

District of Columbia

UNIFORM APPLICATION FY 2009 - STATE PLAN

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

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Center for Mental Health Services
Division of State and Community Systems Development

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane. Rockville. MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

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FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

X **FY2009** **FY 2009-2010** **FY 2009-2011**

STATE NAME: District of Columbia

DUNS #: 14384031

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Mental Health

ORGANIZATIONAL UNIT: Office of the Director

STREET ADDRESS: 64 New York Avenue, NE 4th Floor

CITY: Washington

STATE: DC

ZIP: 20002

TELEPHONE: 202-673-2200

FAX: 202-673-7053

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

NAME: Stephen T. Baron TITLE: Director

AGENCY: Department of Mental Health

ORGANIZATIONAL UNIT: Office of the Director

STREET ADDRESS: 64 New York Avenue, NE 4th Floor

CITY: Washington

STATE: DC

ZIP CODE: 20002

TELEPHONE: 202-673-2200

FAX: 202-673-7053

III. STATE FISCAL YEAR

FROM: 10/01/2008

TO: 09/30/2009

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Anne Sturtz TITLE: Deputy Director, Office of Strategic Planning, Policy & Evaluation

AGENCY: Department of Mental Health

ORGANIZATIONAL UNIT: Office of Strategic Planning, Policy & Evaluation

STREET ADDRESS: 64 New York Avenue, NE 5th Floor

CITY: Washington

STATE: DC

ZIP: 20002

TELEPHONE: 202-671-4074

FAX: 202-673-7053

EMAIL: anne.sturtz@dc.gov

District of Columbia

Executive Summary

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

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

These requirements were operationalized in the Mental Health Service Delivery Reform Act of 2001 under Title I (Department of Mental Health Establishment Amendment Act of 2001) and Title II (Consumer Rights). The District also adopted performance management standards for District agency directors and performance based budgeting. In FY 2009, DMH will be implementing the Management Supervisory Service program for all managers, which also includes performance standards that will be tied to legal requirements and the achievement of the performance levels required to exit the *Dixon* case.

In May 2002, the Transitional Receiver certified to the court that the District had the capacity to implement and was implementing the Final Court-Ordered Plan. The U.S. District Court issued an order terminating the Receivership and appointing the former Transitional Receiver as the Court Monitor and approving agreed upon exit criteria. On December 13, 2003, the U.S. District Court adopted revised agreed upon exit criteria, including measurement methodologies, operational definitions and performance targets, which superseded the agreed upon exit criteria adopted in May 2002. There are a total of nineteen (19) exit criteria, which focus on five general areas: quality, access, specialized services, at-risk populations, and demonstrated efficient use of resources.

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

The main focus for FY 2009 and beyond is the achievement and maintenance of the performance levels established in the December 13, 2003 Consent Order, so that the federal court oversight of the mental health system will no longer be necessary. In July 2008, the Dixon Court Monitor reported data on all seventeen (17) of the quantifiable exit criteria. Sixteen of these seventeen have been verified as to data integrity by both DMH and the Court Monitor. The Court Monitor found that DMH had demonstrated performance on three (3) of the exit criteria at a level sufficient to move to inactive monitoring status in accordance with the terms of the December 2003 Consent Order. DMH has submitted evidence to the Court Monitor of compliance with two (2) additional exit criteria (supported employment and services to homeless children and youth). DMH plans to submit evidence about two (2) more exit criteria (services to homeless adults and consumer satisfaction) by the end of September 2008. The goal is to submit evidence of compliance with at least one (1) additional exit criterion (consumer functioning data) by the end of the calendar year, while demonstrating additional progress with regard to the remaining eleven (11) criteria. Although DMH had not met compliance levels for the remaining exit

criteria, the Court Monitor reported that there has been concerted activity and renewed focused on data integrity and organizational efforts needed to achieve compliance.

DMH continues to struggle with issues relating to data collection and reporting. In January 2008, the RAND Corporation issued phase 1 of its assessment of the District's healthcare system. Phase one provided a detailed analysis of the health status and health care delivery system in the District and included information on the distribution of disease, accessibility of services, utilization and capacity within the system, and the timeliness and quality of care. In June 2008, the RAND Corporation issued the second phase of the report "Assessing Health and Health Care in the District of Columbia." This second report offers guidelines and recommendations for investing tobacco settlement funds in the District's health care infrastructure. Most significantly, the report describes the need for ongoing data collection and analysis to address gaps in data on children's health status, mental illness and substance abuse, which may require additional capital investment. DMH will be working closely with the RAND Corporation to collect the data needed to issue phase three of the report.

In conjunction with the work done on the Dixon data collection and reporting, DMH has also continued its work on the Data Infrastructure Grant. The focus on data collection and data reporting throughout the agency has identified a number of areas that require attention, to ensure the integrity of the data collected. DMH will continue to work on data collection and data reporting in FY 2009. Among other things, DMH will be establishing a unit within the Division of Organizational Development that will focus on data, data collection, data reporting and program evaluation.

In FY 2007, DMH began the process of reviewing the role and governance structure of the D.C. Community Services Agency (DCCSA), as required by both the Final Court-Ordered Plan and the Mental Health Establishment Act. This review will be completed in September 2008. DMH is required by law to submit recommendations about the governance structure for the DCCSA to the City Council by October 1, 2008. A plan for implementation of the governance structure recommendations must be submitted to the City Council by December 31, 2008. Although the plans with regard to the governance structure for the DCCSA are not final as of the date of this application, it is likely that implementation of the recommendations will result in significant changes in the mental health service delivery system. Implementation of the plan will occur throughout FY 2009.

Construction of the new Saint Elizabeths Hospital building was seventy-six (76%) complete as of July 31, 2008. The building is scheduled for occupancy in early 2010. In June 2007, the District negotiated a settlement agreement with the Department of Justice (DOJ) regarding the operation of Saint Elizabeths Hospital. In May 2007, DMH began implementing various initiatives to comply with the requirements of the DOJ settlement and also to obtain Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation when the new hospital opens in 2010. In August 2008, DMH negotiated a corporate integrity agreement with the U.S. Department of Health and Human Services regarding billing practices at Saint Elizabeths Hospital. Both the DOJ settlement agreement and the corporate integrity agreement include a number of requirements regarding the operation of Saint Elizabeths.

DMH will continue to evolve with ongoing stakeholder involvement and input and have as the overall mission to develop, support, and monitor an effective and integrated community-based system of services for persons with identifiable mental health needs. Other initiatives include advancing promising, best and evidence-based practices in service development and delivery to adults, children/youth and families. These include but are not limited to:

1. Supported Housing

The housing strategy is intended to use DMH housing dollars to help leverage housing resources from other agencies – most notably the D.C. Housing Authority (DCHA) and the Dept. of Housing and Community Development (DHCD). In November, 2007, DMH signed an agreement with DHCD to develop 300 affordable housing units for DMH consumers by September, 2009. DMH has transferred \$14 million in capital funds for this effort which will be awarded as grants to developers. These funds will also be leveraged with other local and federal funds to increase affordable housing for low income individuals. There are currently 97 new housing units for DMH in the pipeline.

DMH has also continued to build its partnerships with the DCHA. DMH has multiple MOU's with the DCHA. These MOU's set aside specific federal housing choice vouchers for DMH. The DMH attempts to utilize its limited dollars as "bridge" housing subsidy with the hope that permanent housing vouchers can eventually be accessed. Under either program the consumer pays 30% - 35% of their income for rent.

1. Supported Employment

DMH continues its relationship with the Department of Human Services (DHS) Rehabilitation Services Administration (RSA) to expand opportunities for supported employment services for individuals in recovery from mental illness.

2. Homeless Services

In FY 2007, a contract was awarded to Anchor Mental Health Services, which is part of Catholic Charities, to provide mental health services to people living in homeless shelters. The DMH continues to partner with the addiction treatment and human services systems to operate the Sobering Station (during hypothermia season) for intoxicated men and women who are homeless and refuse a traditional shelter.

DMH launched D.C. SSI/SSDI Outreach, Access and Recovery Services (SOARS). The D.C. SOARS Project attempts to facilitate the acquisition of benefits for individuals who are homeless.

3. Children/Youth Services

DMH continued its partnerships with the Child and Family Services Agency and the Department of Youth Rehabilitation Services. DMH children's services staff has taken the lead in D.C.'s wraparound services initiative, which launched in August 2008. The

wraparound services initiative is funded through blended funds via an MOU signed by DMH, CFSA and DYRS. The contract was executed in June 2008 with a target start date of August 1, 2008. In FY 2009, the wraparound services program will be expanded to include special education students and funded in part by the Office of the State Superintendent of Education.

In August 2008, DMH entered into a contract with Catholic Charities for the provision of mobile crisis response and stabilization services to children. The services include 24/7 mobile crisis response services to children and families who are in the District, including children and youth in foster care placed in homes in Maryland and Virginia. The goal is to stabilize the immediate crisis and avert unnecessary inpatient psychiatric hospitalizations whenever possible, through the utilization of the crisis beds which are accessible only through the mobile crisis response teams. This program will be fully operational in FY 2009.

During FY 2008, DMH proposed a draft Executive Order to establish a common pathway for all PRTF/RTC placements from child-serving agencies in the District. The proposed Commission on Coordination of PRTF/RTC placements (PRTF Commission) would ensure a consistent assessment process as well as ensuring that treatment planning, lengths of stay and discharge planning are appropriately carried out. Although a final decision has not been made regarding the appropriate mechanism for officially establishing the PRTF Commission, all of the child-serving agencies have agreed to the concept of a common pathway for PRTF/RTC admissions.

The School Mental Health Program will be expanded to an additional 10 schools in the 2008 – 2009 school year.

5. Crisis Emergency Services Planning (Adults)

The Crisis/Emergency Planning Work Group was created in February 2007 under the leadership of the Director of DMH. This diverse body included representatives from the court, metropolitan police, emergency medical services, public and private mental health providers, homeless services providers, health, mental health and other agencies, consumers, and advocates. The plan was finalized in December 2007 and recommended the establishment of mobile crisis teams under the direction of the Comprehensive Psychiatric Emergency Program (CPEP). The first team is expected to be operational in FY 2009.

The long awaited renovation of the CPEP building began in July 2007. Phase one of the renovations is scheduled for completion in October 2008. Phase two will commence shortly thereafter. The renovations include construction of eight (8) extended observation beds.

6. Expansion of ACT Services.

DMH retained an expert from the New York State ACT Institute to conduct a fidelity assessment of ACT services. The fidelity assessment was completed in June, July and August 2008. DMH plans to use the results of the fidelity assessment to improve existing ACT services and expand the system capacity to provide ACT.

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2009

I hereby certify that District of Columbia agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

- Subject to Section 1916, the State¹ will expend the grant only for the purpose of:
- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
 - ii. Evaluating programs and services carried out under the plan; and
 - iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms adults with a serious mental illness and children with a severe emotional disturbance and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2008, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

21. The term State shall hereafter be understood to include Territories.

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

(A) Services principally to individuals residing in a defined geographic area (referred to as a service area)

(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.

(C) 24-hour-a-day emergency care services.

(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.

(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;

(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and

(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:

(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and

(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;

(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

- (2) A condition under subsection (a) for a Council is that:
- (A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
 - (B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

- (1) to provide inpatient services;
- (2) to make cash payments to intended recipients of health services;
- (3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
- (4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
- (5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

- (1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
 - (2) the recipients of amounts provided in the grant.
- (b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
- (c) The State will:
- (1) make copies of the reports and audits described in this section available for public inspection within the State; and
 - (2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

- (a) The State will:
- (1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
 - (B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
 - (2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
 - (3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section
- (b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

~~XXXXXX~~
Stephen T. Baron, Director

Date

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about--
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
 Office of Grants Management
 Office of the Assistant Secretary for Management and Budget
 Department of Health and Human Services
 200 Independence Avenue, S.W., Room 517-D
 Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under-

signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children’s services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children’s services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

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

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

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

1. Type of Federal Action: <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. Status of Federal Action <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____
4. Name and Address of Reporting Entity: Prime _____ Subawardee _____ Tier _____, if known: Congressional District, if known: _____		5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, if known: _____
6. Federal Department/Agency: 	7. Federal Program Name/Description: CFDA Number, if applicable: _____	
8. Federal Action Number, if known: 	9. Award Amount, if known: \$ _____	
10. a. Name and Address of Lobbying Entity <i>(if individual, last name, first name, MI):</i> 	b. Individuals Performing Services <i>(including address if different from No. 10a.)</i> <i>(last name, first name, MI):</i> 	
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.		
Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)
Federal Use Only:		

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

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

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age;
- (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

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

District of Columbia

Public Comments on State Plan

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

A copy will be published on the DMH website.

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY X

Federal FY _____

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2007	Estimate/Actual FY 2008
<u>\$6,429,000</u>	<u>\$20,478,592</u>	<u>\$18,570,774</u>

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY X

Federal FY _____

State Expenditures for Mental Health Services

Actual FY 2006	Actual FY 2007	Actual/Estimate FY 2008
<u>\$88,624,509</u>	<u>\$91,322,000</u>	<u>\$96,283,218</u>

MOE Shortfalls

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

(1). Waiver for Extraordinary Economic Conditions

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

(2). Material Compliance

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

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

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Awosika, Samuel O.	Consumers/Survivors/Ex-patients(C/S/X)	DMH/DC CSA, Office of Consumer Affairs	2016 "D" Street, NE, Apt. #2 Washington,DC 20001 PH:202 671-4189 FAX:202 671-1210	samuel.awosika@dc.gov
Bonds, Lorry	State Employees	Housing	1133 North Capitol Street, NE Suite 242 Washington,DC 20002 PH:202-535-2737 FAX:202-535-1102	lbonds@dchousing.org
Carter, Merita E.	State Employees	Other	825 N Capitol Street NE Suite 8116 Washington,DC 20002 PH:202-442-5640 FAX:202-442-5602	merita.carter@k12.dc.us
Daniels, Ted	State Employees	Vocational Rehabilitation	810 First Street, NE 10th Floor Washington,DC 20002 PH:202-442-8419 FAX:202-442-8742	ted.daniels@dc.gov
Galbis, Ricardo	Providers	Andromeda Transcultural Mental Health Center	1843 S Street, NW Washington,DC 20009 PH:202-291-4707 FAX:202-723-4560	galbisb@aol.com
Holliday, Bertha G.	Others(not state employees or providers)		1719 First Street, NW Washington,DC 20001 PH:202-336-6035 FAX:202-336-6040	bholliday@apa.org

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Holt, Maude R.	State Employees	Medicaid	825 North Capitol Street, NE Room 4300 Washington,DC 20002 PH:202-724-7491 FAX:202-478-1397	maude.holt@dc.gov
Jackson, Lauren	Consumers/Survivors/Ex-patients(C/S/X)		4620 Hillside Road, SE Washington,DC 20019 PH:202-582-1258 FAX:	
Lesansky, Henry R.	State Employees	Criminal Justice	1923 Vermont Avenue, NW Suite N121 Washington,DC 20001 PH:202-671-2066 FAX:	henry.lesansky@dc.gov
Massey, Peggy	State Employees	Social Services	64 New York Avenue, NE 6th Floor Washington,DC 20002 PH:202-671-4346 FAX:202-279-7014	peggy.massey@dc.gov
Reaves, Juanita	State Employees	Mental Health	64 New York Avenue, NE 4th Floor Washington,DC 20002 PH:202-673-7597 FAX:202-673-3225	juanita.reaves@dc.gov
Simpson, Senora	Family Members of Children with SED		323 Quackenbos Street, NE Washington,DC 20011 PH:202-529-2134 FAX:	ssimps2100@aol.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Smith, Effie	Consumers/Survivors/Ex-patients(C/S/X)		461 H Street, NW #919 Washington,DC 20001 PH:202-408-1817 FAX:	esmith@can-dc.org
Smith, Lynne M.	Family Members of adults with SMI		921 French Street, NW Washington,DC 20001 PH:202-412-3999 FAX:	lynne.smith@dc.gov
Taymon, Patrick	Consumers/Survivors/Ex-patients(C/S/X)		3005 Bladensburg Road, NE #907 Washington,DC 20018 PH:202-290-3915 FAX:	patrick.tayman@yahoo.com
Wheeler, Burton E.	Others(not state employees or providers)		3800 25th Street, NE Washington,DC 20018 PH:202-468-5607 FAX:202-392-1014	burton.globalbiz@gmail.com

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	16	
Consumers/Survivors/Ex-patients(C/S/X)	4	
Family Members of Children with SED	1	
Family Members of adults with SMI	1	
Vacancies(C/S/X and Family Members)	1	
Others(not state employees or providers)	2	
TOTAL C/S/X, Family Members and Others	8	50.00%
State Employees	7	
Providers	1	
Vacancies	0	
TOTAL State Employees and Providers	8	50.00%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

The individuals listed as family members of children with SED are also family members of adults with SMI but are only counted as family members of children. One individual also has a child/youth with SED.

District of Columbia

Planning Council Charge, Role and Activities

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

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

the role of the Planning Council in improving mental health services within the State.

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

During FY 2008, the District of Columbia State Mental Health Planning Council (D.C. SMHPC) continued initiatives aimed at fulfilling its local and federal mandates. The D.C. SMHPC engaged in a number of activities through its individual members and as a collective body in an effort to improve mental health services for District residents.

Plan Review and Related Activities

The D.C. SMHPC activities related to the review of the FY 2008 Community Mental Health Services Block Grant include:

- The Council implemented the Request for Projects and review process for funding consideration under the FY 2008 Community Mental Health Services Block Grant. The Director of the Department of Mental Health (DMH) approved the Council's recommendations for project funding that included: one (1) non-DMH project for adult consumers with serious mental illness (a weekend day socialization program), three (3) non-DMH projects for children/youth with serious emotional disturbances (an adolescent female forum, mental health services referrals for a youth court, and an arts-based and photography approach to developing positive behavior), one (1) DMH and family member project for children/youth with serious emotional disturbances (self awareness and empowerment teen group), and continuing a set-aside of funding for an Older Adult Initiative and Transition Age Youth Initiative.
- The Council's Interim Chair served as a member of the District's team for the FY 2008 Community Mental Health Services Block Grant Regional Consultative Peer Review held in October 2007 in Newport, Rhode Island. He provided information on the Council's review and comments on the FY 2008 Block Grant and responded to reviewers' questions. The Council was briefed on the review process and issues discussed.
- The Council was briefed on the DMH efforts to develop an Older Adult Targeted Capacity Expansion Grant proposal for persons with serious mental illness and developed a Letter of Support for inclusion in the grant application.
- The Council's Interim Chair attended the ground breaking ceremony for the new Saint Elizabeths Hospital.
- The Council's Interim Chair participated in D.C. Community Services Agency (DC CSA) activities including visit to the Spring Road and Howard Road supported employment programs. He also met with the consultant team to discuss the review of the DC CSA governance structure.
- The Council reviewed the quarterly reports submitted by the FY 2008 Block Grant funded projects.
- A Council member attended the Substance Abuse and Mental Health Services Administration (SAMHSA) 2008 Joint National Conference on the Mental Health Block Grant and National Conference on the Data Infrastructure Grant including attending the pre-Conference Planning and Advisory Councils' meeting.
- The Council initiated a Special Request for Projects in May 2008 in order to fund projects related to Older Adults and Transition Age Youth prior to the end of FY 2008. A total of eight (8) project proposals were reviewed and four (4) were recommended for funding. These included: a transition age youth Transition Resource Guide, a positive approach to maintaining the mental health of Spanish older adults, a senior health and wellness project for individuals who have experienced chronic homelessness, and a workshop series on creative expression for older adults for community reintegration.

- The Council reviewed the request to modify the implementation of the Adolescent Female Forum to Inspire, Respect and Motivate (AFFIRM).
- The Council initiated the Request for Projects for funding consideration under the District's FY 2009 Block Grant. A total of eight (8) proposals were received and 9 initiatives were funded: 1) Peer Health Worker Project (health and wellness program expansion to include two Peer Health Workers), 2) Spanish Senior Center (train mental health promoters to implement 'Mente Positiva'/positive mind Program with peers), 3) FamilyLinks Outreach Center (weekend socialization program), 4) Lens and Pens Creative Expressions (the Arts as a tool for community reintegration), 5) Supportive Housing for Youth, Adults and Families (transition age youth and persons leaving jail), 6) GuidePost (advocacy, outreach and support services for families and children), 7) Youth Trauma Support Program (youth with trauma experience at risk for violent behavior), 8) DMH Child/Youth Program Initiatives, and 9) the D.C. State Mental Health Planning Council. The DMH Director accepted the Council's recommendations and consulted the Council regarding continuation of the family member project.
- The Council will make recommendations for the modifying the District's FY 2008 Block Grant due to the reduction in the federal Block Grant program.

Advocacy Role

The D.C. SMHPC continued to advocate on behalf of children/youth with serious emotional disturbances and their families, as well as adults with serious mental illness. Council members sit on boards and/or are members of organizations that address issues and concerns related to services for children/youth and their families, adult consumers, family members, individuals who are homeless, protection and advocacy issues, health care policy, and others. The D.C. SMHPC has addressed many of these concerns through its review of the Community Mental Health Services Block Grant and other DMH initiatives, and the development of public awareness and education activities through its annual mental health conference.

During FY 2008, as previously referenced under the list of activities, the Council:

- 1) continued to solicit projects for funding consideration under a Special Project Request for Older Adult and Transition Age Youth initiatives during FY 2008 and for the FY 2009 Annual Block Grant Project Request to consumer, family member and community organizations, providers, and others,
- 2) participated in the SAMHSA 2008 Joint Conference and pre-Conference Planning and Advisory Councils' meeting,
- 3) participated in DMH activities and initiatives,
- 4) participated in consumer activities,
- 5) served on DMH advisory bodies and committees,
- 6) developed recommendations to modify the FY 2008 Block Grant due to a federal program budget reduction, and
- 7) submitted a Letter of Support for the DMH Older Adult Targeted Capacity Expansion Grant for persons with serious mental illness.

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

The Council fulfills its role related to participation in system planning and monitoring through member involvement on planning bodies including committees and task forces, and its review and critique of the District's State Mental Health Plan and associated activities. Members serve

on the DMH Partnership Council, child/youth coalitions, family member groups, protection and advocacy, homeless services and other advocacy organizations.

The Council members have participated in a number of DMH planning activities through various forums. These include budget planning and policy development activities through the DMH Partnership Council, development of housing initiatives through the Housing Advisory Committee, review of the Court Monitor reports through the Stakeholders Coalition, conduct of the Adult and Child/Youth Community Services Reviews, and attendance at the DMH Program and Budget Hearings before the District Council.

Public Education Role

During FY 2007, the SMHPC planned convened the Seventh Annual Judge Aubrey E. Robinson, Jr. Memorial Mental Health Conference on September 26, 2007. The theme was "Recovery Through the Ages: Trauma Informed Care." Three panels were convened during this daylong event. They panel topics included: 1) Trauma Knowledge Utilization Project, 2) Service Specific Issues (gender services), and 3) Service Integration Issues (cross agency). District Councilmembers served as moderators for two of the sessions.

The nearly 300 participants included consumers, family members, providers, students, advocates, and others. The annual mental health conference is viewed as a means of advocacy on behalf of children/youth, families and adults, as well as means of public education.

Other Council Activities

The D.C. SMHPC members have also participated in national planning initiatives. These include: 1) attending the Eighteenth Annual Conference on State Mental Health Agency Services Research, Program Evaluation, and Policy (National Association of State Mental Health Program Directors Research Institute, Inc.), and 2) attending the 2008 Joint National Conference on the Mental Health Block Grant and National Conference on the Data Infrastructure Grant.

Directions for FY 2009

During FY 2009, the D.C. SMHPC will continue to more clearly define and strengthen its role relative to system planning, monitoring and evaluation of services and resource allocation in general, and the Community Mental Health Services Block Grant initiatives and funded projects in particular. The Council will also: 1) continue to encourage consumers, family member (serving adults and/or children/youth) and community organizations to submit project proposals for funding consideration under the Block Grant, 2) build its membership including consumer advocate, family members, and various community stakeholders, 3) hold a retreat, and 4) convene the annual mental health conference.

District of Columbia

Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

The Adult Community Service system is comprised of the Mental Health Authority, Saint Elizabeths Hospital, and certified agencies (including both the publicly funded District of Columbia Community Services Agency (DC CSA) and a group of certified private non-profit mental health agencies). Saint Elizabeths Hospital includes both the forensic services of the John Howard Pavilion and the civil hospital. The FY 2009 State Mental Health Plan describes the community-based organizational structure, as it exists today. The emphasis in the current plan is on the objectives to be carried out within the Mental Health Authority related to system development.

1. The Authority

The Mental Health Authority supports the overall administrative mission of the Department of Mental Health (DMH), and encompasses the global functions necessary to support the entire system. The Authority is responsible for establishing priorities and strategic initiatives for DMH, as well as coordinating fiscal services, accountability functions, information systems, and service planning and policy development.

The Authority functions as a regulatory body through which certification will be sought by any provider seeking to provide Mental Health Rehabilitation Services (MHRS). The MHRS program encompasses nine services (four are classified as core services and five as specialty services) provided by DMH-certified community-based providers.

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

The DMH has developed an Access HelpLine that provides 24-hour, 7-day a week access for persons in need of mental health services. Administered as part of the Care Coordination function, this program handles routine requests for services and those requiring both urgent and emergency services. The Access HelpLine provides functions such as enrollment in appropriate DMH services, as well as prior authorization and continuing stay authorization. All these actions are based on consumer choice.

During FY 2008, the Access HelpLine installed a new telephone and reporting system (AVAYA) that went live in June 2008. The training on the system occurred June 23-25 with refresher training in July 2008.

The District originally engaged KPMG to do an overall assessment of DMH's administration of its MHRS system. The August 2006 Report detailed numerous ways for DMH to improve its MHRS programs. Many of these initiatives have been completed. To assist DMH with some of its priority objectives, DMH contracted with KPMG again in early 2007 to provide help in four areas: 1) project management of MHRS improvement initiatives (basically complete, KPMG continues active monitoring on a limited basis for ongoing projects), 2) support for Medicaid-denied claims recovery, 3) movement of Medicaid claims payment to MAA (transition implemented and successfully completed in April 2008), and 4) development of an Administrative Services Organization (ASO) request for proposal. A request for information was disseminated in August 2007. The District Council subsequently advised DMH that the

Mayor and the Council would implement a District-wide ASO function rather than have each agency that bills Medicaid have its own ASO. The DMH efforts to obtain an ASO have been deferred to the District-wide process.

The DMH has also engaged KPMG to do a thorough review of human resources (HR), processes and procedures. This project was initiated in July 2008. In addition, KPMG will review HR policy and underlying regulations with a focus on needed changes. It is anticipated that the overall process will take at least 90 days.

2. Core Service Agencies

The public and private non-profit providers serve as the backbone of the District’s comprehensive, community-based system for providing services to persons with serious mental illness. The objective of a CSA is to create a clinical home for each person receiving DMH services, ensuring a single point of accountability for service delivery. The CSA model ensures that each person has an Individualized Recovery Plan (IRP) that clearly identifies the treatment goal and the services necessary to achieve these goals. This plan and service model is focused on a strengths and rehabilitative approach to each consumer’s recovery.

During FY 2008, DMH began a review of the Mental Health Rehabilitation Services (MHRS) system. The DMH will continually review community needs and provider capacity as the MHRS program is implemented.

In June 2008, 47 agencies were certified as DMH MHRS providers. These agency certifications include:

Core Service Agencies (CSAs)	CSAs also Sub-Providers	CSAs also Specialty Providers	Sub-Providers	Specialty Providers
32	32	12	14	2

D.C. Community Services Agency- The largest of the DMH-certified CSAs is the publicly funded D.C. Community Services Agency (DC CSA), which has been certified as a CSA and Specialty provider. A variety of services are provided to adults in recovery from serious mental illness. In addition to over a dozen community support teams and three assertive community treatment (ACT) teams, some services address special population needs such as older adults, and individuals from multi-lingual and multi-ethnic communities. The DC CSA major accomplishments include the development of a number of protocols (i.e., for forensic populations, acute and long-term care of consumers residing in Saint Elizabeths Hospital, intake at all adult program sites); increased daily attendance at the dually diagnosed day services program; and increased staffing at the mental retardation/developmental disabilities/hearing impaired program.

The major issue for the D.C. CSA continues to be the analysis of alternative service delivery and governance options. The KPMG has been contracted to help DMH manage the assessment and final analysis of options. The work plan for this project shows the completion of the analysis and benchmarking phase by the end of June 2008, with the development of options and

recommendations by mid-August 2008. This process has involved key stakeholders (consumer and other advocates, private providers, unions and D.C. CSA staff).

The KPMG analysis identifies three major factors: 1) whether there is adequate capacity in the community to provide the volume of quality services needed, 2) whether the private sector is willing and able to provide a given service, and 3) whether these services can be provided more efficiently through the private sector. The analysis included a review of key issues including: access to care, clinical and program implications, community needs, personnel implications, legal and regulatory issues, and cost implications. The KPMG and DMH leadership identified five different options (or combinations of options) for future governance and service delivery: 1) continue to operate the CSA, or parts of it, as it is now, 2) transform the CSA into a not-for-profit corporation, 3) transform the CSA into a Public Benefit Corporation (PBC), 4) transfer the delivery of components of the current CSA to private entities through the coordinated transfer of clients, 5) an external private entity would acquire the CSA.

The District Council has included language in the Budget Support Act (BSA) that requires DMH to report to the Council on recommendations for a new governance structure for the D.C. CSA by October 1, 2008. The BSA further requires a plan for implementation by December 31, 2008 and full implementation of the plan by September 30, 2009.

3. Saint Elizabeths Hospital

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

The Acute Care Program currently consists of 92 certified beds (4 units); one unit for all admissions, most of which are stabilized within 14 days; and one unit for patients who require treatment beyond 14 days for stabilization. The Continuing Care Program has 128 beds and provides ongoing psychiatric treatment to a variety of populations, including geriatric, hearing impaired, behavior management, and psychosocial.

The Forensic Services Inpatient Program has 225 beds, as well as an outpatient department that provides treatment and/or monitoring for approximately 105 insanity acquittees on court ordered conditional release in the community. The Forensic inpatient program provides a full range of mental health services to pre and post-trial consumers committed by the Criminal Divisions of the District of Columbia and Federal Courts. The courts control admission to and discharge from the Forensic Program. Services to forensic inpatients include evaluations of competency to stand trial and criminal responsibility; treatment of defendants in need of hospitalization to restore them to competency before trial; treatment of those adjudicated incompetent and unlikely to regain competency in the foreseeable future while awaiting civil commitment; treatment of

consumers found Not Guilty By Reason of Insanity (NGBRI) and committed for inpatient treatment until released by the court.

The Forensic Legal Services Branch provides community-based pre-trial, pre-sentencing, and post-sentencing evaluation and assessment services to individuals residing in the community or at correctional facilities referred by the criminal courts and the District of Columbia's probation and parole authority. The Legal Services Branch also operates field offices in the District of Columbia Courthouse that provide same day competency screenings for both defendants who are detained and on bond.

In keeping with the recovery-based model of care, the Hospital has established an environment of care that primarily allows non-forensic patients to leave their units during the day and receive the majority of treatment at a "treatment mall," and two ward-based geri-malls. This concept promotes community reintegration and assures that all patients are involved in active treatment. The treatment mall provides specialized programming for Geriatrics, Dual Diagnoses, Cognitive Skill Development, Behavioral Management, Psychosocial Rehabilitation, and Acute needs.

The expansion of therapeutic activities in the Forensic Program also was addressed during the fiscal year, in efforts to approximate the over 4,000 hours of active group treatment that is offered in the treatment mall each month. Clinical disciplines increased the amount of active treatment provided patients and nursing staff alone began conducting over 153 additional groups on a weekly basis. In addition, the 2004 initiative to send selected forensic consumers with medium and minimum security classifications who have been difficult to engage in treatment in the maximum security facility to the treatment mall was successful and has continued without interruption. Forensic Services in SEH continues to support the Department's efforts to promote pretrial release of appropriate defendants to community-based case management and treatment by working closely with the CSAs. The Forensic staff's collaboration has helped to facilitate continuity of care for defendant/consumers and their receiving appropriate services in the least restrictive environment. The Forensic Services Pre-trial Branch staff also work closely with the Department of Corrections to ensure continuity of care when defendants are discharged from the John Howard Pavilion and detained.

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

The DOJ letter of April 16, 2008 referenced specific findings of compliance and non-compliance, as well as highlighted four areas that need to be addressed on a priority basis by the time of the next DOJ visit in the Fall 2008. These include: 1) protection from harm and risk management, 2) nursing care, 3) treatment planning and psychiatric care, and 4) behavioral management and psychological care.

The construction of the new 292-bed Hospital at SEH continues with the overall completion at approximately 73% as of June 30, 2008. The planned occupancy is for late 2009 or early 2010.

District of Columbia

Adult - Summary of Areas Previously Identified by State as Needing Attention

Adult - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

See discussion in Adult System Overview, Strengths and Weaknesses, New Developments and Achievements.

District of Columbia

Adult - New Developments and Issues

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

- During FY 2008, the Access HelpLine installed a new telephone and reporting system (AVAYA) that went live in June 2008. The training on the system occurred June 23-25 with refresher training in July 2008. The system will allow better collection and reporting of data about call volume, call response time and abandoned calls.
- DMH engaged KPMG to do a thorough review of human resources (HR), processes and procedures. This project was initiated in July 2008. In addition, KPMG will review HR policy and underlying regulations with a focus on needed changes. It is anticipated that the overall process will take at least 90 days.
- During FY 2008, DMH began a review of the Mental Health Rehabilitation Services (MHRS) system. The DMH will continually review community needs and provider capacity as the MHRS program is implemented. Rates will be increased in FY 2009 for several services – specifically medication/somatic treatment, ACT and counseling as a result of this review process.
- KPMG has been contracted to help DMH manage the assessment and final analysis of governance options for the DCCSA. The development of options and recommendations by mid-August 2008. The District Council has included language in the Budget Support Act (BSA) that requires DMH to report to the Council on recommendations for a new governance structure for the D.C. CSA by October 1, 2008. The BSA further requires a plan for implementation by December 31, 2008 and full implementation of the plan by September 30, 2009.
- In April 2008, the DMH Office of Accountability began a hospital co-morbidity study of consumers with medical and psychiatric diagnoses. The process involves conducting medical chart reviews, on a unit by unit basis, to identify medical care and follow-up for patients with co-morbid mental illness and physical illness. Beginning in September 2008, a quarterly report will be issued summarizing the findings of these chart reviews. Since consumers in inpatient and community settings are presenting more serious health issues, the issue for the hospital is two-fold: 1) can the hospital adequately respond to these health conditions, and 2) if the hospital continues to receive consumers with intensive health needs, what are the supports that will be required. The review process will continue into FY 2009.
- The Office of Accountability revised the process and protocols for conducting retrospective claims audits for all MHRS providers. This was a major focus in FY 2008 and involved considerable work to catch up on prior year audits, enlarge the audit sample for each agency to ensure statistical validity and negotiate clear protocols and agreements with both providers and the Medical Assistance Agency (MAA). The claims audits for prior periods (FY 2005- FY 2007) have been completed and the audits for FY 2008 are in progress. The memorandum of understanding (MOU) between DMH and MAA outlines the process to address failed claims.

- The DMH has created a Compliance Committee, which has membership from key DMH offices (fiscal, legal, human resources, provider relations) and serves in an advisory capacity to the Office of Accountability Director on a variety of compliance issues. As part of the overall compliance process, DMH has now instituted mandatory compliance training for DMH staff including the D.C. CSA. All of the key elements of current compliance issues will be addressed including whistle-blower provisions. The Compliance Committee reviews and recommends on agency-specific issues as these are identified via the auditing process. During FY 2009, DMH will audit providers to evaluate the presence and viability of internal compliance efforts.
- On June 1, 2008 a Compliance Hot Line was instituted by the Office of Accountability for the entire Department of Mental Health. The Hot Line is operated by an independent vendor, and will take reports of suspected fraud, abuse, or unethical behavior by DMH staff or by DMH providers. Callers maintain their anonymity and the information reported is sent directly to the Office of Accountability for investigation. The phone number for the Hot Line has been posted throughout DMH work areas and is also posted on the DMH website.
- Assertive Community Treatment (ACT) Services: During FY 2008, DMH initiated a number of activities related to the ACT program. These include but are not limited to: 1) finalizing the ACT policy in November 2007, 2) establishing an ACT Advisory Committee in January 2008 (will advise on a range of issues including service access, role and functioning of ACT teams, fidelity measurement, etc.), 3) filling the ACT Coordinator position in February 2008, 4) monthly meetings with ACT teams to review progress and discuss common issues, and 5) tracking all requests for ACT admissions, transfers or discharges, resulting in a more accurate data base of active ACT consumers.

The major goals for the remainder of FY 2008 and FY 2009 include: 1) complete a baseline fidelity assessment of all ACT teams being conducted by the National ACT Institute with projected completion by the end of July 2008 with agency-specific training and consultation during FY 2009, 2) initiate Supported Employment as a core service within the ACT teams, 3) increase the census of ACT teams by 25%, and 4) improve the compliance percentage of ACT referrals under the Dixon Exit Criteria.

District of Columbia

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

The FY 2009 Budget Support Act includes the following provisions that are relevant to the Department of Mental Health (DMH):

- Subtitle G, Section 5013 & 5014, Department of Mental Health Funding Allocation Act requires DMH to issue a statement of anticipated funding to each certified MHRs provider at least 30 days prior to the beginning of FY 2009.
- Subtitle I, Section 5017, 5021 & 5022, Reporting Requirements requires the following reports:
 - Report to the Council by January 1, 2009, about the status of the school mental health program including:
 - Status of expanding to 58 schools for the 2008 – 2009 school year
 - Status of efforts to bill Medicaid for school-based services
 - Coordination with other agencies on expansions to school mental health services;
 - Report to the Council by October 1, 2008 about the recommendations for the new governance structure for the DCCSA; and
 - Submit a plan for implementation of the recommendations for the governance of the DCCSA to the Council by December 31, 2008.
- Subtitle P, Sections 5036 & 5037, School Based Mental Health Program requires DMH to enter into a memorandum of understanding with the Office of the State Superintendent of Education for the transfer of at least 1 million dollars from the special education reform *Blackman Jones* settlement to DMH for the expansion of school based mental health services in secondary and tertiary settings.
- Subtitle VIII, Designated Appropriations:
 - \$200,000 to the Birthing Center for parental education and post-partum counseling (Section 8001)
 - \$4,650,000 for school-based mental health services (Section 8004)
 - \$525,000 for the Court-based Urgent Care Clinic at Superior Court (Section 8004)
 - \$5,529,000 for the bridge subsidy program (Section 8004)
 - \$244,000 for the consumer focused activity center (Section 8004)
 - \$3,000,000 for community-based inpatient psychiatric care (Section 8004)
 - \$200,000 to contract with KPMG, LLC for administrative and management projects as needed (Section 8004)

Other provisions that affect DMH are as follows:

- Subtitle F, Sections 5011 & 5012, Closing Mental Health Service Gaps requires the director of the Child and Family Services Agency to prepare a spending plan for the 2.5

million dollars requested in the Mayor's 2009 budget for closing mental health service gaps

- Subtitle F, Sections 5011, 5018 & 5020, Reporting Requirements requires the Department of Health to submit the following two reports:
 - Report to the Council by October 1, 2008, regarding the status of the Health Professional Recruiting Program, including the number of participants delineated by health profession, period of service and service obligation site; number of applicants to date, names of all acceptable service locations in the District and balance and to-date expenditures from the Health Professional Recruitment Fund
 - Report to the Council by October 1, 2008, regarding the efforts to maximize allowable Medicaid reimbursement revenue for health and mental health services provided as part of school-based programs.

