevant stakeholders and will be posted on the DMH website.

RECOMMENDATION SIX

Reduce the fragmentation and complication of the children's mental health system in the District of Columbia by carving-out mental health services from Managed Care Organizations (MCOs).

The children's mental health system in DC is fragmented across multiple agencies, resulting in poorly coordinated care, barriers to access, and persistently low utilization. Improving children's access to mental health services and the quality of care requires reforming structural barriers in the D.C. Medicaid program.

To provide a full continuum of care, a provider must credential with between seven to eleven payors.[18] Because most providers only credential with four or fewer payors, families must navigate multiple agencies and providers to obtain a full range of services. When multiple providers treat the same family, strong care coordination is essential. Unfortunately, between 2007 and 2009, at least seven reports identified care coordination as a critical weakness in the District's children's mental health system.[19]

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[18] D.C. Behavioral Health Association, *Towards a True System of Care: Improving Children's Behavioral Health Services in the District of Columbia, Part 2 of 2* (2009).

[19] Human Systems and Outcomes, Inc., "Report on Children and Youth Served by the District of Columbia Department of Mental Health," at p. 55 (2009) (identifies poor coordination); D.C. Behavioral Health Association, "Towards a True System of Care: Improving Children's Behavioral Health Services in the District of Columbia," vol. 2, p. 46 (2009) (expand care coordination); Healthy Families, Thriving Communities Collaborative Council, "Responding to Gang, Crew and Youth Violence in the District of Columbia" at p. 46 (2009) (expand care coordination); RAND Corporation, "Health and Health Care

Despite the District's proliferation of possible payors, it is difficult for children and families to access mental health services, a fact reflected in low utilization rates. As Table 1 illustrates, both adults and children in the District's managed care organizations receive treatment at levels far below anticipated need.[20] More specifically, one recent study found that, among children enrolled in HSCSN, a substantial number of children with mental health diagnoses appeared to have *no* mental health visits; this included 75% of those with an emotional disturbance, 66% of those with pervasive developmental disorders or adjustment disorders, 50% of those with depressive disorder, and 33% of those with mood disorders.[21] The District's experience thus illustrates what national studies have found: that managed care approaches can drive down access to needed behavioral health care.[22]

2009 Mental Health Utilization	Adult	Child
FFS Beneficiaries		
Number of Enrollees	30,562	3,944
Receiving Basic Mental Health	572	546
Receiving Severe Mental Health	12,945	3,024
Subtotal FFS Served	13,517	3,570
Percentage of Enrollees Served	44.2%	90.5%
MCO Beneficiaries		
Number of Enrollees	32,040	72,363
Receiving Basic Mental Health	238	394
Receiving Severe Mental Health	724	1,200
Subtotal MCO Served	962	1,594
Percentage of Enrollees Served	3.0%	2.2%

Among District of Columbia Youth" at pp. 128-29 (2009) (strengthen care coordination); Center for Health and Health Care in Schools, "School Mental Health Service for the Twenty-First Century: Lessons from the D.C. School Mental Health Program"at p. iv (2008) (expand care coordination); D.C. Primary Care Association, "Slipping Through the Cracks: Closing the Gaps in the District's Mental Health System" at p. 17 (2007) (expand care coordination); Office of the Deputy Mayor for Education, "Great Start: A Comprehensive Early Care and Education Plan for the District of Columbia" at pp. 3-5 (2007) (expand care coordination).

[20] Urban Institute, "Access to Children's Mental Health Services under Medicaid" at p. 5 (August 2004) (13.5% of very poor children need mental health services, and most states are able to serve 10% of Medicaid-enrolled children with mental health services).

[21] RAND Health, *Health and Health Care Among District of Columbia Youth*, (2009) at 93. The study did not break down this data for children enrolled in the other Medicaid MCOs and this data does not seem to be otherwise publicly available.

[22] Wood et al, "A multi-method assessment of satisfaction with services in the medical home by parents of children and youth with special health care needs," *Maternal Child Health J*., 13(1):5-17 (Jan. 2009) (parents of children with specialty health needs dissatisfied with care coordination); Michael Tang *et al*, **"**Medicaid Managed Care and the Unmet Need for Mental Health Care Among Children with Special Health Care Needs**,"** *Health Services Research*, Vol. 43, pp. 882-900 (June 2008) (integrated managed care decreases child access to mental health, while carve-outs increase access); U.S. Dept. for Health and Human Services, Office of the Inspector General, "Mandatory Managed Care: Early Lessons Learned By Medicaid Mental Health Programs" (2000) (all surveyed states carved mental health services out of Medicaid managed care systems and created care coordination positions).

