

I: State Information

State Information

Plan Year

Start Year:

2012

End Year:

2013

State DUNS Number

Number

14384031

Extension

I. State Agency to be the Grantee for the Block Grant

Agency Name

District of Columbia Department of Mental Health

Organizational Unit

Office of Strategic Planning & Policy

Mailing Address

64 New York Avenue, NE, 4th Floor

City

Washington, DC

Zip Code

20002

II. Contact Person for the Grantee of the Block Grant

First Name

Juanita Y.

Last Name

Reaves

Agency Name

District of Columbia Department of Mental Health

Mailing Address

64 New York Avenue, NE, 5th Floor

City

Washington

Zip Code

20002

Telephone

202-673-2200

Fax

202-673-7053

Email Address

juanita.reaves@dc.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

10/1/2009

To

9/30/2010

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name

Last Name

Telephone

Fax

Email Address

Footnotes:

The Department of Mental Health is scheduled to move to a new location in late September 2011. The new mailing address is:

609 H Street, NE
Washington, D.C. 20002

I: State Information

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, regulations and policies governing this program.

Name

Title

Organization

Signature: _____ Date: _____

Footnotes:

I: State Information

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 subgrantees 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 work-place 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 work-place 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 (f) 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

3. Certifications Regarding Lobbying

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

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

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

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, 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.

Name	<input type="text" value="Stephen T. Baron"/>
Title	<input type="text" value="Director"/>
Organization	<input type="text" value="District of Columbia Department of Mental Health"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3)

Community Mental Health Services Block Grant Funding Agreements FISCAL YEAR 2012

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.]

I. Section 1911:

Subject to Section 1916, the State 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.

II. 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].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

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

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

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

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

- (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.

IV. 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.

V. 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.

VI. 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.

VII. 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.

VIII. 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 States 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).

IX. Section 1943:

(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.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	<input type="text" value="Stephen T. Baron"/>
Title	<input type="text" value="Director"/>
Organization	<input type="text" value="District of Columbia Department of Mental Health"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations

Page 22 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Footnotes:

Overview of the District of Columbia

The District of Columbia is the capital of the United States. The U.S. Constitution allows for the creation of a special district to serve as the permanent national capital. The District is not a part of any U.S. state and is governed by an elected Mayor and a 13-member elected Council. The District functions as a state government and local government.

Population: According to the 2010 United States Census, the District of Columbia has a population of 601,723 residents. The District's land area is 61.4 square miles with 9,856.50 persons per square mile. Females comprise 52.8% of the population. The median age is 33.8. The population age breakdown includes:

Age	Percent of Population	Number of Persons
Under 5 years old	5.4%	32,613
Under 18 years old	16.8%	100,815
65 years old and over	11.4%	68,809

The race/ethnic breakdown is as follows:

Race/Ethnicity	Percent of Population	Number of Persons
African American or Black	50.7%	305,125
White	38.5%	231,471
White Not Hispanic	34.8%	209,464
Persons of Hispanic or Latino Origin	9.1%	54,479
Asian	3.5%	21,056
American Indian and Alaska Native	0.3%	2,079
Native Hawaiian and Other Pacific Islander	0.1%	302
Persons Reporting 2 or More Races	2.9%	17,316

Households: There were 296,719 housing units in 2010. The homeownership rate was 42.0% of occupied housing units compared to 58% that were rented. There were 266,707 households in 2010, with 2.11 people per household. The 2009 data show that the median household income was \$59,290; the per capita money income was \$40,797; and the percent of persons below the poverty level was 18.4%.

Prevalence of Mental Disorders and Substance Use: The State Estimates of Substance Use and Mental Disorders from the 2008-2009 National Surveys on Drug Use and Health show the following results for the District of Columbia:

Mental Illness:

Serious Mental Illness- The District was one of 5 States ranked in the lowest 5th for adults age 18 and older with a serious mental illness (SMI) in the past year across all age groups (18 to 25, 26 or older, and 18 or older).

Suicidal Thoughts-The District was the only State where adults age 18 or older had serious thoughts of suicide in the past year with a rate in the lowest 5th among 18 to 25 year olds and in the highest 5th among persons age 26 or older.