- Subtitle N, Sections 5032 & 5033, Health Professional Recruitment Program is amended:
 - to include nurses, nurse practitioners, dental hygienists, clinical social workers, clinical psychologists, professional counselors or physician assistants and has completed any required post-graduate training
 - by changing the definition of service obligation site to include any Department of Mental Health program, any other site designated by the Director of DOH or any nonprofit entity located in a Health Professional Shortage Area or a Medically Underserved Area within the District that provides primary care, mental health or dental services to a District resident regardless of ability to pay

- Subtitle Q, Sections 5038 & 5039, Assistance Form Standardization requires all District government assistance applications to require the applicant to state whether he or she is a veteran and provide contact information for the District's Office of Veteran's Affairs. Each District agency is required to forward information about an applicant's veteran status to the Office of Veteran's Affairs.

District of Columbia

Adult - Description of Regional Resources

Adult - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

The District of Columbia currently directly operates the DC CSA, the Comprehensive Psychiatric Emergency Program (CPEP) and Saint Elizabeths Hospital. All three programs provide direct services to children and youth. The DCCSA provides MHRS services, CPEP provides site-based emergency services (and will begin providing mobile crisis services during FY 09) and Saint Elizabeths Hospital serves as the state psychiatric program for the District.

Most services are provided by a network of community-based providers. A current list of providers is included in Appendix A. In addition, inpatient hospital services are provided by two community-based hospitals. PRTF services are provided by a number of out-of-state programs, since there are currently no PRTFs operating in the District.

District of Columbia

Adult - Description of State Agency's Leadership

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

The DMH Office of Homeless Services works closely with community providers to identify appropriate services for consumers and other individuals who reside on street corners, in abandoned vehicles and buildings, in low-barrier shelters, transitional programs, and other temporary residences. It also includes working with housed individuals in terms of crisis intervention and homeless prevention. These services are directed toward single adults as well as adults in families, and children. The outreach and other services are provided in collaboration with DMH programs, District agencies and community providers.

The staff include a Homeless Services Coordinator, a psychiatrist, a team leader, and seven (7) mental health specialists along with a number of part-time staff who assist with the Sobering Station during the winter. All staff members are trained in trauma, cultural competence, co-occurring issues and crisis services.

The Office of Homeless Services, Homeless Outreach Program (HOP) is a mobile linkage and crisis program for individuals who are homeless and non-homeless. The HOP provides interim case management to unlinked or poorly-linked consumers. In conjunction with family members, peers, community providers, and other available contacts, HOP provides linkages to crisis and long-term mental health services while respecting the wishes of the consumer.

The primary services include regular outreach visits to streets and numerous liaison sites (including single and family shelters, meal programs, drop-in programs and emergency programs), linkage with the D.C. Linkage Plus program (jail diversion and persons formerly incarcerated), and operating the Sobering Station. After initial encounters, the team provides engagement, risk assessments, material assistance, referrals, linkages, benefit and housing applications, travelers' assistance for stranded consumers with mental illness, crisis intervention, and access to overnight shelter services. The HOP makes over 2,000 contacts annually to over 900 different persons who are homeless.

The HOP also sponsors a monthly *Emergency Rounds* meeting to review the status of high-risk individuals who are mentally ill and homeless. Attendees at this meeting include street outreach programs such as First Helping, Downtown Services Collaborative/BID/Pathways outreach program, Georgetown Ministries, Capitol Hill Group Ministries, Salvation Army, United Planning Organization, the Washington Legal Clinic for the Homeless, and other homeless providers. This meeting is facilitated by the HOP psychiatrist and provides an additional opportunity to consult and support "front-line" staff working directly with the target population. This model has been accepted to be presented as an "Innovative Program" at the American Psychiatric Association's annual conference on community psychiatry held in October 2008 in Chicago.

The HOP also provides outreach, assessments and linkages to non-homeless individuals upon request from property managers, Adult Protective Services (APS), Child and Family Services (CFSA), private social workers, and concerned citizens. These activities allow individuals with or without a mental illness to stabilize and form a social support network to avoid falling into homelessness. In addition, HOP has worked closely with low-income housing facilities to link formerly homeless individuals with mental illness to support the goal of homeless prevention.

A number of program expansions occurred during FY 2007-2008. These include:

- Metropolitan Police Department (MPD) Pilot and Expansion- The HOP, in conjunction with MPD and the Office of Unified Communications (OUC), developed a short-term plan pilot project. It involved MPD officers in Police Service Area 101 (downtown area) identifying individuals who were homeless and mentally ill and in need of linkages to mental health services, contact the OUC to dispatch the HOP for on-site assessments and services. This pilot project operated from June through September 2007.

This project was modified and expanded to include Police Service Area 501 and included weekly walk-arounds by the HOP and the Police to make referrals to the team. In addition, attention is given to various Focused Improvement Areas (FIAs), zones of high-crime incidence, which are receiving dedicated and integrated localized involvement by various government agencies.

- Expanded Outreach Services in Overnight Shelter- In FY 2007 DMH entered into a memorandum of understanding (MOU) with the Department of Human Services (DHS) to provide mental health services in the Franklin Shelter (a large emergency shelter). The DMH began providing services under contract with a mental health provider in August 2007.

As part of this project, the HOP team received funding to do additional homeless outreach. Five (5) individual contractors were identified to work in specific shelters. These additional contractors provided services up to 20 hours per week at the following shelters: Adam's Place, Harriet Tubman Shelter, John Young Shelter, New York Avenue Shelter, and 801 East Shelter. The services included counseling, referrals to mental health agencies, financial and medical benefits, healthcare and support attending appointments.

- Expanded Evening Coverage- The HOP team expanded the number of individuals working in the evening as well as the number of liaison sites covered during that time. The HOP team was "on-call" during the hypothermia season from 9 pm through midnight for handling and staffing emergency calls. In order to be proactive and reduce the incidence of problems, the HOP team began calling a large array of service providers each morning to determine whether or not their staff experienced concerns with consumers during the overnight shift; this would provide an opportunity for communication and potential action to alleviate a future crisis.
- Shelter Plus Care- Since Fall 2007, the HOP has been assisting the District in facilitating supportive housing with the Shelter Plus Care (S+C) program. The HOP psychiatrist has been working closely with The Community Partnership for the Prevention of Homelessness to review applications for individuals seeking housing in conjunction with receiving mental health services. Those individuals found to have a sufficient mental health diagnosis are certified to receive care. The larger HOP team also has played an instrumental role in helping numerous existing S+C participants (individuals and especially families) re-establish mental health services.

- Expanded Day Socialization Services- In December 2008, DMH selected a new contractor to provide expanded day services to individuals who are mentally ill and homeless. The agency that provides this service is Catholic Charities at the Hermano Pedro Day Program.
- Fire and Emergency Medical Services (F/EMS)- The HOP, as part of a broader crisis/emergency planning process that DMH implemented with the community, discussed with F/EMS increasing its capacity to provide crisis assessments and interventions to individuals who may be experiencing a mental health crisis. This project is being spearheaded by the HOP psychiatrist. The activities involved in capacity development include: developing training modules, certifying F/EMS staff as Officer Agents (crisis/emergency services admission through CPEP), providing cross-training opportunities to HOP and F/EMS employees and ongoing technical assistance to F/EMS.
- Saint Elizabeths Hospital Psychiatry Residency Training Program and Homeless Services Placements- The Office of Homeless Services works with the Saint Elizabeths Hospital Psychiatry Residency Program to provide six to nine (6-9) placements for psychiatry residents to receive training in homeless programs. These placements involve 2-3 hours per week of direct contact with individuals who are mentally ill and homeless. The psychiatry residents provide assessments and link consumers to mental health services and provide consultation to the homeless programs on effective strategies in working with this target population.

In FY 2008, there were two classes of Psychiatry Residents (13) placed in shelters and outreach programs; with each being integrated into the broader work of the entire HOP team. Two (2) residents served as junior attending psychiatrists on wards at Saint Elizabeths Hospital. The HOP psychiatrist met with each class on a weekly basis to consult and supervise the services the residents provide.

- Enhanced Outreach Services to Children and Youth who are Homeless or At Risk of Homelessness- In January 2008, HOP hired a staff member who has expertise in children with serious emotional disturbances; he has been assigned to visit shelters serving children, youth and families who are homeless and also works with families at risk of becoming homeless. Duties include the assessment and linkage of children and youth to appropriate mental health services.
- SSI Training for Homeless Services and Mental Health Providers- Many adults who are homeless, particularly those who are chronically homeless and have mental illness and/or other disabilities, do not receive Social Security Administration benefits. The DC SSI/SSDI Outreach, Access and Recovery Services (D.C. SOARS) Project attempts to facilitate the acquisition of benefits for these individuals. This project began in FY 2007 and is overseen by the DMH Director of Homeless Services. A four day train-the-trainer model was implemented followed by a District-wide two day planning meeting. Training for approximately 25 providers was held in FY 2007 and follow-up telephone surveys with these providers suggested the training was viewed as helpful in filing an increased number of disability applications for individuals who are homeless and disabled. Data is not available

on how many applications were filed and approved. Additional expedited SSI training is being planned during FY 2009 that will include critical elements of the SOARS training.

Several other initiatives and/or other activities occurred during FY 2008. These include:

- Projects for Assistance in Transition from Homelessness (PATH) Grant- The Homeless Services Coordinator continued to implement the PATH Grant activities. This role also involves annual development of the grant application and provision of programmatic data to the federal PATH Program. The total grant is \$300,000 and requires a \$100,000 match from DMH. The PATH funds pay for homeless outreach services. In addition, funds are used for one time only security deposits and to prevent consumer evictions.
- Interagency Council on Homelessness (ICH)- The ICH is an inter-agency planning body for homelessness, housing, and various emergency services. Comprised of government, not-for-profit organizations, advocates, and consumers, the ICH is becoming an important platform for debate and point of advisory input for the Mayor. The Office of Homeless Services is present at all of the full meetings and has frequently participated in various working groups and the implementation of public meetings. The Office also coordinates with the Director of DMH on these matters. In addition, members of the HOP team often are present at public meetings to assist consumers in need of guidance and referral.
- Outreach Focus Group (OFG)- The OFG is a consortium of homeless outreach and direct service programs that work with street-bound and vulnerable individuals who are homeless. Through their work as “front-line” workers, the group is able to identify problems in the system needing an immediate or strategic response. A member of the HOP team plays a leadership role on the OFG and provides the basis for productive advocacy and coordination.
- Homeless Services Planning- Weekly meetings during the Fall 2007, with the DMH Homeless Services Coordinator, Directors of Human Services and Addiction Prevention and Recovery Administration, and the City Administrator’s office to discuss strategies to transform the homeless services delivery system.
- Encampment Area Services- The collaboration between the HOP team and the Department of Human Services DHS to house individuals residing along the I-395 corridor. This project included obtaining identification information, service need, linkage to social services, and assistance with coordinating relocation activities.
- Sobering Station- The Office of Homeless Services continued to operate the Sobering Station (during hypothermia season) for intoxicated men and women who either refuse or are unable to handle the structure of a traditional shelter. Since the program’s inception in FY 2002 through FY 2006, approximately 1,078 different individuals came to the Sobering Station (unduplicated count per year), with about 194 entering detoxification services. During FY 2007, 206 different men and women were served at the Sobering Station, offering over 900 bed nights of service. At least 10 people entered detoxification services. In FY 2008, 185 different men and women were served, with 374 bed nights, and about 12 going into detoxification. The winter of 2008 was mild and another shelter opened in close proximity to the Sobering Station, which probably contributed to the reduced numbers served.

- Training and Educational Activities- The Homeless Services staff conducted a number of trainings on working with individuals who are homeless and mentally ill for a variety of staff that include but are not limited to: shelter security staff, lawyers/guardians D.C. Bar Association, social workers in government agencies, persons approved to become Officer Agents (a person who can file an application for involuntary psychiatric assessment), and staff in the DMH Office of Programs and Policy (adult and child/youth programs, care coordinators, provider relations, forensic, housing, employment, disaster mental health).

Housing- First Pathways to Housing D.C. Homeless Services

Pathways to Housing D.C. was founded in 2004 to serve Washington, D.C.'s homeless population. The model supports housing first and offers persons who are experiencing homelessness and living with serious and persistent mental illnesses immediate access to an apartment of their own, because that is what they want, without requiring participation in treatment or sobriety.

Pathways to Housing D.C. separates housing from other services. It treats homelessness by providing people with individual apartments, and then treats other needs by providing intensive and individualized support through the Assertive Community Treatment (ACT) team that seek out and actively works with individuals as long as they need, in order to address their emotional, psychiatric, medical and human needs, and on a twenty-four hour, seven-day-a-week basis. In the Pathways to Housing D.C. program, clients lose their housing the same way any tenant loses housing: not paying their bills; running a drug den; acts of violence; creating disturbances intolerable to neighbors; or other violations of a standard lease.

Since opening in 2004, Pathways D.C. has housed 140 formerly homeless individuals. In July 2008, there were 175 people receiving ACT services.

Downtown D.C. Business Improvement District Homeless Services

The Downtown Business Improvement District (DBID), Downtown Services Collective Street Outreach Program is unique in the District. The staff include master-level social workers and psychologists who provide on site clinical assessments and case management. The program is supported by over 100 Safety and Maintenance (SAM) workers who are trained to observe and report homeless issues to the Outreach Team. There are 12 SAMs specially trained in engaging and triaging the needs of homeless individuals. The partnerships include: DMH Homeless Outreach Program, Pathways to Housing D.C., Core Service Agencies, District agencies, homeless services programs, hospitals, nursing homes, and local and federal security agencies. The program provides education and information for property owners, property managers, businesses, and concerned citizens about the issues of homelessness. It also provides strategies for homeless consumer crisis intervention, and on-site crisis de-escalation and interventions.

Some of the reported program outcomes from March 2007 to March 2008 include: 234 persons were able to shower, receive clothing and food; 208 received monitoring, assessment and engagement; 158 were referred to service providers; 78 were connected with their CSA; 60 were

housed in permanent housing; 49 received ID cards, birth certificates and Social Security cards; 43 received Travelers' aid; 36 were connected to substance abuse programs; 37 received representative payee, Spanish case management, and Metro Disability Transportation services; 31 were connected to Income Maintenance; 30 were engaged who had encamped in front of buildings, in building recesses, on sidewalks, in the parks, around parking meters; and 85 refused all services.

District of Columbia

Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

The establishment of the Department of Mental Health (DMH) marked a major milestone in efforts aimed at restructuring mental health services for children/youth and families in the District of Columbia. The termination of the Receivership and transition to a Court-appointed Monitor was accompanied by the development of Exit Criteria and Operational Definitions that included the assessment of the scope and efficacy of the child/youth service delivery system. Achieving satisfactory scores on the Exit Criteria measures will provide not only a baseline for quality improvement, but officially end the Court's decades-long oversight of the delivery system.

The District of Columbia has invested significant resources in the children's System of Care and important collaborations between child-serving agencies have been launched. These collaborations have now evolved into solid partnerships with all of the child-serving agencies: child welfare (the Child and Family Services Agency or CFSA); juvenile justice (the Department of Youth Rehabilitation Services or DYRS), special education (the Office of the State Superintendent of Education or OSSE), the public school system (the District of Columbia Public School System or DCPS) and the family court.

All of the child serving agencies are working together to solve problems and plan for the evolution of the system of care. The Mayor and senior city officials maintain a high focus on children's well being, which means that children's mental health remains a priority for the Executive and the City Council in the annual budget appropriations cycle. Oversight of the child system of care is primarily handled through the newly established Interagency Collaboration and Services Integration Commission (ICSIC). ICSIC is a twenty-five (25) member group that includes the directors of each of the District's child-serving agencies, including the Director of DMH. ICSIC is led by the Mayor and focuses on the needs of at-risk children by reducing juvenile and family violence and promoting social and emotional skills among children and youth through the oversight of a comprehensive integrated service delivery system. ICSIC is organized around six (6) city-wide goals, that requires the District to work across agency boundaries and with community partners to align critical supports and services for children, youth, and their families. ICSIC meets monthly to discuss data relating to one of the six (6) goals and discuss how agencies can collaborate to address the needs of children, youth, and their families around the six goals.

DMH has completed its federally-funded SAMHSA Systems of Care (SOC) grant. While the SOC grant did not achieve its original goals, it has helped to build a foundation for future development. The Family Team Conference (FTC) model is one of the major legacies of the SOC grant. This model has been fully embraced by DMH, DYRS and CFSA. The requirement is for family participation and full cross-agency participation for all children who are fee-for-service Medicaid with multiple complex needs and being considered for out-of-home placement. This model has been in place since October 1, 2006. Children who are diverted from psychiatric residential treatment facilities (PRTF's) (approximately 50%) are then monitored for up to a year.

Reforming the current children's mental health system represents a sound investment in the future. DMH has worked collaboratively with CFSA to comply with the

requirements of the settlement of the *LaShawn A.* case. The 2007 *LaShawn A., et al. vs. Fenty, et al.* Amended Implementation Plan (AIP) built on the progress of the DMH SOC pilot through the blending of funding for a range of additional services and supports. As a result, there has been increased interagency collaboration among all DC child-serving agencies from the direct services to the policy on improving children's mental health into a seamless, comprehensive system of care.

This plan provides a clear direction for the future, while building on previous and ongoing efforts to improve this critically needed and very complex system of care. The call for reform began with motivation and a desire to ease the personal pain and challenges the children and families face in the District and has brought advocates, services providers and government level policymakers together to address this complex issue. Foremost among the challenges faced by families under the current system is a lack of access to treatment for their children.

The DMH School Mental Health Program (SMHP), housed in the Division of Child/Youth Services in the Office of Programs and Policy, offers a comprehensive array of services to children and youth enrolled in the public schools and their families. The SMHP assigns one qualified mental health provider to District public schools selected in collaboration with DCPS. Generally, selected schools represent those schools with poor academic outcomes, high truancy and high rates of social-emotional disturbance; have a functional Student Support Team (SST) and supportive leadership.

In each school, the clinician works collaboratively with the school's mental health providers, such as the school counselor and psychologist, to offer prevention and early intervention services and less intensive, brief treatment for students and families. Services include mental health screening, focused behavioral and emotional assessments, consultation, teacher and administrator training, evidence-based prevention and early intervention programs, and limited case management. Local evaluation offers empirical evidence on the value of school-based interventions in D.C. schools.

District of Columbia

Child - Summary of Areas Previously Identified by State as Needing Attention

Child - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

The *Dixon* Court Monitor conducts an annual Community Services Review (CSR) to assess overall system performance as well as performance of key domains of service including consumer functioning and consumer satisfaction. *Dixon* requires DMH to achieve an overall system performance score of 80% in both adult and child services to exit the Court Ordered Plan. The 2008 CSR revealed large gaps in the children's system of care, particularly around team formation. The Child and Family Services Agency's Quality Services Review (a similar system assessment tool), likewise reflects real need for improvement in this domain. The score for the 2008 CSR was 36% of cases reviewed in the acceptable range, far short of the *Dixon* requirement.

Although DMH began to address practice model and model fidelity issues in FY 2007, there is more work to be done. In 2008, the children's division staff has directed resources toward training, coaching and related support to begin to embed the child/family team model in the community. However, further work remains to be done in FY 2009. This work includes:

- an increase in the rates for children's services, in an effort to attract more qualified providers to the public mental health service system;
- establishing an internal CSR unit to facilitate training and use of the practice model for service delivery.

District of Columbia

Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

1. New Children Crisis Service:

On June 12, 2008, DMH awarded the contract for children's mobile crisis and crisis stabilization services to Anchor Mental Health of Catholic Charities. This is one of the child welfare initiatives required by the *LaShawn A.* AIP. This new children's crisis service is intended to significantly reduce the multiple foster care placement disruptions, particularly those that are the result of avoidable acute care hospitalization. The service will also be provided to all District children and youth and also services foster care children residing in Maryland and Virginia; including performing involuntary commitments as necessary.

2. DC Choices High-Fidelity Wraparound Pilot:

DMH CYSD in collaboration with CFSA and DYRS developed the Wraparound implementation Work Group whose work led to the release of the Wraparound RFP. In June 2008, Choices Inc. out of Indiana was awarded the DC Choices Wraparound contract to implement community-bases alternative services for District youth at risk for or returning from an out of home RTC placement and for youth who have experienced multiple placements and /or hospitalizations. This initiative is funded by intra-district

3. DMH's Participation in Interagency Collaboration and Services Integration Commission (ICSIC)

ICSIC is a twenty-five (25) member Commission aligned around six citywide goals, which outline the District of Columbia's commitment that children and youth make successful transitions from birth to adulthood. The Director of DMH serves on ICSIC, which is the platform for establishing a common process for all child-serving agencies to use to place children and youth in PRTFs.

4. Hiring New Child/Youth Services Division Director.

DMH is has hired a CYSD Director. She is expected to start work in late September 2008.

5. Reimbursement Rate Enhancement.

DMH, with the help of a consultant is currently working on a rate study to analyze the MHRS rates in an effort to enhance the rates for MHRS services, particularly Community Support, CBI, and Psychiatrist services rates for children and youth. A rate increase is expected to take effect on November 1, 2008.

6. Establishment of Internal CSR Capacity.

DMH is establishing a CSR unit within the Division of Organizational Development. The CSR unit will focus on supporting practice model implementation across DMH. The initial focus will be children's services, since the 2008 CSR identified some significant problems in the implementation of the system of care practice model.

District of Columbia

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

The FY 2009 Budget Support Act includes the following provisions that are relevant to the Department of Mental Health (DMH):

- Subtitle G, Section 5013 & 5014, Department of Mental Health Funding Allocation Act requires DMH to issue a statement of anticipated funding to each certified MHRs provider at least 30 days prior to the beginning of FY 2009.
- Subtitle I, Section 5017, 5021 & 5022, Reporting Requirements requires the following reports:
 - Report to the Council by January 1, 2009, about the status of the school mental health program including:
 - Status of expanding to 58 schools for the 2008 – 2009 school year
 - Status of efforts to bill Medicaid for school-based services
 - Coordination with other agencies on expansions to school mental health services;
 - Report to the Council by October 1, 2008 about the recommendations for the new governance structure for the DCCSA; and
 - Submit a plan for implementation of the recommendations for the governance of the DCCSA to the Council by December 31, 2008.
- Subtitle P, Sections 5036 & 5037, School Based Mental Health Program requires DMH to enter into a memorandum of understanding with the Office of the State Superintendent of Education for the transfer of at least 1 million dollars from the special education reform *Blackman Jones* settlement to DMH for the expansion of school based mental health services in secondary and tertiary settings.
- Subtitle VIII, Designated Appropriations:
 - \$200,000 to the Birthing Center for parental education and post-partum counseling (Section 8001)
 - \$4,650,000 for school-based mental health services (Section 8004)
 - \$525,000 for the Court-based Urgent Care Clinic at Superior Court (Section 8004)
 - \$5,529,000 for the bridge subsidy program (Section 8004)
 - \$244,000 for the consumer focused activity center (Section 8004)
 - \$3,000,000 for community-based inpatient psychiatric care (Section 8004)
 - \$200,000 to contract with KPMG, LLC for administrative and management projects as needed (Section 8004)

Other provisions that affect DMH are as follows:

- Subtitle F, Sections 5011 & 5012, Closing Mental Health Service Gaps requires the director of the Child and Family Services Agency to prepare a spending plan for the 2.5

million dollars requested in the Mayor's 2009 budget for closing mental health service gaps

- Subtitle F, Sections 5011, 5018 & 5020, Reporting Requirements requires the Department of Health to submit the following two reports:
 - Report to the Council by October 1, 2008, regarding the status of the Health Professional Recruiting Program, including the number of participants delineated by health profession, period of service and service obligation site; number of applicants to date, names of all acceptable service locations in the District and balance and to-date expenditures from the Health Professional Recruitment Fund
 - Report to the Council by October 1, 2008, regarding the efforts to maximize allowable Medicaid reimbursement revenue for health and mental health services provided as part of school-based programs.

- Subtitle N, Sections 5032 & 5033, Health Professional Recruitment Program is amended:
 - to include nurses, nurse practitioners, dental hygienists, clinical social workers, clinical psychologists, professional counselors or physician assistants and has completed any required post- graduate training
 - by changing the definition of service obligation site to include any Department of Mental Health program, any other site designated by the Director of DOH or any nonprofit entity located in a Health Professional Shortage Area or a Medically Underserved Area within the District that provides primary care, mental health or dental services to a District resident regardless of ability to pay

- Subtitle Q, Sections 5038 & 5039, Assistance Form Standardization requires all District government assistance applications to require the applicant to state whether he or she is a veteran and provide contact information for the District's Office of Veteran's Affairs. Each District agency is required to forward information about an applicant's veteran status to the Office of Veteran's Affairs.

District of Columbia

Child - Description of Regional Resources

Child - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

The District of Columbia currently directly operates the DC CSA and the school mental health program. Both programs provide direct services to children and youth. The DCCSA provides MHRS services, while the school-based mental health program provides primarily early intervention and prevention services, as well as linking children to community-based providers for more intensive services.

Most services are provided by a network of community-based providers. A current list of providers is included in Appendix A. In addition, inpatient hospital services are provided by two community-based hospitals. PRTF services are provided by a number of out-of-state programs, since there are currently no PRTFs operating in the District.

District of Columbia

Child - Description of State Agency's Leadership

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

The DMH has the key leadership role in the design and development of the District's System of Care (SOC), working with and through a network of formal and informal collaborations with D.C. child-serving agencies, children's advocates, community-based organizations that promote improved services for children and families and providers that deliver services. In FY 2009, focus areas for child/youth services include, implementation of the child wraparound initiative, continued hosting of the Children's Roundtable, implementation of the proposed Commission on Coordination of PRTF/RTC placements, implementation of the children's mobile crisis and stabilization services, continued expansion of the School Mental Health program and quality improvement and competence building of the delivery system, with particular attention on core competencies for a child welfare population, including trauma assessment and treatment, intensive home and community services and behavioral coaching.

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

DMH continues to host a bi-monthly Children's Roundtable, whose members consist of children's providers, behavioral health leads of the MCOs and child-serving agency designees, with a focused purpose, which is: drill down into operational processes; eliminate barriers to services; clarifying misperceptions between and among agencies, providers and consumers; share factual information; and produce streamlined, understandable processes that mean children and families are more likely to get the services they need when they need them. Determining that detained DYRS youth could maintain Medicaid eligibility and DMH's identification of local dollar funding mechanism for team meetings and non Medicaid eligible services at DYRS are outcomes of the Roundtable's work.

Currently DMH and CFSA collaborate on all PRTF assessments and placements. Parallel placements occur via DCPS, DYRS, and the Medicaid Managed Care Organizations (MCOs). In FY 2007, the Mayor assumed responsibility for directly overseeing DCPS, through school reform legislation. The school reform legislation established the Interagency Collaboration and Services Integration Commission (ICSIC), a twenty-five (25) member Commission aligned around six citywide goals, which outline the District of Columbia's commitment that children and youth make successful transitions from birth to adulthood. The Director of DMH serves on ICSIC. DMH, through ICSIC proposed establishing a Unified Residential Treatment Placement Commission (RTPC) to provide a common pathway for placing all District children in PRTFs. All of the child-serving agencies have agreed to the concept of the RTPC, although the final details of implementation are still being resolved.

District of Columbia

Adult - Service System's Strengths and Weaknesses

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

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

System Strengths

The DMH adult service system strengths include but are not limited to the following:

- Wellness and Resource Center- The DMH has awarded the Ida Mae Campbell Foundation a \$1.2 million dollar contract over five years to open and operate a community based wellness and resource center for mental health advocacy, work skills training and leadership development. The Ida Mae Campbell Wellness and Resource Center will be run by consumers, called Peer Specialists, and will be open to all individuals who want to participate in peer-supported activities regardless of participation in psychiatric treatment or involvement with traditional case management. The founder and Executive Director of the Center, has a wealth of experience as a direct provider of services and manager of mental health programs. She is a self-advocate and has been involved with the District's Peer Recovery Movement since 2003. The ceremonial opening of the Wellness and Resource Center was held on June 25, 2008.
- Court Urgent Care Clinic- The DMH issued a request for proposals (RFP) for a Court Urgent Care Clinic (CUCC) to be located at the D.C. Superior Court. This service is to provide easy access to people in contact with the court system who need mental health services. The goal is to provide on-site mental health evaluations and referrals for individuals coming before the court on a variety of charges. The contract was awarded to the Psychiatric Institute of Washington (PIW) and began operations on June 23, 2008.
- Evidenced-Based Practices- The DMH is implementing evidenced-based practices related to supported employment, supported housing, medication algorithms, integration of mental health and substance abuse services, and assertive community treatment for persons being discharged from Saint Elizabeths Hospital, being released or diverted from jails and prisons, high users of emergency services, and chronically homeless individuals.
- Supported Employment- During FY 2008 DMH added another supported employment provider and increased the unit rate to provide the service. The DMH also implemented a social marketing plan during FY 2008 to educate clinicians, case workers and consumers about the availability of supported employment services. It includes outreach to providers and consumers, promoting supported employment services through speaking engagements, training for providers and consumers, and development of an ongoing article in a local advocacy group newsletter.
- Supported Housing- The DMH has utilized a number of strategies in order to develop affordable housing options for consumers. These include partnerships with a housing intermediary, the D.C. Housing Authority (administers housing subsidy program), and the acquisition of property. The current goal is to develop, in collaboration with the D.C. Department of Housing and Community Development (via a FY 2008 memorandum of

understanding), 100 affordable housing units per year through FY 2009 with DMH capital funds. Other initiatives during FY 2008 include: developing Draft Housing Rules (public review during the summer), developing Consumer Briefings to begin during the summer (focus on housing rights and responsibilities, housing maintenance, being a good neighbor), working with the Medical Assistance Administration on the District's Money Follows the Person Grant, continuing the implementation of the Long Term Supports and Housing Grant (focuses on persons with mental illness and mental retardation/ developmental disabilities, and transition age youth), and continuing the MyHouse Project (uses mediation in effort to prevent eviction).

- Assertive Community Treatment (ACT)- The activities during FY 2008 include: the development of an ACT Policy, the appointment of an ACT Coordinator, and the establishment of an ACT Steering Committee. One of the major activities in FY 2008 is the conduct of a fidelity assessment for each of the ACT providers and training. This process began in June 2008.
- Newer Generation Antipsychotic Medication- The DMH implemented the Medication Access Project (D.C .MAP) for adults with schizophrenia. The goal is that 70% of these consumers will be prescribed newer generation medications. In 2007, the Court Monitor agreed with DMH that the Department had achieved this goal. The DMH will continue to monitor this process and is also working with the Medical Assistance Administration (MAA) to monitor prescribing practices associated with psychotropic drugs.
- Co-Occurring Disorders- The District's Co-Occurring Disorders State Incentive Grant (COSIG) establishes collaboration between DMH and the Department of Health/Addiction Prevention and Recovery Administration (APRA) with the goal of creating an integrated approach to service delivery where there is "no wrong door" to appropriate treatment for individuals with co-occurring mental illness and substance use disorders in the public mental health and addictions treatment system.

Four operational objectives identify the key areas of COSIG focus where actions are taken to drive systems change: 1) system supports for integrated service_delivery, 2) universal screening for co-occurring disorders, 3. expand workforce_competencies in co-occurring disorders, and 4) system incentives and infrastructure support for continued improvement of co-occurring disorder consumer outcomes.

A promising practice related to co-occurring substance abuse disorder involves provision of mental health services at the Sobering Station (operated during hypothermia season) for intoxicated men and women who refuse a traditional shelter. From the program's inception in FY 2002 through FY 2006, approximately 1,078 different individuals came to the Sobering Station (unduplicated count per year), with about 194 entering detoxification. During 2007, the unduplicated number of persons served was 206 with over 900 bed nights of service and at least 10 persons entering detoxification services. The unduplicated count for persons served during FY 2008 is 185 with 374 bed nights and 12 persons entering detoxification. Two factors contribute to reduced numbers of persons served and bed nights of service in FY 2008: 1) a

shelter for men was opened in the same service area as the Sobering Station (which serves mostly men), and 2) there was a very mild winter.

- Jail Diversion- The DMH Jail Diversion Initiative is a pre-trial program for individuals with mental health issues that have committed misdemeanor offenses and are provided services through the Options Program (post booking). In 2007, DMH along with the Criminal Justice Coordinating Council (CJCC) became the recipient of a \$50,000 BJA planning grant to develop a strategic plan for persons with serious and persistent mental illness or co-occurring mental health and substance abuse disorders involved in the criminal justice system. The DMH, CJCC and the CJCC Substance Abuse Treatment and Mental Health Services Integration Taskforce completed the planning effort (based on the Sequential Intercept Model) and distributed the 2009-2015 Strategic Plan for Persons with Serious and Persistent Mental Illness or Co-Occurring Mental Health and Substance Use Disorders Involved in the Criminal Justice System in the District of Columbia in January 2008. DMH and the CJCC will continue to work with the judicial system, local and federal stakeholders to implement the strategic plan.
- Offender Re-Entry Program- There is a newly established Mayor's Office on Ex-Offender Affairs. The DMH participates in this District-wide initiative for serious, violent offenders between the ages of 18-35 who are returning from the Federal Bureau of Prisons by providing assessment and referral to appropriate mental health services. DMH has a Mental Health Coordinator at the assessment service site to provide the mental health services and accept D.C. Linkage Plus referrals from Court Services and Supervision Agency (CSOSA) and the Bureau of Prisons.
- Chronic Homelessness- The DMH is using the "Housing First" model to serve individuals who are chronically homeless through the Pathways to Housing DC Assertive Community Treatment teams. Pathways of New York City is serving as a mentor for Pathways DC by providing technical assistance. Since its inception in 2004, Pathways has housed 140 individuals and 175 are receiving ACT services.

In FY 2005, the project was awarded a two-year HUD Chronic Inebriates Grant with a goal of providing housing to 36 individuals who are chronically homeless, and addicted to alcohol. Permanent status for these 36 units was included in the District's HUD SuperNOFA application. Pathways' funding for these 36 units of permanent supportive housing was renewed under the 2007 HUD SuperNOFA continuum process.

- Other Homeless Services- During FY 2008, DMH in collaboration with the D.C. Department of Human Services funded site based mental health services at the largest men's shelter that had the fewest support services. Also, DMH funded a drop-in day socialization program for persons who are homeless to facilitate case finding, referral and linkage to the mental health system.
- Crisis/Emergency Services Planning Work Group- In February 2007, DMH launched this 10-month initiative to develop a plan for a centralized, community-based system for providing coordinated crisis emergency services to people requiring emergency psychiatric

care. The initial work group included representatives from the Metropolitan Police Department (MPD), Fire and Emergency Services (FEMS), the Department of Health, Addiction Prevention and Recovery Administration, the Office of Unified Communications, the D.C. Superior Court, the two crisis bed providers, community providers, advocates and consumers. The Final Report was disseminated in December 2007 with implementation of the plan throughout FY 2008.

- Medically Compromised Consumers Planning Meeting- In June 2007, DMH initiated an interagency planning meeting to discuss issues and concerns related to an increasing number of consumers with medical needs that make it difficult to place and/or maintain them in community settings. The first meeting targeted the Department of Health's Medical Assistance Administration and HIV/AIDS Administration, and the Department of Disability Services. The participants were expanded to include public and private health and mental health providers, aging and advocacy agencies. Initial discussions focused on the Medicaid waiver programs, the number of consumers with medical issues, and billing strategies under the DMH Mental Health Rehabilitation Services program. A DMH work group met at the end of FY 2007 and a DMH and provider work group continued to meet during FY 2008. A set of recommendations will be developed by the end of FY 2008.
- Transition Age Youth Planning Initiative- In August 2007, the DMH Divisions of Child/Youth Services and Adult Services met with the Child and Family Services Agency (CFSA) to begin a dialogue about how the two agencies could work collaboratively to more effectively plan for the service needs of youth transitioning from the child to the adult system of care. During FY 2008 DMH child and adult staff leadership continued to meet. One result of this collaboration was the funding of the development of a transition age youth Transition Resource Guide as part of a Special Projects Request with Mental Health Block Grant funds.
- Mental Health Rehabilitation Services (MHRS) Implementation- The DMH has begun a review of the MHRS program. This review will involve many core policy issues including but not limited to: basic eligibility, services array, quality measurement and reimbursement strategies. It is anticipated that the MHRS review will take six (6) to nine (9) months to complete.

System Weaknesses

The Final Court-Ordered Plan provided the blueprint for the reformed mental health system. This new service delivery system would require a new organizational structure, service philosophy and assumptions, funding mechanisms, and infrastructure. In short, the District's mental health system has undergone a major paradigm shift.

The DMH continues to mature as a service delivery system and continues to experience growing pains. It is this evolutionary state that contributes to most of the system weaknesses, as both public and private providers learn their roles in the new system, and the infrastructure to support the system design is developed. The structure is in place and the providers are moving toward providing the services required by the new system.

Some of the system weaknesses are related to implementation of the MHRS program and other DMH initiatives. These include but are not limited to:

- Information Technology (IT)- The development of an adequate information system has been one of the major challenges for DMH since its inception. While significant progress has been made at Saint Elizabeths Hospital with the AVATAR IT system scheduled to “go live” in July 2008 and the past development of the D.C. Community Services Agency (DC CSA) Anasazi system, the DMH Authority programs do not have an integrated data system. This has caused these programs to create their own databases. The DMH needs to improve the information system to provide greater reporting of client related data including tracking of client outcomes, and client movement across service systems (i.e., consumer’s utilization of community hospitals and other services).
- Services Array- Providers have found the current services array under the MHRS program is limited in being able to provide flexible services that meet the unique needs of a given consumer.
- ACT Services- Some of the issues related to the implementation of the ACT services include: overall capacity, referral to ACT teams, and fidelity to the ACT model.
- Priority Populations- DMH has found that the provider system needs to be more focused on priority populations. The results of the Annual Community Services Reviews have shown that services are equally provided to persons with the least and greatest need. Additionally, the services should reflect major initiatives (jail diversion, homelessness, school-based, in-home services for youth, services for transition age youth, housing, supported employment, ACT, etc).
- Supported Employment- DMH would like to increase the supported employment service capacity and effectiveness so that more consumers can be served.
- Homeless Services- Two of the primary service issues are coordination of care among DMH providers within the adult system of care and housing availability for chronically street-bound consumers.