Finally, the bifurcated mental health system also disrupts the continuity of care for high-risk children at their most fragile moments. When a child is taken into state custody or re-united with his family, the child's type of insurance switches between managed care and fee-for-service. The disruption in changing a child's type of Medicaid benefits can often lead to disruptions in the child's access to services at this critical time.

Too often children go without services or treatment until a crisis arises. A recent study found that among DC children drawing from fee-for-service Medicaid, 14% of emergency department visits for children ages 7-12 were related to mental illness.[23] Crisis care is extremely disruptive to children and families and also costs the system significantly more than less-intrusive, community-based mental health care.

Strategies/Activities

1. In the event of a carve out:
    a. DMH will partner with the Department of Health Care Finance to assess whether the MCOs' existing capacity of psychiatrists, psychologists, counselors, social workers, and advanced practice registered nurses with a specialty in psychiatry is sufficient to meet the projected need for services among the D.C. Medicaid/MCO population(s). In preparation for the transition of services from the MCOs to DMH, this assessment will also identify:
        i. How many licensed professionals are credentialed to provide mental health services by each MCO network and if additional human resources are necessary to meet the needs of the system; and
        ii. How many children and adults are served annually by each credentialed provider.
    b. The Department of Mental Health will collaborate with the Departments of Health and Health Care Finance to implement:
        i. Extend health professional, loan repayment to mental health professionals to facilitate recruitment of licensed professionals needed to meet the needs of the system
        ii. Conduct a cost analysis and establish new rates for reimbursement for all services transitioning from the MCOs; and
        iii. Ensure that all regulations are modified and in alignment with the transitioned services.

2. Early Identification

RECOMMENDATION SEVEN

Reduce stigma around mental health needs and increase awareness of the importance of social/emotional health of children to encourage access to mental health services.

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[23] RAND Health, *Health and Health Care Among District of Columbia Youth*, (2009) at 84.

". . . . The mental health field is plagued by disparities in the availability of and access to its services. . . . We have allowed stigma and a now unwarranted sense of hopelessness about the opportunities for recovery from mental illness to erect these barriers. It is time to take them down."[24]

Nationally, one in five children from birth to age 18 has a diagnosable mental disorder. One in 10 youth has a serious mental health problem that is severe enough to impair how they function at home, school or in the community.[25] Without early screening and treatment, childhood conditions may persist and lead to a cycle of school failure, poor employment opportunities and poverty. According to The President's New Freedom Commission on Mental Health, "no other illnesses damage so many children so seriously."[26] Yet despite the high need, there is a significant underutilization of mental health services in the District due to problems with, among others, stigma and access. "[Stigma] reduces patients' access to resources and opportunities (e.g., housing, jobs) and leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking, and wanting to pay for, care. In its most overt and egregious form, stigma results in outright discrimination and abuse."[27] Individual and environmental risk factors such as receiving public assistance, having unemployed or teenaged parents or being in the foster care system can increase the likelihood of mental health problems.[28] Nationally, 21% of low income children and youth aged 6 to 17 have mental health problems.[29] In DC, a child is born into poverty every 6 hours. DC has the second highest child poverty rate in the nation – as of 2008, 22.7% of children in the District are poor.[30]

Despite these alarming statistics, research is beginning to demonstrate that negative perceptions about severe mental illness can be lowered by furnishing empirically based information on the association between violence and severe mental illness.[31] Overall approaches to stigma reduction involve programs of advocacy, public education, and contact with persons with mental illness through schools and other societal institutions. [32]

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[24] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999 at preface.

[25] Shannon Stagman & Janice L. Cooper, *Children's Mental Health: What Every Policymaker Should Know,* National Center for Children in Poverty, (April 2010) at 3.

[26] The President's New Freedom Commission on Mental Health, *Final Report to the President* (2003) at 58.

[27] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999 at 6.

[28] Shannon Stagman & Janice L. Cooper, *Children's Mental Health: What Every Policymaker Should Know,* National Center for Children in Poverty, (April 2010) at 3.

[29] Shannon Stagman & Janice L. Cooper, *Children's Mental Health: What Every Policymaker Should Know,* National Center for Children in Poverty, (April 2010) at 3.

[30] Children's Defense Fund, *Children in the District of Columbia* state fact sheet, (November 2008).

[31] Penn, D. L., & Martin, J. (1998). The stigma of severe mental illness: Some potential solutions for a recalcitrant problem. *Psychiatric Quarterly, 69*, 235–247

[32] Corrigan, P. W. & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist, 54,* 765–776.