Major Depressive Episode- For youth age 12 to 17 who experienced depression during the past year, these rates ranged from 6.8% in the District and Pennsylvania to 10.3% in Oregon. According to the RAND Technical Report on Behavioral Health Care in the District of Columbia (www.rand.org/pubs/technical_reports/TR914.html):

- The prevalence of mental health conditions in the District resembles patterns nationally, among both adults and youth. One exception is that, compared to children nationally, D.C. youth appear to have a higher percentage of parent-reported behavioral problems.
- Suicide attempts among District high school students are more common than among high school students nationally, and prevalence appears to be rising in the District. Among high school students who attempt suicide, District youth are twice as likely to require medical care because of an injury.

Substance Use:

Illicit Drug Use- The District was among the 10 states that were in the top 5th for past month illicit drug use among persons age 12 or older and also ranked in the top 5th for past month marijuana use. With regard to the prevalence of past year cocaine use among persons age 12 or older, the District was among 3 states with the lowest 5th for ages 12 to 17 and the highest 5th for ages 26 or older.

Alcohol Use- The District was among 11 States where the past month alcohol use rates increased among persons age 12 or older.

Substance Dependence, Abuse, and Treatment Need- The District had the highest rate of past year alcohol dependence or abuse among persons age 26 or older (8.1%) and the lowest rate among persons age 12 to 17 (3.0%). The District also had the highest rate of past year illicit drug dependence or abuse (4.4 %) among persons age 12 or older.

Of the 10 States that ranked in the highest 5th for past year alcohol dependence or abuse, the District was among 8 States also ranked in the top 5th for past year dependence on or abuse of illicit drugs or alcohol among persons age 12 or older.

Although the District ranked in the top 5th for needing but not receiving treatment for an alcohol problem among persons age 26 or older (7.3%), it ranked in the lowest quintile group among 12 to 17 year olds (3.3%).

Health Status: The State Health Plan (November 2007) indicates that the District has a long history of exhibiting unacceptably high rates of prematurity and infant mortality as well as high rates for chronic conditions such as heart disease, diabetes, asthma, cancer, and HIV/AIDS.

Analysis of the 10 leading causes of death (heart disease, cancer, hypertension, HIV/AIDS, accidents, cerebrovascular disease, diabetes, homicide, chronic lower respiratory disease, and influenza/pneumonia), points to several key health concerns for District residents. Chronic non-infectious diseases including heart disease, cancer, cerebrovascular disease, diabetes and hypertension are the major cause of death and illness among persons over age 45. HIV is the chronic infectious disease exhibiting the heaviest impact on younger adults. Injury, both intentional and unintentional, has the largest impact on infants, children and youth.

According to the RAND Working Paper on Assessing Health and Health Care in the District of Columbia Phase 2 Report, June 2008 (www.rand.org/pubs/working_papers/WR579):

- Among adult District residents, more than 1 in 4 adults reported having hypertension, making it the most common among the chronic diseases reported.
- Following hypertension, in order of prevalence, are asthma (10%), diabetes (8%), heart disease (6%), and cerebrovascular disease (3%).
- Over half of adult District residents qualify as overweight or obese, and nearly one-quarter qualify as obese.
- District-wide, mortality rates from heart disease and cancer were higher than those from other causes, although cancer and HIV/AIDS contribute the most to rates of premature mortality.
- Among District children, 36% between ages 6 and 12 were overweight, based on reported height and weight, while 17% between ages 13 and 17 were overweight.
- 9 percent of children were reported to have a dental health problem.
- 12% were reported to have asthma.
- 11% of parents reported that their children require services for a behavioral health issue.
- 8% of District children were estimated to have a serious emotional disturbance (in 2000).
- Among adults, residents of Wards 7 and 8 had generally higher rates of chronic disease, poor health status, and premature mortality. However, other areas of the city also have poor health outcomes.
- Among adults, Ward 5 had rates of hypertension and overweight/obesity that exceeded the District-wide average.
- Breast and prostate cancer incidence rates among adults were highest in Wards 4 and 8. The cervical cancer incidence rate was highest in Ward 7 and for colon cancer, Ward 6.
- Among children, health outcomes were better among those in Ward 3 than in other wards.
- Asthma prevalence among children was highest in Ward 7, with 18% of children reported to have asthma of any severity.