District of Columbia

Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

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

Consumer Satisfaction

A. Mental Health Statistics Improvement Program (MHSIP) Surveys

- 2008 MHSIP Surveys- A contract was let to a family member organization to conduct the 2008 MHSIP Surveys. Training on the survey process was conducted by the Principal Investigator for the Data Infrastructure Grant (DIG) during July 2008. The surveys will be conducted and the results reported in the 2008 Progress Implementation Report.
- 2007 MHSIP Surveys- The DMH completed the 2007 MHSIP Surveys that were conducted by a consumer-run organization. Three separate nationally-normed instruments were used- the MHSIP (adults), the ROSI (supplemental survey for adults) and the YSS-F (children and youth). All of the surveys were conducted by telephone during the late Summer and Fall of 2007.

The findings for the Adult MSHIP Survey across the five domains (access to services, quality and appropriateness, outcomes, participation in treatment, general satisfaction) show: 1) the location, staff availability, service times and the extent of services received were rated at 90 or above, 2) the respondents indicated that they felt free to complain (91) and that staff encouraged them to take responsibility for how they lived their lives (92), 3) the respondents rated at 90 percent and above that they are better able to deal more effectively with their problems, better able to take control of their lives, and are getting along better with their families, 4) the respondents reported they had a voice in deciding their treatment goals (90), and 5) the respondents reported a high level of satisfaction regarding services they received within the D.C. Mental Health System for 2007.

B. Consumer Action Network Consumer Satisfaction Methods

The Consumer Action Network (CAN) method for assessing consumer satisfaction involves conducting focus groups and convenience sampling. The consumer satisfaction survey was conducted during May- July 2008. A draft of findings was circulated at the beginning of August 2008.

The CAN Consumer Satisfaction Survey goal was to obtain data from 400 adult consumers and 125 child consumers and their families for a total of 525 survey participants. The actual data collection included 521 adult consumers and 74 child consumers and their families, for a total of 595 survey participants.

The demographic data for the sample of adult consumers show the following characteristics: 1) 84% were Black, 11% White, and 5% were in the Hispanic/Asian category, 2) there were nearly equal numbers of males and females, and 3) the majority were between the ages of 18

and 50. The program affiliation for these consumers included: Core Service Agency (226), Housing Program (116), Day Treatment (94), Employment Program (39), Homeless Shelter (23), and Hospital (23).

Some of the findings related to agency and housing satisfaction is briefly described.

- Agency Satisfaction- Most adult consumers expressed satisfaction with their Core Service Agency (CSA), with only 23% expressing any disagreement..
- Case Management and Treatment Team Meetings- Consumers indicated that at least their case managers meet with them regularly and not always including doctors and other team members. Thirty-nine (39%) of the sample said that they meet with their treatment teams at least once a week, and nearly 15% said that they meet with their treatment teams less than one time a month.
- Community Support Worker Helpfulness in Resolving Issues- A majority of the adult consumers agree that the Community Support Worker has been helpful to them in resolving important issues, while 14% disagree.
- Housing Satisfaction- The living arrangements included: community residential facilities, family/independent, supported independent living, and shelters. Satisfaction with housing varied, while a majority of the adult consumers expressed satisfaction with their current housing, a good portion said they strongly disagreed that they have the type of housing that they need.

C. Community Services Reviews

The Annual Adult Community Services Reviews (CSR) provides another data source for assessing unmet service needs and system gaps. The Year 6 (2008) of the Adult CSR was conducted during June 2008. The total number of cases reviewed was 88, which was the target for statistically acceptable numbers. The Year 6 results show that 74% of the cases reviewed were in the acceptable range for individual consumer status and that system performance was also at 74%.

District of Columbia

Adult - Plans to Address Unmet Needs

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

Establish Choice Provider Network:

DMH is moving expeditiously to finalize awards for the vendors selected as Choice providers; while simultaneously crafting creative ways to establish base funding for these providers to have flexibility in crafting services that fit the needs of children and families served.

Enhance Services Array:

DMH and CFSA recognizes in the need for an enhanced service array for children and youth. Combined efforts of the MHRS Steering Committee, Wraparound Implementation Work Group, the PRTF Commission and the multi-year plan out of the CFSA Funding Workgroup and being assessed collectively in effort to increase and improved the services array for Children and Youth in the District of Columbia.

Reimbursement Rate Enhancement:

DMH, with the help of a consultant is currently working on a rate study to analyze the MHRS rates in an effort to enhance the rates for MHRS services, particularly Community Support, CBI, and Psychiatrist services rates for children and youth.

District of Columbia

Adult - Recent Significant Achievements

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

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

Co-Occurring Disorders

The DMH has continued its national “best practice” model for the planning and delivery of integrated services for persons with both mental illness and substance abuse. The DMH and Addiction Prevention and Recovery Administration (APRA) continue to provide joint support of this federally-funded effort through the Co-Occurring State Incentive Grant (CO-SIG). This grant project is now in its third year. The progress on the four major objectives are as follows: 1) System Supports for Integrated Service Delivery- The focus is on aligning both agencies rules, policies and processes to promote an integrated “no wrong door” model. A key cross-agency initiative is the Youth Work Group, which has identified a significant funding source for youth (EPSDT) and is working to engage, train and certify local providers to serve co-occurring youth. 2) Universal Screening -Both DMH and APRA have now adapted standards that require all consumers seeking service to be screened for co-occurring disorders. Given the historic issues of under-identification of co-occurring disorder (COD), this is a major step forward. 3) Expand Workforce Competencies in COD- The DMH has developed a comprehensive 100-hour training program which certifies its graduates. This training manual will soon be available in final form to DMH, APRA and community agencies either as a comprehensive training package or for specific modules. The training effort for clinical staff has been ongoing over the past 1 ½ years and is on track to meet its goal of training 150 professionals by August 2008. 4) CQI Supports for Consumer Outcomes - With the assistance of George Washington University, DMH has developed a Clinically Informed Outcome Management (CIOM) project. This project is currently being piloted with several DMH and APRA providers. CIOM collects consumer self-reports on treatment effectiveness on a continuous basis and provides immediate feedback to treatment teams.

Supported Housing

The Housing Division continues to identify and adopt best practices to obtain permanent housing for persons with serious mental illness (SMI). DMH is currently working with the D.C. Department of Housing and Community Development to use capital funds to develop 100 units of affordable housing each year for as long as capital funds are available. Affordable is defined as sustainably affordable for individuals receiving SSI and paying 30% of their total income for housing. Some of the accomplishments during FY 2007 and FY 2008 include: 1) providing housing options for over 1500 DMH consumers, 2) expediting the placement of consumers leaving institutional settings (Saint Elizabeths Hospital, jails and prisons) into community housing, 3) receiving 20 housing vouchers as a result of an application through the District’s HUD SuperNOFA, 4) ongoing work with developers and landlords to identify sites for affordable housing including project site visits, 5) continuation of the MyHouse Project (uses mediation in order to prevent eviction), 6) drafting Housing Rules for public review, 7) working with the District’s licensed community residential facilities (CRFs), and 8) continuing the implementation of the long-term supports and housing initiative to assist providers in the removal of barriers to accessing housing and increasing homeownership for persons with mental illness, mental retardation and/or developmental disabilities youth aging out of the foster care system.

Supported Employment

The DMH and the Rehabilitation Services Administration (RSA), in collaboration with Dartmouth College are implementing a Supported Employment Initiative. Supported employment programs have been established at seven (7) sites throughout the District. The Supported Employment initiatives from FY 2006-FY 2008 include: 1) a four-part Supported Employment Specialist training series (job development techniques, providing employment services for transitional age youth, and previously incarcerated persons), 2) established an annual Employer and Consumer Orientation Forum (promotes supported employment services to employers as well as have them meet consumers currently searching for employment), 3) a Pilot Transition Supported Employment Program (to promote successful strategies for assisting Transition-Age-Youth ages 18-24 obtain and maintain employment along with support as they transition to adult life), 4) increased the supported employment unit rate from \$45 to \$65 per hour to assist providers in covering costs associated with the service and to serve more consumers, and 5) initiated a social marketing program (aimed at consumers and clinicians to improve awareness and knowledge of the Supported Employment program, and facilitate access).

Homeless Services

A major development of the past year is the creation and activation of the Interagency Council on Homelessness (ICH). By District law, the ICH is the governmental interagency group responsible for planning and coordinating services to the District's homeless population, including housing and various emergency services. This group is the Mayor's focal point on policy and implementation for all services for persons and families who are homeless. The DMH has been very active with this Council and its various work groups.

The Homeless Services Program (HOP) continues to perform key functions for DMH and the District. The staff are all trained in trauma, cultural competence, co-occurring issues and crisis services. The ongoing services provided include but are not limited to: 1) short-term case management to homeless consumers who are unconnected to services or poorly connected, 2) travelers assistance to stranded consumers with mental illness, 3) mobile crisis services to homeless and non-homeless individuals (mobile crisis services to non-homeless individuals will be transferred to the new Comprehensive Psychiatric Emergency Program (CPEP) mobile teams as soon as they are prepared to take this on this responsibility), 4) active collaboration with the D.C. jail diversion efforts, and 5) direct operation of the Sobering Station during each hypothermia season for intoxicated men and women who refuse or are unable to handle the structure of a traditional shelter.

District of Columbia

Adult - State's Vision for the Future

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

It is envisioned that the adult mental health system will reflect the mission, vision and values of DMH. In other words, DMH will provide adult consumers with access to flexible and responsive services, in a service delivery system that is recovery-based, dynamic, innovative and outcome-oriented, and holds in high esteem values that include respect, accountability, consumer choice, quality, learning, and caring. The system will also develop, in collaboration with District and other community agencies and stakeholder groups, strategies to address the needs of unique populations including persons leaving institutional settings (psychiatric and other hospitals and rehabilitation settings, jails or prisons), are homeless, have co-occurring substance use disorder, transition age youth, older adults, and medically compromised consumers.

The Core Service Agencies (CSAs) will assure that: a) consumers and families are provided timely and accurate information; b) consumer communication needs are addressed; c) staff are fully oriented to the service delivery system and to a wide range of consumer needs; d) services are made available for consumers with routine, urgent and emergent needs; e) consumers' rights relating to access to services, treatment planning and service delivery are fully explained and protected; f) clinical operations and treatment planning processes are consumer and family-centered and provided in a culturally competent manner; g) consumers and their families have full freedom to choose a CSA and a clinical manager; and h) consumers and families can access support services such as supported employment, supported housing and other residential services.

A number of program proposals were developed for implementation during FY 2005 that continued during FY 2006- FY 2008. Some of the outcomes achieved include:

1. Shift all Civil Acute Care to Community Hospitals- DMH negotiated an agreement with Providence Hospital that became operational during FY 2008. This agreement will provide up to 10 beds for DMH as part of an existing 25-bed inpatient acute unit. This agreement is similar to the agreement that DMH has with Greater Southeast Hospital for a 20-bed unit to serve involuntary and uninsured patients. DMH also has an agreement with the Psychiatric Institute of Washington (PIW) to serve patients as needed.
2. Enhance Community Crisis and Psychiatric Emergency Services- Currently DMH has two (2) community crisis providers, Crossing Place and Jordan House for a total of 15 residential beds. Some of the results of the implementation of the Comprehensive Plan for Crisis/ Emergency Services include the following: 1) the DMH awarded the contract for a Court Urgent Care Clinic (located at D.C. Superior Court) to the Psychiatric Institute of Washington (PIW), to provide on-site mental health evaluations and referrals for individuals coming before the court on a variety of charges, which began in June 2008; 2) the Director of the new mobile crisis services has been hired, the plan is to have five 2-member teams to provide 16 hours of coverage 7 days per week and be fully operational by October 1, 2008; and 3) the child/youth crisis services was awarded to Catholic Charities who will fund and provide four (4) crisis beds and two (2) mobile crisis teams with operations expected to begin by September 2008.

1. Expand ACT Services- Over time teams have been added with a focus on specific client populations including forensic, mental illness and co-occurring developmental disabilities, and chronic homelessness. Currently the ACT teams are undergoing a fidelity review, which will determine the future operation and development of this service.
2. Begin Conversion of Day Services and Development of Support Alternatives- a system-wide review of the utilization and implementation of Day Services was undertaken and the results of the review supported this proposal. While the DMH continues to provide Day Services, the request for services is closely reviewed and monitored. Once the consumer obtains maximum rehabilitative benefit from the service, they are transitioned to lower levels of care (i.e., community support and other community-based services).

In keeping with the Exit Criteria for the Dixon Case, the adult mental health system will be able to consistently demonstrate: 1) implementation and use of functional consumer satisfaction methods, 2) use of consumer functioning review method(s) as part of the DMH quality improvement, 3) planning for and delivery of effective and sufficient consumer services, and 4) high degree of system performance.

The strategic plan for DMH includes the development of a new hospital on the grounds of Saint Elizabeths. The new hospital is projected to be completed by 2009 or early 2010 and will have a capacity of 292 beds (175 forensic and 117 long-term). In order to prepare for the opening of the new hospital and in keeping with the DMH commitment to allow people to function in the most integrated, least restrictive environment, the Department has put forth an initiative to:

- Develop comprehensive adult services for those leaving the hospital,
- Develop appropriate incentives for providers to encourage the successful transition of consumers with serious mental illness and multiple needs,
- Provide appropriate residential and housing resources, and
- Develop system capability to respond to consumer needs with training and organizational changes.

District of Columbia

Child - Service System's Strengths and Weaknesses

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

System Strengths

The DMH child/youth service system strengths include but are not limited to the following:

- Network Capacity. DMH now has a sufficient number of certified child/youth providers. The moratorium on certifying new providers, now in place for almost three years, has resulted in no shortage of qualified providers. Access issues do exist, however, and will be addressed below as challenges.
- Expansion of Resources. The total resources directed to children/youth grew from \$15 million in FY 2001 to \$32 million in FY 2004. In FY 2006, the District Council has added \$5.8 million local dollars to the DMH operating budget for services directed to children in the child welfare or juvenile justice systems.
- DMH continues to work collaboratively with the local public and private child-serving agencies (DYRS and CFSA) as well as the Department of Health Medical Assistance Administration (MAA) with the common goal of improving the children's mental health service delivery system. In FY08 DMH issued Request for Proposals (RFP) seeking contractors for several new initiatives set forth in the LaShawn vs. Fenty Amended Implementation Plan (AIP); which are definite steps toward an improved service delivery system.

New Children Crisis Service:

To assure adequate resources to implement these initiatives the DMH FY 2008 budget allocated \$2.6 million dollars of new funding to implement a new crisis service to include mobile and crisis beds. Based on CFSA estimates, the potential need for this service varies according to the time of year; anecdotally, the need increases around periods of required performance at school. DMH expects that crisis service utilization will increase as: (1) The vendor establishes, operates and markets—through education and outreach to parents, foster parent and child advocacy groups—a quality, comprehensive and reliable crisis service; (2) One children's crisis service operates in the District of Columbia and also services foster care children in Maryland and Virginia.

On June 12, 2008, *Anchor Mental Health of Catholic Charities* was the successful vendor awarded the Crisis Mobile and Crisis Beds contract. This vendor will address plans for surge capacity in the proposal and will collect a more rigorous set of data in order for the District to assess and plan to meet need. The scope of crisis services, defined within, includes: assessment; collaboration with the child's Core Service Agency (CSA) (if enrolled); enrollment support or engagement with service alternatives based on clinical appropriateness if child is not enrolled; mechanisms to assure the child is discharged to and engaged with appropriate services and supports upon discharge; and a crisis bed component that shall provide an alternative to non-acute inpatient admissions.

- For children and youth in the child welfare system, this new children's crisis service is intended to significantly reduce the multiple foster care placement disruptions,

particularly those that a result of avoidable acute care hospitalization. As well, crisis mobile services will be expanded the availability and accessibility of crisis services to all District children and youth and also services foster care children residing in Maryland and Virginia; including performing involuntary commitments as necessary. As the city is prepared to wholly supporting operating costs in the start up years (rather than discounting expected costs for expected Medicaid revenues from billing MHRS crisis services), the vendor will be held to the expectation of directing resources to educating and informing the community about how to access and utilize crisis services.

The co-location of Mental Health Staff at CFSA:

The *LaShawn* AIP also supported DMH's increase of child and Youth Services Division by establishing a new mental health team with co-located staffing to support enhanced children's mental health services at CFSA. This team consists of a) systems coordinator / Program Manager for Medicaid eligible and non-Medicaid eligible services; b) a program analyst to analyze data and program effectiveness; c) CBI coordinator; d) A staff to coordinate all referrals from CFSA within the public mental health system in collaboration with the CFSA Behavioral Services unit (BSU); and e) One clinical psychologist and one clinical social worker to be assigned to CFSA's Child Protective Services (CPS) unit under the direct supervision of CFSA's BSU. (Provision of mental health services to the child welfare population has in large part served to staff DMH's children's services division. In 2005, along with funds to support mental health services, CFSA transferred money for DMH to hire four fulltime staff to build the children's services division.)

Establishment of a Choice Provider Network:

The third AIP charge for DMH is issue a Request for Information (RFI) for a dedicated network of 3-5 mental health providers to provide comprehensive mental health assessments and meet the identified service needs of children and youth in the child welfare system including those placed in foster care Maryland. The goal of this Choice Provider Network is to provide a continuum of care for children in the child welfare system and create a framework for the organization and concentration of existing and planned services. This is an important step in building a children's mental health system of care. This network of 3-5 dedicated Core Services Agencies are committed to providing high quality services to children and youth.

The establishment of this network of providers is a unique opportunity to strengthen provider competencies and build capacity, as well as address the CSR recommendation. DMH plans to achieve this through training, coaching and fidelity monitoring, in a wide array of services including Evidence-Based Practices (EBP), targeted to this small cohort of community-based mental health providers. To establish this strategy, DMH and CFSA continue to collaborate to identify and award contracts by September 2008; in order to begin support awarded Choice Providers with the necessary training, coaching hence enhanced competency and skills. Trauma Focused Cognitive Behavioral Therapy (TF-CBT) is one of the first of such training that shall be provided the Choice Providers immediately after award. TF-CBT training and coaching initiative is the result of collaboration and partnership with the Office of Victim Services (OVS) and Duke University, DMH also issued two additional training RFPs for Community Based

Intervention (CBI) and Behavioral Coaching, which are geared toward training coaching for this network of Choice Providers

DMH also anticipates cost containment and saving with the implementation of the CFSA Choice Providers. Through the implementation of early mental health screenings of children and youth entering the child welfare system by DMH co-located clinicians; children and youth needing mental health services will be identified much earlier and linked to the necessary services and supports. This will over time preempt a significant cost reduction in 100% locally funded high cost court-ordered Psychological and Psychiatric Evaluations by Family Court Judges.

Child Welfare Mental Health Needs Assessment

In an attempt to determine the amount of funding needed to be maintained in the CFSA budget for FY08 and future budgets to purchase mental health services needed for CFSA-involved children and families and not available through DMH provided or contracted resources. DMH staff teamed up 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 a multi-year plan, which prioritize the implementation of new services, training and coaching for Choice Providers over the next three years.

DC Choices High-Fidelity Wraparound Pilot:

DMH CYSD in collaboration with CFSA and DYRS developed the Wraparound implementation Work Group whose work led to the release of the Wraparound RFP. In June 2008, Choices Inc. out of Indiana was awarded the DC Choices Wraparound contract to implement community-based alternative services for District youth at risk for or returning from an out of home RTC placement and for youth who have experienced multiple placements and /or hospitalizations. This initiative is funded by intra-district shared local funding between CFSA-50%, DMH-25% and DYRS-25%.

Moving children and youth with the most complex mental health needs from high cost residential treatment centers (RTC) to less restrictive community-based environments with intensive in-home services and supports. DC Wraparound pilot's primary goal is to reduce the number of children and youth placed out-of-state in high cost PRTF's and maintain them in their communities, close to their families with services and supports. DMH hopes to gain this funding knowledge through data collection and analysis from the implementation of the Wraparound pilot; with the intention of expanding to full scale implementation pending evidence of significant cost saving data.

School Mental Health Program:

The 2008 budget, as in recent years, has reflected the City Council and the Executive's continued support of the School Mental Health Program, providing resources to complete the expansion of SMHP services from 42 to 48 schools and providing administrative and IT FTE resources. The

SMHP continues to be a strong program with demonstrated efficacy according to an organized evaluation program which includes outcomes and satisfaction measures. In 2007, the SMHP initiated a pilot to introduce Ohio Mental Health Scales into four schools. The implementation was successful and outcomes were promising, supporting a roll out of the pilot in FY 2008.

School Mental Health Crisis Team:

This team is comprised of a specialized group of trained SMHP clinicians, in partnership with D.C. Public Schools, responds to a range of crises that impact students and their families, including unexpected death, neighborhood violence and child abuse. A 2006-2007 Safe Schools/Health Students grant to the Center for Student Support Services, to which DMH is a collaborating partner, supports a contract with George Washington University's School for Health and Health in Schools to assess the strength of the SMHP evaluation plan, identify evidence based and promising practices in similar urban school settings across the country, interview key system stakeholders and nationally recognized school mental health experts, and develop recommendations for the clinical program—including prevention, early intervention and treatment components—and an evaluation design. The first phase of the report will be produced by the fall of 2007 and the final report by the end of 2008. This report will serve as a guide for developing, with stakeholders, a strategic plan for future growth and development of the program.

Data Support for Process Monitoring and Outcomes Assessment.

In the spring of 2007, Ohio Mental Health Scales (OMHS) were implemented as an outcome measure for children/youth in the SOC. While volume and implementation challenges made manual data capture impossible, scanning technology currently being implemented will result in the first available outcomes data for the children's System of Care (SOC), organized assessment of the SOC initiative. CFSA resources have established a fulltime Program analyst who will capture key indicators of system performance and changes over time. While data and evaluation technology and human resources are coming into place, valid reliable data about system performance with respect to family and child outcomes have yet to be produced. Wary stakeholders remain skeptical about forthcoming promises for the evolving SOC. (This issue will be discussed further below in system challenges.)

Partnership with Child Welfare System.

The three-year collaboration with CFSA has evolved into a solid partnership. A shared vision is operationalized through both joint planning and problem solving forums. Partnership does not mean that staffs across the two agencies view cases from a similar perspective; system change is not without tension and tension most often plays out at the case level. Partnership does mean there is a framework within which problems are resolved in the best interest of the child. Issues that come up around cases are seen as opportunities to fix larger system problems and the focus is consistently maintained on the safety and well-being of children and families. The establishment of a new CFSA Mental Health program Manager who is hired by DMH resulted in significant reduction in communication barriers. Although housed at DMH, this manager serves as a liaison and a single point of contact for both agencies whenever issues arise.

Partnership with Juvenile Justice System.

With DMH's withdrawal from the provision of mental health services at the DYRS-operated detention facilities, the nature of DMH's partnership with DYRS has shifted. DYRS and DMH continue to work together closely in larger system reform issues, such as the SOC pilot and wraparound planning, described above. Referral processes for enrolling pre-adjudicated and/or discharged youth into Multi-Systemic Therapy (MST) are now well-established and staff attention to these cases is rare. Recently, DMH and DYRS have partnered on two new elements of system change:

- 1) Training DYRS case managers in the youth-family team meeting model. The DMH SOC Practice Manager devotes a substantial portion of time training and coaching DYRS newly developed Youth Family Team Meeting (YFTM) unit staff and supervisors in the FTM team-based services planning model. This represents a fundamental shift in the DYRS services structure of DYRS order to place the youth and family in the drivers seat for the planning and managing their re-engagement with the community.
- 2) Working with MAA to optimize Medicaid funding for CSAs to provide services in DYRS detention facilities for youth that are awaiting placement. A workgroup commissioned by the Children's Roundtable determined that D.C. had taken an overly restrictive interpretation of federal law and was not claiming federal match on any Medicaid youth once they entered detention. Federal law allows claiming so long as the youth is awaiting placement, which applies to all but a small population in DYRS facilities. DMH and DYRS did a joint training for providers and DMH created a billing code to enable providers to bill local dollars for services not deemed Medicaid billable for DYRS youth. Establishing mechanisms to bring community providers into DYRS facilities opens up new opportunities to engage youth in need of mental health services by establishing relationships while the youth is detained so that those relationships can follow the youth out into the community and help to support his/her reintegration.

Community Partnerships, Consumer Outreach and Education:

Currently DMH hosts a bi-monthly "Children's Roundtable" which provides a forum for government child-serving agencies, community mental health providers, consumers, community stakeholders, and service providers to partner and address strengths and challenges within the children's mental health system. This collaborative effort affords DMH a very unique feedback opportunity consistent with the established Continuity of Care guidelines set forth by the department. New resources, system changes affecting service delivery, consumer education and outreach efforts information is generally shared and disseminated at these meeting.

School-Based Teen Outreach Program for Suicide (STOP Suicide) Grant.

DMH was awarded this two year grant in September 2005. This grant was scheduled to run until the end of September 2007 but with a no cost extension will have funding available until approximately September 2008.

The goals include:

- 1) increase the number of adolescents identified as at risk and assessed for suicide or suicidal behavior;
- 2) enhance the ability of child mental health providers to identify and assess for risk of suicide;
- 3) provide training to school staff and community leaders on depression and suicide prevention;
- 4) improve the coordination of care provided to students at risk for suicide and their families; and
- 5) improve family/caregiver education and access to mental health resources and services.

Additionally, STOP Suicide has applied for a supplemental grant that, if received, would also run until September 2008.

Multi-Systemic Therapy (MST).

MST was introduced into the city in FY 2005 via a federal funding by the Senate Appropriations Committee to strengthen the mental health system serving children in the child welfare system. The service is now strongly embedded in the MHRS system and the baseline budget assures ongoing support for about 100-130 children/youth per year, drawn principally from the child welfare and juvenile justice communities.

Psychiatric Residential Treatment Center (PRTF) Clinical Monitoring Program.

The DMH clinical team is comprised of a licensed psychologist, who serves as the Clinical Program Manager and four (4) Residential Clinical Coordinators who perform at least three on-site clinical reviews and participate telephonically for monthly treatment planning and discharge staffing meetings for CFSA and DMH PRTF placements. Clinical Monitoring has four primary objectives: (1) assuring the treatment program meets clinical needs identified in the treatment plan; (2) assuring that the clinical program is adequate to meet the psychiatric and behavioral needs of the child; (3) initiating discharge planning and assure services are in place at discharge; and (4) following discharged youth for at least six months after discharge to support the youth's successful reintegration into the community.

The DMH RTC Reinvestment Program staff continues to successfully carry out its function as a change agent in the provision of mental health services to District children (CFSA and DMH placements) in PRTFs. As the impetus responsible for facility practice changes, the DMH Clinical Program Manager and staff have and continue to diligently work in partnership with the providers to address areas of improvement identified by DMH. The DMH residential clinical coordinators generate a comprehensive site visit report following each site visit. As a result, DMH has been very demonstrative on several occasions in impacting policy and practice changes and are making recommendations whose end results include provider consistency with best practices and improvement in the provision of mental health treatment and service delivery

DMH's Participation in Interagency Collaboration and Services Integration Commission (ICSIC)

ICSIC is a twenty-five (25) member Commission aligned around six citywide goals, which outline the District of Columbia's commitment that children and youth make successful transitions from birth to adulthood. This is a Director level governance structure facilitated by the District of Columbia's Mayor. ICSIC addresses the needs of at-risk children by reducing juvenile and family violence and promoting social and emotional skills among children and youth through the oversight of a comprehensive integrated service delivery system. In the most basic terms, the six goals are:

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

By looking at ways to measure our success in each goal, the current Administration can determine how to make improvements in each critical area. Implementing the six citywide goals requires the District to work across agency boundaries and with community partners to align critical supports and services for children, youth, and their families. The Commission meets monthly to discuss data around one of the goals and how agencies can collaborate to address the needs of children, youth, and their families around the six goals. ICSIC Action Items and timelines are identified for each agency out of the Commission meetings.

Establishment of a Unified Residential Treatment Placement Commission (RTPC)

The RTPC shall assist the District in ensuring that all placements of District children in PRTFs are needed, that appropriate community based alternatives have been considered and placements are in the best interest of the youth and their families and are in accordance with relevant District of Columbia and federal laws.

System Weaknesses

One of the major current challenges for DMH is to find a new Director for its child/youth division. The previous Director left in early 2008. DMH commenced a national search and

included stakeholders from the child-serving agencies, providers and advocates on the search committee. This is a key leadership position in DMH – with its importance, heightened by the number of projects and issues at hand. In the interim, the DMH Director for the Office of Planning and Programs (OPP) has taken on many of the cross-agency leadership tasks. As of the date of this application, DMH has extended an offer to a candidate for the position of Director of the Child/Youth Division. She is expected to start work in late September 2008.

Current service capability challenges include quality, model fidelity and access.

Resources were established in the FY 08 baseline budget to support ongoing provider training, clinical supervision and fidelity assessment in intensive home and community based services. Plans call for replicating this process in FY 09 to achieve practice improvements in trauma assessment and intervention, behavioral coaching (as a community support intervention) and home and community based services. Access to services for CFSA youngsters continue to be challenging for CFSA Social workers, which serves as the custodial parent for wards of the state, finds that only a small number of providers meet the needs of their children. Periodically, those providers get backlogged by staff turnover and seasonal referral peaks. Building the new network of *CFSA's Choice Providers* will require special attention to managing access. The CFSA Program Analyst will be conducting routine audits of wait time so that required interventions can be timely. The new *Home and Community Based Services Coordinator* has established a CBI providers group that meets regularly to review program issues, including access barriers. As a result of these meetings the group work has identified systemic barriers in the funding structure and reimbursement which hinders services delivery.

Overall system performance as measured by the CSR.

The *Dixon Court* monitor conducts annual community service reviews (CSRs) of both the child and the adult system. The CSRs are two (2) of the nineteen (19) exit criteria. (The CSR for children and youth is Exit Criterion #4). An overall system performance score of 80% of the cases reviewed falling in the acceptable range (rated 4, 5 or 6) is required. This is the sixth year of the review. Although the same review instrument was used, there were four (4) significant changes made to the review process. First, the sample size was increased from 54 cases to a target of 85 cases. The purpose of this change was to ensure that a statistically valid sample of cases was reviewed. Second, external reviewers conducted approximately two-thirds of the reviews, with DMH reviewers conducting one-third. Third, the Court Monitor's Office established a case judge to discuss and validate the scoring of each case reviewed by a DMH reviewer. Both the second and the third change were intended to ensure inter-rater reliability. Fourth, maximum effort was given to doing reviews for the selected sample – with careful scrutiny on any needed replacement cases.

The Child/Youth CSRs were conducted from March 3-14, 2008. The target was to review 85 cases out of the total 1475 children who received a billable service between April 1 and October 31, 2007. The final completed sample was 73 – with 53 cases reviewed by HSO personnel and 20 by DMH. 62% of the cases had involvement with both DMH and CFSA. For the first time, CFSA staff participated directly in 17 of the CFSA cases to allow a “co-review” under both CFSA and Dixon protocols.

Unfortunately, the findings for year six were similar to prior years. The overall child/youth status was 79% – which compares favorably to 2007 at 75% and 2006 at 81%. The child/youth status showed acceptable results among several indicators e.g. safety of the child (88%), health/physical well-being (90%), lawful behavioral (77%) and home and school placement (85%). Scoring less well were academic status (67%) and stability (67%).

In system performance the score for 2008 was 36% - a drop from 48% in 2007 and 54% in 2006. This drop in system performance may well be a function of the case judging process that served to tighten inter-rater reliability. Nevertheless, the same issues that predominated in prior years continue. These include very poor scores in critical areas e.g. service team functioning (26%), service team formation (47%), functional assessment (48%), goodness-of-service fit (51%), and service coordination and continuity (32%). The focus groups that were conducted as part of the CSR reviews corroborate the point that there has been good progress at the leadership level in developing cross-system relationships, common philosophy and commitment to a family-centered system of care. However, these commitments have not been translated into every day practice. The Court Monitor recommended that the upcoming year should focus on one major goal – to increase the quality of teamwork and communication for each child served across all of the necessary providers, family members and agencies.

Assessment Center Appointment Wait Time.

Wait times for Court-ordered juvenile assessments have considerably improved for fiscal year 2008. The initiatives implemented to reduce the wait time thus far have included: (1) streamlining the current process with expected overall process improvement; (2) brining Managed Care Organizations (MCOs) into the process and; (3) implementing the *Case Expediting Reforms* introduced and agreed to by District Officials on October 25, 2007. In an effort to address the shortage of psychiatrists to conduct psychiatric evaluations, a Request for Proposal (RFP) has been issued and awards are expected for fiscal year 2009. A second Request for Proposal (RFP) was issued to identify a group of *Choice Providers* allowing DMH the ability to divert neglect and abuse referrals for mental health treatment assessments from the assessment center to the community.

- As a result of the initiatives that have taken place thus far to address the wait time for the juvenile assessments, the outcomes data for the Assessment Center for FY 08 to date shows an average total process time from the time of the Court order to the submission of the evaluation to the Court of 29.2 days. This is a 75% improvement from FY 07 pointing out a reduction from an average of 10-12 weeks to a current average of 2-6 weeks.
- Scheduling appointments within five (5) days of the referral continue to present challenges for the assessment center staff. However, every effort is consistently made by DMH staff to schedule all appointments within five days of the referral and for the majority of the cases this does occur. However and due to mitigating circumstances, in most instances where the appointment was originally scheduled within five days and was later either cancelled or the client failed to call and show, the overall process time from the referral to the evaluation completion date has exceeded the 30 day reporting time. In some cases where the client failed to show for the appointment, he/she may have

absconded or eloped prior to the scheduled appointment and in the interim the case remains open resulting in an excessive number of overall days from the Court order to case closure.

Establishing one Family Organization(s).

The DC CINGS grant left a number of legacies, one of the most difficult was the fractured relationship with a long time D.C. family organization. As grant carryover funds were moved into the community, grants were provided to an existing family organization and a new one to provide program and infrastructure building support. Efforts to build effective relationships are ongoing. DMH sole sourced funding to the Child and Youth Investment Trust Corporation to issue RFPs for a single Family Organization and Technical Assistance to support the infrastructure building of this Family Organization

Data driven decision making.

Data resources to support data driven decision are new to children's services and the impact of technology supports will not be known until midway through the FY 08 year. It is critical, however, that DMH make good on its commitment to SOC stakeholders to demonstrate outcomes of services and SOC processes—such as follow up to assure referred children are engaged in needed services.

Shortage of Psychiatrists

There is a significant shortage of psychiatrists in metropolitan Washington that is willing to accept Medicaid rates. The shortage results in long delays for psychiatric appointments, which is particularly critical for children discharged from the hospital with medications that need to be filled. Resolving the shortage will require broad, system wide interventions in a number of domains.

High Turnover Rate at the Provider Level.

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

Resources Devoted to Children Deep in the System.

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

District of Columbia

Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

The discussion about the challenges and weaknesses in the District's child/youth service system identifies various unmet needs. However, the results of the annual *Dixon* CSR provide the best and most comprehensive description of the problems that exist in the mental health delivery system for children.

Overall system performance is lacking as measured by the CSR.

The *Dixon* Court monitor, through an independent consultant, Human Systems and Outcomes, conducts annual community service reviews (CSRs) of the child system. The annual child CSR is Exit Criterion #4). An overall system performance score of 80% of the cases reviewed falling in the acceptable range (rated 4, 5 or 6) is required. This is the sixth year of the review.

The Child/Youth CSRs were conducted from March 3-14, 2008. The target was to review 85 cases out of the total 1475 children who received a billable service between April 1 and October 31, 2007. The final completed sample was 73 – with 53 cases reviewed by HSO personnel and 20 by DMH. 62% of the cases had involvement with both DMH and CFSA. For the first time, CFSA staff participated directly in 17 of the CFSA cases to allow a “co-review” under both CFSA and Dixon protocols.

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Unmet needs include the following:

- Ensuring that quality services are consistently delivered in fidelity to the program model (evidenced based practice, promising practice, etc.)
- Limited access to therapy for children in the child welfare system
- Shortage of psychiatrists and other qualified mental health professionals (contributes to limited access and inconsistent quality in service delivery)

District of Columbia

Child - Plans to Address Unmet Needs

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

Establish Choice Provider Network:

DMH is moving expeditiously to finalize awards for the vendors selected as Choice providers; while simultaneously crafting creative ways to establish base funding for these providers to have flexibility in crafting services that fit the needs of children and families served.

Enhance Services Array:

DMH and CFSA recognizes in the need for an enhanced service array for children and youth. Combined efforts of the MHRS Steering Committee, Wraparound Implementation Work Group, the PRTF Commission and the multi-year plan out of the CFSA Funding Workgroup and being assessed collectively in effort to increase and improved the services array for Children and Youth in the District of Columbia.

Reimbursement Rate Enhancement:

DMH, with the help of a consultant is currently working on a rate study to analyze the MHRS rates in an effort to enhance the rates for MHRS services, particularly Community Support, CBI, and Psychiatrist services rates for children and youth.

District of Columbia

Child - Recent Significant Achievements

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

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

- Award of the contract for the Children's Mobile Crisis and Crisis Stabilization Services required by the LaShawn AIP;
- Partnership with CFSA and DYRS to fund the contract for the contract for the Child Wraparound initiative, which launched in August 2008;
- Partnership with OSSE to expand the Child Wraparound initiative in FY 2009 to include special education students;
- Issuance of the RFP for the Child Choice Providers (contracts expected to be awarded by December 31, 2008);
- Expansion of the SMHP to an additional six (6) schools during the 2007 – 2008 school year;
- Expansion of the SMHP to an additional ten (10) schools during the 2008 – 2009 school year; and
- Implementation of effective outreach program to homeless children and youth.

District of Columbia

Child - State's Vision for the Future

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

When fully implemented, all of the District's children receive the mental health services and supports they need through a comprehensive, seamless system that delivers services at the local level and recognizes that children and their families come first. The District's mental health services system for children will be accessible, culturally competent, and flexible enough to meet individual and family needs; and family-centered and focused on attaining positive outcomes for all children. . The plan also continues to address a tragic consequence of the current fragmented complex system that oftentimes results in multiple barriers to accessing needed mental health services. The plan that follows in this report is not a DMH plan to address children's mental illness, but rather it is a district plan for a full spectrum of services and supports needed to provide for the mental health of all children in the District. To that end, the children's mental health system will focus on prevention, early identification and intervention as well as the community-based treatment and hospitalization services that are needed in a comprehensive system. The comprehensive system will include interagency collaboration on policy development, financing and policy initiatives. Services will be evidence-based and organized by developmental stages through a matrix of services, health promotion, access to care, and evaluation and quality monitoring.

District of Columbia

Adult - Establishment of System of Care

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

A. Description of Services

The Adult Community Service system is comprised of the Mental Health Authority, Saint Elizabeths Hospital, and certified agencies (including both the publicly funded District of Columbia Community Services Agency (DC CSA) and a group of certified private non-profit mental health agencies). Saint Elizabeths Hospital includes both the forensic services of the John Howard Pavilion and the civil hospital. The FY 2009 State Mental Health Plan describes the community-based organizational structure, as it exists today. The emphasis in the current plan is on the objectives to be carried out within the Mental Health Authority related to system development.

1. The Authority

The Mental Health Authority supports the overall administrative mission of the Department of Mental Health (DMH), and encompasses the global functions necessary to support the entire system. The Authority is responsible for establishing priorities and strategic initiatives for DMH, as well as coordinating fiscal services, accountability functions, information systems, and service planning and policy development.