Strategies/Activities

1. Develop and implement a social marketing and public awareness campaign to build awareness about children's social and emotional well-being and mental health needs. This campaign should have a public health approach and stress prevention and early intervention as well as treatment, collaboration between public and private sectors; close coordination with consumers and other stakeholders; multi-faceted approaches, i.e. public education strategies, consumer to-target-audience; interpersonal contact methods, e.g. dialog meetings and speakers' bureaus.[33]
   a. Special attention should be paid to the mental health needs of young children

   b. DMH should create a task force to develop and launch this campaign and consider how to seek funds for outside contractors, if necessary, as well as other costs.

2. Produce and distribute resources for parents, childcare providers, doctors, schools and others which explain healthy social and emotional development and provide referral information.
3. Develop and distribute a comprehensive, mental health services access guide that is easily accessed and understood by child-serving members of the workforce, parents and caregivers.
4. Ensure that DMH's website is up-to-date and provides all information that is needed to access and navigate through the system, as well as information re: stigma
5. Outreach to and partner with faith communities to promote mental health awareness
   a. Propose representatives from DMH visit faith communities on "5th Sunday months."
6. Partner with African American community-based agencies to promote mental health awareness.

RECOMMENDATION EIGHT

Promote the early identification of mental health problems in children by advocating for early screening as a standard practice through partnerships with other child-serving, government agencies and pediatric practices.

Children and youth with mental health concerns have problems in school, greater involvement in the juvenile justice system, and fewer stable placements and longer-term placements in the child welfare system than their peers. Children with mental health problems are more likely to experience problems in school such as multiple absences, suspension or expulsion, compared to children with other disabilities.[34] In the course of a school year, children with mental health problems may miss as many as 18 to 22 days of school. These children are also more likely to

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[33] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003. (P.24).
[34] Shannon Stagman & Janice L. Cooper, *Children's Mental Health: What Every Policymaker Should Know,* National Center for Children in Poverty, (April 2010) at 4.

drop out or fail out of school – up to 14% of students with mental health problems receive mostly Ds and Fs and up to 44% of them drop out of high school.[35] 50% of children in the child welfare system have mental health problems.[36] 67% of youth in the juvenile justice system have a diagnosable mental health disorder.[37]

Children with mental health conditions are often seen in primary care settings. All children should be seen for well-child visits and these visits are an ideal time for parents to discuss with their pediatrician, any mental health concerns they may have regarding their child. The pediatrician is a good option, as she is likely someone with whom the family already has a relationship and who has the benefit of history with the child. In June 2010, the American Academy of Pediatrics Task Force on Mental Health recommended that pediatricians screen for possible mental health issues at every visit.[38]

Nationally, about half of the care for common mental disorders is delivered in general medical settings and primary care providers prescribe the majority of psychotropic drugs for both children and adults.[39] Especially when there is a known shortage of child psychiatrists and other mental health professionals, pediatricians have a large role to play in addressing mental illnesses; however, there are many challenges in assuring that pediatricians have the skills and knowledge to properly identify and treat mental health concerns and make appropriate referrals. Too often, mental health problems go undiagnosed and untreated in primary care settings. Studies show that children and adolescents and uninsured and low-income patients seen in the public sector are particularly unlikely to receive care for mental disorders.[40]

Early identification of mental health problems is critical. National data shows that early detection and treatment of mental disorders can result in a substantially shorter and less disabling course of illness.[41] Early identification and treatment also decreases the stress and negative outcomes on the child's whole family, decreases the child's penetration further into mental health and other formal systems (child welfare and juvenile justice), and significantly decreases the long term costs of mental health care.

Strategies/Activities

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[35] Shannon Stagman & Janice L. Cooper, *Children's Mental Health: What Every Policymaker Should Know,* National Center for Children in Poverty, (April 2010) at 4.

[36] Shannon Stagman & Janice L. Cooper, *Children's Mental Health: What Every Policymaker Should Know,* National Center for Children in Poverty, (April 2010) at 3.

[37] Shannon Stagman & Janice L. Cooper, *Children's Mental Health: What Every Policymaker Should Know,* National Center for Children in Poverty, (April 2010) at 3.

[38] Shirley S. Wang, *Call for Kids' Mental-Health Checks,* Wall Street Journal, (June 1, 2009).

[39] The President's New Freedom Commission on Mental Health, *Final Report to the President* (2003) at 59. See also Renee Goodwin, Madelyn Gould, et al *Prescription of Psychotropic Mediations to Youths in Office-Based Practices,* Psychiatric Services (August 2001) (a study which found that 84.8% of prescriptions for psychotropic medications were provided by general practitioners or pediatricians); Thomas Reuters, *General Practitioners Write Most Prescriptions for Mental Health Drugs, According to Study from Thomas Reuters and SAMHSA* (Sept 30, 2009) (a press release citing a study by SAMHSA which found that 59% of prescriptions filled for psychotropic medications are written by general practitioners, which include pediatricians).