Behavioral Health Prevention, Early Identification, Treatment and Recovery Support Systems

Overview of District of Columbia Behavioral Health Care System

In the District of Columbia three (3) agencies form the core of the public behavioral health care system: 1) Department of Mental Health, 2) Department of Health Care Finance, and

3) Department of Health, Addiction Prevention and Recovery Administration. These agencies provide services, funding, and policy leadership for adults, children, and special populations that access the behavioral care system. A more detailed description of the District's behavioral health system is available in RAND's Working Paper entitled "Guide to the Behavioral Health Care System in the District of Columbia, which is available on the RAND website (www.rand.org/pubs/working_papers/WR777.html).

Attachment A-1, provides a detailed description of services organized by the five (5) statutory criteria. The description of Criterion 1, Comprehensive Community-Based Mental Health Service Systems, is based on the Substance Abuse and Mental Health Services Administration (SAMHSA) Strategic Initiatives and includes some of the AIMS addressed in the Block Grant Application. There are references to the Behavioral Health Assessment and Plan across the criteria as appropriate. It concludes with the performance goals, targets and actions that are responsive to the national outcome measures (NOMs).

The District recommends reviewing Attachment A-1 first. It places the District's initiatives, programs and services in a national context (SAMHSA strategic initiatives), and it supports the system overview required in the Behavioral Health Assessment and Plan. This latter document appears to be most closely aligned with the WebBgas format. Each document is designed to describe in a coherent manner the two (2) components required in the FY 2012- FY 2013 Mental Health Block Grant Application.

Department of Mental Health

This cabinet-level agency is responsible for the delivery and financing of public mental health services and operates separately from the Department of Health Care Finance, and the Department of Health.

The Department of Mental Health (DMH) supports prevention, resiliency and recovery for District residents in need of public mental health services. It 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.

To accomplish its mission, DMH contracts with a network of community-based, private providers for mental health rehabilitation services (MHRS) for children, youth and adults; as well as other services. DMH also provides some direct services and is structured with a separation between its Authority role and its provider components.

The DMH Authority role is that of policy maker for the mental health system. It involves: planning, policy development, and grants management; certification of qualified service providers, licensure of mental health facilities, and quality improvement; provider oversight and administration of the MHRS program; care coordination; development of systems of care for adults, children, youth and their families; integrated care; enforcement of consumer rights; organizational development including applied research and evaluation, training, and adult and

child community services reviews; and finance and administration including contracts and procurement, information technology, and claims billing.

The DMH Provider role includes specialized community mental health services (Mental Health Services Division); school mental health services (School Mental Health Program); early childhood services (Healthy Start, P.I.E.C.E., Healthy Futures, Primary Project); psychiatric emergency services, mobile crisis services, and homeless outreach services (Comprehensive Psychiatric Emergency Program); and inpatient hospitalization services (Saint Elizabeths Hospital).

Department of Health Care Finance

The Department of Health Care Finance (DHCF) is the District's Medicaid agency and also administers the D.C. Alliance program for uninsured individuals. DHCF delegated responsibility for administering the mental health rehabilitation services (MHRS) program to DMH in 2001. DMH processes claims for MHRS and transmits claims for Medicaid eligible individuals to DHCF for payment. DMH pays for the local match portion of the Medicaid payment (30%), which is included in the DMH budget. Local match funds are sent to DHCF via MOU. In addition, DHCF reimburses both the local and federal portion of costs of covered behavioral health care services for Medicaid FFS enrollees who are not in MHRS, including the costs of psychotropic medications. Federal dollars are also passed through DHCF to pay for the per-member per-month fee to managed care organizations (MCOs) serving Medicaid enrollees.

DHCF also finances services to persons enrolled in the D.C. Alliance. Though the program currently has no mental health benefit, it does include psychotropic medications. The DHCF current annual budget is \$1,995,691.48 to purchase medications for the approximately 24,055 (as of April 2011) Alliance beneficiaries. The Alliance has just one psychotropic medication, Zoloft, on its formulary.