The Authority functions as a regulatory body through which certification will be sought by any provider seeking to provide Mental Health Rehabilitation Services (MHRS). The MHRS program encompasses nine services (four are classified as core services and five as specialty services) provided by DMH-certified community-based providers.

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

The DMH has developed an Access HelpLine that provides 24-hour, 7-day a week access for persons in need of mental health services. Administered as part of the Care Coordination function, this program handles routine requests for services and those requiring both urgent and emergency services. The Access HelpLine provides functions such as enrollment in appropriate DMH services, as well as prior authorization and continuing stay authorization. All these actions are based on consumer choice.

During FY 2008, the Access HelpLine installed a new telephone and reporting system (AVAYA) that went live in June 2008. The training on the system occurred June 23-25 with refresher training in July 2008.

The District originally engaged KPMG to do an overall assessment of DMH's administration of its MHRS system. The August 2006 Report detailed numerous ways for DMH to improve its MHRS programs. Many of these initiatives have been completed. To assist DMH with some of its priority objectives, DMH contracted with KPMG again in early 2007 to provide help in four areas: 1) project management of MHRS improvement initiatives (basically complete, KPMG continues active monitoring on a limited basis for ongoing projects), 2) support for Medicaid-denied claims recovery, 3) movement of Medicaid claims payment to MAA (transition implemented and successfully completed in April 2008), and 4) development of an

Administrative Services Organization (ASO) request for proposal. A request for information was disseminated in August 2007. The District Council subsequently advised DMH that the Mayor and the Council would implement a District-wide ASO function rather than have each agency that bills Medicaid have its own ASO. The DMH efforts to obtain an ASO have been deferred to the District-wide process.

The DMH has also engaged KPMG to do a thorough review of human resources (HR), processes and procedures. This project was initiated in July 2008. In addition, KPMG will review HR policy and underlying regulations with a focus on needed changes. It is anticipated that the overall process will take at least 90 days.

2. Core Service Agencies

The public and private non-profit providers serve as the backbone of the District’s comprehensive, community-based system for providing services to persons with serious mental illness. The objective of a CSA is to create a clinical home for each person receiving DMH services, ensuring a single point of accountability for service delivery. The CSA model ensures that each person has an Individualized Recovery Plan (IRP) that clearly identifies the treatment goal and the services necessary to achieve these goals. This plan and service model is focused on a strengths and rehabilitative approach to each consumer’s recovery.

During FY 2008, DMH began a review of the Mental Health Rehabilitation Services (MHRS) system. The DMH will continually review community needs and provider capacity as the MHRS program is implemented.

In June 2008, 47 agencies were certified as DMH MHRS providers. These agency certifications include:

Core Service Agencies (CSAs)	CSAs also Sub-Providers	CSAs also Specialty Providers	Sub-Providers	Specialty Providers
32	32	12	14	2

D.C. Community Services Agency- The largest of the DMH-certified CSAs is the publicly funded D.C. Community Services Agency (DC CSA), which has been certified as a CSA and Specialty provider. A variety of services are provided to adults in recovery from serious mental illness. In addition to over a dozen community support teams and three assertive community treatment (ACT) teams, some services address special population needs such as older adults, and individuals from multi-lingual and multi-ethnic communities. The DC CSA major accomplishments include the development of a number of protocols (i.e., for forensic populations, acute and long-term care of consumers residing in Saint Elizabeths Hospital, intake at all adult program sites); increased daily attendance at the dually diagnosed day services program; and increased staffing at the mental retardation/developmental disabilities/hearing impaired program.

The major issue for the D.C. CSA continues to be the analysis of alternative service delivery and governance options. The KPMG has been contracted to help DMH manage the assessment and final analysis of options. The work plan for this project shows the completion of the analysis and

benchmarking phase by the end of June 2008, with the development of options and recommendations by mid-August 2008. This process has involved key stakeholders (consumer and other advocates, private providers, unions and D.C. CSA staff).

The KPMG analysis identifies three major factors: 1) whether there is adequate capacity in the community to provide the volume of quality services needed, 2) whether the private sector is willing and able to provide a given service, and 3) whether these services can be provided more efficiently through the private sector. The analysis included a review of key issues including: access to care, clinical and program implications, community needs, personnel implications, legal and regulatory issues, and cost implications. The KPMG and DMH leadership identified five different options (or combinations of options) for future governance and service delivery: 1) continue to operate the CSA, or parts of it, as it is now, 2) transform the CSA into a not-for-profit corporation, 3) transform the CSA into a Public Benefit Corporation (PBC), 4) transfer the delivery of components of the current CSA to private entities through the coordinated transfer of clients, 5) an external private entity would acquire the CSA.

The District Council has included language in the Budget Support Act (BSA) that requires DMH to report to the Council on recommendations for a new governance structure for the D.C. CSA by October 1, 2008. The BSA further requires a plan for implementation by December 31, 2008 and full implementation of the plan by September 30, 2009.

3. Saint Elizabeths Hospital

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

The Acute Care Program currently consists of 92 certified beds (4 units); one unit for all admissions, most of which are stabilized within 14 days; and one unit for patients who require treatment beyond 14 days for stabilization. The Continuing Care Program has 128 beds and provides ongoing psychiatric treatment to a variety of populations, including geriatric, hearing impaired, behavior management, and psychosocial.

The Forensic Services Inpatient Program has 225 beds, as well as an outpatient department that provides treatment and/or monitoring for approximately 105 insanity acquittees on court ordered conditional release in the community. The Forensic inpatient program provides a full range of mental health services to pre and post-trial consumers committed by the Criminal Divisions of the District of Columbia and Federal Courts. The courts control admission to and discharge from the Forensic Program. Services to forensic inpatients include evaluations of competency to stand trial and criminal responsibility; treatment of defendants in need of hospitalization to restore them to competency before trial; treatment of those adjudicated incompetent and unlikely to regain competency in the foreseeable future while awaiting civil commitment; treatment of

consumers found Not Guilty By Reason of Insanity (NGBRI) and committed for inpatient treatment until released by the court.

The Forensic Legal Services Branch provides community-based pre-trial, pre-sentencing, and post-sentencing evaluation and assessment services to individuals residing in the community or at correctional facilities referred by the criminal courts and the District of Columbia's probation and parole authority. The Legal Services Branch also operates field offices in the District of Columbia Courthouse that provide same day competency screenings for both defendants who are detained and on bond.

In keeping with the recovery-based model of care, the Hospital has established an environment of care that primarily allows non-forensic patients to leave their units during the day and receive the majority of treatment at a "treatment mall," and two ward-based geri-malls. This concept promotes community reintegration and assures that all patients are involved in active treatment. The treatment mall provides specialized programming for Geriatrics, Dual Diagnoses, Cognitive Skill Development, Behavioral Management, Psychosocial Rehabilitation, and Acute needs.

The expansion of therapeutic activities in the Forensic Program also was addressed during the fiscal year, in efforts to approximate the over 4,000 hours of active group treatment that is offered in the treatment mall each month. Clinical disciplines increased the amount of active treatment provided patients and nursing staff alone began conducting over 153 additional groups on a weekly basis. In addition, the 2004 initiative to send selected forensic consumers with medium and minimum security classifications who have been difficult to engage in treatment in the maximum security facility to the treatment mall was successful and has continued without interruption. Forensic Services in SEH continues to support the Department's efforts to promote pretrial release of appropriate defendants to community-based case management and treatment by working closely with the CSAs. The Forensic staff's collaboration has helped to facilitate continuity of care for defendant/consumers and their receiving appropriate services in the least restrictive environment. The Forensic Services Pre-trial Branch staff also work closely with the Department of Corrections to ensure continuity of care when defendants are discharged from the John Howard Pavilion and detained.

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

The DOJ letter of April 16, 2008 referenced specific findings of compliance and non-compliance, as well as highlighted four areas that need to be addressed on a priority basis by the time of the next DOJ visit in the Fall 2008. These include: 1) protection from harm and risk management, 2) nursing care, 3) treatment planning and psychiatric care, and 4) behavioral management and psychological care.

The construction of the new 292-bed Hospital at SEH continues with the overall completion at approximately 73% as of June 30, 2008. The planned occupancy is for late 2009 or early 2010.

District of Columbia

Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing services;
Educational services;
Substance abuse services;
Medical and dental services;
Support services;
Services provided by local school systems under the Individuals with Disabilities Education Act;
Case management services;
Services for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities leading to reduction of hospitalization.

Health Services, Training and Planning Initiatives

Health Screening: The DMH Mental Health Rehabilitation Services (MHRS) standards require that the health status of the consumers of DMH services be screened at least every 90 days as part of the assessment process that is part of the Individual Recovery Plan (IRP). It is the responsibility of the assigned Core Service Agency (CSA) clinical manager to assure that the health issues are followed up.

Registered Nursing Training: The DMH Training Institute, D.C. Community Services Agency (DC CSA) Nurse Training Committee and Howard University School of Nursing partnered to offer a five-day nursing continuing education series on adult consumer physical health examinations and health assessments for approximately 30 registered nurses. The DC CSA management requested all psychiatric nurses to perform physical health examinations and many of the nurses believed they could benefit from a continuing education refresher course on this topic. Howard University School of Nursing convened several planning meetings with the DMH Training Institute and the DC CSA Nursing Training Committee to design the series to meet the current practice standards and nurses' needs. The course, An Integrative Approach for Adult Consumer Physical Health Assessments and Data Interpretation Series for Nurses, was successfully launched in August 2007.

Medically Compromised Consumers Planning Group: As a result of increasingly more consumers with medical conditions that make it difficult to place and/or maintain them in community settings, in June 2007 DMH hosted a small interagency meeting with the Department of Health (Medical Assistance Administration, HIV/AIDS) to begin a dialogue about how to collectively address this issue. In August 2007, the meeting grew into an expanded meeting of public and private health and mental health providers, advocates, and District agencies including disability services, and aging. Some of the activities included: 1) reviewing the existing Medicaid waivers, 2) beginning to document consumer serious health conditions, and 3) discussing the billing opportunities under the MHRS program to bill for Medication/Somatic. This activity came to be known as the Medically Compromised Consumers Planning Group.

A DMH small work group met in September 2007 to further review issues and convene a conference call with a best practice model, the Washington Hospital Center Medical House Call program. This program provides home-based medical and social services for frail elders. The majority of the clients (60%) have neurological and psychiatric problems.

A small work group with provider representatives and advocate agency continued to meet during FY 2008. The development of an interim report with recommendations is planned for September 30, 2008.

Health Status of Adults via Community Services Review: Health status is one of the person status indicators in the Adult Community Services Review (CSR) protocol. The DMH Director of Adult Services requested data on health status for the 2008 Adult CSR, as it was believed that this information would be helpful to the ongoing health related planning initiatives. With regard to health status, each indicator is rated by the review on a scale of 1- 6 with 1 being the worst rating and 6 the best rating. An unacceptable rating is a 1, 2 or 3 score. A rating of 4, 5 or 6 are acceptable scores.

There were 88 adults in the 2008 Adult CSR sample. The data show that 21 consumers or 23.86% had an unacceptable health status rating. This subset of the consumers included: 10 males and 11 females, 15 were in the age range of 50-69 (6 males and 9 females) and 6 were between 30-49 (4 males and 2 females), 16 were African American, 2 Latino American, 1 Euro-American, and 1 ethnicity was unknown. Their health status included various combinations of the following disease categories: diabetes, hypertension, hepatitis C, obesity, asthma, Tardive Dyskinesia, arthritis, seizure disorder, substance abuse, serious back injury, chronic pain, chronic obstructive pulmonary disease (COPD), poor dental care, tuberculosis (TB), abnormal gait, neurological problems, HIV positive, sickle cell trait, cataracts, glaucoma, congestive heart failure, and partial paralysis.

Incorporation of Mental Health and Health Data: The DMH and the Department of Health, via memoranda of understanding, have incorporated mental health questions into the annual health survey, the Behavioral Risk Factor Surveillance System Survey (BRFSS). The 2007 survey included questions about anxiety and depression. This data is being summarized by the Principal Investigator for the Data Infrastructure Grant. The 2008 survey will include questions about mental health and stigma.

Saint Elizabeths Hospital Co-Morbidity Study: In April 2008, the DMH Office of Accountability began a hospital co-morbidity study of consumers with medical and psychiatric diagnoses. The process involves conducting medical chart reviews, on a unit by unit basis, to identify medical care and follow-up for patients with co-morbid mental illness and physical illness. Beginning in September 2008, a quarterly report will be issued summarizing the findings of these chart reviews. Since consumers in inpatient and community settings are presenting more serious health issues, the issue for the hospital is two-fold: 1) can the hospital adequately respond to these health conditions, and 2) if the hospital continues to receive consumers with intensive health needs, what are the supports that will be required. The review process will continue into FY 2009.

Mental Health and Rehabilitation Services

Mental Health Rehabilitation Services (MHRS) Program: The DMH has developed and is implementing a comprehensive set of service standards through the MHRS program. This program consists of four core services (diagnostic/assessment, medication/somatic treatment, counseling, and community support) and five specialty services (crisis/emergency, rehabilitation, intensive day treatment, community-based intervention, and assertive community treatment). A DMH-certified Core Services Agency (CSA) or Sub-Provider provides the core services while a DMH-certified Specialty Provider offers the specialty services. There were a total of 49 MHRS providers in June 2008.

The Core Service Agency (CSA) serves as the consumers' clinical home and is responsible for the coordination of the consumer's care across services and provider agencies. The Individual Recovery Plan (IRP) is a key to the development of mutually agreeable treatment and rehabilitative goals and objectives, and to coordinate the care of multiple providers who often participate in the consumer's care plan. Representatives of each service being provided and the CSA's clinical manager and qualified practitioner, consumer and others that the consumer would like to be a part of the treatment planning process are involved. The IRPs and Integrated Service

System Plans (ISSPs), which are the authorization requests for services to the DMH Authority flow from the treatment objectives that are completed every 90 days or whenever there is a change in the consumer's course of care.

Technical Assistance and Support for MHRS Providers: The DMH Office of Programs and Policy Provider Relations Division continues to provide technical assistance and communication linkage on both clinical and financial issues, as well as troubleshooting of problems for the provider network. This Division convenes and/or participates in separate regular meetings for the providers' Chief Operating Officers and Chief Financial Officers (CEOs/CFOs), the Clinical Directors, and the User Group.

MHRS and Other Compliance Related Issues: The Office of Accountability revised the process and protocols for conducting retrospective claims audits for all MHRS providers. This was a major focus in FY 2008 and involved considerable work to catch up on prior year audits, enlarge the audit sample for each agency to ensure statistical validity and negotiate clear protocols and agreements with both providers and the Medical Assistance Agency (MAA). The claims audits for prior periods (FY 2005- FY 2007) have been completed and the audits for FY 2008 are in progress. The memorandum of understanding (MOU) between DMH and MAA outlines the process to address failed claims.

The DMH has created a Compliance Committee, which has membership from key DMH offices (fiscal, legal, human resources, provider relations) and serves in an advisory capacity to the Office of Accountability Director on a variety of compliance issues. As part of the overall compliance process, DMH has now instituted mandatory compliance training for DMH staff including the D.C. CSA. All of the key elements of current compliance issues will be addressed including whistle-blower provisions. The Compliance Committee reviews and recommends on agency-specific issues as these are identified via the auditing process. During FY 2009, DMH will audit providers to evaluate the presence and viability of internal compliance efforts.

On June 1, 2008 a Compliance Hot Line was instituted by the Office of Accountability for the entire Department of Mental Health. The Hot Line is operated by an independent vendor, and will take reports of suspected fraud, abuse, or unethical behavior by DMH staff or by DMH providers. Callers maintain their anonymity and the information reported is sent directly to the Office of Accountability for investigation. The phone number for the Hot Line has been posted throughout DMH work areas and is also posted on the DMH website.

The Office of Accountability is also involved in the development of a set of quality and process-related performance indicators that could be measured for all providers. This "score card" would include a variety of measurable components of overall compliance efforts at the local level. Once completed, it would be publicly available and would hopefully prompt providers to build more comprehensive and timely compliance programs. The intent is to have this effort completed by the end of FY 2008.

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

following:

- Assertive Community Treatment (ACT) Services: During FY 2008, DMH initiated a number of activities related to the ACT program. These include but are not limited to: 1) finalizing the ACT policy in November 2007, 2) establishing an ACT Advisory Committee in January 2008 (will advise on a range of issues including service access, role and functioning of ACT teams, fidelity measurement, etc.), 3) filling the ACT Coordinator position in February 2008, 4) monthly meetings with ACT teams to review progress and discuss common issues, and 5) tracking all requests for ACT admissions, transfers or discharges, resulting in a more accurate data base of active ACT consumers.

The major goals for the remainder of FY 2008 and FY 2009 include: 1) complete a baseline fidelity assessment of all ACT teams being conducted by the National ACT Institute with projected completion by the end of July 2008 with agency-specific training and consultation during FY 2009, 2) initiate Supported Employment as a core service within the ACT teams, 3) increase the census of ACT teams by 25%, and 4) improve the compliance percentage of ACT referrals under the Dixon Exit Criteria.

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

The D.C. Linkage Plus began in 2005 and has continued to implement the Sequential Intercept Model in a variety of ways. This program focuses on serious and persistent mental illness (SPMI) and co-occurring disorders who are in the criminal justice system as well as consumers who are in the community but have frequent contacts with the Metropolitan Police Department (MPD), Fire and Emergency Medical Services (F/EMS) or the Comprehensive Psychiatric Emergency Program (CPEP). The specific points of intercept are at four distinct points: 1) Pre-booking- this service is performed via CPEP, the Homeless Outreach Program (HOP) and the expanding collaborations with MPD, 2) Post-booking- DMH provides screenings for the Pre-trial Services Agency (PSA) and recommends release conditions and referrals for mental health services-referrals can be made to the Linkage Plus program or to the Options program (contract via designated CSA with the capacity for 35 consumers and 10 short-term residential beds), 3) Jail-based Linkage- DMH has a full-time Jail Liaison Coordinator to track all individuals with SPMI and to re-connect them to a CSA upon release if they have one or to connect them with a CSA if they do not and CSAs with a forensic program have designated criminal justice liaisons who meet with jailed consumers within 48 hours to ensure that linkage to mental health services occurs upon release, a total of 399 consumers have been linked through the D.C. Linkage Program, and 4) Re-entry- DMH has a Mental Health Coordinator on site at the assessment center to both provide mental health screenings/assessments and accept

referrals from the Court Services and Supervision Agency (CSOSA), the Office of Ex-Offender Affairs and the Bureau of Prisons (of the 634 screenings and assessments from April 1, 2007 to March 31, 2008, 164 were identified as having primarily mental health issues that needed referral with the majority of the remainder having substance abuse disorders).

The DMH has maintained the Outpatient Competency Restoration Program (OCRP) that began in July 2005. This program attempts to restore competency for individuals in the community instead of hospitalizing them at Saint Elizabeths Hospital. Prospective referrals have a screening and full competency evaluation prior to being Court-Ordered to participate in this unique program at the DC CSA. During the past year, there were 24 referrals to OCRP. There have been 78 total referrals since the program's inception.

During FY 2008, the DMH Director and the Pre-Trial Services Director served as co-chairs of the Substance Abuse and Mental Health Services Taskforce. Some of the major areas of focus include: 1) oversee and support the development of the newly created Urgent Care Clinic at the D.C. Superior Court, 2) develop an improved system to assess, treat and refer persons with SMI and co-occurring disorders at the D.C. Jail and move them to community based services upon discharge from the jail, 3) increase opportunities for crisis intervention and treatment alternatives (versus arrest) through the new DMH mobile crisis services and the Homeless Outreach Team, 4) target specific populations for treatment and diversion opportunities through data analysis to determine programmatic needs of particular populations, and 5) improve data and information sharing within the criminal justice agencies by exploring a mechanism to create a comprehensive data base with the technology for "real time" access to consumer records that would include access to important medical, psychiatric and criminal justice information. The goal would be that all stakeholders should have access to appropriate, available information to improve service delivery.

Also during FY 2008, DMH hired a forensic psychiatrist at the Authority who came onboard on July 7, 2008. This individual will help provide additional leadership and psychiatric support.

- Co-Occurring Mental Illness and Mental Retardation: The DMH and the Department of Disability Services (DDS) have had a memorandum of understanding (MOU) since October 2004. This cross-agency effort is intended to provide intensive tracking and intervention for individuals in the DDS system who also have an Axis I mental illness. There are 118 consumers enrolled with 25 in ACT services and 25 receiving community support services as of June 2008.
- Clubhouse Program: The DMH has funded an International Center for Clubhouse Development (ICCD) Certified Rehabilitative Clubhouse for the past five years as a grant to a community provider. The ICCD clubhouse is an evidence-based model founded on the realization that recovery from serious mental illness must involve the whole person in a vital and culturally sensitive community. The participants are called "members" and work in the clubhouse. Their work whether it is clerical, data input, meal preparation or reaching

out to their fellow members, provides the core healing process (.i.e., Work Ordered Day). Every opportunity provided is the result of the efforts of the members and small staff, who work side by side, in a unique partnership. The Clubhouse offers an array of specific services from which members can choose as their needs and life goals indicate. Members can take advantage of daytime programming, vocational rehabilitation, employment opportunities, housing support services, case management, social and recreational programs, supported education, advocacy and crisis response services. During FY 2008, DMH solicited the ICCD Clubhouse model through an RFP process and this service will operate as a contract in FY 2009.

- Wellness and Resource Center: The DMH awarded the Ida Mae Campbell Foundation a \$1.2 million dollar contract over five years to open and operate a community based wellness and resource center that will include: communication and education, work enhancement skills and computer training, wellness recovery and peer support, advocacy, creative arts, and social activities. The Center is open Monday through Saturday. The Ida Mae Campbell Wellness and Resource Center will be run by consumers, called Peer Specialists, and will be open to all individuals who want to participate in peer-supported activities regardless of participation in psychiatric treatment or involvement with traditional case management. The founder and Executive Director of the Center is a self-advocate and has been involved with the District's Peer Recovery Movement since 2003. The Wellness and Resource Center became operational in June 2008.
- Court Urgent Care Clinic: The D.C. Superior Court and DMH opened an Urgent Care Clinic at the Moultrie Courthouse, starting June 23, 2008, to assist individuals who are in contact with the court system and who may need mental health services. The DMH has awarded a \$1.5 million dollar contract over three years to the Psychiatric Institute of Washington to provide direct mental health services to defendants who need them and to assist the court in referring defendants to mental health treatment when appropriate.

The urgent care clinic will provide easy access to mental health services primarily for individuals who appear in misdemeanor and traffic court who may show signs of mental illness, have been diagnosed as mentally ill, or show signs of both mental illness and substance abuse disorders. While it is expected that the D.C. Misdemeanor and Traffic Community Court, the Mental Health Diversion Program, and the East of the River Community Court will be the primary referral sources for the Urgent Care Clinic, all Criminal Division judges and the D.C. Pretrial Services Agency will have the authority to make referrals to the program.

Employment Services

Supported Employment

The DMH provides an evidence-based supported employment program designed for consumers with significant mental health diagnoses for whom competitive employment has not traditionally been available or for whom competitive employment has been interrupted or intermittent as a result of a significant mental health problem. Supported employment involves obtaining a part-

time or full-time job in which a consumer receives supports in a competitive employment setting and in which the consumer earns at least minimum wage. Supports include ongoing work-based vocational assessments, job development, job placement, job coaching, crisis intervention, development of natural supports and follow-up for each consumer, including offering job options that are diverse and permanent.

Supported Employment Interagency Agreements: The DMH has partnered with the Department of Disability Services, Rehabilitation Services Administration (DDS/RSA) through a formal memorandum of understanding (MOU) to develop and expand supported employment services for individuals with mental illness. DDS/RSA transferred \$100,000 to DMH for the provision of supported employment services for individuals with mental illness in FY 2007 and under the same MOU DMH transferred \$19,249 for support of a portion of the time of the DDS/RSA Supported Employment Supervisor. The supervisor devoted 25% time to coordinate supported employment services provided by DDS/RSA for consumers referred by DMH approved supported employment programs and to develop mutual service procedures with DMH's Employment Manager.

The FY 2008 MOU requires DDS/RSA to transfer \$100,000 to DMH and for DMH to transfer \$20,000 to DDS/RSA for community outreach and education so that mental health consumers can learn about the availability of supported employment services and how to access the service.

Supported Employment Provider Programs: During FY 2008, seven (7) programs provided evidence-based supported employment services funded by the DMH. They include: 1) Anchor Mental Health, 2) Community Connections, Inc., 3) D.C. Community Services Agency (DC CSA), 4) Deaf Reach, Inc., 5) Green Door, Inc., 6) Pathways to Housing, Inc., and 7) Psychiatric Center Chartered, Inc.

Supported Employment Performance Measurement: There are two primary methods of performance measurement of the DMH Supported Employment program: 1) the assessment of the supported employment programs' fidelity to the model, and 2) the assessment of achievement and/or maintenance of the supported employment Dixon Exit Criteria. The most recent fidelity audit was conducted in FY 2007.

Five (5) of the six (6) Supported Employment providers' fidelity scores ranged from 70-75, considered Good Supported Employment. The average score was 73. One (1) provider's fidelity score was 64, considered Fair Supported Employment. In FY 2008, supported employment programs will be evaluated during the fourth quarter.

The Supported Employment Dixon Exit Criteria is that 70% of persons referred receive supported employment services within 120 days of a referral. The average for the reporting period of October 2007 through June 2008 is 95%.

A comparison of other state supported employment programs implementing the Evidence-Based Practice model was undertaken by DMH as part of a benchmarking process. In comparison to other states such as Maryland, Vermont, Connecticut, and Kansas, DMH's overall system capacity and number of consumers currently served compares favorably.

The Supported Employment Consumer Outcomes Table that follows provides performance outcome data for DMH approved supported employment programs for FY 2007 and October through June of FY 2008. It is noted that a successful job placement is defined as a consumer employed for thirty (30) days.

Supported Employment Consumer Outcomes Data:

Supported Employment Program	Number of Consumers Enrolled in Service		Number of Consumers Placed in Competitive Employment		Average Number of Hours Worked Per Week		Average Hourly Wage	
	FY07	FY08	FY07	FY08	FY07	FY08	FY07	FY08
D.C. Community Service Agency	108	63	22	22	20.0	20.0	\$8.00	\$8.00
Green Door, Inc.	78	113	52	67	27.9	26.9	\$10.09	\$9.50
Anchor Mental Health	75	70	32	32	27.0	24.2	\$9.50	\$10.00
Psychiatric Center Chartered	50	65	39	50	37.6	38.4	\$8.90	\$9.45
Community Connections	67	75	30	40	25.0	24.0	\$9.20	\$9.20
Pathways To Housing 1	0	49	0	6	0	19.0	0	\$8.10
Deaf Reach, Inc.2	24	44	11	9	24.0	28.0	\$8.00	\$9.00
Total:	402	479	186	226	26.92	25.79	\$8.95	\$9.04

Notes:

1 Pathways to Housing began operation in the first quarter of FY 2008.

2 Deaf Reach, Inc. provides services to individuals who are deaf and have a mental illness.

Supported Employment Programmatic Expansions: In FY 2006, through a request for proposal solicitation to increase services during FY 2007, an attempt was made to add a new supported employment program to serve adults as well as a new supported employment provider to serve Transition-Age-Youth. This process did not result in either of the intended outcomes, consequently there was no expansion of supported employment services in FY 2007.

In FY 2008, a new supported employment program was brought on-line to serve adults, bringing the total number of programs providing supported employment services to seven (7). Also in during FY 2008, the supported employment unit rate paid to supported employment programs was increased from \$45 to \$65 per hour to assist providers in covering costs associated with the service and so they could serve more consumers.

Supported Employment Social Marketing Strategy: The DMH has implemented a social marketing plan to educate clinicians, case workers and consumers about the availability of supported employment services. The social marketing plan consists of the following activities:

outreach to providers and consumers, promoting supported employment services through speaking engagements, training for providers and consumers, and development of an ongoing article in a local advocacy group newsletter.

Outreach activities during FY 2008 include presentations by the DMH Supported Employment Program Manager to various advocacy groups and government agencies. For example, recent presentations at the FamilyLinks Outreach Center, Inc. (a family member organization) and the Department of Youth Rehabilitation Services (DYRS) resulted in a total of eight (8) referrals. Other presentations to mental health service providers and referral sources (including the District of Columbia Public Schools) are scheduled by the end of FY 2008.

The DMH Supported Employment Program Manager collaborated with the DMH Training Institute and developed and implemented ongoing supported employment training targeted to clinicians and consumers. The training for clinicians is designed to help educate clinicians about consumers' ability to work and how to link consumers to supported employment services. The training for consumers is designed to help them understand the nature of supported employment services, that they can work, and how to request the service. The training will continue to be offered throughout calendar year 2008 to both consumers and clinicians. The initial clinician training session was conducted on March 26, 2008 and the initial consumer training session was held on March 27, 2008. The following training sessions were scheduled for June 26, 2008 (consumers) and July 24, 2008 (clinicians).

In addition, DMH is partnering with the D.C. Chapter National Alliance for the Mentally Ill (NAMI) to write two articles per year about supported employment services. The first article was published in May 2008.

Supported Employment Annual Employer Orientation: The first Annual Employer Orientation was held in May 2007 and the second one in June 2008. This event brings together potential employers with consumers and providers as a means of promoting supported employment job opportunities.

Other Employment Programs

In addition to the DMH Supported Employment Program evidenced-based model, Saint Elizabeths Hospital and the DC CSA operate Work Adjustment Training Programs (WATP). Also, the DMH Office of Consumer and Family Affairs has a small office-based program for consumers. The DMH Supported Employment Program Manager collaborates with the other employment programs.

Housing Services

The DMH provides supported housing for consumers with serious and persistent mental illness to assist them to select, acquire and maintain safe, decent, and affordable housing. Supported housing is defined as services and supports to assist individuals in finding/obtaining and maintaining appropriate housing arrangements. It is a specific program model in which a consumer lives in an apartment, house or similar setting, alone or with others, and has

considerable responsibility for housing upkeep and maintenance, but receives periodic visits from DMH staff, family and others for the purpose of monitoring and/or assisting with housing responsibilities.

Most participants in the DMH Supported Housing Program are homeless, at the time of referral. These consumers have extremely low incomes and without the availability of DMH supported housing resources, they would remain homeless. The scarcity of federal housing dollars and the continued high cost of rental units in the District of Columbia is an ongoing challenge.

The DMH continues its practice of prioritizing housing supports for persons who are homeless, discharge-ready from Saint Elizabeths Hospital (SEH), released from jails/prisons, other institutions and treatment settings, living in a community residential facilities (CRFs), living in substandard housing, or who require special needs assistance. The basic eligibility requirements are enrollment in a Core Service Agency (CSA), registered for a voucher with the D.C. Housing Authority, and willingness to pay 30% of income for rent.

The DMH maintains a formal application process – working through DMH housing liaisons from the individual's referring CSA. Qualified applications are either approved or placed on a waiting list. The DMH Housing Program maintains a housing vacancy list to assist in the housing search.

Guiding Principles of Supported Housing Program: The following principles guide the DMH Supported Housing Program: 1) consumers exercise choice about where they receive services, 2) consumers exercise choice about where they live and with whom they live, 3) the lease is signed by the consumer, not the agency, 4) the rent is paid by the consumer (or representative payee) directly to the landlord, 5) consumers pay 30% of their income for rent and DMH pays the remainder, 6) housing is integrated into the community.

Supports in Supported Housing: The “supports” in supported housing are critical to consumer recovery and success. They include but are not limited to: 1) MHRS services provided by Core Service Agencies, 2) life skills training, 3) socialization and leisure opportunities (loneliness can be a barrier to recovery), 4) money management, 5) identification of and access to community resources (banking, medical, shopping), 6) consumer education on tenant/landlord rights and responsibilities, 7) housing search and selection, and 7) move-in/move-out support.

Scope of the Supported Housing Program: The demand for housing is one of the highest priorities for consumers. The DMH Supported Housing Program assists people with psychiatric disabilities by providing affordable housing linked to individualized and flexible supports and services. The program provides bridge rental subsidies to adults with serious mental illness and children with serious emotional disturbances. Participants in the program include persons who are homeless, substance abusers, youth in transition, and persons ready to leave institutional and other treatment settings.

The DMH provides funding resources for both housing subsidies to assist consumers with leasing costs and capital funds that help finance the development of new affordable housing units. With regard to the latter, DMH entered into a Memorandum of Understanding (MOU) with

the D.C. Department of Housing and Community Development (DHCD) in November 2007 to develop 300 affordable housing units by September 2009. The DMH has transferred \$14 million to DHCD to be awarded as grants and leveraged with other local and federal funds for the development of affordable housing specifically for housing units for people with serious mental illness. This process (targeted toward the creation of 100 new units per year) has resulted in a total of 97 new housing units in the pipeline.

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

- Housing Partnership Model- The DMH is continuously expanding utilization of partnerships to better leverage/ maximize supported housing resources. Important partnerships have been established with both public and private housing and related agencies and organizations in the District, including the D.C. Housing Authority, D.C. Department of Housing and Community Development, the Agency for HIV/AIDS, and Advance Dispute Resolution Service (ADRS). The “supports and services” in supported housing are provided through the DMH Mental Health Rehabilitation Services (MHRS) provider network. These agency providers are contracted by DMH to provide clinical treatment services and supports.

The DMH formed a Housing Advisory Committee to advise it in implementing the housing development production goals and to provide continuous planning and monitoring of the DMH Housing Plan. The Advisory Committee consists of mental health advocacy groups, consumers, housing and support service providers and others.

- Housing Subsidies/Vouchers for Affordability- The DMH Bridge housing subsidies provide “temporary” subsidies until Federal vouchers become available to consumers. Housing is affordable to consumers who pay 30% of their income for rent. The DMH also has several MOUs with the D.C. Housing Authority for Federal voucher programs that provide additional housing for consumers.
- Capital Funds Used to Leverage other Public Sources of Housing Funds- The DMH capital fund is used to finance the acquisition, construction and rehabilitation of 100 new housing units per year through FY 2009.

Supported Housing Programs

Program	Total Housed
DMH Bridge Housing Subsidy	1133
Federal Vouchers	451
Totals	1584

Bridge Housing Subsidy Programs (Local Programs)	Number of Units
DMH Bridge Rental Subsidy Program <ul style="list-style-type: none"> • Tenant & Project-based bridge subsidy program • Consumer chooses housing & signs lease for housing • Consumer pays 30% of income for rent • Includes homeless, DC Linkage Program/Options /Jail Diversion, S.E.H., Long Term Supports Grant, victims of domestic violence, older adults, families, Pathways Housing First , transition age youth, dually diagnosed with mental illness & substance abuse, MR • Must be registered with DC Housing Authority 	665
Supported Independent Living (SIL) Contract <ul style="list-style-type: none"> • Includes Mental Health Rehabilitation Services (MHRS) as needed and documented in the Individual Recovery Plan (IRP); also monthly onsite visits and monitoring required by CSA - Anchor (41), Careco (5), Coates & Lane (35); Community Connections (240); Deaf Reach (15), Green Door (70); Woodley House (55) 	461
HIV/AIDS Administration (HAA/MOU)	7
Totals for Local Programs	1,133
FEDERAL PROGRAMS	
HUD Shelter Plus Care <ul style="list-style-type: none"> • Permanent housing subsidy program; targets homeless, dual diagnoses of mental illness, substance and /or HIV/AIDS 	181
HUD Mainstream Housing for People with Disabilities/MOU	40
HUD/DCHA Housing Choice Voucher Program – DMH Set-Aside/ MOU	50
HUD Partnerships for Affordable Housing- Project-based HCVP	73
HUD Housing Choice Vouchers – Pathways/ ACT	75
HUD Chronic Inebriates Grant - Pathways to Housing (Grant)	32
Totals Federal Housing	451
TOTAL LOCAL & FEDERAL SUBSIDIES	1584

Community Residential Facilities: In addition to the supported housing programs, a number of consumers reside in licensed 24-hour supervised group homes. There are 223 facility beds under contract with DMH and 441 facility beds that are independently operated. All of the facilities are licensed by DMH.

Strengths and Resources of the DMH Housing Program: The strengths and resources include:

- Housing Data Base- The data base provides the capacity to track and report accurately critical housing activities. This program tool was started in FY 2007 and will continue to assist in the improvement of the overall program.
- Draft Housing Rules- The current Supported Housing Rule is being revised. The new Housing Rules are being drafted and include a review process with many stakeholders. The plan is to have the draft ready for public review and comment prior to the end of FY 2008.
- Consumer Briefings- This is a session that formally introduces the consumer to their housing rights and responsibilities and provides information about how to maintain their housing, good housekeeping, and how to be a good neighbor. These briefings began in July 2008.
- Eviction Prevention Resources- The DMH utilizes two (2) primary tools for prevention of evictions:
 1. MyHouse Project- During FY 2006, planning began for the MyHouse Project, a pilot project funded by the Conrad Hilton Foundation for assisting District of Columbia tenants who are consumers of mental health services in danger of losing their homes. The project uses mediation rather than traditional court proceedings to facilitate landlord/tenant communication in order to avoid potential homelessness. The project was implemented during FY 2007 and continued during FY 2008.
 2. Emergency Rental Assistance Program (ERAP)- A Department of Human Services (DHS) program that helps low income citizens who face housing emergencies.
- Housing Vacancy List- This listing of available housing is distributed citywide to mental health and other community agencies. It serves as a resource for affordable housing across the city and lists a variety of housing that is available to consumers for lease.
- Landlord/Developer Network- The DMH works with over 200 landlords and developers. Special Cluster Meetings with landlords help solve problems and expand their knowledge and understanding about mental illness and recovery. All DMH housing is made available by these business owners and managers. Plans are underway to expand this network.
- Housing Liaison Network- Each Core Service Agency (CSA) in the DMH provider network has designated at least one person to serve as the central point of contact for housing applications and related issues. Monthly meetings with this group assist with the coordination of supported housing across the city.
- Monthly Home Visits- The CSA staff conduct visits with consumers once per month and submit a report on housing satisfaction, payment of rent and status of repairs.
- Federal Housing Grant Resources- These resources during FY 2008 include:
 1. Projects for Assistance in Transition from Homelessness (PATH)- provides \$57,000 for one-time payments for security deposits and to prevent eviction for persons who are homeless.
 2. Mental Health Block Grant- Provides \$380,000 in bridge subsidy funding
 3. Real Choice Systems Long Term Supports and Housing Grants:

- This grant is designed to address the need to improve access and coordination of long-term supportive services with affordable housing for persons with mental illness, mental retardation and/or developmental disabilities (MI/MRDD) and transition age youth. This project brings together government agencies that address the needs of this population and service provider organizations responsible for housing, to remove barriers to accessing housing and to increase homeownership for these targeted citizens through an improved infrastructure. The grant effort concentrates on the following tangible results: 1) an integrated and streamlined process for applying for Medicaid funded long-term supports and housing choice options; 2) a mechanism is being established to pay for transition needs (i.e., rental deposits, furniture, bedding, etc.) of individuals moving out of an Intermediate Care Facility for Mental Retardation (ICF-MR) to community housing; 3) a process has been developed that provides individuals with disabilities access to housing of their choice, to include both individual and collaborative relationship housing options; 4) a Section 1115 Research and Demonstration Project Medicaid waiver will be created to eliminate barriers that prevent individuals sharing a home from pooling long-term supports; and 5) a new infrastructure is being developed comprised of the District agencies that will facilitate implementation of housing options for persons with disabilities who can receive information and support in the process of purchasing their own home. A Housing Advisory Group was established comprised of consumers, advocates, housing representations, Medical Assistance Administration and other stakeholders. The Advisory Group meets monthly to develop the infrastructure for long-term supports and housing. This grant project currently houses 10 individuals with mental retardation or who are developmentally disabled and 10 transition age youth.
 - Assets for Independence Grant (not activated) - The Assets for Independence (AFI) demonstration project will establish an Independent Development Account (IDA) program targeting mental health consumers with a particular emphasis on alleviating poverty through the promotion of homeownership. Through the use of matching deposits and supportive services, DMH will help low-income mental health consumers to acquire both the capital and the skills that they need to set goals for the future, integrate themselves into the mainstream economy, and achieve economic self-sufficiency. In order to achieve the project goal, DMH has established four strategic objectives: 1) increase the number of project participants who are homeowners, 2) increase the number of project participants who acquire post-secondary education, 3) increase the number of project participants who create or expand a micro-enterprise, and 4) enhance the capacity of the national AFI program to support mental health consumers. The DMH has identified the non-public funding match and plans to begin implementation now that the match has been identified. The grant requires a \$200,000 local match in order to become activated. It is anticipated that this grant will be activated during FY 2009.
4. Shelter Plus Care- Through the HUD SuperNOFA grant process under the Continuum of Care, DMH placed number one in the new programs category and received 20 new Shelter Plus Care Program subsidies.