[40] President's New Freedom Commission on Mental Health, *Final Report to the President* (2003) at 60.

[41] The President's New Freedom Commission on Mental Health, *Final Report to the President* (2003) at 60.

1. Survey the mental health screening tools used by sister agencies/partners and other child-serving professionals in effort to streamline the processes of screening and referral.
   a. Engage and partner with representatives from CFSA, DYRS, DOH, Pediatric Primary Care and DC Primary Care Association to begin discussions.
   b. Partner with the Department of Health and the Pediatric Primary Care provider groups (such as American Academy of Pediatrics and DC Primary Care Association) to advocate for periodic screenings for mental and developmental disorders in all pediatric practices throughout the District as a standard practice, using a clinically sound, formal screening tool.
   c. Convene a work group to investigate whether all insurance companies, public and private, reimburse for these services. The workgroup should include representatives from pediatric provider groups, DHCF, the MCOs and major private insurers.
   d. Educate all providers and stakeholders regarding available programs and services and how to access each.
2. Partner with pediatric primary care provider groups (such as American Academy of Pediatrics and DC Primary Care Association) to:
   a. Provide training sessions on key topics in children's mental health, with a focus on how to screen children and when to refer children to specialists.
   a. Develop a psychiatric referral protocol for children and youth from primary care providers to DMH and its provider network
   b. Determine if DMH and its provider network are inclined to accept faxed referrals and/or referral forms electronically sent from primary providers
   c. Determine the communication flow of DMH and its provider network with primary care providers to ensure coordination of care

RECOMMENDATION NINE

Promote easily accessible, high-quality school-based mental health services for all children in need.

Schools are where children spend a large percentage of their time and mental health is essential to social and emotional developmental as well as learning. There are also important connections between emotional health and school success: children with serious emotional disturbances have the highest rates of school failure – 50% of these students drop out of high school compared to 30% of all students with disabilities.[42]

Providing supportive school environments and appropriate behavioral health services (either within the school, through partnerships or through timely and appropriate referrals to external providers) can improve outcome measures such as decreased rates of suspensions, expulsions and other punitive disciplinary responses; decreased hospitalizations; decreased absenteeism, tardiness, truancy and drop-out rates, and increased time spent on learning, improved test scores and other measures of school success.

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[42] The President's New Freedom Commission on Mental Health, *Final Report to the President* (2003) at 58.

School based mental health is more complex than simply providing individual children with counseling sessions. A robust program involves activities including: group therapy, prevention and positive school culture work, conflict resolution skills, parenting classes and training sessions, crisis management, and consultation and training programs for teachers and other staff.

DMH currently serves 47 District of Columbia Public Schools and 11 Public Charter Schools through its School-Based Mental Health Program. 37 of these schools are Tier 1 and 21 of these schools are Tier 2. Tier 1 schools offer a full time clinician who provides prevention, early intervention and treatment services (less intensive treatment model). Tier 1 schools have a demonstrated need (high utilization) and readiness for the program, and have a student body of at least 200. Tier 2 schools offer a part-time clinician who provides an array of specialized services that may include evidence-based practices such as: Cognitive Behavioral Intervention for Trauma in Schools (CBITS) and Child-Centered Play Therapy. Tier 2 schools also offer prevention programs such as Good Touch/Bad Touch and Too Good for Violence.

During the 2009-2010 school year, the school mental health program conducted:
- 2667 individual therapy sessions
- 946 parent consultations
- 1819 teacher consultations
- 852 classroom observations

Strategies/Activities

1. Continue to serve children in 58 schools. Expand this program into 5-10 additional schools in FY12, targeting those with the highest need.
2. Partner with the MCOs, OSSE, provider communities and DCPS to develop a strategy to meet the unmet mental health needs of children in the public school system, including charter schools.
3. DMH will partner with DCPS and the charter schools to obtain funding to conduct the following analysis:
   a. Assess the need and capacity of all DCPS and charter schools to meet the behavioral health needs of students. Current statistics to include in this assessment include but are not limited to:
      i. The number of school staff employed to do mental health related work (this may include school nurses, social workers, psychologists, etc) and the populations with which these individuals work (are they limited to working only with children on IEPs, for example).
      ii. What other District or outside supports exist within the school with regards to the delivery of mental health services?

RECOMMENDATION TEN

Promote easily accessible, high-quality, early childhood mental health services for all children in need.

Early childhood is a critical age for the onset of emotional and behavioral impairments.[43] Nationwide, many preschoolers are expelled from childcare facilities for disruptive behaviors that often stem from undiagnosed and untreated emotional disorders. Notably, African-American preschoolers are three to five times more likely to be expelled than non-African American children.[44] In DC, 64 % of children under 18 are African-American.[45]

Emerging neuroscience shows how environmental factors shape brain development; therefore early detection, assessment and treatment are critical for young children.[46] Studies have found that mental health consultation in preschools leads to children exhibiting less distributive behaviors and getting suspended less often.