The District opted for early implementation of Medicaid expansions available under the Patient Protection and Affordable Care Act. Effective July 1, 2010, the District offered coverage to all adult residents with incomes under 133 percent of the Federal Poverty level (FPL) effective July 1, 2010. This coverage change resulted in the move of approximately 32,000 Alliance beneficiaries into the Medicaid managed care program. Effective November 1, 2010, the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) approved DHCF's 1115 waiver request. Through this waiver, DHCF expanded Medicaid coverage to individuals with incomes between 134 and 200 percent of FPL. This resulted in the transfer of approximately 4,000 residents into Medicaid managed care from the Alliance.

Department of Health, Addiction Prevention and Recovery Administration

As part of the District of Columbia Department of Health, the Addiction Prevention and Recovery Administration (APRA) serves as the Single State Authority for substance abuse services and is organizationally separate from DMH.

APRA promotes access to substance abuse prevention, treatment and recovery support services. Prevention services, which are primarily federally-funded, include preventing the onset of alcohol, tobacco, and other drug use by children and youth, reducing the progression of risk and increasing protective factors that increase the likelihood of healthy, drug-free youth and their families. Treatment services include assessment and referrals for appropriate levels of care and maintenance of a comprehensive continuum of substance abuse treatment services including outpatient, intensive outpatient, residential, detoxification and stabilization, and medication assisted therapy. Youth treatment is primarily supported by Medicaid funds and adult treatment is supported by a combination of District and federal funds. Recovery support services wrap-around services, such as mentoring services, education skills building and job readiness training, as well as counseling, transportation, and environmental stability. These services, which are primarily funded through the federal Access to Recovery (ATR) grant, are designed to address issues that may serve as barriers to substance abuse recovery. APRA promotes the quality of these services through its regulation and certification authority and quality improvement activities.

Specific Populations

This section describes the services that are intended to address the needs of the four (4) asterisked populations for mental health: 1) children with serious emotional disturbances (SED) and their families; 2) adults with serious mental illness (SMI); 3) women pregnant with substance use and/or mental health disorder; and 4) parents with substance use and/or mental health disorders who have dependent children.

It also addresses the targeted services category, individuals with mental and/or substance use disorders who are homeless or involved in the criminal or juvenile justice systems.

(1) Children with SED and their families (Criterion 3); and (2) Adults with SMI (Criterion 1)

Mental Health Rehabilitation Services (MHRS) Program: DMH has developed and implemented a comprehensive set of service standards through the MHRS program for children and youth with SED and adults with SMI. This program consists of four (4) core services (diagnostic/assessment, medication/somatic treatment, counseling, and community support) and five (5) specialty services (crisis/emergency, rehabilitation, intensive day treatment, community-based intervention, and assertive community treatment). A DMH-certified Core Services Agency (CSA) or Sub-Provider provides the core services while a DMH-certified Specialty Provider offers the specialty services. There were a total of 38 MHRS providers in June 2011, of which 22 were child serving agencies. Four (4) are also APRA certified treatment programs.

The 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) for adults and the Individual Plan of Care (IPC) for children and youth, is important to the development of mutually agreeable treatment and rehabilitative goals and objectives, and to coordinate the care of multiple providers who often participate in the consumer's care plan. Representatives of each service being provided and the CSA's clinical manager and qualified practitioner, the consumer, and others that the consumer would like to be a part of the treatment

planning process are involved. The IRP/IPC is derived from the treatment objectives that are completed every 180 days or whenever there is a change in the consumer's course of care.

With regard to the child serving providers, a cohort of six (6) CSAs are designated as Choice Providers. These CSAs have the ability to provide quality, evidence-based, innovative services and interventions to meet the needs of children and their families.

The majority of individuals receiving MHRS are covered by Medicaid FFS, followed by persons without insurance, and those in the D.C. HealthCare Alliance (medical assistance to needy residents who are not eligible for federally-financed Medicaid benefits). While there are a number of entry points for MHRS, the main portal is through the Access HelpLine. Persons can also directly present to core service agencies (CSAs), enter the system through the D.C. Jail, or through Pre-Trial Services.