Housing Program Dixon Exit Performance Criteria: The Housing Program Dixon Exit Performance Criteria is that 70% of adults with serious mental illness receive supported housing services within 45 days of a referral. One of the types of supported housing services is assistance with obtaining and maintaining housing. During the Court Monitor reporting period (April 1, 2007 through March 31, 2008) 37 consumers met this criterion. The percentages based on the total number of consumers housed across the four quarters show that 5%, 7%, 10% and 3% respectively were housed within 45 days.

The DMH staff and the Court Monitor have had ongoing discussions regarding the specific Exit Criterion for Supported Housing (especially services versus housing). Despite the overall DMH efforts, the scores for this criterion continue to be very low. The DMH has is undertaking an in-depth review of this issue. A Dixon Supportive Housing Work Group has been created and an outside consultant from the Corporation for Supportive Housing (CSH) has been engaged. The beginning steps are to create an inventory of all supported housing programs/units within DMH and analyze the current ability of DMH to capture complete data on individuals referred to housing within provider agencies.

Educational Services

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

Ida Mae Campbell Wellness and Resource Center: This DMH funded peer supported center opened in June 2008. The activities include communication and education, work enhancement skills and computer training, wellness recovery and peer support, advocacy, creative arts and social activities.

Consumer Action Network: This consumer run organization provides forums on various topics. The most recent was held in August 2008 entitled, "Educational Opportunities for Developing Skills."

D.C. Community Services Agency (DC CSA): The DC CSA has consolidated its two consumer education programs, Computer Training Center and Life Long Learning Center, into one centralized location. The services include: basic computer literacy, employment related services (cover letter and resume writing), searching employment websites, referral for adult educational programs (literacy and remedial educational instruction including preparation for the General Equivalency Diploma/GED).

Office of Consumer and Family Affairs (OCFA): The OCFA has focused on educating consumers about community resources so that they do not depend totally on DMH for services that are available in the community. This education has included resources such as assistance with utilities, food banks, rehabilitation services for those consumers who want employment options and other essential needs of consumers living in the community. During FY 2008, the OCFA staff continued to conduct consumer rights training to educate consumers about their rights and responsibilities associated with receiving services and supports from the mental health system. The OCFA also continued oversight for the peer grievance contract being implemented

by the Consumer Action Network (CAN) that involves educating consumers about the grievance process including how to file a grievance.

DMH Training Institute: The Dixon Final Court-Ordered Plan (March 2001) required the establishment of a departmental Training Institute. When the DMH Training Institute was established in August 2001, the primary focus was educating the stakeholder community of providers, consumers, family members, advocates and citizens about the new system reform under the Medicaid Rehabilitation Option (MRO) and the new Mental Health Rehabilitation Services (MHRS) that were being launched in the District of Columbia. The first Institute series was held September-December 2001 throughout ten training venues across the city. During the first 16 months of the Training Institute, most of the training sessions covered MRO and MHRS issues.

Over time, the Institute's Fall and Spring training series broadened the scope of course offerings and provided information on a range of topics (i.e., mental health diagnoses, consumer populations (child/youth, adults, older adults, homeless), consumer choice, consumer leadership skill building, family member issues, recovery model, MHRS training, service delivery models and settings, co-occurring disorders, cultural competency, evidence-based practices, privacy issues (HIPAA), workforce development issues). After six successful years of implementation, the DMH Training Institute has evolved and expanded its focus to become a primary mental health workforce development training and community education medium for the District Government, their human services provider partners, consumers, their caregivers and family members, advocates, and community residents. The training program is developed in collaboration with these partners, as well as academic, professional, and federal agencies. An important feature of the DMH Training Institute is the award of continuing education units (CEUs) for several disciplines.

During FY 2008, a Fall, Spring and Summer training series was implemented. Also, the Deputy Director of the DMH Office of Programs and Policy and the new Coordinator of the DMH Training Institute independently conducted one-on-one interviews with DMH stakeholders to assess areas of stated need for staff development and training with senior program and management staff. In addition, DMH policies, reports, assessment results, and workgroup findings were reviewed to identify immediate training needs. Some of the identified and emerging priority areas for training include: 1) provider and consumer access to services and supports, 2) practice-oriented, on-going MHRS training, 3) computer literacy and customer service, 4) best practice and evidence-based models of treatment, and 5) quality improvement and data-driven clinical decision making.

Substance Abuse Services

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

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

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

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

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

Memorandum of Understanding (MOU) with the Addiction Prevention and Recovery Administration (APRA): Since FY 2006 DMH and APRA have had a MOU whereby APRA would provide choice in drug treatment vouchers and mental health services at the detoxification facility for persons with mental illness and co-occurring substance abuse disorder. This has led to two Social Work positions at the APRA Assessment and Referral Center to screen for mental health issues, and one Social Work position at the APRA Detoxification Facility.

Medical and Dental Services

Mental Health Rehabilitation Services (MHRS): The documentation of annual physicals is a MHRS requirement. Health services are available through medical and dental services clinics provided through Saint Elizabeths Hospital, medical services provided by the DC CSA, as well as the District's community health system.

The DMH currently provides free medical as well as psychiatric medications to those individuals who do not have Medicaid or other means to purchase them. The Department's goal is to increase the number of consumers enrolled in the D.C. Health Care program and other medical resources. A resource guide was developed and disseminated that includes information on how to assist those consumers who do not have Medicaid in accessing health insurance through the D.C. Health Care program. The focus has been on coordinating services through other health care providers while concentrating on providing care to consumers difficult to connect to other medical services (i.e., geriatric and undocumented consumers).

D.C. Medication Algorithm Project (D.C. MAP): The D.C.MAP has been implemented throughout the District system of care and Saint Elizabeths Hospital. Algorithms for schizophrenia and depression have been distributed. The D.C.MAP has a consumer/family education component that is very helpful for consumers in understanding the nature of their illnesses, use of medications, reasons to continue medications, and self-assessment. Easy to understand, consumer educational materials have been developed in English and Spanish.

Prescribing Practices: The DMH is working with the Medical Assistance Administration (MAA) and their contractor (Comprehensive Neuro-Sciences) to analyze medical point of sell data by examining poly-pharmacies and dosage of all psychotropics. Beginning in FY 2005, a plan was

initiated for prescribers whose practices fall outside of practice guidelines, whereby educational letters would be forwarded to have them review their prescribing practices.

Dixon Exit Criteria on Newer Generation Medications: In FY 2007, there was agreement between the Court Monitor and DMH that the Department met the Dixon Exit Criteria to increase the number of adults with schizophrenia who receive the new generation antipsychotic medications to 70%. This performance measure was monitored during FY 2008 and will continue to be monitored during FY 2009.

Support Services

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

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

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

Another key function of the OCFA is its role as the Streicher Coordinator, which involves tracking, monitoring and ensuring that Periodic Psychiatric Examinations (examinations to determine if a consumer should remain on committed status) are conducted for all committed consumers (inpatient and outpatient). Also, in its role as the Streicher Coordinator, OCFA is also responsible for tracking, monitoring and ensuring that "Certificate of Physicians (Renewal of Commitment) is completed in accordance with established deadlines.

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

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

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

Multicultural Services: The DC CSA Multicultural Community Support Program (MCSP) provides a range of mental health services for the ethnic, cultural, and linguistic minority communities in the District. The MCSP also provides language translation including document development for limited and non-English proficient individuals, and developments data on the city’s diverse ethnic populations.

The DMH developed the Biennial Language Access Plan for 2007-2008. The purpose of the plan is to establish and provide greater access and participation in public services, programs and activities for District residents with limited or no-English proficiency (LEP/NEP) who access services and information through DMH. “Access and participate” means to be informed of, participate in, and benefit from public services, programs, and activities offered by DMH at a level equal to English proficient individuals. The removal of language barriers is critical to achieving access to needed services. In accordance with Section 5(a) (2) of the Language Access Act of 2004, each Language Access Plan (LAP) shall be updated on a biennial basis or every two years. The BLAP will be reported to and is subject to the review of the Mayor and City Administrator.

During FY 2007-2008 DMH: 1) enrolled and treated approximately 100 LEP/NEP consumers (D.C. CSA and Saint Elizabeths Hospital), 2) translated and printed materials (DMH Access Helpline cards, DMH organization and services description, DMH Language Access Program Description, glossary of terms that are commonly used by DMH), and other vital documents into Spanish, Amharic, Vietnamese, Chinese and Korean, 3) provided 60 hours of cultural competence related trainings to staff DMH and core service providers through the DMH Training Institute, 4) hired 43 bilingual and or multilingual employees, 5) provided outreach to community-based organizations that primarily provide services to the LEP/NEP communities (Clinical del Pueblo, Mary Center, Centro Catolico, Neighbors Consejo, Newcomers Community Service Center, Ethiopian Community Center, etc), 6) conducted a public meeting for the staff of the Mayor’s Offices of Latino Affairs, Asian and Pacific Islanders Affairs and African Affairs regarding Mental Health Rehabilitation Services and provided an orientation on the requirements and certification process for community service providers to become DMH certified Core Service Agencies.

Case Management Services

The DMH strives to create an effective, welcoming, community support/case management system that is based on the consumer strengths and choices, promotes recovery through the

attainment of individualized goals to help the consumer develop the skills to live the best possible quality of life, and provides aggressive outreach to maintain consumers in the community. The DMH case management is provided to consumers in a number of ways by both DMH practitioners and private providers and is based on the individual consumer's treatment needs as determined through the individualized recovery planning process where attainable, mutually agreeable goals and objectives are developed. Each consumer is assigned a clinical manager (case manager) and qualified practitioner to coordinate consumer care, often across multiple provider agencies and to provide rehabilitation services, treatment and supports. At a minimum of every 90 days the consumer's clinical manager is responsible for assessing with the consumer each of the consumer's major life domains and assess which areas of need are to be worked on for the next time period.

The following values and principles guide the DMH in achieving this goal of effective case management:

- Consumers are provided choice in choosing their Core Services Agency, Clinical Manager, and type of housing.
- Consumers can expect to be provided empathetic, hopeful, rehabilitative services that develop measurable skills to promote successful independent living.
- Clinical Managers maintain continuous responsibility for their client until the consumer chooses another Clinical Manager or recovers; responsibility continues even when the consumer is hospitalized, in a residential setting, or incarcerated.
- The DMH is committed to expanding the scope of community-based services
- The DMH provides a comprehensive and effective continuum of assessment and treatment and assures movement within service settings so that the most appropriate, least restrictive setting is utilized when available.
- All DMH consumers have the right to access high quality care in a timely manner.
- The DMH facilitates the integration of a full range of services that is available to each consumer and meets the mental health needs of each consumer.
- The case manager is supported by regular supervision, both administratively and clinically, from managers and/or senior clinicians. The DMH provides on-the-job training and course work to supplement the basic qualifications of the case manager.
- Services will be provided in the least restrictive, most appropriate setting.
- Clinical Managers and providers strictly respect the confidentiality and privacy rights in all treatment planning and provision of services. Complete adherence to all confidentiality mandates pursuant to local and federal regulations will be maintained at all times.

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

The DMH has continued its national "best practice" model for the planning and delivery of integrated services for persons with both mental illness and substance abuse. The DMH and Addiction Prevention and Recovery Administration (APRA) continue to provide joint support for this federally-funded effort (Co-occurring State Incentive Grant/COSIG). The status of the four major objectives for this initiative in the third year of the Grant include:

1. System Supports for Integrated Service Delivery- The focus is on aligning both agency's rules, policies and processes to promote an integrated "no wrong door" model. A key cross-agency initiative is the Youth Work Group, which has identified a significant funding source for youth (Medicaid Early Periodic Screening, Diagnosis and Treatment/EPSDT) and is working to engage, train and certify local providers to serve co-occurring youth.
2. Universal Screening for Co-Occurring Disorders- Both DMH and APRA have now adapted standards that require all consumers seeking service to be screened for co-occurring disorders.
3. Expand Workforce Competencies in Co-Occurring Disorders- The DMH has developed a comprehensive 100-hour Clinical Competency Certificate Program. This training manual will soon be available in final form to DMH, APRA and community agencies either as a comprehensive training package or for specific modules. The training effort for clinical staff has been ongoing over the past year and half and is on expected to meet the goal of training 150 professionals by August 2008.
4. Continuous Quality Improvement Supports for Cross-Agency Improvement of Consumer Outcomes- The DMH, with the assistance of George Washington University, has developed a Clinically Informed Outcome Management (CIOM) project. This project is currently being piloted with several DMH and APRA providers. The CIOM project collects consumer self-reports on treatment effectiveness on a continuous basis and provides immediate feedback to treatment teams.

Other Activities Leading to Reduction of Hospitalization

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

Crisis Stabilization: Each Core Service Agency (CSA) must have an on-call system for crises and provide a crisis plan for each consumer in their Individual Recovery Plan (IRP) or Individual Service Specific Plan (ISSP). The DC CSA is certified to provide crisis/emergency services that include mobile and on-site crisis assessment and stabilization services 24 hours a day, seven days a week and serve as a central point of entry into DMH for non-DMH consumers experiencing crises, especially those requiring hospitalization. The Access HelpLine also receives referrals for crisis services.

Crisis Beds: The DMH currently funds two providers for a total of 15 crisis beds. These include eight (8) at Jordan House and seven (7) at Crossing Place.

Use of Local Hospitals for Acute Care: The DMH has an agreement with Greater Southeast Hospital for a 20-bed acute care unit, which is running at full capacity with an average of 28 DMH admissions per month from DMH referrals for the first six (6) months of FY 2008.

The DMH has negotiated an agreement with Providence Hospital that should become operational in September 2008. This agreement will provide up to 10 beds for DMH as part of an existing

25 bed inpatient acute unit. The general contractual arrangements will be similar to Greater Southeast, namely that Providence will provide involuntary acute care to designated DMH patients for up to 14 days.

Comprehensive Psychiatric Emergency Program (CPEP): The CPEP is managed by the DMH Mental Health Authority and is located on the grounds of the District of Columbia General Hospital (DCGH). It functions as the exclusive site-based facility to provide emergency psychiatric services for District residents who are 18 years of age and older and need crisis services. The program provides: 1) acute psychiatric and medical screening and assessment of persons in crisis, and 2) observation for up to 72 hours and intensive psycho-pharmacological and psychotherapeutic services.

The CPEP provides services, 24 hours a day, seven days a week and includes crisis assessment and stabilization. There is a total of six (6) beds, four (4) of which are psychiatric observation beds on site. Two (2) of these beds are reserved for persons who present a danger to self or others and need to be restrained. These individuals are usually brought to CPEP by the Metropolitan Police Department (MPD) and admitted involuntarily. Restrained consumers require one-on-one observation and monitoring and in some instances, require staff to handle their violent or combative behavior.

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

During FY 2008, CPEP served an average of 281 individuals per month with approximately 54% involuntary admissions and 34% psych admissions.

Crisis/Emergency Services Planning Work Group: The DMH initiated a 10-month process to develop a Comprehensive Plan for Crisis/Emergency Services for adults. The original work groups that oversaw the plan development have continued to meet on a quarterly basis. There are several noteworthy developments that are a direct result of this planning effort that include:

- Court Urgent Care Clinic (CUCC): The DMH is funding a CUCC located at the D.C. Superior Court that provides on-site mental health evaluations and referrals for individuals coming before the court. The Psychiatric Institute of Washington (PIW) was awarded the contract that became operational in June 2008.
- Same Day Evaluation and Referral: The DC CSA has implemented an initiative to provide same day evaluation and referral for adults needing more immediate interventions.

- Mobile Crisis Services: The Director of the new mobile crisis services has been recruited. The plan is to have five 2-member teams to provide 16 hours of coverage 7 days per week. The goal is to have this service fully operational by October 1, 2008.
- Proposed Rules for Officer-Agent Certification: The DMH has published proposed rules for certification of Officer-Agents. These rules establish a DMH Officer-Agent Certification Committee and clarify the eligibility and training required to become a DMH Officer-Agent. The final Officer-Agent rules were published in the District Register on July 11, 2008.

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

The DMH is committed to providing an Integrated Care Model with a Case Rate financing mechanism that promotes and supports individualized, flexible, effective and efficient services designed to assist these consumers to function effectively in the community. To this end, DMH proposes a new funding model that incorporates an aggregate Case Rate that includes the continued use of the Mental Health Rehabilitation Service (MHRS) fee for service structure. The goal of this financing structure is to provide the vendor with the necessary resources and flexibility to ingrate service as needed and defined by the consumer. The cost of all needed services will be covered by the combination of the aggregated rate and reimbursement for MHRS services. The model also incorporates outcome measures and goals based on systemic values that are combined with guidance, oversight and training provided by DMH. There is ample evidence that with creative, flexible, individualized approaches, these individuals can succeed in the community. The literature and experience of similar projects strongly support the potential for success.

This Project is important to DMH because it allows the service provider and consumers to achieve their full potential when provided with flexible funding, strong leadership, appropriate outcome and clinical training. The RFP solicitation for this service was disseminated on July 18, 2008.

Saint Elizabeths Hospital Census Reduction Initiative: During FY 2005 and FY 2006, the Saint Elizabeths Hospital census ranged between approximately 412- 431 (average is 200-225 on the civil side and 206-212 for forensic). During FY 2007, there was an average census of 428 patients (210-Civil and 218-Forensic) and during FY 2008 to date, there was an average census of 412 (216-Civil and 196-Forensic). The hospital is in the process of being reduced to accommodate a 292 bed new facility projected to open in early 2010.

To accomplish this reduction in census, the DMH Office of Programs and Policy has been focusing on working with the community provider network and the hospital on a weekly basis to facilitate discharge planning, assist in resource utilization and development towards placing

consumers in the least restrictive setting that best meets their individual needs. The plan and process includes developing services and resources for individuals with special needs such as mental retardation, developmental disabilities, hearing impaired or persons with physical disabilities. Also the process engages community providers in transition planning and efforts to promote continuity between the hospital and community.

Saint Elizabeths Hospital still has major responsibility for adult forensic services, however there are a number of special initiatives that the community is exploring that would enable that population to return to the community sooner and provide the additional support to assure a successful transition for the consumer and provide safeguards for the community. One of those initiatives includes consideration of moving the outpatient follow-up services for insanity acquitees on court ordered conditional release from the hospital to Core Services Agencies instead of it being a component of the hospital. This multi-year initiative will require extensive discussions with criminal justice stakeholders and legislative change.

In FY 2006, The DMH Authority, Saint Elizabeths Hospital and the D.C. Community Services Agency (DC CSA) collaborated with the Court, United States Attorney’s Office for the District of Columbia, the defense bar, and the Court Services and Offender Supervision Agency (CSOSA) to implement the *Incompetent Defendants Criminal Commitment Act of 2004* which became law on May 25, 2005. The statute permits defendants adjudicated incompetent to stand trial in D.C. Superior Court to be treated and restored to competency while in the community unless the Court finds that an inpatient setting is necessary to provide appropriate treatment or the defendant is unlikely to comply with an order for outpatient treatment. Outpatient treatment, competency restoration and evaluation are a collaborative effort of the clinical staff from the DC CSA and Forensic Legal Services clinical staff. The DMH in collaboration with Saint Elizabeths Hospital, the Court and other criminal justice stakeholders continue to explore ways to enhance outpatient competency restoration services so that treatment and evaluation outside of a hospital setting will be a viable alternative for an increasing number of defendants.

Evidence-Based Practices

The DMH is implementing a number of evidenced-based practices (EBPs) and promising practices, (i.e., supported housing, supported employment, medication algorithms, integration of mental health and substance abuse services, and assertive community treatment) for persons being released from Saint Elizabeths Hospital, from jails and prisons, persons who are high users of emergency services, and chronically homeless individuals. The table that follows briefly summarizes these initiatives.

EBPs/Emerging Best Practices	Activities	Partners	Issues/Solutions
Supported Housing	Working with public and private partners on permanent housing for persons with SMI. Administering federal grant program on long-term supports and housing for persons with mental illness and mental	Housing Authority (DCHA), Department of Housing and Community Development (DCHCD), Community Partnership for the Prevention of Homelessness (TCP), Department of Disability Services (DDS), Child	Finding safe, decent and affordable housing for consumers with extremely low incomes. Continue the rental subsidy program to bridge the gap between consumer financial resources (primarily entitlements) and housing costs.

EBPs/Emerging Best Practices	Activities	Partners	Issues/Solutions
	retardation and transition age youth. Trying to reach Dixon Exit Criteria target that 70% of persons referred receive housing services within 45 days of a referral.	and Family Services Agency (CFSA)	
Supported Employment	Implementing the Individual Placement and Support (IPS) model at seven agencies. Trying to maintain the Dixon Exit Criteria target that 70% of persons referred receive services within 120 days of a referral.	Rehabilitation Services Administration (RSA), Dartmouth Psychiatric Research Center, ISP providers (i.e., Anchor Mental Health, Community Connections, Deaf-Reach, D.C. Community Services Agency, Green Door Pathways D.C., Psychiatric Center Chartered	A service access issue has been raised, namely does everyone who wants the service receive it. DMH increased the daily rate and brought on a new provider on-board to increase capacity. A social marketing plan has been implemented directed at providers and consumers. DMH will explore developing a Medicaid waiver for supported employment to bring in federal funds along with local dollars.
Assertive Community Treatment (ACT)	Collecting and analyzing data, providing information to ACT teams, and providing consistent procedures across teams, and educating referral sources and stakeholders about service. Trying to reach Dixon Exit Criteria target that 85% of persons referred receive services within 45 days of a referral.	Pathways to Housing, DC CSA, Family Preservation Services, Inc.	Developed ACT Policy, hired ACT Coordinator, developed ACT Steering Committee. As a result of capacity, composition and clinical issues, conducted baseline fidelity audit of each team to determine training and technical assistance needs.
Medication Algorithms	Implementing D.C. MAP (provision of newer generation antipsychotic medications to adults with schizophrenia). In 2007 reached the Dixon Exit Criteria target that 70% of persons with schizophrenia receive these medications.	Saint Elizabeths Hospital and provider network	DMH is working with the Medical Assistance Administration (MAA) to analyze medical point of sell data by examining poly-pharmacies and dosage of all psychotropics. Educational letters are sent to have prescribers review their practices. In active monitoring status of Dixon Exit Criteria.
Integrated MH/SA Services	Implementing a comprehensive, integrated systems model for persons with mental illness and co-occurring substance abuse disorder via a Co-Occurring Disorders State Incentive Grant (COSIG).	Department of Health (DOH)/Addiction Prevention and Recovery Administration (APRA)	The COSIG is the mechanism by which the integrated model for individuals with mental health and substance abuse issues is being implemented.
Jail Diversion	DMH jail diversion program called D.C. Linkage Plus, provides pre- and post-booking continuity of care services for individuals with mental illness connected to the	DMH Options Program at Community Connections, D.C. Superior Court, Supervision Unit of D.C. Court with Pre-trial Services and	In March 2005 a MOU was initiated between D.C. Pre-trial Services (PSA), Court Services and Offender Supervision Agency (CSOSA) and DMH to ensure full integration of systems so that service delivery

EBPs/Emerging Best Practices	Activities	Partners	Issues/Solutions
	criminal justice system; screening and referral for individuals referred from traffic court; and funds substance treatment and housing for women referred pre and post arrest for services.	Traffic/Community Court, Central Detention Facility (jail), N Street Village Recovery House	is completely seamless. In late FY 2005, D.C. Linkage Plus was launched as the umbrella program for the DMH jail diversion services. In FY 2006 DMH and Criminal Justice Coordinating Council awarded a Bureau of Justice Assistance Grant to develop an overall strategic plan for persons with serious mental illness or co-occurring conditions who are involved with the criminal justice system. This plan was based on the Sequential Intercept approach and implementation began in January 2008.
Offender Re-Entry Program	DMH participates in the District's community re-entry program for serious, violent offenders between the ages of 18-35 who are returning from the Federal Bureau of Prisons. It is estimated that approximately 2500 will return each year. DC conducted pilot program (FY 2004- FY 2006) for 400 previously incarcerated persons. DMH provides assessment and referral to appropriate mental health services.	Court and D.C. multi-agency venture	DMH has a Mental Health Coordinator at the assessment service site to provide the mental health services and accept D.C. Linkage Plus referrals from Court Services and Supervision Agency (CSOSA) and the Bureau of Prisons.

Annual Adult Community Services Reviews

The Final Court-Ordered Plan required that performance measures be developed and used within a methodology for measuring service system performance. The Annual Community Services Reviews (CSRs) for adults and children fulfill this mandate.

As in previous years the Court Monitor contracted with Human Systems and Outcomes (HSO) to conduct Year 6 (2008) reviews for both children/youth and adults. The changes that were agreed to and fully implemented in Year 6 include: 1) sample cases were significantly increased, 2) HSO reviewers conducted approximately two-thirds of the reviews and DMH one-third, 3) HSO provided a case judge function for all DMH-reviewed case, and 4) maximal effort was given to doing reviews for the selected sample with careful scrutiny on any needed replacement cases.

The sixth year of the Adult CSR was conducted during the first two weeks in June 2008. The total number of cases reviewed was 88, which was the target for statistically acceptable numbers. The Year 6 (2008) results show that 74% of the cases reviewed were in the acceptable range for

individual consumer status. This compares favorably to Year 5 (2007) results at 69% and Year 4 (2006) at 65%. Year 6 (2008) showed very positive results in areas of safety (82%), economic security (84%) and overall satisfaction (88%). Scoring less positively were areas of education/career preparations (39%), work (44%) and recovery activities (54%).

The Year 6 (2008) results for system performance were also at 74%. While lower than the Year 5 (2007) mark of 80%, this score represents a stable pattern of performance in the overall adult system. High performances continued for: engagement efforts by staff (83%), culturally appropriate practice (95%), and medication management (80%). The systems areas that scored low were service team formation (53%) and service team functioning (51%). It was very evident from the adult debriefings that consistent efforts to communicate and collaborate among the core practitioners would bring this performance level above the Court-required standard of 80%.

District of Columbia

Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

Definition of Serious Mental illness

Prior to FY 2002, the Department of Mental Health (DMH) defined serious mental illness as follows:

- Extended or repeated psychiatric hospitalization, or
- Multiple episodes or intensive outpatient care (i.e., day program services, emergency services), or
- Poor reasoning and/or perceived likelihood of injury to self or others. (The likelihood of actual danger need not necessarily be physical or involve violence. Likelihood of injury includes situations wherein the person inadvertently places himself/herself in a position of danger or harm to self or others), or
- Remission periods reflecting only partial rather than full recovery and return to the community, or
- Daily functioning that demonstrates persistent problems in a general life area (i.e., self-care, cognitive, emotional, social, economic, vocational/educational, residential and/or recreational).

Further, the DMH clinically defined a person who is seriously mentally ill according to diagnostic classification. He or she was a person who:

- Has a diagnosis on Axis I or II as contained in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV),
- Has or had a DSM Axis V Global Assessment Function Scale (GAF) of 50 or less, and
- Will need to be in treatment indefinitely because the GAF is likely to remain less than 51 if not in treatment.

The definitions were operationalized as follows:

- A DSM-IV 295 or 296 diagnosis (schizophrenia or major affective disorder);
- Extended psychiatric hospitalization of 90 days or more in a one year period of time;
- Two or more hospitalizations within a year; and
- Danger of injury to self or others.

At the time, these definitions were consistent with the orders in *Dixon vs. Fenty* and its civil commitment law. As the District's mental health system has continued to evolve, a review of the

definition of serious mental illness was undertaken. A new definition of serious mental illness is captured in Chapter 12, Title 22A, DCMR. Persons with serious mental illness are:

Individuals age 22 or over who currently have, or at any time during the prior year have had, a diagnosable mental, behavioral or emotional disorder (including those of biological etiology) that:

- Is or was of sufficient duration to meet diagnostic criteria specified within DSM-IV or the ICD-9-CM equivalent (and subsequent revisions), except for DSM-IV “V” codes;
- Is not a substance abuse disorder or a developmental disorder, unless co-occurring with another diagnosable mental illness; and
- Results, resulted in, or will without treatment or other support services result in a functional impairment that substantially interferes with or limits one or more major life activities, including basic daily living skills, instrumental living skills, and functioning in social, family and vocational or educational contexts.

In FY 2003, implementation began on a Level of Care Utilization System (LOCUS), for adults, to support the clinical operationalization of the new definition. The LOCUS has proven easy to use and has shown a high degree of inter-rater reliability. The DMH has used this instrument successfully in the reconfiguration of residential service placements and rates for adults with serious mental illness.

During FY 2005, DMH began to fine tune developmental activities related to establishing priority populations and priority services. Draft adult and child priority populations were developed. For adults, the profile includes persons who:

- Have a serious mental illness
- Are involved in the criminal justice system
- Have been recently discharged or diverted from an inpatient stay
- Are homeless or at risk of homelessness
- Have been dually diagnosed as having substance abuse disorder and/ or mental retardation/developmental disability

Priority services would be considered those services that: 1) that assist consumers in their recovery or building resiliency, and 2) help consumers stabilize; reduce psychiatric or behavioral symptoms that could lead to incarceration, homelessness, institutionalization or continually chaotic lives. These include:

- Assertive Community Treatment
- Jail/Residential Treatment Diversion Services

- Mobile Crisis
- Crisis Emergency
- Supported Employment
- Community-based Intervention

The DMH conducted orientation sessions with MHRS providers on the priority populations and priority services during the fourth quarter of FY 2005.

During FY 2006, the DMH Chief Clinical Officer chaired a Priority Populations Work Group that included provider representation. This body developed clinically-based, draft criteria for DMH's refinement and operationalization of its focus on Priority Populations. As part of this process, draft definitions for priority adult and child populations were developed. The Adult priority population is defined as follows:

1202 PERSONS WITH SERIOUS MENTAL ILLNESS

1202.1. Persons with serious mental illness are:

District of Columbia residents;

- (a) Who are over the age of 18 (or over the age of 21 if in special education, MRDDA, or in foster care);
- (b) Have at any time in the last year received a DSM Axis I diagnosis or the diagnosis of Borderline Personality Disorder;
- (d) Have either a:
 - (1) documented significant treatment history as defined in §1202.2; or
 - (2) coexisting condition or circumstance as defined by §1202.6.

1202.2 A significant treatment history is defined as any one or combination of the following:

- (a) Current residence in or discharge from an inpatient psychiatric facility, or community or correctional inpatient mental health service where the admission(s) totaled twenty (20) or more days within the past two (2) years;
- (b) Five (5) or more face-to-face contacts with mobile crisis or emergency services within the past two (2) years; or
- (c) A history characterized by the previous or current treatment of symptoms that was unsuccessful at achieving control or remission of symptoms even with intensive and/or repeated exposure, the result of which was limited

success in symptom control even for short periods of time outside of structured settings

1202.3 A coexisting condition or circumstance is defined as:

- (a) Release from criminal detention within the last year; or
- (b) Court ordered to treatment; or
- (c) A risk of harm certified by a qualified practitioner to be serious to extreme as evidenced by symptoms as severe or more severe than any one or combination of the following:
 - (1) Current suicidal/homicidal ideation with expressed intentions and/or a past history of carrying out such behavior;
 - (2) A history of chronic impulsive suicidal or homicidal behavior;
 - (3) A recent pattern of excessive substance use resulting in disinhibition and clearly harmful behaviors with little or no ability to abstain from use; or
 - (4) A clear compromise of ability to adequately care for oneself or to be adequately aware of the surrounding environment.

It was envisioned that an expanded work group, including clinicians and administrators with financial and data expertise would use the clinical criteria to frame how *Priority Populations* would be operationalized. This process was revisited during FY 2008.

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

Description of Estimation Methodology

The District of Columbia originally developed prevalence estimates in the early 1990s. These prevalence estimates were based on Epidemiological Catchment Area (ECA) data, and assumed that sociodemographic characteristics in most areas have a general consistent relationship to psychiatric disorder as measured in the ECA study. Indirect estimation was employed to project six-month prevalence rates of mental illness for adult residents in the District.

In brief, a multivariate estimation model was developed which was based on a cross classification of five categorical variables drawn from the 1990 Decennial Census for the District. These variables, which have a demonstrated empirical relationship to mental illness, include age, race/ethnicity, gender, marital status and high school graduation. Through logical regression analysis, estimates of the prevalence of mental illness by diagnostic category were generated and subsequently applied to local demographic data.

This procedure yielded a total six-month prevalence rate (expressed as a percentage) of 21.61 for any Diagnostic Interview Schedule (DIS) disorder, which translates into a total of 105,900 cases. In other words, during any six-month period, one of every five people ages 18 and older in the District suffers from a diagnosable mental disorder. This rate is slightly higher than that of the U.S. adult population in general which is estimated at 19.5 (Regier, et al 1984). Since the publication of these data, changes have occurred in the District's population and a more precise estimation of prevalence was published by the Center for Mental Health Services in the Federal Register March 29, 1997, Vol. 62, No. 60 pp. 14928-14932.

In FY 1999, DMH contracted with the University of Texas, Department of Psychiatry and Behavioral Sciences to provide prevalence estimates and service analyses for the District. The analyses were made available at the beginning of FY 2000. Highlights from the prevalence estimate document and the application of the prevalence estimates to program planning were presented to DMH managers by the authors of the District's prevalence estimates analyses.

The prevalence estimates are derived from an indirect estimation technique, which utilized the 1990-1992 National Co-morbidity Survey (NCS) to estimate the prevalence of mental illness in the District's population.

An assumption that underlies indirect estimation is that demographic characteristics have a consistent general relationship with psychiatric disorder. For the District, there were seven demographic variables, which were used to develop the estimation model. The demographic variables used were age, sex, race and ethnicity, marital status, education, poverty, and residential setting. Prevalence estimates across these demographic variables are provided for persons with serious mental illness and persons with serious and persistent mental illness.

The definition of these terms incorporated definitions, which evolved out of the NCS and the Center for Mental Health Services published definitions. Persons with serious and persistent mental illness (SPMI) include the 12-month prevalence of non-affective psychosis or mania; lifetime prevalence of non-affective psychosis or mania if accompanied by evidence that the individual would have been symptomatic if it were not for treatment (use of medication or any professional treatment in the past 12 months); or 12-month prevalence of either major depression or panic disorder with evidence of severity indicated either by hospitalization or use of major psychotropic medications. This definition is less restrictive than past definitions of severe mental illness and chronic mental illness.

The definition of serious mental illness (SMI) includes all individuals meeting the SPMI definition; individuals with a 12-month DSM-IV mental disorder and either planned or attempted suicide at some time during the past 12 months, persons with a 12-month DSM-IV that

substantially interferes with vocational capacity, and persons with a DSM-IV disorder who had serious interpersonal difficulty demonstrated by: lack of marriage, intimate relationships, confiding relationships or affiliative interactions more frequent than once a month; or (b) reported lack of intimacy, ability to confide, and sense of being cared for or supported in all social relationships.

Publications in the Federal Register provide estimates for states. These include Estimation Methodology for Adults with Serious Mental Illness, Federal Register March 28, 1997 (Volume 62, Number 60) and Estimation Methodology for Adults with Serious Mental Illness, Federal Register: June 24, 1999 (Volume 64, Number 121). Overall these documents estimate that 2.6% of the U.S. population has SPMI and 5.4% have SMI. This contrasts with the NCS estimate of 23.9% of the U.S. population has at least one DSM-IV mental disorder during a 12-month period. The Center for Mental Health Services estimates for SMI and SPMI adults in the U.S. did not provide estimates below the county level nor did the estimates use demographics since 1990. The District's prevalence estimate addressed these issues.

In 1999, the University of Texas conducted a study of mental health need and services in the District of Columbia. The findings were reported in the FY 2003 State Mental Health Plan. The 2003 edition of the project provides a set of estimates of the need for mental health services for the District's population for 1990 and 1995 through 2000. These estimates are based on the NCS and related surveys and are projected to the District based on data from the U. S. Census. An analysis of services relative to the estimated need for 1997 and 1998 was also provided. It is hoped that the service comparisons can be updated in the near future.

As in previous studies, it is noted that the estimated rates of need for mental health services appear to be relatively high compared to the country overall, particularly due to the high levels of poverty in the District's population.

The estimates of **Serious Mental Illness** are:

6.43% (32267 cases) for 1990,
5.81% (23020 cases) for 1999 (projected),
6.10% (27889 cases) for 2000 (from the Decennial Census).

For the household population, excluding those in institutions in group quarters, the estimates are:

5.20% for 1990,
5.04 for 1999 (projected), and
5.68 for 2000 (based on the decennial census).

The estimates for **Severe and Persistent Mental Illness** for the total adult population including those institutionalized or in group quarters are:

2.81% (14104 cases) for 1990,

2.60% (10308 cases) for 1999, and
2.73% (12472 cases) for 2000.

For the household population only, the estimates are:

2.27% (10489 cases) for 1990,
2.26% (8304 cases) for 1999, and
2.53% (10772 cases) for 2000 based on the new census.

The original estimates of need for mental health services for 2000 is broken out by age, gender, ethnicity, marital status, education, poverty level, and residence in the tables at the end of this criterion.

Based on discussions with the Court Monitor and an external panel of experts, DMH modified its penetration goals to 3% for adults and 2% for adults with serious mental illness with reporting in FY 2005.