As of May 2010, DMH's Healthy Futures Program, an early childhood mental health consultation initiative for children up to 5 years, is locating early childhood mental health clinicians in 28 child development and head start centers across the District. The program screens for early identification of emotional concerns. In addition, the initiative trains teachers and administrators in effective behavior management techniques, how to access mental health resources, provides crisis intervention services and supports center staff on individual child behavior and classroom management. The program is estimated to serve 600 young children and their families in its first year.

As of summer 2010, DMH is also beginning the Early Childhood Mental Health Treatment Program. The Program will treat infants and toddlers 0-3, preschool and school aged children 5-8 and adolescent mothers and their infants who are at risk for compromised emotional development. The Program will offer a variety of services, including diagnostic assessments, developmental screenings, individual and family therapy, parent psycho-educational groups and consultations. The program's estimated capacity is 80 children within its first six months. It is funded with local dollars.

Strategies/Activities

1. Rigorously evaluate the first year of the Healthy Futures Program
   a. Publish a report on the first year of the program, detailing the numbers of children seen, staff and parents trained and referrals made, as well as its successes and areas for improvement.
   b. If the program is deemed successful in its first year, DMH will seek additional sources of funding to expand the program to additional centers, focusing on high-needs centers in low-income areas where access to mental health services is most difficult.

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[43] The President's New Freedom Commission on Mental Health, *Final Report to the President* (2003) at 57.
[44] Shannon Stagman & Janice L. Cooper, *Children's Mental Health: What Every Policymaker Should Know,* National Center for Children in Poverty, (April 2010) at 3.
[45] Kids Count Data Center, Profile for District of Columbia, Data from 2008.
[46] The President's New Freedom Commission on Mental Health, *Final Report to the President* (2003) at 57.

2. Rigorously evaluate the first year of its Early Childhood Mental Health Treatment Program
    a. Publish a report on the first year of the program, detailing the numbers of children and parents seen (and any gaps or waitlists) and referrals made, as well as its successes and areas for improvement.
    b. If the program is deemed successful in its first year, DMH should seek additional sources of funding to expand the program. DMH should work with DHCF to ensure that Medicaid revenue is being maximized.
3. Collaborate with other District agencies serving young children with disabilities to promote the provision of robust, coordinated mental health services.
    a. Collaborate with the Infant and Toddlers with Disabilities Division at the Office of the State Superintendent for Education (IDEA Part C) to ensure the proper provision of mental health screenings, assessments and treatment. DMH should also consider joint training sessions for clinicians and parents.
    b. Collaborate with Early Stages at the District of Columbia Public Schools to ensure the proper provision of mental health screenings, assessments and treatment. DMH should also consider joint training sessions for clinicians and parents.

3. Accountability and Systems Integration

RECOMMENDATION ELEVEN

Implement a coordinated team based approach to service delivery at all levels of service delivery, from mental health promotion to early intervention to intensive intervention as a framework for best practice for serving children, youth, their families, and communities.

A coordinated approach to service delivery that focuses on implementation of best practice/evidence-based practice at all levels of service delivery is essential to holding all child and youth serving agencies accountable to the greater child serving system. Robust service coordination amongst child serving agencies reduces gaps in access to services and ensures that services received are evidence based and of high quality to meet the needs of the child, youth and family system. (Hurlburt, et al., 2004). Coordination in service delivery yields better clinical outcome for children and prevents adverse mental health and educational outcomes for children. Multi-agency acceptance of a multi-system approach to service delivery is essential to support families receiving needed services. There is a growing body of research that shows that early identification, assessment and intervention of emotional and behavioral problems for children and adolescents can delay or prevent more serious problems, such as academic failure, substance abuse, involvement with juvenile justice, or suicide (Aratani, et al., 2008). Families and youth who receive services from public and private organizations must have service plans that are family driven, youth guided, and culturally and linguistically competent at all levels of service delivery. It is important for all who serve children and families to understand that services cannot be provided in isolation.

Strategies/Activities

1. Develop a common language and definition around multiple levels of service needs so that youngsters with complex service needs are easily identifiable and best practices supporting their needs and goals are clearly articulated to and within whatever child serving system they enter. Such a common language will enable all child serving agencies to know what child/family presentation warrants what level of service coordination including children whose needs require full wraparound services for optimal success.
2. DMH should work with other child serving agencies to identify mutual elements of service delivery and align assessment, documentation and planning processes. An example is the identification of a common screening and assessment tool and procedure that would be used to assess mental health needs of all children and youth entering child welfare, juvenile justice system, etc.
3. Increase collaboration between family support programs, family run organizations and early intervention programs through enhanced outreach activities.
4. DMH to provide training on System of Care (SOC) guiding principles and support agencies in working within this framework.
5. Monitor and collect data on efficacy and fidelity of model. Use this information to identify training needs across stakeholder groups.