(3) Women pregnant with substance use and/or mental health disorder (Criterion 1 and Criterion 3); and (4) Parents with substance use and/or mental health disorders who have dependent children (Criterion 1 and Criterion 3)

Early Identification and Intervention Services: These services fall under the administrative purview of the DMH Child and Youth Services Division (CYSD).

Healthy Start Project (SAMHSA Strategic Goal 1.1)- This project is a collaboration with the Department of Health (DOH), Maternal and Family Health Administration and has been operational since FY 2005. DMH provides services to women of child bearing age who have children between birth and age 2, identified as having experienced depression during and around pregnancy. This includes services to enhance the emotional health of the women/mothers as well as their interactions with their children.

Early Childhood Mental Health Consultation (Healthy Futures) (SAMHSA Strategic Goal 1.1)- This program began in FY 2010 for children age 0-5. It is both a center based and child and family centered model. Services are provided to the Child Development Centers in the form of center based consultation involving training for child care staff on social/emotional issues and development. If specific children are identified by the center staff, the program provides child and family specific consultation and/or referral for more intensive services.

Parent Infant Early Childhood Enhancement (P.I.E.C.E.) Program (SAMHSA Strategic Goal 1.1)- This program began in FY 2011. It provides culturally competent community-based mental health services to infants, toddlers, pre-school, and school age children (ages 6 and under), who have shown significant emotional/behavioral concerns and are often disruptive in pre-school, early school, or home settings. Parent child interactions are an important part of this program.

Primary Project (SAMHSA Strategic Goal 1.1) - This program for children in Kindergarten through First Grade began in FY 2009 and is operated by the DMH School Mental Health Program. It screens for school adjustment issues and provides early intervention services through child led play sessions offered by para-professionals (Child Associates) and refers children with

more intensive needs to School Mental Health clinicians. Parent child interactions are not part of this model. In School Year 2010-2011 it operated in 13 schools .

School Mental Health Program (SMHP) (SAMHSA Strategic Goal 1.1): The SMHP began in Summer 2000 with a SAMHSA Safe Schools Healthy Students Grant. It follows a public health model providing prevention, early intervention, and treatment. In School Year 2010- 2011 the SMHP operated in 59 schools (50 D.C. Public Schools and 9 Public Charter Schools). In addition to direct treatment, the SMHP provides consultations to teachers, parents and others. It also provides general information/presentations to staff that are more focused on primary prevention.

(5) Individuals with mental and/or substance use disorders who are homeless (Criterion 4) or involved in the criminal or juvenile justice systems (Criterion 1 and Criterion 3)

- DMH-sponsored Crisis Intervention Officer (CIO) Training (SAMHSA Strategic Goal 2.4) - grew out of the Crisis Intervention Collaborative, spearheaded by DMH, Metropolitan Police Department (MPDC), and the National Alliance on Mental Illness (NAMI) to improve the outcomes of police interactions with people with mental illnesses. The Collaborative addresses the diverse professional development needs of officers at various levels of their law enforcement careers. The CIO Initiative is the newest most extensive activity within the Collaborative, and its framework is based on a survey of crisis intervention response initiatives from law enforcement jurisdictions across the country. Since its inception in Spring 2009, approximately 282 MPDC officers and other District-based police officers have participated in the 40-hour training.
- Court Urgent Care Clinic (CUCC) at the Superior Court of the District of Columbia (SAMHSA Strategic Goals 1.1, 1.2 and 2.4)- has operated since June 2008 by the Psychiatric Institute of Washington (PIW) under contract with DMH. It was established to provide assessment, evaluation and short-term treatment services for individuals referred to this clinic. Consumers receive case management assistance to obtain linkages to DMH CSAs and referrals for medical care, benefits, soup kitchens, shelters and other emergency services. The CUCC staff coordinate services with the DMH provider network to ensure that consumers return to their existing provider as soon as possible. In FY 2011, through a Memorandum of Understanding (MOU) with APRA, this contract was expanded to provide substance use disorder assessment and referral services at the CUCC.