Profile of Consumers Currently Served by the Public Mental Health System

As of July 7, 2008, there were approximately 8,832 adult consumers who had received at least one service from the DMH MHRIS program. The data on services by age, gender, and race/ethnicity (Basic Tables 2A and 2B) will be developed at the end of FY 2008 (September 30, 2008) to allow for a full year of data. This data will be reported in the District of Columbia FY 2008 Progress Implementation Report (submitted to SAMHSA on December 1, 2008).

At the beginning of FY 2003, the DMH MIS changed to a claims processing system (e-Cura). As DMH transitioned to the new MIS, challenges were experienced in both data gathering and reporting. The DMH has been working to correct issues that contribute to the reporting difficulties.

On April 1, 2005, DMH launched a tool to capture data related to the Dixon Exit Criteria measures. This quarterly data event screen, however, was not fully implemented until July 1, 2005; when it became attached to the service Authorization Plan. The data for this mandatory reporting event screen is completed every 90 days in conjunction with the 90-day Consumer Review. The implementation of this reporting process is gradual and a sufficient number of these quarterly events are needed to obtain a representative data sample. The DMH reported the data that was available for the last quarter of FY 2005 in the FY 2005 Progress Implementation Report submitted to SAMHSA.

A more detail profile of adult consumers served is being developed. The changes that occur in the adult consumer profiles will largely be dependent on the profile information that is developed as part of the Data Infrastructure Grant. The District of Columbia is going into a sixth year of developing strategies for ensuring enhancements to the information system and implementing the enhancements within the requirements of Federal grants and HIPAA requirements and federal information system standards.

The status of information system enhancements and the needs for information system enhancements for the District of Columbia mental health system is captured in the table that appears follows.

DIG Table	Report Data	Enhancements/Reporting
Table 1. Profile of the State Population by Diagnosis	Yes	DMH supplies data for federal reporting. Data are captured by information system.
Table 2. Profile of Clients Served, All Programs by Age, Gender and Race/Ethnicity	Yes	Data elements modified in e-Cura and data are reported for federal purposes.
Table 3 A. Profile of Clients Served in Community Mental Health Settings by Homeless Status	Yes	Operational Definition was developed. Homeless data are currently being reported.
Table 3B. Profile of Clients Served in State Psychiatric Hospitals and Other Inpatient Settings	Yes	The Hospital legacy system stored these data, which are being reported for federal purposes. A new system was implemented in July 2008.
Table 4. Profile of Adult Clients by Employment Status	Yes	Capturing data every 90 days on persons served in the community mental health setting and employment status over past 90 days
Table 5. Profile of Clients by Type of Funding Support (Medicaid/Non-Medicaid)	Yes	Modifications of information system were required. Incorporation of reporting capacity in new systems achieved.
Table 6. Profile of Client Turnover	Yes	Modification of information system was required and incorporation of capacity in new systems achieved.
Table 7. Profile of State Mental Health Agency Service Expenditures and Sources of Funding	Yes	Analyses conducted of Mental Health Authority data. Data reported for federal purposes.
Table 8. Profile of Community Mental Health Block Grant Expenditures for Non-Direct Service Activities	Yes	Analyses conducted of contract, procurement and budget data. Data reported for federal purposes.
Table 9. Public Mental Health Service System Inventory Checklist	Yes	Analyses are conducted of mental health data and report data.
Table 10. Profile of Agencies Receiving Block Grant Funds Directly from the State Mental Health Authority	Yes	Conduct analyses of Block Grant data and Report Data Years 1-3
Table 11. Summary Profile of Client Evaluation of Care	Yes	Conduct MHSIP survey yearly and provide analyses for report
Developmental Tables		
Table 12. State Mental Health Agency Profile	Yes	Conduct analyses of mental health data, which are currently reported for federal purposes.

DIG Table	Report Data	Enhancements/Reporting
Table 14. Profile of Clients Served with Serious Mental Illness and Serious Emotional Disturbance, All Programs by Age, Gender, and Race/Ethnicity	Yes	Reviewed operational definitions and implemented data collection requirements. Data are reported for federal purposes.
Table 15. Profile of Clients' Living Situation in Institutional and Non-Institutional Settings	No	Reviewed operational definitions and implemented data collection requirements. Data are being reviewed for federal reporting purposes.
Table 16. Profile of Clients with Serious Mental Illness and Clients with Serious Emotional Disturbance receiving Evidenced-based Services (Supported Housing, Supported Employment, Assertive Community Treatment-Adults, and Therapeutic Foster Care-Children)	No	Reviewed operational definitions and implemented data collection requirements. Data are reported for federal project purposes using Ecura and independent data bases.
Table 17. Profile of Adult Clients with Serious Emotional Disturbance receiving Evidenced-Based Services of Family Psycho education, Integrated Treatment for Co-occurring Disorders and Illness Management and Recovery Skills	No	Reviewed operational definitions, extracted data and currently reviewing data for federal project purposes.
Table 18. Profile of Adults with Schizophrenia receiving New Generation Medications	No	Reviewed operational definitions and implemented data collection requirements. Data are being reviewed for federal project purposes.
Table 19. Summary Profile of Client Outcomes for Children with Increased Level of School Attendance, Children who have had Contact with the Juvenile Justice System, and Adults who have had Contact with the Criminal Justice System	Partial	Reviewed operational definitions, assessed methodology for data collection, and modified information systems to capture data. Data collection process needs to be validated. Data are used with caveats.
Table 20. Rate of Readmission to State Psychiatric Hospitals within 30 Days and 180 days	Partial	Reviewed operational definition and modified DMH information systems. Working with private hospitals to collect data from their systems.

Mental Health Transformational Activities

During FY 2009, the DIG Tables will be reviewed for the purposes of assessing the collection of data from stand alone “independent” data bases that need to be incorporated into the major information systems (e.g. e-Cura). An assessment will be undertaken to understand what currently exists and for what purposes. This activity will facilitate an increase to accessing data within the DMH.

District of Columbia

Adult - Quantitative Targets

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

B. Performance Goals, Targets and Action Plans

Criterion 1: FY 2009 Goals, Targets and Action Plans

Goal 1: Improve Continuity of Care

Targets:

1. Maintain the number of adults re-admitted to Saint Elizabeths Hospital within 30 days of discharge at 9%.
2. Maintain the number of adults re-admitted to Saint Elizabeths Hospital within 180 days of discharge at 23%.

Action Plans:

The DMH will continue to implement the strategies aimed at supporting adult consumers in the least restrictive setting and reducing the number of beds at Saint Elizabeths Hospital. This will include: 1) continue emphasis on adherence to the Continuity of Care Policy Practice Guidelines that assure every inpatient is seen within 48 hours of admission to the Hospital, 2) continue the meetings held between Hospital, Authority and Core Service Agency (CSA) staff to review all clients in the Hospital 30 days or longer, 3) continue the housing priority to place individuals leaving the Hospital, 4) continue Assertive Community Treatment (ACT) services placement priority for individuals leaving the Hospital, 5) implement an Integrated Care Project to address the needs of some of the most clinically challenging inpatients to support them in the community, and 6) review the with the Dixon Court Monitor the status of the Dixon Performance Target that 80% of adults discharged from inpatient care must be seen within seven days

**DISTRICT OF COLUMBIA
FY 2009 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

Name: Improve Continuity of Care

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

NOM: Reduced Utilization of Psychiatric Inpatient Beds

Population: Adults with mental illness in the District of Columbia

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Target: Decrease number of adults re-admitted to Saint Elizabeths Hospital within 30 days of discharge to 9% in FY 2009

Performance Indicator Value:

Numerator: Number of adults re-admitted to Saint Elizabeths Hospital within 30 days of discharge in FY 2009

Denominator: Number of adults discharged from Saint Elizabeths in FY 2009

Sources of Information: Hospital Management Information System

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

Special Issues: DMH is building a new state-of-the-art 292 bed hospital and needs to reduce beds accordingly. The completion date is FY 2009 or early 2010. An overflow plan has been developed.

Name of Performance Indicator: Improve Continuity of Care				
Population: Adults with mental illness in the District of Columbia			Criterion 1: Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target
Performance Indicator (Value)	11%	8.8%	10%	9%
Numerator	75	85	---	---
Denominator	690	962	---	---

Note: FY06 - FY 07 data includes civil and forensic clients.

**DISTRICT OF COLUMBIA
FY 2009 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

Name: Improve Continuity of Care

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

NOM: Reduced Utilization of Psychiatric Inpatient Beds

Population: Adults with mental illness in the District of Columbia

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Target: Decrease number of adults re-admitted to SEH within 180 days of discharge to 23% in FY 2009

Performance Indicator Value:

Numerator: Number of adults re-admitted to Saint Elizabeths Hospital within 180 days of discharge in FY 2009

Denominator: Number of adults discharged from Saint Elizabeths in FY 2009

Sources of Information: Hospital Management Information System

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

Special Issues: DMH is building a new state-of-the-art 292 bed hospital and needs to reduce beds accordingly. The completion date is FY 2009 or early 2010. An overflow plan has been developed.

Name of Performance Indicator: Improve Continuity of Care				
Population: Adults with mental illness in the District of Columbia			Criterion 1: Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target
Performance Indicator (Value)	29%	20.3%	25%	23%
Numerator	200	195	---	---
Denominator	690	962	---	---

Note: FY06 - FY 07 data includes civil and forensic clients.

Goal 2: Improve Access to Evidence-Based Practices

Evidence-based practices data, as reported in Developmental Tables 16 and 17, will not be developed until after the end of FY 2008 (September 30, 2008). This data will be reported in the FY 2008 District of Columbia Community Mental Health Services Progress Implementation Report (submitted to SAMHSA on December 1, 2008) for categories for which there is data in the Contract Management System.

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

Targets:

1. Continue the review of the ACT teams in FY 2009.
2. Increase the number of persons receiving evidence-based practices in FY 2009:
 - 2-1- Broaden the Dixon Performance Target definition for what can be measured as providing housing services to 70% of persons referred within 45 days of a referral.
 - 2-2-Continue to maintain the Dixon Performance Target to provide employment related services to 70% of persons referred within 120 days of a referral.
 - 2-3-Continue to try to reach the Dixon Performance Target to provide ACT services to 85% of persons referred within 45 days of a referral.
 - 2-4-Continue to maintain the Dixon Performance Target to provide new generation antipsychotic medications to 70% of adults with schizophrenia.

Action Plans:

The DMH has made the development of evidence-based practices a focal point for the reformed mental health system. In this regard, DMH has incorporated supported housing, supported employment, ACT teams, medication algorithms, and co-occurring disorder services into the service delivery system. The DMH will continue to:

- 1) provide housing and support services to consumers most in need and try to broaden the spectrum of housing services and supports that can be measured related to the Dixon Performance Target to provide housing related services to 70% of persons referred within 45 days of a referral, 2) continue the social marketing strategy including training for consumers and clinicians and orientation for potential employers, and try to maintain the Dixon Performance Target to provide employment related services to 70% of persons referred within 120 days of a referral, 3) continue to review the ACT teams to addresses overall referrals, capacity, staffing and service delivery issues including training and technical assistance based on fidelity audit, and try to reach the Dixon Performance Target to provide ACT to 85% of persons referred services within 45 days of a referral, 4) maintain the Dixon Performance Target to ensure that 70% of adults with schizophrenia have access to the newer generation antipsychotic medications, and 5) continue to implement the integrated systems model for persons with co-occurring disorders in collaboration with the addiction service system through the Co-Occurring State Incentive Grant (COSIG).

It is noted that DMH encountered a tracking problem when trying to measure the ACT performance target using the service Authorization Plan. In order to address this issue DMH had

to develop a module that would allow services authorization and services delivery to be matched. The reporting of this baseline data began in FY 2007 for the period April 2006 through March 2007. This reporting continued during FY 2008.

In July 2008, a total of 358 consumers were receiving ACT services.

**DISTRICT OF COLUMBIA
FY 2009 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

Name: Improve Access to Evidence-Based Practices

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

NOM: Increased Evidence-Based Practices

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

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

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Target: Continue review of ACT Teams in FY 2009

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

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

Special Issues: The review of the ACT teams focuses on areas raised by the Court Monitor that include referrals, capacity, staffing and service delivery issues. At the beginning of FY 2006 there were 9 ACT teams (DC CSA=3, Psychotherapeutic Outreach Services =1, Pathways to Housing =2 (chronically homeless teams), Marshall Heights =1 (mental illness/developmental disabilities), and Family Preservation Services, Inc. = 2 (forensics and mental illness/developmental disabilities teams). By the end of FY 2006, Marshall Heights stopped providing mental health services reducing the number of teams to 8. There was no planned expansion during FY 2007 and FY 2008. The fidelity audits of the teams and overall review process that began in FY 2008 will continue in FY 2009. The focus in FY 2009 will be to address ACT composition, operational and performance issues in order to improve this service. There is no planned expansion.

Name of Performance Indicator: Improve Access to Evidence-Based Practices				
Population: Adults with SMI in the District of Columbia			Criterion 1: Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target
Performance Indicator	8	8	8	Service Improvement Following Baseline Audits

**DISTRICT OF COLUMBIA
FY 2009 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

Name: Improve Access to Evidence-Based Practices

Goal: Increase number of adults receiving supported housing services

NOM: Increased Evidence-Based Practices

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

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

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Target: Broaden measures to increase to 70% the number of adults with SMI receiving supported housing services within 45 days of a referral in FY 2009

Performance Indicator Value:

Numerator: Number of adults receiving supported housing services within 45 days of referral in FY 2009

Denominator: Number of adults referred for supported housing in FY 2009

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

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

Special Issues: During FY 2008 DMH and the Court Monitor discussed the issues that housing services was too narrowly defined (solely as housing) and that housing placement within 45 days was not a reasonable expectation. There are also budgetary constraints. The data highlight these issues. FY 2006 data for the Court Monitor report show a rate of 51% of persons housed within 45 days. FY 2007 data show that 12% were housed in 45 days. However, 104 were housed after this period and there was also a slow down in housing during the 2nd and 3rd quarters due to concerns about staying within the budget. The target remains at 70% until a revised approved approach is adopted.

Name of Performance Indicator: Improve Access to Evidence-Based Practices				
Population: Adults with serious mental illness in the District of Columbia			Criterion 1: Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target
Performance Indicator (Value)	51%	12%	70%	70%
Numerator	88	28	---	---
Denominator	172	242	---	---

DISTRICT OF COLUMBIA

**FY 2009 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

Name: Improve Access to Evidence-Based Practices

Goal: Increase number of adults receiving supported employment services

NOM: Increased Evidence-Based Practices

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

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

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Target: Maintain at 70% the number of adults with SMI receiving supported employment services within 120 days of a referral in FY 2009

Performance Indicator Value:

Numerator: Number of adults receiving supported employment services within 120 days of referral in FY 2009

Denominator: Number of adults referred for supported employment in FY 2009

Source of Information: DMH Authority Supported Employment Database

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

Special Issues: In FY 2007, the Supported Employment algorithm was used unlike previous years. It includes quarterly and annual referrals. During FY 2007 DMH met the Dixon Performance Target for supported employment. However, the Court Monitor wants to ensure that consumers who want this service are able to access it. A Supported Employment Promotion, Outreach and Training Plan was implemented in FY 2008. The FY 2009 target remains 70%.

Name of Performance Indicator: Improve Access to Evidence-Based Practices				
Population: Adults with serious mental illness in the District of Columbia			Criterion 1: Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY2006 Actual	FY 2007 Actual	FY2008 Projected	FY2009 Target
Performance Indicator (Value)	77%	89%	70%	70%
Numerator**	306	98	---	---
Denominator**	395	109	---	---

DISTRICT OF COLUMBIA

**FY 2009 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

Name: Improve Access to Evidence-Based Practices

Goal: Increase number of adults receiving ACT services

NOM: Increased Evidence-Based Practices

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

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

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Target: Complete review and follow-up activities to increase to 85% the number of adults with SMI receiving ACT within 45 days of a referral in FY 2009

Performance Indicator Value:

Numerator: Number of adults receiving ACT services within 45 days of referral in FY 2009

Denominator: Number of adults referred for ACT service in FY 2009

Source of Information: Contract Management System

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

Special Issues: The Dixon Performance Target is 85%. FY 2006 data could not be developed because DMH could not match service authorization and service delivery dates. In FY 2007 baseline data was reported to the Court Monitor. The data show that 51.52% of persons referred received ACT services within 45 days of a referral. During FY 2008 fidelity audits were begun with the ACT teams and training and technical assistance will be planned during FY 2009. The target remains at 85%.

Name of Performance Indicator: Improve Access to Evidence-Based Practices				
Population: Adults with serious mental illness in the District of Columbia			Criterion 1: Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target
Performance Indicator (Value)	Tracking Issue	51.52%	85%	85%
Numerator		34	---	---
Denominator		66	---	---

**DISTRICT OF COLUMBIA
FY 2009 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

Name: Improve Access to Evidence-Based Practices

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

NOM: Increased Evidence-Based Practices

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

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

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Performance Indicator Value:

Numerator: Number of adults of with schizophrenia receiving new generation antipsychotic medications in FY 2009

Denominator: Number of adults with schizophrenia in FY 2009

Source of Information: Contract Management System

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

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

Name of Performance Indicator: Improve Access to Evidence-Based Practices				
Population: Adults with serious mental illness in the District of Columbia			Criterion 1: Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target
Performance Indicator (Value)	69.3%	84.37%	70%	70%
Numerator	2392	2882	---	---
Denominator	3452	3416	---	---

Goal 3: Improve Client Perception of Care

Mental Health Statistics Improvement Program Surveys

Mental Health Statistics Improvement Program Surveys 2007: The federal Data Infrastructure Grant and the State Mental Health Block Grant requires states to administer an annual Consumer Satisfaction Survey that is conducted with adults, parents and guardians of children and adolescents served by the mental health system. The 2007 survey was administered through a telephone survey during the period July-September 2007. The surveys were coordinated by the DMH Office of Strategic Planning, Policy and Evaluation with the assistance of the Gregory Project, a consumer operated organization also known as the House of Sharon. The surveys were administered by a team of consumers and family members. Three (3) instruments were used: 1) the Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey, 2) Youth Services Survey for Families (YSS-F), and 3) the Recovery Oriented Systems Indicator (ROSI). The DMH used the “official version” of each of these instruments to measure consumer satisfaction.

Survey Administration: For the MHSIP Survey there were approximately 1110 phone calls made to consumers and 279 participated in the survey (25%). However, 15 of these participants failed to complete the minimum required questions suggested by the standardized instrument. Consequently, their responses were not included in the statistical analyses. A total of 57 consumers who participated in the MHSIP Survey also agreed to participate in the ROSI, participation in the ROSI was optional.

Respondent Characteristics: The adult respondents who participated in the MHSIP Survey can be described as follows: 35% were male and 65% were female; 96% self identified as African American, 3 % as White and 1% as Hispanic; 56% had less than a high school education, 30% completed high school/GED, 10% completed college/technical training, and 4% completed graduate school. At the time of the survey, 35% of the respondents were receiving mental health services for more than three (3) years and 65% received services for more than five (5) years.

Survey Findings: The findings for the Adult MSHIP Survey across the five domains (access to services, quality and appropriateness, outcomes, participation in treatment, general satisfaction) show: 1) the location, staff availability, service times and the extent of services received were rated at 90 or above, 2) the respondents indicated that they felt free to complain (91) and that staff encouraged them to take responsibility for how they lived their lives (92), 3) the respondents rated at 90 percent and above that they are better able to deal more effectively with their problems, better able to take control of their lives, and are getting along better with their families, 4) the respondents reported they had a voice in deciding their treatment goals (90), and 5) the respondents reported a high level of satisfaction regarding services they received within the D.C. Mental Health System for 2007.

Recovery Oriented System Indicators (ROSI) Consumer Survey: The respondents were asked to participate in this optional survey following the administration of the MHSIP Survey. It is noted that the MHSIP Survey is the chosen instrument for reporting consumer satisfaction for both the Data Infrastructure Grant and Mental Health Block Grant purposes. Only 57 participants responded to the ROSI Survey. The sample size is relatively small and is not considered representative of the population served within the D.C. Mental Health System. Overall, respondents reported a high percentage of satisfaction with the services they received. Less positive responses were given for questions pertaining to affordable housing, education, peer

support, and opportunities for a greater range of choices in their mental health services. The results suggest that there is need for improvement in these areas.

Mental Health Statistics Improvement Program Surveys 2008: A contract will be let to conduct the 2008 MHSIP Surveys. A request for proposals (RFP) was disseminated and closed in July 2008. The surveys will be conducted and the results reported in the 2008 Progress Implementation Report.

Adult Community Services Reviews

During FY 2008, the Annual Adult Community Services Review (CSR) was conducted. The target reported here is related to the Adult CSR process.

Target:

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

Action Plans:

During Year 5 (2007), the Dixon required system performance score of 80% was achieved. The results for Year 6 (2008) show a score of 74%. The adult debriefings suggested that consistent efforts to communicate and collaborate among the core practitioners would bring this performance level above the Court-required standard of 80%. The focus in FY 2009 will be on improving service team formation and service team functioning.

**DISTRICT OF COLUMBIA
FY 2009 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

Name: Improve Client Perception of Care

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

NOM: Client Perception of Care

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

Population: Adults with mental illness in the District of Columbia

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Target: Increase to 80% the ratings for system performance measures in the Annual Adult CSR in FY 2009

Source of Information: Human Systems and Outcomes (HSO)

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

Special Issues: The Dixon Performance Target is 80% and HSO calculates the data. FY 2006 data show an acceptable level of system performance was rated at 69%. The FY 2007 data show the rating was 80%. While the performance target was met, issues related to sample size and inter-rater reliability were addressed beginning in FY 2008. The FY 2008 score was 74%. The FY 2009 target is 80%.

Name of Performance Indicator: Improve Client Perception of Care				
Population: Adults with mental illness in the District of Columbia			Criterion 1: Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target
Performance Indicator	69%	80%	74%	80%

District of Columbia

Adult - Outreach to Homeless

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

The DMH Office of Homeless Services works closely with community providers to identify appropriate services for consumers and other individuals who reside on street corners, in abandoned vehicles and buildings, in low-barrier shelters, transitional programs, and other temporary residences. It also includes working with housed individuals in terms of crisis intervention and homeless prevention. These services are directed toward single adults as well as adults in families, and children. The outreach and other services are provided in collaboration with DMH programs, District agencies and community providers.

The staff include a Homeless Services Coordinator, a psychiatrist, a team leader, and seven (7) mental health specialists along with a number of part-time staff who assist with the Sobering Station during the winter. All staff members are trained in trauma, cultural competence, co-occurring issues and crisis services.

The Office of Homeless Services, Homeless Outreach Program (HOP) is a mobile linkage and crisis program for individuals who are homeless and non-homeless. The HOP provides interim case management to unlinked or poorly-linked consumers. In conjunction with family members, peers, community providers, and other available contacts, HOP provides linkages to crisis and long-term mental health services while respecting the wishes of the consumer.

The primary services include regular outreach visits to streets and numerous liaison sites (including single and family shelters, meal programs, drop-in programs and emergency programs), linkage with the D.C. Linkage Plus program (jail diversion and persons formerly incarcerated), and operating the Sobering Station. After initial encounters, the team provides engagement, risk assessments, material assistance, referrals, linkages, benefit and housing applications, travelers' assistance for stranded consumers with mental illness, crisis intervention, and access to overnight shelter services. The HOP makes over 2,000 contacts annually to over 900 different persons who are homeless.

The HOP also sponsors a monthly *Emergency Rounds* meeting to review the status of high-risk individuals who are mentally ill and homeless. Attendees at this meeting include street outreach programs such as First Helping, Downtown Services Collaborative/BID/Pathways outreach program, Georgetown Ministries, Capitol Hill Group Ministries, Salvation Army, United Planning Organization, the Washington Legal Clinic for the Homeless, and other homeless providers. This meeting is facilitated by the HOP psychiatrist and provides an additional opportunity to consult and support "front-line" staff working directly with the target population. This model has been accepted to be presented as an "Innovative Program" at the American Psychiatric Association's annual conference on community psychiatry held in October 2008 in Chicago.

The HOP also provides outreach, assessments and linkages to non-homeless individuals upon request from property managers, Adult Protective Services (APS), Child and Family Services (CFSA), private social workers, and concerned citizens. These activities allow individuals with or without a mental illness to stabilize and form a social support network to avoid falling into homelessness. In addition, HOP has worked closely with low-income housing facilities to link formerly homeless individuals with mental illness to support the goal of homeless prevention.

A number of program expansions occurred during FY 2007-2008. These include:

- Metropolitan Police Department (MPD) Pilot and Expansion- The HOP, in conjunction with MPD and the Office of Unified Communications (OUC), developed a short-term plan pilot project. It involved MPD officers in Police Service Area 101 (downtown area) identifying individuals who were homeless and mentally ill and in need of linkages to mental health services, contact the OUC to dispatch the HOP for on-site assessments and services. This pilot project operated from June through September 2007.

This project was modified and expanded to include Police Service Area 501 and included weekly walk-arounds by the HOP and the Police to make referrals to the team. In addition, attention is given to various Focused Improvement Areas (FIAs), zones of high-crime incidence, which are receiving dedicated and integrated localized involvement by various government agencies.

- Expanded Outreach Services in Overnight Shelter- In FY 2007 DMH entered into a memorandum of understanding (MOU) with the Department of Human Services (DHS) to provide mental health services in the Franklin Shelter (a large emergency shelter). The DMH began providing services under contract with a mental health provider in August 2007.

As part of this project, the HOP team received funding to do additional homeless outreach. Five (5) individual contractors were identified to work in specific shelters. These additional contractors provided services up to 20 hours per week at the following shelters: Adam's Place, Harriet Tubman Shelter, John Young Shelter, New York Avenue Shelter, and 801 East Shelter. The services included counseling, referrals to mental health agencies, financial and medical benefits, healthcare and support attending appointments.

- Expanded Evening Coverage- The HOP team expanded the number of individuals working in the evening as well as the number of liaison sites covered during that time. The HOP team was "on-call" during the hypothermia season from 9 pm through midnight for handling and staffing emergency calls. In order to be proactive and reduce the incidence of problems, the HOP team began calling a large array of service providers each morning to determine whether or not their staff experienced concerns with consumers during the overnight shift; this would provide an opportunity for communication and potential action to alleviate a future crisis.
- Shelter Plus Care- Since Fall 2007, the HOP has been assisting the District in facilitating supportive housing with the Shelter Plus Care (S+C) program. The HOP psychiatrist has been working closely with The Community Partnership for the Prevention of Homelessness to review applications for individuals seeking housing in conjunction with receiving mental health services. Those individuals found to have a sufficient mental health diagnosis are certified to receive care. The larger HOP team also has played an instrumental role in helping numerous existing S+C participants (individuals and especially families) re-establish mental health services.

- Expanded Day Socialization Services- In December 2008, DMH selected a new contractor to provide expanded day services to individuals who are mentally ill and homeless. The agency that provides this service is Catholic Charities at the Hermano Pedro Day Program.
- Fire and Emergency Medical Services (F/EMS)- The HOP, as part of a broader crisis/emergency planning process that DMH implemented with the community, discussed with F/EMS increasing its capacity to provide crisis assessments and interventions to individuals who may be experiencing a mental health crisis. This project is being spearheaded by the HOP psychiatrist. The activities involved in capacity development include: developing training modules, certifying F/EMS staff as Officer Agents (crisis/emergency services admission through CPEP), providing cross-training opportunities to HOP and F/EMS employees and ongoing technical assistance to F/EMS.
- Saint Elizabeths Hospital Psychiatry Residency Training Program and Homeless Services Placements- The Office of Homeless Services works with the Saint Elizabeths Hospital Psychiatry Residency Program to provide six to nine (6-9) placements for psychiatry residents to receive training in homeless programs. These placements involve 2-3 hours per week of direct contact with individuals who are mentally ill and homeless. The psychiatry residents provide assessments and link consumers to mental health services and provide consultation to the homeless programs on effective strategies in working with this target population.

In FY 2008, there were two classes of Psychiatry Residents (13) placed in shelters and outreach programs; with each being integrated into the broader work of the entire HOP team. Two (2) residents served as junior attending psychiatrists on wards at Saint Elizabeths Hospital. The HOP psychiatrist met with each class on a weekly basis to consult and supervise the services the residents provide.

- Enhanced Outreach Services to Children and Youth who are Homeless or At Risk of Homelessness- In January 2008, HOP hired a staff member who has expertise in children with serious emotional disturbances; he has been assigned to visit shelters serving children, youth and families who are homeless and also works with families at risk of becoming homeless. Duties include the assessment and linkage of children and youth to appropriate mental health services.
- SSI Training for Homeless Services and Mental Health Providers- Many adults who are homeless, particularly those who are chronically homeless and have mental illness and/or other disabilities, do not receive Social Security Administration benefits. The DC SSI/SSDI Outreach, Access and Recovery Services (D.C. SOARS) Project attempts to facilitate the acquisition of benefits for these individuals. This project began in FY 2007 and is overseen by the DMH Director of Homeless Services. A four day train-the-trainer model was implemented followed by a District-wide two day planning meeting. Training for approximately 25 providers was held in FY 2007 and follow-up telephone surveys with these providers suggested the training was viewed as helpful in filing an increased number of disability applications for individuals who are homeless and disabled. Data is not available

on how many applications were filed and approved. Additional expedited SSI training is being planned during FY 2009 that will include critical elements of the SOARS training.

Several other initiatives and/or other activities occurred during FY 2008. These include:

- Projects for Assistance in Transition from Homelessness (PATH) Grant- The Homeless Services Coordinator continued to implement the PATH Grant activities. This role also involves annual development of the grant application and provision of programmatic data to the federal PATH Program. The total grant is \$300,000 and requires a \$100,000 match from DMH. The PATH funds pay for homeless outreach services. In addition, funds are used for one time only security deposits and to prevent consumer evictions.
- Interagency Council on Homelessness (ICH)- The ICH is an inter-agency planning body for homelessness, housing, and various emergency services. Comprised of government, not-for-profit organizations, advocates, and consumers, the ICH is becoming an important platform for debate and point of advisory input for the Mayor. The Office of Homeless Services is present at all of the full meetings and has frequently participated in various working groups and the implementation of public meetings. The Office also coordinates with the Director of DMH on these matters. In addition, members of the HOP team often are present at public meetings to assist consumers in need of guidance and referral.
- Outreach Focus Group (OFG)- The OFG is a consortium of homeless outreach and direct service programs that work with street-bound and vulnerable individuals who are homeless. Through their work as “front-line” workers, the group is able to identify problems in the system needing an immediate or strategic response. A member of the HOP team plays a leadership role on the OFG and provides the basis for productive advocacy and coordination.
- Homeless Services Planning- Weekly meetings during the Fall 2007, with the DMH Homeless Services Coordinator, Directors of Human Services and Addiction Prevention and Recovery Administration, and the City Administrator’s office to discuss strategies to transform the homeless services delivery system.
- Encampment Area Services- The collaboration between the HOP team and the Department of Human Services DHS to house individuals residing along the I-395 corridor. This project included obtaining identification information, service need, linkage to social services, and assistance with coordinating relocation activities.
- Sobering Station- The Office of Homeless Services continued to operate the Sobering Station (during hypothermia season) for intoxicated men and women who either refuse or are unable to handle the structure of a traditional shelter. Since the program’s inception in FY 2002 through FY 2006, approximately 1,078 different individuals came to the Sobering Station (unduplicated count per year), with about 194 entering detoxification services. During FY 2007, 206 different men and women were served at the Sobering Station, offering over 900 bed nights of service. At least 10 people entered detoxification services. In FY 2008, 185 different men and women were served, with 374 bed nights, and about 12 going into detoxification. The winter of 2008 was mild and another shelter opened in close proximity to the Sobering Station, which probably contributed to the reduced numbers served.

- Training and Educational Activities- The Homeless Services staff conducted a number of trainings on working with individuals who are homeless and mentally ill for a variety of staff that include but are not limited to: shelter security staff, lawyers/guardians D.C. Bar Association, social workers in government agencies, persons approved to become Officer Agents (a person who can file an application for involuntary psychiatric assessment), and staff in the DMH Office of Programs and Policy (adult and child/youth programs, care coordinators, provider relations, forensic, housing, employment, disaster mental health).

Housing- First Pathways to Housing D.C. Homeless Services

Pathways to Housing D.C. was founded in 2004 to serve Washington, D.C.'s homeless population. The model supports housing first and offers persons who are experiencing homelessness and living with serious and persistent mental illnesses immediate access to an apartment of their own, because that is what they want, without requiring participation in treatment or sobriety.

Pathways to Housing D.C. separates housing from other services. It treats homelessness by providing people with individual apartments, and then treats other needs by providing intensive and individualized support through the Assertive Community Treatment (ACT) team that seek out and actively works with individuals as long as they need, in order to address their emotional, psychiatric, medical and human needs, and on a twenty-four hour, seven-day-a-week basis. In the Pathways to Housing D.C. program, clients lose their housing the same way any tenant loses housing: not paying their bills; running a drug den; acts of violence; creating disturbances intolerable to neighbors; or other violations of a standard lease.

Since opening in 2004, Pathways D.C. has housed 140 formerly homeless individuals. In July 2008, there were 175 people receiving ACT services.

Downtown D.C. Business Improvement District Homeless Services

The Downtown Business Improvement District (DBID), Downtown Services Collective Street Outreach Program is unique in the District. The staff include master-level social workers and psychologists who provide on site clinical assessments and case management. The program is supported by over 100 Safety and Maintenance (SAM) workers who are trained to observe and report homeless issues to the Outreach Team. There are 12 SAMs specially trained in engaging and triaging the needs of homeless individuals. The partnerships include: DMH Homeless Outreach Program, Pathways to Housing D.C., Core Service Agencies, District agencies, homeless services programs, hospitals, nursing homes, and local and federal security agencies. The program provides education and information for property owners, property managers, businesses, and concerned citizens about the issues of homelessness. It also provides strategies for homeless consumer crisis intervention, and on-site crisis de-escalation and interventions.

Some of the reported program outcomes from March 2007 to March 2008 include: 234 persons were able to shower, receive clothing and food; 208 received monitoring, assessment and engagement; 158 were referred to service providers; 78 were connected with their CSA; 60 were

housed in permanent housing; 49 received ID cards, birth certificates and Social Security cards; 43 received Travelers' aid; 36 were connected to substance abuse programs; 37 received representative payee, Spanish case management, and Metro Disability Transportation services; 31 were connected to Income Maintenance; 30 were engaged who had encamped in front of buildings, in building recesses, on sidewalks, in the parks, around parking meters; and 85 refused all services.

District of Columbia

Adult - Rural Area Services

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

The District of Columbia is an urban area. There are no services provided to individuals in rural areas.

District of Columbia

Adult - Older Adults

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

The DMH older adult consumers who are outpatients receive MHRS and other services necessary for living in the community through both a specialized geriatric program at one DC CSA service center and integration of geriatric services into Community Services at another site, and the service teams of the other CSAs. The consumers are supported through community support services in their own homes or may be placed in community residential facilities (CRFs), nursing homes, or with their immediate guardian.

During FY 2008, DMH, the D.C. Office on Aging, and the Department of Health Medical Assistance Administration partnered to develop a grant proposal in response to the Substance Abuse and Mental Health Services Administration request for applications for an Older Adult Targeted Capacity Expansion Grant Program. The announcement of awards is pending.

In June 2008, the Director of the D.C. Office on Aging and the DMH Director of Adult Services participated in a community forum on excessive hoarding in older adults. Their role was to provide comments and feedback for the recommendations that were developed by the service development group and the policy development group.

The D.C. State Mental Health Planning Council set aside funds in the FY 2007 Block Grant to develop an Older Adult Initiative and recommended additional FY 2008 Block Grant funds for this initiative. The Council initiated a Special Project Request during FY 2008 and recommended funding for several older adult projects that included: a senior health and wellness project for persons who experience chronic homelessness, the development of a positive approach for maintaining mental health for Hispanic seniors, and a 12-week workshop utilizing creative expression to enhance community reintegration for seniors. These projects began implementation in June 2008 and continue through the end of September 2008.

District of Columbia

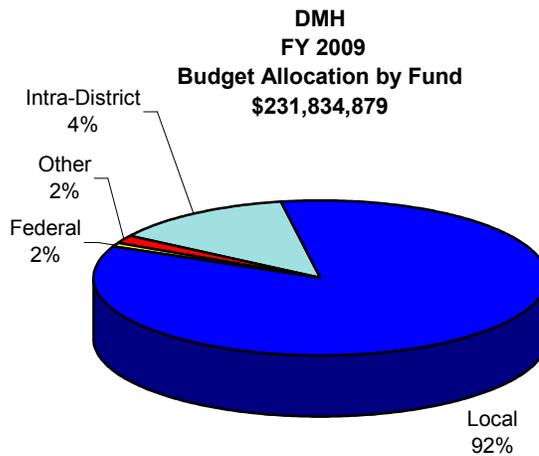
Adult - Resources for Providers

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

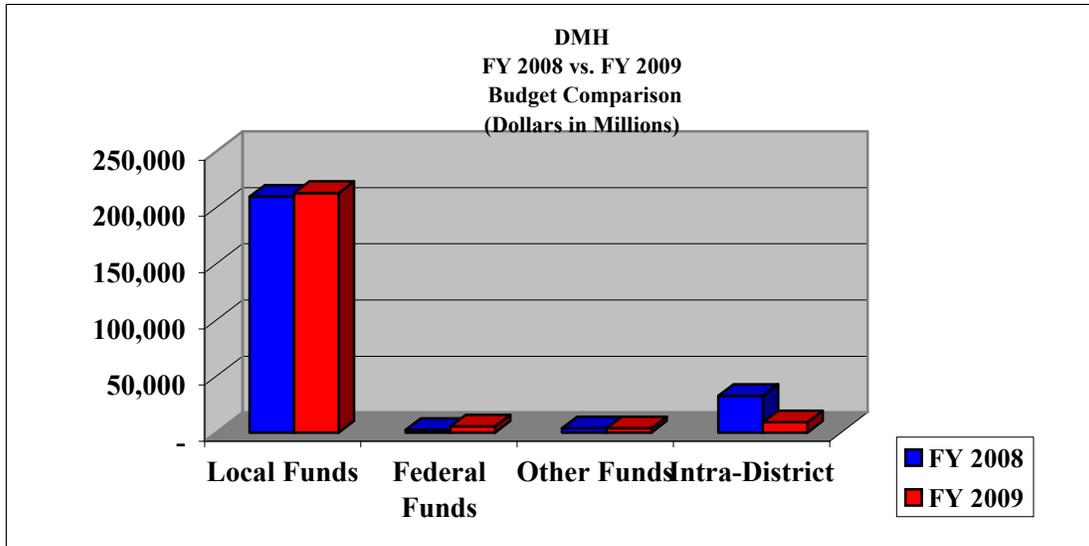
The approved DMH FY 2009 Budget is \$231,834,879. The breakdown of the FY 2009 Budget by program budget category is as follows:

Agency Management	\$17,123,783
Financial Operations	1,628,023
Mental Health Authority	38,796,226
Community Services Agency	36,595,930
Saint Elizabeths Hospital	95,346,628
Community Care Providers	42,344,289
	\$231,834,879

Revenue to support the budget comes from four major revenue sources. **Local** funds are the largest funding source and accounts for \$213,180,771 or 92% of the FY2009 Budget.