RECOMMENDATION TWELVE

By leveraging cross-systems governance structure(s) such as the Statewide Commission on Children, Youth and their Families (SCCYF), DMH will enhance cross systems collaboration and advocate for shared child, family, and system outcomes measures and data to support accountability.

Children, youth and families need the appropriate skills, tools, and services to reach their maximum potential. Many of DC's families have a high level of need resulting in multi-system involvement. The District of Columbia government agencies whose primary missions are to serve children and families must coordinate their work and desired outcomes to yield the maximum results for families. Services available and delivered based on clearly identified needs and resources further improve a child's ability to attain school success, and achieve social and emotional wellbeing. SCCYF represents a major milestone in moving DC government agencies towards an enhanced system integration. Continued collaboration, and increased efforts to move towards integration on the part of all child serving systems, ensures that children and families are served within a seamless system of care. The role of SCCYF should include the development of a clear set of expected/required family and system outcomes. The success of the collaboration is contingent upon policies from various agencies reflecting the same values and principles and directed toward comparable objectives. Partnerships and changes in the relationships amongst stakeholder agencies represents one of the most frequently cited ways that lead state leaders to believe that System of Care principles had infiltrated their service delivery system (Aratani, et al., 2008).

Strategies/Activities

1. Create a subcommittee of State Directors of Child-Serving Agencies and Entities to include: DMH, CFSA, DCPS, DYRS, APRA, OSSE, to encourage unified participation on the part of the same to address issues affecting DC's children. This subcommittee will address the following tasks:
   a. Sign MOUs to facilitate information and data sharing
   b. Meet monthly to resolve system barriers across agencies
   c. Review cross system data outcomes
   d. Address recommendations for system improvements within respective agencies

2. Create a three to five year plan outlining specific a timeline for implementation of the recommendations and strategies of the Children's Mental Health Plan. The plan will incorporate methods of tracking progress and evaluation.
3. Recommend that the commission establish a workgroup to explore opportunities to fund a shared accountability initiative that can identify relevant data and accountability mechanisms to guide decision making and quality improvement at both the system and service delivery level. Reliable and timely information is essential to integrating systems and holding them accountable.
4. Initiate data-sharing memoranda of understanding with sister agencies to facilitate treatment planning and care coordination. The exchange of health-related data across systems is an essential element for care coordination. Appropriate data-sharing agreements need to be in place to protect the privacy of children and families and to ensure that their medical information is handled judiciously and used only for the purpose of providing the most appropriate care (Allen, 2008).
5. Create cluster maps of individual agency priorities to identify shared goals and to develop linkage between agency goals through the Commission
6. Engage in a process-concept mapping to identify system readiness in implementing SOC. Assess for belief in difficulty in implementation and level of importance to identify where more work needs to be done
7. Increase initiatives to improve cross-systems outcomes that advance services for children, youth and families, involved with multiple systems in the district.   The inability to develop and track shared outcomes impedes collaboration across systems.
8. Identify initiatives in other states that have focused on tracking cross-system outcomes in relation to service delivery
9. Increase provider capacity to collect and report data, as well as District level ability to integrate data that is then used to inform policy, training, and planning decision-making.

RECOMMENDATION THIRTEEN

Implement shared data systems based on common elements of information across all child serving agencies that provide real time data.

DC does not currently have a database or other centralized access record whereby one District child serving agencies can interface with one another to facilitate collaboration in assessing

children's needs and planning services to support those needs. These multiple systems between agencies create barriers to exchanging relevant and timely information necessary to effectively plan for children and families. The capacity to share data facilitates coordination of care in services to children and families, accurately measures the true costs of serving a family and accurately measures improvements over time. This, in turn, allows for the development of a more effective and efficient service delivery system. (Division of Children and Families, Office of Planning, 2008) Families are frustrated and children do not receive maximum benefit from the services delivered. Uncoordinated services can compromise the effectiveness of the services or lead to unnecessary disruptions in services. A shared data system will increase accountability amongst families and partnering agencies.

Strategies/Activities

1. Define and measure common element of information that need to be exchanged or aggregated
2. Review and reduce barriers to data sharing, e.g. confidentiality regulations
3. Research the compatibility of systems to share information or make accessible these common data elements in a timely manner
4. Explore software to allow for interagency access to common elements of information with different levels of access relative to roles and responsibilities of people accessing the data
5. Incentivize and ensure multiple child-serving systems can work together towards the development of single treatment/service plans that coordinate services, goals and outcomes.