Services for Youth Involved with the Juvenile Justice System (SAMHSA Strategic Goal 2.4):

The Juvenile Behavioral Diversion Program (JBDP) was established as a problem-solving court in January 2011. The program's goals include: 1) connect the juvenile and status offender with appropriate mental health services in the community; 2) provide support for and involve the youth's parents, guardian, or custodian in mental health treatment for their child; 3) provide a period of engagement with mental health services that is monitored by the court in order to increase treatment engagement by youth and their families; 4) increase the number of youth able to remain in the community with the appropriate mental health services and supports and to reduce the number of youth who otherwise without such services and support might be detained; 5) reduce the individual's contact with the criminal justice system as a juvenile and later as an adult; and 6) reduce crime in the community and protect public safety by reducing the number

of times that juveniles with mental disorders re-offend. DMH and identified child-serving core service agencies (CSAs) are actively involved in the JBDP. Youth with substance use disorder issues participate in the JBDP.

Services for Individuals Involved with the Criminal Justice System: In the District the criminal justice system can interface with the behavioral health care system on a number of levels. These may include: law enforcement's initial response to the scene; after arrest and detention; during pre-trial services; at the D.C. Jail and later the Bureau of Prisons; at the time of re-entry; and during the post-re-entry period. These services are provided by several agencies.

- Court Services and Supervision Agency for the District of Columbia (CSOSA) (SAMHSA Strategic Goal 2.4)- a federal executive branch agency, was created by Congress in 1997 to perform the offender supervision function for the District, in coordination with the Superior Court of the District of Columbia and the U.S. Parole Commission. The Pre-Trial Services Agency (PSA), a subdivision of CSOSA, operates a number of mental health and substance abuse services at the period between arraignment and sentencing. Many of the interventions are designed to provide treatment for individuals to help reduce more severe criminal sanctions. The PSA and Community Supervision Program, which provides services for persons from arraignment through trial as well as in the post-release phase, is financed through federal funds. There is a memorandum of understanding (MOU) between CSOSA, PSA and DMH for the provision of mental health services to this population.
- D.C. Department of Corrections (DOC) (SAMHSA Strategic Goal 2.4) - offers mental health and substance use disorder services at the D.C. Jail. On the jail site the Residential Substance Abuse Treatment (RSAT) program is available for persons who voluntarily wish to receive detoxification.
- DMH Post Booking Initiatives (SAMHSA Strategic Goal 2.4) - a DMH Court Liaison position was developed in 2001 and is co-located at the Superior Court of the District of Columbia. The Court Liaison screens individuals referred from the Pre-Trial Services Agency (PSA), and makes referrals for mental health services to the Court Urgent Care Clinic and the PSA Special Supervision Unit. In addition, the DMH Court Liaison contacts DMH core service agencies (CSAs) for mental health information and screens candidates for the Community Connections Options Program.

The DMH contract with the Community Connections operated Options Program began in 2001. This program provides mental health services to defendants who are not currently linked to DMH and have a history of non-compliance with court dates. The services provided to the defendants include: case management, psychiatric care, benefits application assistance, housing referrals, and support following through on meeting court requirements.

- Services Targeted to Incarcerated Offenders- include the following:

DMH Jail Liaison (SAMHSA Strategic Goal 2.4) - is co-located at the D.C. Jail and screens and links inmates requiring mental health services and ensures continuity of care for those

inmates already linked to DMH. This service has been provided by the DMH for over a decade. This function is performed by one (1) individual. Inmates not linked to DMH but require services are linked prior to release to the D.C. Linkage Plus program. Services are coordinated in conjunction with staff from the Department of Corrections and Unity Healthcare the existing health and mental healthcare provider serving the D.C. Jail.

D.C. Linkage Plus (DCLP) (SAMHSA Strategic Goal 2.4) - program began in 2005. It serves inmates with misdemeanor and felony charges currently unlinked to DMH. The goal of this program is to engage individuals involved with the criminal justice system while incarcerated in order to reduce the likelihood of further penetration into the criminal justice system. The link to a DMH CSA upon release from jail with specific supports ensures that participants make court appearances and adhere to conditional release. Referrals generally occur within 90 days of release. Inmates are seen within 48 hours of a referral.

Two (2) of the CSAs, Green Door and Volunteers of America (VOA), were the recipients of contracts to provide this service that began in October 2009, however in FY 2011 Green Door became the only DMH provider under the D.C. Linkage Plus Program.