Intra District is the second greatest funding source of the FY2009 budget at \$9,280,251 or 4% of the total. **Federal** funds total \$5,565,737 or 2% of the FY 2009 Budget. Finally, the **Other** or Special Purpose Revenue Funds total \$3,808,120 or 2% of the FY 2009 Budget.



The DMH FY 2009 Proposed Budget appears in Appendix A.

Information Services

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

The establishment of the WAN and the deployment of personal computers configured with state-of-the-art software set the stage for the implementation of the Contract Management System and other information system applications that comprise the DMH Information System (IS). The DMH Information Services topology is comprised of an integrated WAN of routers connecting multiple locations on a single protected network within the District of Columbia's infrastructure. Each location can access any servers, printers or shared resources within that topology.

This includes the Contract Management Information System (CMS), Anasazi, a Client Data System for the D.C. Community Services Agencies, and a Legacy Hospital Management Information System, and many small-specialized databases that can be accessed on the network or across the Internet. This provides the capability to record data on any of the measures defined and specified to be included in the system. The new IS infrastructure utilizes state-of-the-art networking technology, data warehousing and mining technology, relational database management systems, all of which facilitate easy incorporation of data elements for recordation and reporting.

The DMH has continued to work with the Office of Chief Technology Officer (OCTO) in order to implement the Safe Passages Information System (SPIS), a District-wide data repository.

The current state mental health system is designed to support the new business model for DMH. In this model, DMH provides services and coordinates payment for services provided by qualified/certified community-based mental health providers. In this new authority role, DMH is implementing a CMS to track and pay providers based upon services rendered and to coordinate Medicaid reimbursement through the Medical Assistance Administration (MAA).

The CMS tracks outpatient services provided by public and private community agencies. It contains a contract on each provider qualified/certified to provide mental health services to DMH. Each contract specifies an agreed upon dollar value, provider demographic data, and rates for services provided. The CMS validates Medicaid eligibility by matching CMS data against the MAA data in a weekly update tape of matching data, to facilitate enrollment and serve as payer of last resort.

Reimbursement must be sought from all other coverage before submitting a claim to DMH. The CMS is designed to conform to HIPAA regulations and adjudicate claims based on certain valid data rules. Once a claim is adjudicated and approved the provider will seek reimbursement from the MAA. The system will also process claims for Medicaid non-reimbursable services, paying providers using locally appropriated funds. The CMS is accessible via the DC-WAN by authorized users and is administered by the DMH Information Services with claims and appeals processing supported by a finance team.

The system serves as the driving force for centralized claims processing, contracts management, provider payment, MAA reimbursement, and budget and accounts management. It also serves as the basis for decision-making in the development of each fiscal year's budget. Grant expenditures will continue to be entered and tracked in DMH finance systems (i.e., Procurement Automated Support System (PASS) and System of Accounting and Reporting (SOARS), the finance packages used by District agencies.

During FY 2007, the DMH Information Services department implemented activities for the new Hospital Information System called AVATAR. Phase 1 of this implementation, will allow the hospital to have a fully integrated system governing traditional administrative functions (admissions, census, billing, etc) as well as a new laboratory and pharmacy management application. Phase 2 will then bring the project to completion by adding in the clinical tracking functionality.

In addition, DMH intends to continue to enhance the CMS and Anasazi applications to more effectively meet Departmental requirements. Specifically, these include implementation of a Comprehensive Clinical Module in the Anasazi application and the implementation of the Accounts Receivable Module in the CMS application, which facilitate improved revenue management. Further, the CMS application is being enhanced to include greater transparency and a more flexible service authorization process to minimize data entry errors.

During FY 2008, Information Services began implementing Phase I of the AVATAR Hospital system scheduled for completion by July 22, 2008. This phase activates the Admission, Treatment Mall, Census, Discharge, Billing, Pharmacy and Lab modules. In FY 2009,

Information Services plans to complete Phase II of the AVATAR Hospital system by June 30, 2009. This phase will initialize the clinical modules of AVATAR

Additionally, in FY2008, Information Systems implemented the Accounts Receivable (AR) Module in the CMS application. This functionality allows CMS to automatically post and reconcile payments and report AR information. Information Systems also implemented a major change in provider payment for services rendered to MAA eligible consumers. Effective 11/01/2007 DMH implemented a transition that allows MAA to pay providers directly for Medicaid services. DMH continues to authorize services and ensure that claims from providers are adjudicated against authorized services, but now sends the approved Medicaid eligible claims to MAA for payment to providers. This change minimizes the pay-and-chase practice in the previous DMH payment model and standardizes the payment process for Medicaid services. The method for processing claims for Medicaid non-reimbursable services, paying providers using locally appropriated funds, is unchanged.

By the end of FY 2008 and into FY 2009, Information Systems intends to install the latest version of the CMS software to improve the authorization process and to also reconfigure the CMS application so that consumer MAA eligibility data can be better managed to stay aligned with IMA data and to eliminate many manual activities currently employed to coordinate MAA eligibility in the system.

In summary, DMH continues to invest in systems that facilitate the transformation of its role from a provider of services to one of a purchaser of services and manager of the public mental health service delivery network for the residents of the District of Columbia. With the consolidation of shared resources, facilities and personnel throughout, the Department is becoming more reliable, dependable and cost effective.

Human Resources Development Efforts

The total number of DMH staff at the end of FY 2007 was 1482. The total in each of the Department's three organizational components include the following:

The Mental Health Authority	287
The D. C. Community Services Agency	288
Saint Elizabeths Hospital	907

The total number of DMH staff during the third quarter of FY 2008 was 1493. The total staff in each of the Department's three organizational components include the following:

The Mental Health Authority	288
The D. C. Community Services Agency	293
Saint Elizabeths Hospital	912

The total number of DMH staff projected for the end of FY 2008 is 1436. The total staff in each of the Department's three organizational components includes the following:

The Mental Health Authority	289
The D. C. Community Services Agency	268
Saint Elizabeth's Hospital	879

Filling Vacancies in FY 2008

Critical vacancies/positions filled in the first three quarters of FY 2008 include the following:

- Medical Officer (Psych.) (7)
- Supervisory Medical Officer (1)
- Deputy Director Civil Programs (1)
- Director of Business Operations (1)
- Social Worker (15)
- Supervisory Social Worker (2)
- Clinical Psychologist (13)
- Supervisory Clinical Psychologist (2)
- Clinical Psych. Intern (4)
- Clinical Administrator (3)
- Interpreter (American Sign Language) (1)
- Supervisory Psychiatric Nurse (10)
- Lead Psychiatric Nurse (6)
- Psychiatric Nurse (10)
- Clinical Nurse (2)
- Mental Health Specialist (5)
- Mental Health Specialist (Bilingual) (1)
- Medical Records Administrator (1)
- Director of Consumer and Family Affairs (1)
- Patient Accounts Services Representative (1)
- Nurse Educator (1)
- Chaplain (2)
- Creative Arts Therapist (1)
- Dental Assistant (2)
- Dental Resident(4)
- Forensic Clinical Administrator (1)
- Forensic Psych. Technician (22)
- Psychiatric Nursing Assistant (22)
- Psychiatric Practical Nurse (4)
- Treatment Team Coordinator (1)
- Medical Technologist (1)
- Pharmacy Technician (1)

During the fourth quarter of FY 2008, it is expected that additional key/critical positions will be filled. This will include the following positions:

- Social Worker (5)
- Mental Health Specialist (5)
- Clinical Administrator (6)
- Psychiatric Nurse (16)
- Forensic Psych. Technician (10)

- Psychiatric Nursing Assistant (8)
- Medical Officer (Psych.) (5)

Human Resources Activities in FY 2008

A number of significant human resource development activities were undertaken during FY 2008. These include:

- Recruiting and hiring staff for critical positions;
- Decentralization of human resources functions to Saint Elizabeths Hospital;
- In conjunction with the D.C. Office of Labor Relations, engaged in bargaining with four DMH unions for re-openers of contracts
- Implementation of the Management and Supervisory Service Program in DMH;
- Implementation of the Performance Management System in DMH for MSS and Excepted Service employees;
- Implementation of New PO Form 12, Performance Evaluation Form for non-supervisory DMH employees;
- Implementation and Management of the DMH Retirement Incentive Program;
- Planning and managing an expanded Passport-to-Work Mayor's Summer Youth Program;
- Co-development of Policy, Implementation and Management of Department's Alternative Work Schedule Program;
- Co-Development of Policy, Implementation and Management of Criminal Background Checks for Unlicensed Personnel in DMH;
- Coordination of Mandatory Training for all Management Supervisory Service Employees;
- In collaboration with the DMH Policy Division to Developed Drug and Alcohol Testing Policies for DMH;
- Active Participation in the Spring City-Wide Job Fair;
- Planned and began implementation of the DMH transition to the Employee Self Service PeopleSoft Module for time entry including Electronic Time Reporting System-E-Time and providing employees online access to their personal information.

Planned Activities for the Fourth Quarter of FY 2008

Some of the activities planned by the end of FY 2008 include:

- Implement pay increases for bargaining unit employees;
- Implement market adjustment pay increase for Management Supervisory Service employees;
- Conduct classification reviews of selected positions in the D.C. CSA;
- Continue recruitment for identified key/critical positions;
- Continue work to implement Drug and Alcohol testing for certain DMH employees;
- Complete implementation of Criminal Background Checks for Certain Unlicensed employees of DMH;
- Begin cycle of periodic Criminal Background Checks for designated DMH employees who have direct contact with Children or Youth;
- Work with KPMG as they review and document current HR business processes; and
- Complete DMG transition to e-time.

DMH Training Institute and Other Training

The DMH Training Institute has evolved into a primary mental health workforce development training and community education medium for District agencies, human services providers, consumers, family members, and community residents. The Institute's training series provide a wealth of information on a range of topics. Over the years, partnerships have been established with consumer, family member, community, academic, professional, federal and local government agencies. An important feature of the DMH Training Institute is the award of continuing education units (CEUs) for several disciplines.

During FY 2008, the DMH Training Institute implemented a Fall, Spring and Summer training series. The course offerings included but were not limit to the following:

- Consumer Focused Treatment Planning
- Language Access: An Overview
- Equal Employment Opportunity (EEO) and the D.C. Human Rights System
- DMH 101: Overview of Services and Supports Offered Through the D.C. Department of Mental Health
- Supported Employment: How to Help Consumers Get and Keep a Job (Providers)
- How to Get and Keep a Job Through a Program Called Supported Employment (Consumers)
- Co-Occurring Disorders: Basic Principles of Integrated Treatment and Best Practices
- Contingency/Management Skills Building for Treatment of Co-Occurring Disorders
- Ethical Practice in Contemporary Mental Health Practice
- Mental Health Needs of Lesbian, Gay, Bi-sexual, Transgendered and Questioning (LGBTQ) Youth
- The D.C. DMH Compliance Community of Practice
- Community-Based Intervention
- Service Authorization for Clinicians and Direct Service Staff
- Rapid Psychological First Aid
- "Helping Keep Children Safe"
- NTU Training
- Teen Dating
- Assertive Community Treatment (ACT) Core Training
- Child Abuse and Neglect Training
- EEO/Sexual Harassment
- Culturally and Linguistically Practice Training
- Ethics Training for Social Workers
- Domestic Violence
- Compliance Requirements Workshop

Mental Health Training for Providers of Emergency Services

In addition to providing training for consumers and a variety of mental health stakeholders and the public, DMH is committed to training others who impact consumers and families.

Crisis Restraint Training: During FY 2007, the DMH Training Institute developed a Crisis Restraint Training series (Effective Crisis Intervention and Passive Restraint Strategies with Adult Consumers in Community Work Settings). The participants included the Comprehensive Psychiatric Emergency Program (CPEP) staff, Saint Elizabeths Hospital staff, and District Community Services Agency crisis staff.

Crisis Services and Related Training: The DMH Homeless Outreach Program (HOP) provides crisis services for individuals who are homeless and non-homeless (this later category will be eliminated once the mobile crisis teams are up and running). As part of the crisis related services, the HOP provides training to District government and community agencies. During FY 2008, training on how to identify potential crisis situations, crisis services, linkages to the mental health system, and signs and symptoms of mental illness for Child Protective Services staff, two of the Family Collaboratives, and family shelter staff. The DMH School Mental Health Program staff were trained in how to safely conduct home visits.

Other training provided by the HOP during FY 2007 and FY 2008 include:

- Hypothermia Training (100 people)- The target audience is staff working in emergency shelters or providing street outreach to individuals who are homeless and may be at risk of hypothermia or are presenting signs of mental health crisis. This training provides information on identifying the signs and symptoms of mental health crisis and how to access appropriate services in those situations. This training is provided annually in October or November and is conducted in collaboration with The Community Partnership for the Prevention of Homelessness (TCP), the Department of Human Services (DHS), the Department of Health, Addiction Prevention and Recovery Administration (DOH/APRA), the Washington Legal Clinic for the Homeless, and other public and private agencies.
- Shelter Security Staff (100 people)- At the request of DHS, the HOP assisted in providing training on working with individuals residing in overnight shelters who are homeless and mentally ill. The target audience was special police officers with Hawk One and the Protective Services Police. Topics included basic information on the rights of individuals with mental illness and how to interface with the consumers in a shelter setting in way that reduces the incidence of conflict and behavioral problems. These trainings were provided during the Summer of 2007 and the Winter of 2008.
- Lawyers/Guardians with D.C. Bar Association (50 people)- For this training, the target audience included attorneys who are appointed guardians for individuals with mental illness. Information was provided on how to access services at DMH and how to access crisis services for their wards. This training was provided in the Fall 2008.
- Working with Homeless Families with Mental Illness (30 people)- The target audience for this training was social workers and staff working in government agencies who provide services to families who are homeless and mentally ill. This training was provided in the Spring of 2007 with another training was provided in the Winter of 2008.

- Officer Agent Training- This target audience for this training is DMH staff who have been approved by the administration to provide crisis services and make application for individuals who are suspected of having a mental illness who may need an involuntary assessment by a psychiatrist. The HOP provides this training several times a year in conjunction with the D.C. Government Office of the Attorney General. Annually approximately 50 individuals are trained. This activity will be integrated into the DMH Training Institute in the Summer of 2008.
- Disaster Mental Health Training: The DMH is planning to increase its ability to respond to catastrophic emergencies by increasing the number of Emergency Response Teams (ERTs) by five (5). Currently there are 7 teams in place for immediate deployment – three (3) located within the DC CSA and four (4) teams located within the School Mental Health Program, which responds to emergencies within the DC Public School (DCPS) system. All of the DMH team members have some training in crisis counseling. The DMH Senior Executive staff and members of the ERTs have a current schedule of trainings in the Incident Command System (ICS) and the National Incident Management System (NIMS) provided by the Homeland Security and Emergency Management Agency (HSEMA). The Department expects to be NIMS compliant by the end of calendar year 2008.

Twenty-one (21) Senior Executive Staff and Emergency Response Team Leaders completed ICS/NIMS training scheduled in May 2008. This training will be offered on a quarterly basis until all members of the Senior Executive Staff, Emergency Response Teams, School Teams, Crisis Teams, and Homeless Outreach Team have been trained. In addition, DMH is developing a core curriculum that ensures state-of-the-art best practice training for disaster mental health.

Crisis/Emergency Planning: In February 2007, DMH launched a 10-month Crisis/Emergency Services Planning Work Group that had broad participation from Metropolitan Police Department (MPD), Fire and Emergency Medical Services (F/EMS), the courts, crisis providers, consumers, family members, homeless providers, public and private mental health providers, and advocates. An Interim Report was disseminated in July 2007 and the Final Report in December 2007.

District of Columbia

Adult - Emergency Service Provider Training

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

See Adult Resources for Providers for information about training on emergency health services.

District of Columbia

Adult - Grant Expenditure Manner

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

The D.C. State Mental Health Planning Council (SMHPC) initiated the Request for Projects from consumer, family member (focus on programs serving adults and children/youth), and community organizations for funding consideration under the FY 2009 Block Grant. A total of 8 projects were submitted in response to the Request for Projects. One project was submitted by a family member organization, one by a youth organization, two by DMH programs, and four were submitted by community-based organizations. The Council's recommendation was to fund six projects, the Council and set aside funds for DMH child/youth program initiatives. The DMH Director accepted the Council's recommendations and consulted with the Council to add continuation funding for a family member project.

The FY 2009 Block Grant award is based on the FY 2008 federal allocation. The breakdown is as follows:

FY 2009 Award:	\$715,760.00
Administrative Fee (5%):	\$35,788.00
Funds for Projects:	\$679,972.00

All of the proposed FY 2009 Block Grant funded projects are presented in the table below. The Adult Plan projects are listed first and the Child Plan projects are identified as Child/Youth. The D.C. State Mental Health Planning Council is identified as Adult and Child/Youth.

FY 2009 BLOCK GRANT FUNDED PROJECTS

Type of Project	Project	Organization	Purpose	Amount
Adult and Child/Youth	D.C. State Mental Health Planning Council	Citizen Advisory Body	Fund the Planning Council initiatives including mental health conference	\$25,000.00
Adult	Pathways DC Peer Health Worker Project	Pathways to Housing DC	Expand existing health and wellness program by adding two (2) Peer Health Workers each with a caseload of 15 for total of 30 consumers	\$19,759.00
Older Adults	Program Implementation and Evaluation of the "Mente Positiva" Program for Promoting Positive Mental Health for Hispanic Seniors	Educational Organization for United Latin Americans (EOFULA) Spanish Senior Center	Move from initial training of mental health promoters to the full implementation and evaluation of the first year of the "Mente Positiva" program	\$19,732.00
Adult	Lens and Pens Creative Expression	The Spoken Word	Expand this project for forensic inpatients and outpatients that uses the Arts as a tool in support of consumer community reintegration, total of 20 consumers	\$18,045.00
Adult	Family Links Outreach Center	Family Links Outreach Center	Continue a weekend day socialization program for adults with SMI	\$10,000.00

Transition Age Youth and Adults	Supportive Housing for Youth, Adults and Families	DMH Division of Housing	Continue the bridge rental subsidies for 58 consumers , 25 transitioning into the adult system and 35 leaving jail	\$380,000.00
Child/Youth	GuidePost	Total Family Care Coalition	Provide advocacy and outreach support services for families and youth diagnosed with severe emotional behavior disorder through a series of workshops, seminars, and family and youth events. Targets minimum of 75 families.	\$10,000.00
Child/Youth	Youth Trauma Support Program	Time Dollar Youth Court	Implement pilot support program for 25 youth who have experienced trauma and are at risk for violent behavior, includes support groups, recreational activities, professional facilitation, and referral to outreach services when necessary	\$20,000.00
Child/Youth	Child and Youth Initiatives	DMH Child and Youth Division	Child and Youth Initiatives	\$177,436.00

**Table C. MHBG Funding for Transformation Activities
State: District of Columbia**

	Column 1	Column 2	
	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the <i>actual</i> or <i>estimated</i> amount of MHBG funding that will be used to support this transformation goal in FY	
		Actual	Estimated
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	<input checked="" type="checkbox"/>	19,759	
GOAL 2: Mental Health Care is Consumer and Family Driven	<input checked="" type="checkbox"/>	615,485	
GOAL 3: Disparities in Mental Health Services are Eliminated	<input checked="" type="checkbox"/>	19,732	
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	<input type="checkbox"/>		
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	<input type="checkbox"/>		
GOAL 6: Technology Is Used to Access Mental Health Care and Information	<input type="checkbox"/>		
Total MHBG Funds	N/A	654,976	0

*Goal 5 of the Final Report of the President’s New Freedom Commission on Mental Health states: Excellent Mental Health Care is Delivered and Research is Accelerated. However, Section XX of the MHBG statute provides that research ... Therefore, States are asked to report expected MHBG expenditures related to program evaluation, rather than research.

District of Columbia

Table C - Description of Transformation Activities

For each mental health transformation goal provided in Table C, briefly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State's transformation activities are described elsewhere in this application, you may simply refer to that section(s).

Goal 1: Americans Understand that Mental Health Is Essential to Overall Health

FY 2009 Block Grant funds will be used to support the Pathways to Housing D.C. Peer Health Worker (PHW) Project (\$19,759.00) for persons who have histories of chronic homelessness. The existing health and wellness program will be expanded to hire two PHWs (caseload of 15 each) who will act as role models, mentors, and allies to the consumers they serve and will facilitate self-help groups, provide one-on-one listening, assist consumers in identifying needs and resources, and accompany consumers to community groups (AA, NA, Weight Watchers, etc.), classes (nutrition, yoga, etc.), or appointments (physician, dentist, clinic, etc.).

Other DMH supported initiatives related to health and mental health include: the provision of acute psychiatric care in community hospitals (\$1,750,040), and enhancing the mental health of disadvantaged families through personalized, community-based, supportive maternity care (\$200,000).

Goal 2: Mental Health Care is Consumer and Family Driven

Several of the FY 2009 Mental Health Block Grant funded projects are related to consumer and family driven initiatives. The DMH Supportive Housing for Youth, Adults and Families Project (\$380,000) will continue to provide a bridge subsidy for 58 consumers (25 transition age youth and 35 leaving jail). The Lens and Pens Creative Expression Project (\$18,045.00) will expand this project for forensic inpatients and outpatients that uses the Arts as a tool to support consumer community reintegration (total of 20 consumers). The FamilyLinks Outreach Center Project (\$10,000) will continue to provide a weekend day socialization program for adults. The Total Family Care Coalition GuidePost Project (\$10,000) will provide advocacy and outreach support services for families and youth diagnosed with severe emotional behavior disorder through a series of workshops, seminars, and family and youth events and targets a minimum of 75 families. The Time Dollar Youth Court Youth Trauma Support Program (\$20,000.00) will pilot a support program for 25 youth who have experienced trauma and are at risk for violent behavior that includes support groups, recreational activities, professional facilitation, and referral to outreach services when necessary. The DMH Child and Youth Division program initiatives (\$177,436.00) will also be supported.

Other DMH supported initiatives related to consumer and family driven services include: the peer run Wellness and Resource Center (\$1.2 million over a 5-year period), the Court Urgent Care Clinic (\$1.5 million over a 3-year period), and the International Center for Clubhouse Development (ICCD) Clubhouse (\$989,000).

Goal 3: Disparities in Mental Health Services are Eliminated

One of the FY 2009 Mental Health Block Grant projects addresses the needs of older adults. The Educational Organization for United Latin Americans (EOFULA) Spanish Senior Center Project (\$19,732.00) will move from initial training of mental health promoters to the full implementation and evaluation of the first year of the “Mente Positiva” (positive mind) program.

Goal 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice

There are no FY 2009 Mental Health Block Grant funded projects related to this goal. The DMH School Mental Health Program (SMHP), however, continues to provide an array of prevention, early intervention and treatment services. The number of schools has grown from 42 to 48 over the past year. The volume of most services has continued to grow as well. There has been corresponding growth in individual/group/family services, student participation in conflict resolution interventions, parent consultation, prevention groups, etc. An average of three (3) children per month are admitted to psychiatric inpatient care based on SMHP assessment and referral. The FY 2009 budget is approximately \$4,834,165.

Goal 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated

The EOFULA Spanish Senior Center Project referenced under Goal 3 is also relevant to this goal because of the evaluation component. The DMH Evidence-Based Supported Employment Program (\$1,264,575) supports seven (7) provider programs and conducts annual assessments of the programs' fidelity to the model.

Goal 6: Technology Is Used to Access Mental Health Care and Information

There are no FY 2009 Mental Health Block Grant funded projects related to this goal. It is noted that information technology supports all DMH components including the Authority, D.C. Community Services Agency and Saint Elizabeths Hospital.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	9,732	10,123	13,000	14,000	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To improve access to care.

Target: Target is consistent with the penetration rate target for adults established by Dixon Exit criterion #6 - 3% of the estimated adult population for the District of Columbia.

Population: Estimated adult (18 and over) population for the District of Columbia.

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator: Number of adults receiving at least one mental health service during the reporting period.

Measure: Number of adults receiving at least one mental health service during the reporting period as a percentage of the total population of adults.

Sources of Information: Claims management system.

Special Issues: DMH is resolving issues with the Medicaid MCO's regarding coordination of and reporting of mental health services provided to adults enrolled in the Medicaid MCOs.

Significance: Required to exit from court oversight.

Action Plan: Negotiating MOU with MCOs to improve data collection and integrity. This will improve overall performance and facilitate exit from court oversight.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	10.87	8.84	10	9	N/A	N/A
Numerator	75	85	--	--	--	--
Denominator	690	962	--	--	--	--

Table Descriptors:

Goal: To improve continuity of care.

Target: Decrease the number of adults re-admitted to Saint Elizabeths Hospital within 30 days of discharge to 10%.

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

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of adults re-admitted to Saint Elizabeths Hospital within 30 days of discharge during the reporting period.

Measure: Number of adults discharged from Saint Elizabeths Hospital during the reporting period.

Sources of Information: Hospital Information Management System

Special Issues: DMH is building a new state-of-the art 292 bed hospital and needs to reduce beds accordingly. The completion date for construction is early 2010. An overflow plan has been developed.

Significance: Achievement of this performance measure will facilitate the reduction in the size of the public hospital, from 400 beds to 292. Current census ranges between 388 - 392. The new hospital building is scheduled to open in 2010. Reducing short term admissions is also an indicator that more effective discharge planning is occurring, in accordance with the terms of the settlement with the DOJ. Longer stays in the community after discharge also is an indicator that the District is complying with the requirements of the Dixon consent order, because consumers are receiving services in the community, in the least restrictive environment.

Action Plan: The DMH will continue to implement the strategies aimed at supporting adult consumers in the least restrictive setting and reducing the number of beds at Saint Elizabeths Hospital. This will include: 1) continue emphasis on adherence to the Continuity of Care Policy Practice Guidelines that assure every inpatient is seen within 48 hours of admission to the Hospital, 2) continue the meetings held between Hospital, Authority sand Core Services Agency (CSA) staff to review all clients in the Hospital 30 days or longer, 3) continue the housing priority to place individuals leaving the Hospital, 4) continue Assertive Community Treatment (ACT) services placement priority for individuals leaving the Hospital, and 5) continue to try to reach the Dixon Performance Target that 80% of adults discharged from inpatient care must be seen within seven days. The matching of data across the hospital and contract monitoring systems to track this measure proved very difficult. In June FY 2007, DMH developed a preliminary data base to track this variable. The DMH will continue to refine the data base, validate the data, and do baseline reporting in FY 2009.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	28.99	20.27	25	23	N/A	N/A
Numerator	200	195	--	--	--	--
Denominator	690	962	--	--	--	--

Table Descriptors:

Goal: Improve Continuity of Care

Target: Decrease the number of adults re-admitted to Saint Elizabeths Hospital within 180 days of discharge to 25%.

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

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of adults re-admitted to Saint Elizabeths Hospital within 180 days of discharge during the reporting period.

Measure: Number of adults discharged from Saint Elizabeths Hospital during the reporting period.

Sources of Information: Hospital Management Information System.

Special Issues: DMH is building a new state-of-the-art 292 bed hospital and needs to reduce beds accordingly. The completion date for the new hospital is early 2010. An overflow plan has been developed.

Significance: Achievement of this performance measure will facilitate the reduction in the size of the public hospital, from 400 beds to 292. Current census ranges between 388 - 392. The new hospital building is scheduled to open in 2010. Reducing short term admissions is also an indicator that more effective discharge planning is occurring, in accordance with the terms of the settlement with the DOJ. Longer stays in the community after discharge also is an indicator that the District is complying with the requirements of the Dixon consent order, because consumers are receiving services in the community, in the least restrictive environment.

Action Plan: See action plan for NOM for reduced utilization of psychiatric inpatient beds for patients re-admitted within 30 days of discharge.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	51.16	11.57	70	70	N/A	N/A
Numerator	88	28	--	--	--	--
Denominator	172	242	--	--	--	--

Table Descriptors:

Goal: Improve access to Evidence-Based Practices.

Target: See State Indicator. Target is the percentage of people receiving supported housing services within 45 120 days of referral.

Population: Adults with SMI living in the District of Columbia.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of persons receiving supported housing.

Measure:

Sources of Information: DMH Housing Division database and other sources.

Special Issues: Note: The Dixon Performance Target is 70%. FY 2005 data for the 3rd and 4th quarters show that 44% of individuals received housing placement within 45 days of a referral. FY 2006 data for the 1st and 2nd quarters show a rate of 51%. FY 2007 data for 3 quarters show 11.6% were housed in 45 days, however 71 consumers were housed for the reporting period. During the FY 2007 2nd and 3rd quarters concerns about staying within the budget caused a slow down in housing that accounts for this lower rate of persons housed within 45 days. The FY 2009 target remains 70%.

Significance: The DMH has made the development of evidence-based practices a focal point for the reformed mental health system. Achievement of the target of providing supported housing to 70% of adult consumers with SMI within 45 days of referral is also a performance target established in the Dixon consent order. Achievement of this performance level is necessary for the District to exit from continued court oversight of the mental health system and to complete the system reform envisioned in the 2001 Final Court Ordered Plan. It is also consistent with NFC Goal 5.2.

Action Plan: During FY 2008, DMH and the Dixon Court Monitor discussed the fact that housing services was too narrowly defined (solely as housing) and that housing placement within 45 days was not a reasonable expectation, given the District's housing market. There are also budgetary constraints. DMH is working with the Court Monitor on revising the data collection and reporting metric for this measure, so that it truly reflective of supportive housing best practice.

ADULT - GOALS TARGETS AND ACTION PLANS
Evidence Based - Adults with SMI Receiving Supported Housing
Foot Notes

Data about receipt of supported housing is collected in accordance with the Dixon exit criteria. The data is reported as a percentage of referrals who received supported housing within 45 days of referral. The block grant format does not support entry of the data in this format. Data is reported in the section of this form entitled "Special Issues."

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	77.47	89.91	70	70	N/A	N/A
Numerator	306	98	--	--	--	--
Denominator	395	109	--	--	--	--

Table Descriptors:

Goal: Improve access to evidence-based practices.

Target: Increase to 70% the number of adults with SMI receiving supported employment services within 120 days of a referral.

Population: Adults with SMI living in the District of Columbia.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of persons receiving evidence based practices.

Measure:

Sources of Information: Contract management system.

Special Issues: Note: The Dixon Performance Target is 70%. FY 2005 data for 3/05-9/05 show that 62% of persons referred receive supported employment services within 120 days of a referral. FY 2006 data show a rate of 77%. FY 2007 data show a rate of 89%. The FY 2008 target remains 70%, although actual performance is expected to be better than the Dixon target.

Significance: The DMH has made the development of evidence-based practices a focal point for the reformed mental health system. Achievement of the target of providing supported employment to 70% of adult consumers with SMI within 120 days of referral is also a performance target established in the Dixon consent order. Achievement of this performance level is necessary for the District to exit from continued court oversight of the mental health system and to complete the system reform envisioned in the 2001 Final Court Ordered Plan. It is also consistent with NFC Goal 5.2.

Action Plan: During FY 2009, DMH will continue to focus on building service capacity. The DMH will continue to implement its Supported Employment Promotion, Outreach and Training Plan, to disseminate information about the availability of supported employment services to consumers and clinicians to increase access to the service. This will include ongoing supported employment training targeted to clinicians and consumers. The training will help to educate clinicians that consumers can work and how to link consumers to supported employment services. The consumer training will help consumers understand the service, that they can work, and how to request the service.

Also during FY 2009, DMH will continue to work with all service providers to help them develop and provide supported employment services that are programmatically effective and financially efficient. The DMH will also try to continue to maintain the Dixon Exit Criteria measure to provide supported employment services to 70% of the persons referred within 120 days of referral.

ADULT - GOALS TARGETS AND ACTION PLANS
Evidence Based - Adults with SMI Receiving Supported Employment
Foot Notes

DMH collects data about supported employment in accordance with the Dixon exit criteria. The data is collected as a percentage of persons referred for supported employment who receive services within 120 days of referral. The block grant form will not accept the data in this format. It is reported in the section of this form entitled "Significant Issues."

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	51.52	85	85	N/A	N/A
Numerator	N/A	34	--	--	--	--
Denominator	N/A	66	--	--	--	--

Table Descriptors:

Goal: Improve access to evidence-based practices.

Target: Increase to 85% the number of adults with SMI receiving ACT services within 45 days of a referral.

Population: Adults with SMI living in the District of Columbia.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of persons receiving evidence-based practices.

Measure:

Sources of Information: Contract management system.

Special Issues: This is one of the Dixon exit criteria. The performance level is set at 85%. The performance level of 85% is established in the consent order setting forth the exit criteria. It will remain the same for FY 2009. DMH is not able to report data for FY 2005 or FY 2006 because of issues matching service authorizations with service delivery dates. In order to address this issue DMH had to develop a module that would allow services authorization and services delivery to be matched. The reporting of this baseline data began in FY 2007 for the period April 2006 through March 2007. This reporting will continue in FY 2009.

Significance: The DMH has made the development of evidence-based practices a focal point for the reformed mental health system. Achievement of the target of providing ACT to 85% of adult consumers with SMI within 45 days of referral is also a performance target established in the Dixon consent order. Achievement of this performance level is necessary for the District to exit from continued court oversight of the mental health system and to complete the system reform envisioned in the 2001 Final Court Ordered Plan. It is also consistent with NFC Goal 5.2.

Action Plan: During FY 2009, DMH will continue to address its data collection and tracking issues. At the same time, DMH will continue to work with all service providers to help them develop and provide ACT services that are programmatically effective and financially efficient. The results of the recent fidelity audit will be used to provide technical assistance and training about fidelity to the ACT model. The DMH will also try to continue to maintain the Dixon Exit Criteria measure to provide ACT services to 85% of the persons referred within 45 days of referral.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: **Indicator Data Not Applicable:**

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: **Indicator Data Not Applicable:**

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: **Indicator Data Not Applicable:**

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: **Indicator Data Not Applicable:**

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	74	80	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Improve client perception of care.

Target: Maintain the rating of 80% for system performance measures in the annual Adult Community Service Review.

Population: Adults with mental illness living in the District of Columbia who receive publicly funded mental health services.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Positive report by independent review team using an agreed upon instrument to measure system performance.

Measure: Cases pulled for review by independent review team. Projected that 88 cases to be reviewed in FY 2008 to ensure statistically valid results.

Sources of Information: Annual community service reviews, conducted by the Dixon Court Monitor through its contractor, HSO.

Annual MHSIP, including the ROSI. Consumer satisfaction surveys conducted by consumer organization through convenience sampling and focus groups.

Special Issues: This is one of the Dixon exit criteria. The performance target of 80% system performance was established in the consent order setting forth the exit criteria. The target for exiting active monitoring on this exit criteria is 80% and will remain at 80% for FY 2008.

Significance: Achievement of 80% systems performance is required to exit from federal court oversight.

Action Plan: The results of the FY 2006 CAN Report suggest the need for improvements related to: 1) Housing (affordable that meets unique consumer needs), 2) Appropriate services (consistent individualized consumer-driven care), and 3) Access to information (clear and concise information about mental health and other related services). The DMH Quality Council reviewed the Report and made a series of recommendations noting that issues related to housing should be a top priority.

The results from the FY 2006 and FY 2007 Annual Adult CSR suggested the need to address social network, work and recovery activities. The systems performance score (Dixon requirement) was rated much higher in 2006 (69%) than in 2005 (51%). However, it was still lower than the required 80%. In 2007, the system performance score of 80% was achieved. Although the target was met, going forward issues such as appropriate sample size and inter-rater reliability will need to be addressed.

In FY 2007, the DMH Director and Senior Staff asked the Court Monitor and Human Systems and Outcomes, Inc. (HSO) to present themes, trends, and data points over the past five years from the Annual CSR process. These findings were discussed extensively with senior leaders as part of an initiative that DMH has undertaken via the Institute for Healthcare Improvement

(IHI). The overall goal is to identify specific practice or system performance areas in which DMH can make a real impact. This process will continue in FY 2008.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

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

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Data currently not available. DMH plans to report this data in the FY 07 status report, which is due on December 1, 2007. This will allow for a full fiscal year of reporting, since the District of Columbia's fiscal year ends on September 30th.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Data currently not available. DMH plans to report this data in the FY 07 status report, which is due on December 1, 2007. This will allow for a full fiscal year of reporting, since the District of Columbia's fiscal year ends on September 30th.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Data currently not available. DMH plans to report this data in the FY 07 status report, which is due on December 1, 2007. This will allow for a full fiscal year of reporting, since the District of Columbia's fiscal year ends on September 30th.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	88.84	90	90	N/A	N/A
Numerator	N/A	892	--	--	--	--
Denominator	N/A	1,004	--	--	--	--

Table Descriptors:

Goal: To improve consumer outcomes.

Target: Increase percentage of consumers participating in the MHSIP report positively about social connectedness.

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

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure: Number of adult consumers surveyed in the MHSIP report positively on social connectedness questions.

Sources of Information: MHSIP

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	89.64	90	90	N/A	N/A
Numerator	N/A	675	--	--	--	--
Denominator	N/A	753	--	--	--	--

Table Descriptors:

Goal: To improve consumer functioning.

Target:

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

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations

Indicator:

Measure:

Sources of Information: MHSIP

Special Issues:

Significance: Aggregating, tracking and trending data about consumer functioning is one of the Dixon exit criteria. DMH is currently working on implementing a web-based application of LOCUS/CALOCUS to collect data about consumer functioning. This data will be used through the quality improvement process to improve overall service delivery and mix of services.