RECOMMENDATION FOURTEEN

DMH will initiate a dialogue with child serving agencies to create an interagency accountability office or points of contacts that ensure permanent local structures to support cross systems implementation of best practices in the District of Columbia.

Children in child welfare are more likely to be involved in multiple child-serving public systems, such as juvenile justice, public mental health, and special education. Lack of formal communication mechanisms among these agencies impedes the ability to provide coordinated care. Silos in service delivery make the process of accessing services cumbersome for families while at the same time, creating challenges for providers. Child serving agencies overlap with regard to purpose and goals. Interagency accountability encourages partner agencies to blend and develop unified protocols to better serve the children and youth in the District. To enhance the effectiveness of our cross-system infrastructure change will need to occur on the policy and service delivery level. An effective partnership amongst stakeholders can best clarify and address the ways in which policies and practices can be strengthened to support the systems building.

Strategies/Activities

1. Work with agencies to develop teaming protocols for children who are DMH and multi-system involved. This would include APRA, CFSA, DCPS, CSS, DYRS.
2. Initiate Memoranda of Understanding (MOUs) between sister agencies that establish guidelines for shared accountability, responsibility and agree upon expectations to promote "buy-in", i.e. collaboration as DMH moves forward in implementing the Children's Plan.
3. Link information systems and promotion of Evidence Based Programs
4. Review current functional collaborative systems to highlight various strengths of those systems. For example look at program models like the full service school models where all services are delivered collaboratively.
5. Develop a process to better understand the realities of each of the major stakeholders so system change can occur by devising mutually beneficial situations rather than relying on good will alone.

RECOMMENDATION FIFTEEN

Provide on-going, cross-system training and technical assistance to agencies to illustrate methods of System Integration and Accountability design and implementation.

Professionals and families need more education around Systems of Care. Agencies must engage families in a non-judgmental manner. Family strengths and competencies should drive service delivery as much as their needs. Consideration of family needs including cultural and linguistic competencies and family areas for development (fear, literacy, past experience in mental health system, etc) are essential for planning care and successfully delivering services that meet the needs of the child. Families need the appropriate skills, tools, services, and supports to reach their full participation in their care planning. A common language that is easily understood by families needs to be adopted within and across agencies. More effective team planning and problem solving will lead to improved capability to prevent or quickly respond to crisis situations. A common understanding of System of Care allows for buy-in between agencies at all levels and allows parents to participate in all levels of service delivery and planning.

Strategies/Activities

1. Review cross-system training approaches of other state and local jurisdictions with proven evidence of success.
2. DMH will develop and conduct regular trainings, for all child serving agencies. This could include a training video with parent reflections on the Systems of Care process.
3. DMH will recommend that the Commission develop a multi-series training regarding the Accountability and System Integration design and implementation, to include DMH's own quality measurement and accountability components.
4. Develop a procedural guide that is user friendly for families and agencies.
5. Encourage "buy-in" from all other child serving agencies to increase chances of participation in trainings.
6. Research funding opportunities for funding of this training initiative.

4. Family and Youth Engagement

RECOMMENDATION SIXTEEN

DMH will engage with family and youth as partners at all levels of the children's public mental health system, to develop and implement the System of Care in the District of Columbia.

"Not only is family involvement therapeutic for the patient, but it is the key to sustaining continuity of care and providing high-quality care." [47] Research has shown that even minimal engagement of children/youth, family members and natural supports in the treatment process leads to more effective "buy-in" from the family system members, thus promoting longer sustained efforts on the part of those members which ultimately lead to better, long-term outcomes. The New Freedom's Commission on Mental Health (2003) states that,

> ". . . currently . . . parents of children with severe emotional disturbance typically have limited influence over the care they or their children receive. Increasing opportunities for consumers to choose their providers and allowing consumers and families to have greater control over funds spent on their care and supports facilitate personal responsibility, create an economic interest in obtaining and sustaining recovery, and shift the incentives towards a system that promotes learning, self-monitoring, and accountability."[48]

Additionally, Beth Stroul (2002), in her work on the framework of a true system of care, specifies that the families and surrogate families of children with severe emotional disturbance should be full participants in all aspects of the planning and delivery of services.[49] This specification is one of ten requirements within her framework, each defined as essential parts of the whole "System of Care."

Strategies/Activities

1. Increase integration of parents/caregivers of children/youth with serious emotional disturbance (SED) in all decision-making committees, councils and departments of DMH, e.g.:

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[47] Department of Health and Human Services (DHHS). *Report of a Surgeon General's working meeting on the integration of mental health services and primary health care*; 2000 Nov 30–Dec 1; Atlanta, Georgia. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; 2001.

[48] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003. (P. 27).

[49] Stroul, B. (2002). *Issue Brief—System of care: A framework for system reform in children's mental health.* Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health. (p. 4).

a. the Block Grant Council
b. the Partnership Council
c. the Subcommittee on Residential Placement (SRP) Group
d. the Office of Consumer and Family Affairs

2. Increase parent participation as co-trainers in all DMH delivered trainings whenever possible.
3. Increase efforts around the education and training of family organizations, community peer-support partners, family members, youth individuals, child-serving agencies, clinicians and other child-serving professionals in the philosophy and framework of Systems of Care to increase family involvement in all levels of planning and treatment, system-wide.

RECOMMENDATION SEVENTEEN

Facilitate the development of a Family Organization Coalition for the District of Columbia.

Strategies/Activities

1. Partner with the family-run organizations (Family Voices Network, Parent Watch and Total Family Care Coalition) to convene a series of meetings. Assist in the development of the agenda by proposing the following:

      i. Develop a youth and family leadership curriculum
     ii. Develop a strategic plan to recruit, train and hire family leaders
    iii. Identify funding streams to support training costs
     iv. Identify strategies to develop partnerships with other states' family-run organizations

2. DMH will create a formal family advisory committee for the Children's System of Care to inform policy and program development.
3. DMH will create a more formalized, family leadership position in the Office of Consumer Affairs at DMH.
4. Provide technical assistance and coaching to agencies experiencing challenges to fully engaging families in the treatment planning and delivery process.

RECOMMENDATION EIGHTEEN

Ensure that the delivery of services and treatment for children/youth with serious emotional disturbance (SED) in the public mental health care system are truly family-driven, consistent with the guiding principles of the SOC in the District of Columbia.

Strategies/Activities

1. Ensure that family members are primary, decision-making members of the child/youth/family's treatment team.
2. Develop and provide training on Family and Professional Partnerships and the Family Care planning process in partnership with the family organizations to:
   a. members of the Children and Youth Services Division (CYSD)
   b. the Provider Network
   c. parents of children/youth with SED emphasizing;
      i. informed consent and their rights as parents
      ii. necessity of their involvement in their children's treatment
3. Provide targeted trainings in developing successful Family/Professional Partnerships to the Choice Provider Network.
4. DMH will use the Community Services Review (CSR) to measure outcomes of "Family Engagement" throughout the provider network.
5. Partner with the Family Organizations to further develop additional family support partners for the System of Care.

5. Workforce Development

RECOMMENDATION NINETEEN

Continue and expand the role of consumers in the public mental health system.

Strategies/Activities

1. Continue to fund consumer and family operated programs and services such as the Ida Mae Campbell Center, the Consumer Action Network and Total Family Care Coalition, and
2. Fully implement the Medicaid reimbursed peer specialist services program through the Rehabilitation Services program.

RECOMMENDATION TWENTY

Expand workforce development activities to improve the quality of services and the stability of the workforce. These recommendations are consistent with the federal health reform legislation and SAMHSA Strategic Initiative 4 and will be required to implement the above recommendations.

Strategies/Activities

1. Extend health professional, loan repayment to mental health professionals to facilitate recruitment of licensed professionals needed to meet the needs of the system;
2. Implement community support worker certification program to increase the quality of the service and the stability of the workforce, and

3. Implement training and development programs to support the provision of evidence-based practices and changes to the service delivery system.

RECOMMENDATION TWENTY-ONE

Develop and implement outcome measures for all services to ensure that quality services are delivered.

6. Financial Strategies

The co-chairs of the Financial Strategies subcommittee determined early on in the development phase that a different process would be necessary to accomplish its goal: the development of a city-wide grid highlighting both local and federal funding actively being spent on mental health-related activities or that had flexibility to be used for mental health initiatives if repurposed. The findings would then be reviewed to better determine funding streams that could be accessed to fund the recommendations for services and supports coming out of the other subcommittees. As a first step to achieve this goal, the co-chairs of the subcommittee met with financial administrators and directors from other child-serving agencies to ascertain this information, with notable collaboration from our sister agencies. Our Financial Strategies co-chairs and other DMH officials met with representatives from the Department of Human Services/Income Maintenance Administration, the Child and Family Services Administration the Department of Health, the Office of the State Superintendent of Education, the Department of Rehabilitation Services and the DC Public Schools.

CONCLUSION

The District of Columbia Department of Mental Health has made considerable strides over the past three years in building the infrastructure and support required to develop a coordinated system of care. The Children's Plan offers a blue print to build on these accomplishes to develop a robust system of care that provides early intervention, a broad array of evidenced based practices proven to make a difference, expands access, and ensures the participation of families as decision-makers.