Action Plan: DMH is currently working on implementing a web-based application of LOCUS/CALOCUS to collect data about consumer functioning. This data will be used through the quality improvement process to improve overall service delivery and mix of services. The goal is to submit evidence of compliance with the exit criterion to the Dixon Court Monitor in January 2009.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: ACT Teams

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	8	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** Improve access to evidence-based practices.
- Target:** Continue review of ACT services and ACT teams in FY 2008.
- Population:** Adults with SMI living in the District of Columbia.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Number of evidence-based practices.
- Measure:** Number of ACT teams operating in the District of Columbia.
- Sources of Information:** Access Helpline/Care Coordination.
- Special Issues:** By the end of FY 2005 there were 9 ACT teams (DC CSA=3, Psychotherapeutic Outreach Services =1, Pathways to Housing =2 (chronically homeless teams), Marshall Heights =1 (mental illness/developmental disabilities, and Family Preservation Services, Inc. = 2 (forensics and mental illness/developmental disabilities teams). During FY 2006 , Marshall Heights stopped providing mental health services (6/30/06) reducing the number of teams to 8. The planned two teams were not added in FY 2006 and none were planned in FY 2007 pending the review of the ACT team services. The review of the ACT teams focuses on referrals, capacity, staffing, and service delivery issues and will continue in FY 2008. The target remains 8.
- Significance:** ACT is one of the evidence-based practices that DMH has identified as needed in the District of Columbia. The DMH has made the development of evidence-based practices a focal point for the reformed mental health system. There is a Dixon exit criteria that specifically addresses ACT referrals (which is addressed in another state indicator). Achievement of that performance target is required for the District to exit from court oversight of the mental health system. Capacity to deliver ACT services in fidelity to the evidence-based practice model is a critical component of a functioning mental health system in the District.
- Action Plan:** See action plan for evidence-based practices.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Availability of Newer Generation Medications

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	69.30	85.30	70	70	N/A	N/A
Numerator	2,392	3,028	--	--	--	--
Denominator	3,452	3,549	--	--	--	--

Table Descriptors:

- Goal:** To increase access to new generation antipsychotic medications.
- Target:** To increase to 70% the number of adults with schizophrenia receiving new generation antipsychotic medications.
- Population:** Adults with SMI living in the District of Columbia.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Number of persons receiving evidence-based practices.
- Measure:** Number of adults with schizophrenia living in the District of Columbia.
- Sources of Information:** Contract management system and Office of the Chief Clinical Officer.
- Special Issues:** The Dixon Performance Target is 70%. FY 2005 and FY 2006 data is based on the Court Monitor’s July 2006 Report (4/05-3/06), showing a rate of 69.3%. FY 2007 data has been updated to reflect actual performance. While the Dixon Court Monitor agrees that DMH met this target in FY 2007, DMH still has to monitor this performance target. The FY 2009 target remains 70%.
- Significance:** Achievement of the performance target established in the Dixon consent order is required for the District to exit from court oversight of the mental health system.
- Action Plan:** See action plan for NOM regarding evidence-based practices.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Continuity of Care

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** Improve continuity of care.
- Target:** Increase the number of adults receiving a community-based mental health service (other than a crisis service) within 7 days of discharge from an inpatient psychiatric unit.
- Population:** Adults with mental illness living in the District of Columbia.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** 80% of adults (all known inpatient discharges) who received a documented non-emergency service from a CSA/provider within 7 days of discharge from an inpatient psychiatric unit (including Saint Elizabeths Hospital).
- Measure:** All known discharges from an inpatient psychiatric unit, including Saint Elizabeths Hospital.
- Sources of Information:** Contract management system, information about discharges provided by local community hospitals and the Department of Health's Medical Assistance Administration.
- Special Issues:** This performance indicator is one of the Dixon exit criteria. During FY 2005 and FY 2006, DMH worked on addressing a number of data matching issues, as well as establishing a process for obtaining accurate data about discharges from community hospitals. In addition, work was done to develop a data collection and extraction method that complied with the requirements of the Dixon consent order. The data collection and matching issues have been very complicated. However, DMH is able to report preliminary and unvalidated data for the first two quarters of FY 07.
- Significance:** Achievement of the performance target of 80% is required for the District to exit from court oversight of the mental health system.
- Action Plan:** See action plan for NOMs regarding the re-admission of adult patients to Saint Elizabeths Hospital. Work on refining the data collection system and validating the data collected will continue throughout FY 2008. Other plans for improving the performance of the mental health system with regard to this specific performance indicator include staff of the Access Helpline contacting providers after notice of a hospital discharge is received, to ensure that the provider is following up with the patient.

ADULT - GOALS TARGETS AND ACTION PLANS

Continuity of Care

Foot Notes

This performance indicator, which is required by the Dixon consent order is actually a percentage of patients known to be discharged, who receive a non-emergency, community-based service within 7 days of discharge from an inpatient psychiatric unit.

The performance indicators for this measure are percentages. The form does not permit entry of percentages in the performance indicator box. The projected performance target for FY 07 is 84.3% The projected performance target for FY 08 is 70%.

District of Columbia

Child - Establishment of System of Care

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

The Department of Mental Health (DMH) is a cabinet-level agency whose Director reports to the Mayor of the District of Columbia. The mission of DMH is to support prevention, resiliency and recovery for District residents in need of public mental health services.

DMH is responsible for developing, supporting and overseeing a comprehensive, community-based, consumer driven, culturally competent, quality mental health system that is responsive and accessible to children, youth, adults, and their families. DMH contracts with a network of community-based, private providers and also provides direct services to children and youth through the District of Columbia Community Services Agency (DCCSA), the Comprehensive Psychiatric Emergency Program, the Homeless Outreach Program and the School-Based Mental Health Program. Contracted services include mental health rehabilitation services (medication/somatic treatment, counseling, community-based intervention, multi-systemic therapy) and some school-based services. DMH also contracts with the Children's National Medical Center for the provision of site-based psychiatric emergency services. New services include:

- Mobile crisis and stabilization services for children
- Wrap-around initiative
- Expansion of the school mental health program

DMH works collaboratively with the Child and Family Services Agency (child welfare), the Department of Youth Rehabilitation Services (juvenile justice), the Office of the State Superintendent of Education (special education), and the District of Columbia Public School System (education), as well as the charter schools to provide needed mental health services.

District of Columbia

Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing services;
Educational services;
Substance abuse services;
Medical and dental services;
Support services;
Services provided by local school systems under the Individuals with Disabilities Education Act;
Case management services;
Services for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities leading to reduction of hospitalization.

Mental Health and Rehabilitation Services

The Child Plan addresses the reliable and effective provision of mental health and related rehabilitation services to children/youth and their families, no matter how complex their needs, with maximum consideration given to child/youth and family choice in treatment.

As a mechanism for achieving reliable and effective services, DMH implemented the MHRS program to provide for a comprehensive, integrated system of community-based care for children, adults and their families by ensuring quality improvement, provider oversight, planning and policy development, and administration of Medicaid reimbursement to community-based public and private provider agencies. Under a State Plan Amendment establishing the Medicaid Rehabilitation Option, MHRS services are eligible for a 70% federal match, thus moving appropriate services and supports within the MHRS framework is an important strategy toward assuring sustainability of needed services.

In FY 2006, Multi-Systemic Therapy (MST), Intensive Home and Community Based Services (IHCBS) and Crisis Response and Community Support Services (CRCSS) were integrated into the MHRS system. All three services were implemented in the District under grant arrangements in 2005, supported by an Appropriation by the U.S. Senate to improve the efficacy of mental health services for foster children/youth. All three services have an evidence base and offer critical home and community-based interventions for children and youth at risk of out-of-home placement and/or transitioning into the community from secure detention or an RTC placement. New MHRS rules took effect October 2006, officially expanding the scope of services known as Community-Based Intervention (CBI) to encompass IHCBS and MST under the MHRS taxonomy. IHCBS and CRCSS are fully reimbursable under the State Medicaid Plan. MST is reimbursable under a split formula: 40% of services are reimbursable at the Medicaid 70/30 split; and 60% of services are funded under District local dollar appropriations.

A fundamental principle of the MHRS program is organizing the system in a manner that assures that each child/youth has his/her own “clinical home,” an entity responsible for and accountable to that child/youth, for the full array of his/her service and support needs on a continuous basis, regardless of the child/youth’s legal, clinical or physical status. Known as a Core Services Agency (CSA), the clinical home assures access, promotes continuity, and works to prevent cost-shifting through inappropriate institutional placement. Monitoring the efficacy of the CSAs with respect to the quality of processes and the achievement of desired outcomes is a key responsibility of DMH Office of Accountability.

The MHRS allows children/youth access to the following Medicaid-supported services:

- Diagnostic/assessment;
- Medication and somatic treatment;
- Counseling;
- Community support;

- Crisis/emergency (a required service of all CSAs; also offered by a provider as a niche, or specialty service);
- Community-based intervention (focused on in-home supports);
- Intensive day treatment;
- Day services (rehabilitation); and
- Community-based intervention (may be provided by a CSA or by a provider offering CBI as a niche service, such as the MST provider).

In addition, the DMH may make other services available through the use of local-dollar only funded services such as:

- Adjunctive child therapy (i.e., psychodrama, art therapy, music therapy);
- Acute inpatient psychiatric services;
- Residential services;
- Psycho-educational services; and
- Peer and family supports.

Treatment through the CSA model is guided by an Individual Plan of Care (IPC), which the CSA updates in collaboration with the parent every 90 days. Development and monitoring of the plan is an opportunity to set resilience-based goals and to assess where and when additional services and supports are required.

Access to the MHRS system is coordinated through the Access HelpLine, a 24-hour, 7-days-a-week telephone hotline and service hub operated by DMH Division of Care Coordination.

Mobile Crisis Services

The DCCSA's Mobile Urgent Stabilization Team (MUST) serves children/youth ages 5-18, which are in the community and are in need of assessment and emergency crisis stabilization, on a 24-hour basis. The program provides emergency transport when appropriate to an area hospital in the District. In addition, debriefing services are available to children/youth in D.C. Public Schools (DCPS) and in the community who have witnessed or have been victims of traumatic episodes of violence and disasters. These services are provided in collaboration with other DMH programs (i.e., School Mental Health Program). Appropriate linkages and timely referrals to other agencies in the public and private sector are made based upon individual need. The program also provides: conflict resolution, anger management, decision-making/problem-solving skills development, and consultation to other mental health and social services agencies.

In FY 2009, mobile crisis and stabilization services will be offered by Anchor Mental Health, pursuant to a contract required by the LaShawn A. AIP.

Wrap-around Initiative

DMH is partnering with CFSA (child welfare) and DYRS (juvenile justice) to launch a new wrap-around services for children/youth at risk of placement in a PRTF. This initiative launched in August 2008 and is funded by all three agencies: DMH, CFSA and DYRS.

Homeless Services

In FY 08, the Homeless Outreach Program (HOP) hired a staff member who will focus exclusively on outreach to children and youth. DMH anticipates engaging a minimum of one-hundred (100) children and youth who are homeless or at risk of becoming homeless during the first year.

The focused outreach to homeless children and youth primarily requires work with homeless families. The HOP staff member makes regular visits to the homeless shelters and other homeless service providers. The emphasis is engaging, assessing and building a therapeutic relationship with homeless families and their children, in an attempt to refer and link the families and children to needed mental health services. Other activities include:

- participating in mobile crisis outreach and response activities, collaborating with other child-serving agencies (CFSA, DYRS, DCPS, OSSE and the charter schools) to facilitate expedient intervention and positive outcomes;
- community outreach to homeless service providers and other District agencies concerned with child welfare and social services, including, but not limited to providing training and education, case consultation and technical assistance.

School Based Mental Health Program

DMH's school mental health program provides intervention and prevention services in public and charter schools throughout the District. The program will expand to 58 schools during the 2008 – 2009 school year. It will also expand through a partnership with OSSE to provide services to special education services in 8 middle schools throughout the District. .

Housing Services

The DMH Supported Housing Program coordinates housing services for children/youth and families. The identified client might be a child/youth or an adult family member.

The DMH long-term supports and housing grant that originally included homeownership as a housing option for persons with mental illness and a developmental disability, was expanded during FY 2006 to include youth aging out of the foster care system. In order

to serve this population DMH will build upon the infrastructure development activities generated under the Portals from EPSDT to Adult Supports Initiative Grant.

Medical and Dental Services

The MHRS service providers collaborate with the District's Medicaid D.C. Healthy Families program to assure delivery of comprehensive medical and dental services and EPSDT benefits to eligible District children, which includes children of families with household incomes at or below 200% of the Federal Poverty Guidelines. In addition to D.C. Healthy Families, District children are also eligible to receive Medicaid benefit-level services through the District's Health Program, a District funded program for adults who are not eligible for Medicaid because there are no children in the home and children who are not eligible for federally funded benefits, including children of immigrants who are undocumented or otherwise ineligible for federally supported services. Through the D.C. Health Program and D.C. Healthy Families, the District's Medicaid expansion program, low income District children and their families are eligible for health benefits including medical and dental services.

Substance Abuse Services

Children's service providers have been actively involved in the Department's co-occurring disorders initiative to develop a comprehensive, integrated system model. The DMH COSIG grant will further this initiative by standardizing screening and treatment methodologies across the substance abuse and mental health systems.

Activities to Reduce Hospitalization

Two hospitals provide acute services to District children and adolescents: Children's National Medical Center and the Psychiatric Institute of Washington. The DMH collaborations with the juvenile justice program has heightened the need to assure smooth and timely admissions, coordinated discharge planning, post-discharge follow-up and transition to community-based care.

Complying with federal and the Dixon Exit Criteria challenged the Department to establish baseline measures to effect System of Care improvements to meet the following performance targets:

1. Decrease the number of children/youth re-admitted to inpatient care within 30 days of discharge,
2. Decrease the number of children/youth re-admitted to inpatient care within 180 days of discharge, and
3. Eighty (80%) of children/youth discharged from inpatient care must be seen within seven (7) days.

Other Support Services

One of the elements of the DMH System of Care for children/youth and families is to provide treatment and support services in their homes and in natural settings. The Dixon Performance Targets related to these settings include:

1. Eighty-five percent (85%) of children/youth with serious emotional disturbances (SED) should receive services in their own homes or surrogate homes.
2. Seventy-five percent (75%) of children/youth with SED should receive services in a natural setting (i.e., schools).

The DMH will continue its efforts to improve performance in these targets during FY 2008.

Evidence-Based Practices

The DMH has made the adoption and implementation of evidence-based and promising practices one of the overall goals of the reformed System of Care for children/youth and their families. In this regard, the School Mental Health Program has incorporated data-driven/curriculum-based or best practices into its program design, information and

materials. The STOP Suicide grant utilizes Columbia University TeenScreen, an evidence-based screen for suicide prevention.

District of Columbia

Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

DMH has continued to experience challenges in both data gathering and reporting with regard to children's services. The DMH is working to correct issues that contribute to the reporting difficulties. One concern with the child data is the large number of children who receive mental health services through Medicaid managed care organizations. Another concern with the child data is the fact that complete inpatient data is not available for reporting purposes. Children are admitted to private hospitals within the District of Columbia for acute care services. DMH has been working with child serving providers through the Children's Roundtable to improve data collection and data integrity. In addition, DMH is finalizing a memorandum of understanding with MAA and the Medicaid MCO's regarding data and data reporting. There is a workgroup developing custom reports, which should improve the data collection and integrity of data about mental health services provided to children.

Prevalence and Definition of Serious Emotional Disturbances

The Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA) published a methodology for estimating the prevalence of Serious Emotional Disturbance (SED) in children in the Federal Register, July 17, 1998 (Volume 63, Number 137). This methodology uses 1995 census data and provides prevalence percentages based on assessed level of poverty and selected levels of functioning using the Children's Global Assessment Scale (CGAS). The methodology offers a range of prevalence for two Levels of Functioning (LOF): the more conservative LOF 50 (and below) and the less conservative LOF 60 (and below).

Within the SAMHSA methodology, the District of Columbia is assessed as having a high percentage of children living in poverty (Group C). The range of prevalence percentages for LOF 50 in Group C is 7%-9%. The SAMHSA methodology estimates the population of children ages 9-17 and does not include children ages 0-9. The D.C.CSA clients between the ages of 0-5 account for approximately 10 % of its population, while clients between the ages of 6-12 account for approximately 53% of its population.

The District continues to build upon the earlier work of SAMHSA and over the past several years a number of activities have been undertaken to refine the prevalence estimates for serious emotional disturbances. In FY 1999, DMH contracted with the University of Texas, Department of Psychiatry and Behavioral Sciences to provide prevalence and service analyses for the District of Columbia. The final report, District of Columbia Mental Health Needs and Services Estimation Project was made available at the beginning of FY 2000. "Chapter 7: Estimate Procedures for Children and Adolescents" contains prevalence estimates for the District of Columbia. The child and adolescent estimates are based on the method of estimation as published by SAMHSA, Center for Mental Health Services. While the Center for Mental Health Services estimates are for ages 9-17, the District of Columbia estimates are 0-17. The District of Columbia estimates are also based on the SAMHSA 1993 definition of SED. The CMHS defines children with serious emotional disturbances as follows:

“Children with serious emotional disturbance, are from birth up to age 18; who currently or at any time during the past year, has had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R, that resulted in functional impairment which substantially interferes with or limits the child’s role or functioning in family school or community activities.”

The definition goes on to indicate that “these disorders include any mental disorder, including those of biological etiology listed in the DSM-III-R or the ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-III-R ‘V’ codes, substance abuse and developmental disorders which are excluded unless they co-occur with another diagnosable serious emotional disturbance.”

Further, the definition indicates that “functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills. Functional impairments of episodic, recurrent and continuous duration are included unless they are temporary and expected responses to stressful events in their environment. Children who would have met the functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition” (previously cited Federal Register, p. 29425).

During FY 2002 an update of the 1999 prevalence estimates was undertaken through a contractual arrangement with the University of Texas. This update is based on the 2000 Census data and was completed during FY 2003. The estimates include projections for years 2001 through 2005. Attention was focused on possible limitations of the earlier projections, which over-estimated the number of children in the District of Columbia. The update utilized the newly developed definition of serious emotional disturbance delineated in Priority Populations, Chapter 12, Title 22A, DCMR. This definition is as follows:

“Children or youth with serious emotional disturbance includes children/youth under age 22 who currently have, or at any time during the prior year have had, a diagnosable mental, behavioral, or emotional disorder, including those of biological etiology that is or was of sufficient duration to meet diagnostic criteria specified within the DSM-IV or the ICD9-CM equivalent, except for DSM-IV “V” codes; is neither a substance abuse disorder nor a developmental disorder, unless co-occurring with another diagnosable serious emotional disturbance; results, resulted in, or will without treatment or other support services, result in a functional impairment that either substantially interferes with or limits the consumer’s role or functioning in family, school, or community activities, or that limits the consumer from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, or adaptive skills, and includes functional impairments of episodic, recurrent, and continuous duration but not temporary and expected responses to stressful events in the consumer’s environment.”

During FY 2006, a DMH work group chaired by the Chief Clinical Officer, which included provider representation, developed clinically-based, draft criteria for DMH's refinement and operationalization of its focus on Priority Populations. As part of this process, draft definitions for priority adult and child populations were developed. The Children and Youth priority population is defined as follows:

1201 CHILDREN OR YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE

1201.1 Children or youth with serious emotional disturbance are:

- (a) District of Columbia residents;
- (b) Under the age of 18 (or age 18 to less than 22 if enrolled in special education services, or committed to the child welfare or juvenile justice system);
- (c) Have at any time in the twelve (12) month period immediately preceding the request for certification as "a child or youth with serious emotional disturbance," received a DSM Axis I diagnosis, excluding individuals whose sole DSM Axis I is that of substance abuse;
- (d) Have a Global Assessment of Functioning Scale rating of fifty (50) or below, and a Child and Adolescent Level of Care Utilization System (CALOCUS) composite score of level four (4) or higher;
- (e) Have either a:
 - (1) documented significant treatment history as defined in §1201.2; or
 - (2) coexisting condition or circumstance as defined in §1201.3.

1201.2 A significant treatment history is defined as any one of the following:

- (a) Current residence in or discharge from an inpatient psychiatric facility or correctional inpatient mental health service more than one (1) time within the last year;
- (b) Two (2) or more face-to-face contacts with mobile crisis or emergency services within the past year; or
- (c) A treatment history that is characterized by a demonstrated and frequent vulnerability to stressors, resulting in periods of sustained

distress and the hindrance of developmental progress, where intensive and/or repeated treatment has not yielded symptom control for even limited periods of time.

1201.3 A coexisting condition or circumstance is defined as any one of the following circumstances:

- (a) Homelessness;
- (b) Release from a criminal detention facility within the last year;
- (c) HIV/AIDS diagnosis;
- (d) Court ordered to treatment;
- (e) A risk of harm certified by a qualified practitioner to be serious to extreme as evidenced by symptoms as severe or more severe than any one or combination of the following:
 - (1) Current suicidal or homicidal ideation with expressed intentions, which may include a past history of carrying out such behavior, and the child and/or the child's caretakers have expressed ambivalence or are unable to carry out a safety plan or to contract for safety;
 - (2) A history of chronic impulsive suicidal or homicidal behavior or physical or sexual aggression that is significantly endangering to self or others;
 - (3) An indication of consistent deficits in ability to care for self, use environmental/community resources, or access helpful adults to achieve safety;
 - (4) A recent pattern of excessive substance use resulting in clearly harmful or risky behaviors and little or no indication that the child or caretakers can restrict this use; or
 - (5) Serious to extreme risks for victimization, abuse, or neglect.

An expanded work group, including clinicians and administrators with financial and data expertise is now using the clinical criteria to frame how *Priority Populations* will be operationalized in FY 2007. It is expected that the schema will be phased in, coinciding with annual Diagnostic Assessments and an update of the Individual Plan of Care (IPC). A key element of the phase in is identifying where/how children/youth are served that do

not meet Priority Populations diagnostic criteria. This will involve strengthening interfaces with the Medicaid Managed Care Organizations, which offer all services except those provided in the community for children with TANF Medicaid. These interfaces and communications to stakeholders and consumers will comprise much of the FY 2007 efforts associated with the Priority Populations initiative.

The estimates for Severe Emotional Disturbance for all youth, including those in institutions, are:

7.67% (8070 cases) for 1990,
7.46% (9230 cases) for 1999 (projected), and
7.79% (8961 cases) for 2000 (from 2000 Census).

For the household population only, the estimates are:

7.41% (7644 cases) for 1990,
7.33% (8876 cases) for 1999 (projected), and
7.73% (8770 cases) for 2000 (from 2000 Census).

The original estimates of need for mental health services for 2000 is broken out by age, gender, ethnicity, poverty level, and residence in the table at the end of this criterion.

The FY 2004 Community Mental Health Services Block Grant reported that based on discussions with the Court Monitor and an external panel of experts, DMH was modifying its penetration goals to 5% for children/youth and 3% for children/youth with serious emotional disturbances (SED) in FY 2005. During FY 2005, DMH expanded its child/youth service provider capacity with 59% of the 43 certified MHRS providers having the capability to serve children/youth and families. In FY 2006, 63% of the 51 certified MHRS providers had this capacity.

Data Infrastructure Grant

Through the DMH Data Infrastructure Grant, attention has focused on capturing data that provides a demographic profile of children/youth within the DMH service system. Historical challenges have been the capture of inpatient acute care stays, school attendance, and involvement in the juvenile justice system and other developmental measures associated with the grant. Beginning in FY 2007 and continuing through FY 2009, a concerted effort will be made to begin populating child/youth data for all the required tables.

Estimates of Serious Emotional Disturbance (SED) for Washington DC, Total for 2000			
	Total Population (HH, Inst. & Group)	Household Population	Households <100% poverty

Youth	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Youth total	8963	114992	7.79	8773	113428	7.73	3604	36042	10.00
Age	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
00-06	3607	46404	7.77	3583	46182	7.76	1535	15354	10.00
07-12	3165	40375	7.84	3143	40168	7.82	1286	12856	10.00
13-17	2191	28213	7.77	2047	27079	7.56	783	7832	10.00
Gender	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Male	4539	57920	7.84	4404	56851	7.75	1809	18092	10.00
Female	4424	57072	7.75	4369	56578	7.72	1795	17950	10.00
Ethnicity	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
White-NH	873	14038	6.22	873	14038	6.22	51	507	10.00
Black-NH	7019	87470	8.02	6880	86332	7.97	3219	32193	10.00
Asian-NH	143	1812	7.90	115	1576	7.29	40	402	10.00
Native-NH	26	244	10.81	4	54	6.57	1	8	10.00
Hispanic	902	11428	7.89	902	11428	7.89	293	2933	10.00
Poverty level	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Below 100%	3760	37286	10.09	3604	36042	10.00	3604	36042	10.00
100%-199%	2115	26375	8.02	2101	26268	8.00	0	0	0.00
200%+ pov	3088	51331	6.01	3067	51118	6.00	0	0	0.00
Residence	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Household	8773	113428	7.73	8773	113428	7.73	3604	36042	10.00
Institution	82	405	20.25	0	0	0.00	0	0	0.00
Group	108	1158	9.35	0	0	0.00	0	0	0.00

District of Columbia

Child - Quantitative Targets

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

Pursuant to the terms of the Dixon Consent Order, DMH is required to provide or arrange for mental health services to 5% of the estimated child/youth population (0 - 17) annually. The target for FY 2009 is 5,525. Sixty percent of those children should have an SED diagnosis or 3,315. Currently, DMH includes only children receiving MHRS services in reporting data. However, work is underway to include children who receive a school-based mental health service and children who receive a service from a Medicaid MCO in this count.

District of Columbia

Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

Social services;
Educational services, including services provided under the Individuals with Disabilities Education Act;
Juvenile justice services;
Substance abuse services; and

Health and mental health services.

DMH is partnering with CFSA, DYRS, DCPS and OSSE to ensure that children receive all needed services. These initiatives include implementation of mental health and related services required by the LaShawn A. AIP, such as the child mobile crisis services; the wrap-around initiative and the homeless outreach program for children and youth.

Medical and Dental Services

The MHRS service providers collaborate with the District's Medicaid D.C. Healthy Families program to assure delivery of comprehensive medical and dental services and EPSDT benefits to eligible District children, which includes children of families with household incomes at or below 200% of the Federal Poverty Guidelines. In addition to D.C. Healthy Families, District children are also eligible to receive Medicaid benefit-level services through the District's Health Program, a District funded program for adults who are not eligible for Medicaid because there are no children in the home and children who are not eligible for federally funded benefits, including children of immigrants who are undocumented or otherwise ineligible for federally supported services. Through the D.C. Health Program and D.C. Healthy Families, the District's Medicaid expansion program, low income District children and their families are eligible for health benefits including medical and dental services.

Substance Abuse Services

Children's service providers have been actively involved in the Department's co-occurring disorders initiative to develop a comprehensive, integrated system model. The DMH COSIG grant will further this initiative by standardizing screening and treatment methodologies across the substance abuse and mental health systems.

District of Columbia

Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.

Services are provided throughout the District of Columbia without geographic limitation.

District of Columbia

Child - Outreach to Homeless

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

District Strategy

In 2004, Mayor Anthony A. Williams released “Homeless No More: A Strategy for Ending Homelessness in the District of Columbia by 2014” (the “District’s Homeless Services Strategy”). The District’s Homeless Services Strategy was developed by the Mayor’s Policy Academy Team, a group of District of Columbia (“District”) officials, including the Director of the Department of Mental Health (“DMH”).

The District’s Homeless Services Strategy includes three (3) central policy objectives:

- Increasing the District’s homeless prevention efforts using local and federal resources;
- Developing and/or subsidizing at least six thousand (6,000) new units of affordable supportive housing by 2014; and
- Actively coordinating mainstream social services for homeless Continuum of Care residents.

The District’s Homeless Services Strategy also includes three (3) implementation strategies. The implementation strategies are intended to guide the work of the District and its community-based partners. The implementation strategies are:

- Interdepartmental coordination and cross-system policy implementation;
- Community education and community outreach to gain support for the 10-year plan and the “housing first” and “housing plan” approaches;
- Advocacy for reduction of federal and other barriers to delivering services and housing that can prevent and end homelessness.

The District’s Homeless Services Strategy identified the establishment of an interagency council on homelessness as the first step in the implementation process.

In 2005, the Council of the District of Columbia enacted the Homeless Services Reform Act of 2005, D.C. Law 16-35 (the “Reform Act”). The Reform Act established the Interagency Council on Homelessness (the “Interagency Council”). The Interagency Council is chaired by the City Administrator and includes the directors of various cabinet agencies, including the Director of DMH. The Interagency Council is responsible for providing leadership in the development of strategies and policies that guide the implementation of the District’s policies and programs for meeting the needs of the homeless or those at imminent risk of becoming homeless (the “homeless”). Among other things, the Interagency Council is responsible for developing the annual plan describing how the District will provide or arrange for services to the homeless. In addition, the Interagency Council is responsible for the annual plan describing how the District will provide hypothermia shelter. DMH strategies and plans for providing or arranging for services to the homeless are driven by the District’s annual plan.

The Fenty Administration is committed to ending homelessness in the District. On January 11, 2007, shortly after taking office, Mayor Fenty issued “100 Days and Beyond:

2007 Action Plan for the District of Columbia” (the “2007 Action Plan”), which included many goals for meeting the needs of the homeless, including the provision of services and affordable housing.

In 2007, the Fenty Administration closed the DC Village Shelter, relocating families to apartment-style housing and linking them to case management services as part of a more comprehensive approach to delivering services to the city's homeless families. DMH actively participated in this process through its Homeless Outreach Program and the DC Community Services Agency. In addition, Mayor Fenty unveiled a housing plan for the District’s chronically homeless. The District will ensure that two thousand five hundred (2,500) units of permanent supportive housing are developed by 2014.

The 2008 Action Plan for the District included additional initiatives for addressing homelessness and homeless services, DMH supports the Mayor’s Action Plan in a number of ways. The 2009 Action Plan has not been released as of the date of this application, but is expected to include initiatives that continue and expand upon the District’s Homeless Strategy.

DMH Strategy – Direct Services

The DMH Homeless Services Program (“HOP”) consists of ten (10) FTEs. Four (4) of the FTEs are funded by the SAMHSA, Projects for Assistance in Transition from Homelessness or PATH Grant. The remaining six (6) FTEs are funded by local funding.

The HOP provides a wide variety of services not only to consumers with mental illness but also to providers and community members. Primary services include outreach and crisis services to individuals through regular visits to shelters, streets and homes in the District, coordination with other outreach programs, social workers and community members to provide assessments, referrals, travelers’ assistance, brief intervention services, and referrals to overnight shelter services.

The HOP convenes monthly meetings with the street outreach providers and drop-in center providers, to discuss people who are homeless and deemed to be “at risk.” The risk may be a physical health crisis, instability, or high-end user of District services. The entire HOP attends these monthly meetings. Representatives from the Metropolitan Police Department (“MPD”) and representatives from the Fire and Emergency Services (“FEMS”) Street Call program also participate in these monthly meetings. Any of the meeting participants may propose a person for discussion. The meeting provides a forum for discussing intervention strategies and sharing information about the individual’s history.

Other HOP activities include:

- technical assistance, outreach and support services to single adult and family shelters and Adult Protective Services (“APS”), which is part of the District’s Department of Human Services;

- transition services/interim services to unlinked or underlinked consumers who are homeless or in crisis;
- placement of Psychiatry Residents in homeless programs;
- collaboration with DC Linkage Plus program to make referrals to the DMH network of providers working with this special population;
- training for shelter providers, hypothermia providers, and street outreach workers on working with mentally ill consumers who are homeless;
- assistance for travelers with mental illness who are stranded in the District to return home; and
- providing mobile crisis services to non-homeless individuals.

The HOP also oversees the Sobering Station (operated during each hypothermia season) for intoxicated men and women who either refuse a traditional shelter or are living within the structure of a traditional shelter.

Services for Children

In FY 08, HOP hired a staff member who focuses exclusively on outreach to children and youth. The focused outreach to homeless children and youth primarily requires work with homeless families. The HOP staff member makes regular visits to the homeless shelters and other homeless service providers. The emphasis is engaging, assessing and building a therapeutic relationship with homeless families and their children, in an attempt to refer and link the families and children to needed mental health services. Other activities include:

- participating in mobile crisis outreach and response activities, collaborating with other child-serving agencies (Child and Family Services Agency (“CFSA”), Department of Youth Rehabilitative Services, D.C. Public Schools, D.C. Charter Schools, State Office of Education) to facilitate expedient intervention and positive outcomes; and
- community outreach to homeless service providers and other District agencies concerned with child welfare and social services, including, but not limited to providing training and education, case consultation and technical assistance.

Since children are typically part of family groups, many of the homeless services activities targeted to adults also are directed toward the other members of the family unit. A full description of DMH’s homeless programs is included in the Adult section of this application.

District of Columbia

Child - Rural Area Services

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

The District of Columbia is an urban area. There are no services provided to individuals in rural areas.

District of Columbia

Child - Resources for Providers

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

See Adult Resources for Providers for information about financial resources, staffing and training for child mental health services providers.

District of Columbia

Child - Emergency Service Provider Training

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

See Adult Resources for Providers for information about emergency services training for child providers. +

District of Columbia

Child - Grant Expenditure Manner

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

See Adult Grant Expenditures for information about the allocation of the FY 2009 Block grant funds.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: **Indicator Data Not Applicable:**

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	2,810	3,123	3,300	5,000	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** To improve access to care.
- Target:** Target is consistent with the penetration rate target for children established by Dixon Exit Criterion #5 - 5% of the estimated child/youth population in the District of Columbia.
- Population:** Estimated child/youth population in the District of Columbia
- Criterion:** 2:Mental Health System Data Epidemiology
3:Children's Services
- Indicator:** Number of children/youth receiving at least one mental health service during the reporting period.
- Measure:** Number of children/youth receiving at least one mental health service during the reporting period as a percentage of the total population of children and youth.
- Sources of Information:** Claims management system.
- Special Issues:** DMH is resolving issues with the Medicaid MCO's regarding coordination or and reporting of mental health services provided to children and youth enrolled in the Medicaid MCO's.
- Significance:** Required to exit from Court Oversight.
- Action Plan:** Negotiating MOU with MCOs to improve data collection and integrity. Also resolve data collection issues with respect to the school mental health program (not currently reported).

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Improve continuity of care.

Target: Decrease number of children/youth re-admitted to inpatient care within 30 days of discharge by 65%.

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

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

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

Measure: Number of children/youth discharged from inpatient care during reporting period.

Sources of Information: Contract management system. Department of Health, Medical Assistance Administration Data.

Special Issues: DMH has previously reported data regarding readmission of children to inpatient care. During FY 2007, DMH began to analyze the historical data and to collect new data for analysis. DMH has determined that there may be problems with the integrity of the data. Therefore, no data is being reported at this time. DMH will continue to review the data about inpatient hospitalizations for children and youth and will provide an update on the status of its analysis with the implementation report in December 2008.

Significance: Required to exit from Court Oversight.

Action Plan: The DMH refers children to three facilities for inpatient care (Children’s National Medical Center, Psychiatric Institute of Washington, Riverside Hospital). During FY 2006, DMH continued the “linkage meetings” between various child-serving agencies and other stakeholders regarding linkages between providers and inpatient care facilities, residential treatment, etc. These meetings serve as a forum for discussion of continuity of care issues and problem resolution (i.e., re-admission to inpatient care, and service linkage leading to discharge). Also during FY 2006, DMH continued to try to reach the Dixon Performance Target that 80% of children/youth discharged from inpatient care must be seen within seven (7) days. These strategies and performance target will be continued in FY 2009. See comments regarding data integrity and validation in special issues section above.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	.44	N/A	N/A	N/A	N/A	N/A
Numerator	2	N/A	--	--	--	--
Denominator	450	N/A	--	--	--	--

Table Descriptors:

Goal: Improve continuity of care.

Target: Decrease the number of children re-admitted to inpatient care within 180 days of discharge.

Population: Children/youth with mental illness living in the District of Columbia.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of children/youth re-admitted to inpatient care within 180 days of discharge during the reporting period.

Measure: Number of children/youth discharged from inpatient care during the reporting period.

Sources of Information: Contract management system, Department of Health, Medical Assistance Administration data.

Special Issues: DMH has previously reported data regarding readmission of children to inpatient care. During FY 2007, DMH began to analyze the historical data and to collect new data for analysis. DMH has determined that there may be problems with the integrity of the historical data. DMH will continue to review the data about inpatient hospitalizations for children and youth and will provide an update on the status of its analysis with the implementation report in December 2007. a, however showed the rate was .5%. The FY 2006 projection was based on that data. In FY 2006, the rate was .4% for the period 10/1/05-6/30/06. DMH will need to review this data to resolve any inconsistencies. The FY 2007 target remains .4% pending the review. Further work is required to ensure data integrity.

Significance: Required to exit from Court Oversight.

Action Plan: The DMH refers children to three facilities for inpatient care (Children’s National Medical Center, Psychiatric Institute of Washington, Riverside Hospital). During FY 2006, DMH continued the “linkage meetings” between various child-serving agencies and other stakeholders regarding linkages between providers and inpatient care facilities, residential treatment, etc. These meetings serve as a forum for discussion of continuity of care issues and problem resolution (i.e., re-admission to inpatient care, and service linkage leading to discharge). Also during FY 2006, DMH continued to try to reach the Dixon Performance Target that 80% of children/youth discharged from inpatient care must be seen within seven (7) days. These strategies and performance target will be continued in FY 2009. Also see comments regarding data integrity and validation in special issues section above.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: **Indicator Data Not Applicable:**

Name of Performance Indicator: Evidence Based - Children with SED Receiving Therapeutic Foster Care
(Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: **Indicator Data Not Applicable:**

Name of Performance Indicator: Evidence Based - Children with SED Receiving Multi-Systemic Therapy
(Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	130	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To improve the range of services available to children and youth and to divert them from PRTF placement.

Target: 130 youth.

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

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of children and youth who receive MST.

Measure: Number of children and youth who receive MST.

Sources of Information: Contract management system -- Medicaid claims.

Special Issues:

Significance: One of the evidence based practices used in the child system of care, intended to provide alternatives to PRTF admission for children and youth with SED who are also involved in the child welfare and juvenile justice systems.

Action Plan: Continue to make service available in fidelity to the model.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: **Indicator Data Not Applicable:**

Name of Performance Indicator: Evidence Based - Children with SED Receiving Family Functional Therapy
(Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** Increase the system performance rating for services provided to children/youth as measured by the annual Dixon community service review.
- Target:** Achieve and maintain the rating of 80% for system performance as measured in the annual Child/Youth Community Service Review.
- Population:** Children/youth with mental illness living in the District of Columbia who receive publicly funded mental health services.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services
- Indicator:** Positive report by independent review team, using an agreed upon instrument to measure system performance.
- Measure:** Cases pulled for review by independent review team. Projected that 85 cases will be reviewed in FY 2008 to ensure statistically valid results.
- Sources of Information:** Annual community service reviews, conducted by the Dixon Court Monitor, through its contractor HSO.
Annual MHSIP including ROSI. Consumer satisfaction surveys conducted by consumer organizations through convenience sampling and focus groups.
- Special Issues:** This is one of the Dixon exit criteria. The performance target of 80% system performance was established in the consent order setting forth the exit criteria. The target for exiting active monitoring for this exit criteria is 80% system performance and will remain at 80% for FY 2008.
- Significance:** Achievement of 80% systems performance is required by the terms of the Dixon consent order to exit from federal court oversight.
- Action Plan:** Team formation has been established as a primary driver of overall performance in the child/youth system. The family/child team model offers a family-centered, evidence-based approach to strengthening the work of teams. Using a rollout strategy (one at a time depending on organizational readiness factors) children’s services staff, coached by community resource experts will train, consult and support providers in FY 2008 to begin to implement this model. Although full implementation of the model will take several years, some improvements in team formation should be evidence by year end in the one or two providers trained during the first half of the year.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Data is not currently available to report for this performance indicator.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Data is not currently available to report for this performance indicator.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	78.61	80	80	N/A	N/A
Numerator	N/A	632	--	--	--	--
Denominator	N/A	804	--	--	--	--

Table Descriptors:

Goal: To improve child functioning.

Target: Maintain social connectedness at 80%.

Population: Children and youth

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: URS table - MHSIP survey.

Measure:

Sources of Information: MHSIP.

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	74.46	80	N/A	N/A	N/A
Numerator	N/A	752	--	--	--	--
Denominator	N/A	1,010	--	--	--	--

Table Descriptors:

Goal: To improve child outcomes by improving functioning.

Target: 75%

Population: children and youth living in the District of Columbia

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations

Indicator:

Measure:

Sources of Information: MHSIP

Special Issues:

Significance:

Action Plan: Data is not currently available to report for this indicator.

District of Columbia

Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan

Not received as of 7:00 pm on September 2, 2008.

District of Columbia

Appendix A (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.