- Prison Re-Entry (SAMHSA Strategic Goal 2.4) - is coordinated by the DMH Re-Entry Coordinator who is co-located with the Department of Employment Services Project Empowerment Employment program. This service has been provided for approximately 4 years and offers screening and assessment for individuals with mental illness returning to the District from correctional facilities across the country. Offenders are offered mental health linkages and resources as they are returning to the District. The Re-Entry Coordinator works closely with the Court Services and Offender Supervision Agency, U.S. Parole Commission, the Bureau of Prisons and the DMH CSAs.
- Outpatient Competency Restoration (OCRCP) (SAMHSA Strategic Goal 2.4) - has operated since 2006. It helps defendants to understand the legal process, their role in that process and improves their ability to function as the legal process unfolds. The program staff conducts psychoeducational groups and competency evaluations for the Court to determine whether an individual is competent to stand trial. This program is staffed by a part-time psychiatrist, part-time mental health specialist and part-time nurse.
- Outpatient and Inpatient Commitment- consumers who have been ordered to obtain and comply with mental health care in the District must have regular periodic examinations and reviews of their commitment status with the Superior Court of the District of Columbia. Consumers may be inpatients at Saint Elizabeths Hospital or reside in community settings and linked to DMH CSAs. There have been on average 200 consumers committed at any given time since 2009.

Common Behavioral Health Areas

Bi-Directional Integration of Behavioral Health and Primary Care Services

Behavioral Health Services

DMH has partnered with APRA in some of the planning and implementation of behavioral health services.

Planning Initiatives

Co-Occurring State Incentive Grant (COSIG) (SAMHSA Strategic Goal 4.1)- DMH completed the initial four (4) active years of its SAMHSA COSIG in August 2009. The final year involved project evaluation activities conducted by George Washington University and ended August 31, 2010. Cross-agency collaboration was established between DMH and APRA to carry out this project. One of the most significant achievements of the grant was the development of a manualized, sustainable competency training course for practitioners. During the course of the grant over 150 individual practitioners were trained. The original course was 100-hours, but has been streamlined and adjusted to a 72-hour course after the first session was taught in 2006 - 2007. Since the end of the COSIG, DMH has continued to offer the comprehensive Clinical Competency Certificate Program and Manual awards graduates a "Certificate of Co-Occurring Clinical Competency."

Request for Projects for Block Grant Funding- The D.C. State Mental Health Planning (D.C. SMHPC) initiates an annual Request for Projects process for funding consideration under the Mental Health Block Grant. The FY 2012 project proposal requirements incorporated a behavioral health focus and the SAMHSA Eight Strategic Initiatives.

Three (3) of the project proposals focused on substance use disorder issues. The D.C. SMHPC asked APRA to review the proposals to determine whether: 1) the proposed services and/or activities enhance APRA's service strategies for persons with substance use disorder issues; 2) the projects are already being funded -Or- the proposed project introduces a new aspect of a current service/activity; 3) APRA would be willing to fund the projects in total; and 4) APRA would be willing to fund the projects in a partial manner. The APRA Deputy Director for Treatment and Recovery Services reviewed the projects and provided a thoughtful and helpful critique. There were no current funding options available through APRA or its block grant funds.

Training Initiatives (SAMHSA Strategic Goals 4.1 and 8.4)

DMH has continued to offer the Co-Occurring Clinical Competency Curriculum Certificate Program through its Training Institute. APRA has integrated modules from the original training into their course offerings as well.

The Certificate Program course is taught by the DMH Co-Occurring Training Coordinator. The training program is appropriate for both mental health and addiction clinicians who are currently delivering services to a population that includes individuals with mental health and substance use

disorder. In FY 2011, Twenty-six (26) individuals completed the course and were granted Certificates of Co-Occurring Clinical Competency.

Service Initiatives (SAMHSA Strategic Goals 1.1, 1.2 and 4.1)

DMH and APRA- DMH has been operating a Court Urgent Care clinic (CUCC) at the Superior Court of the District of Columbia under contract with the Psychiatric Institute of Washington (PIW) since June 2008. In FY 2011, through a Memorandum of Understanding (MOU) with APRA, this contract was expanded to provide substance use disorder assessment and referral services at the CUCC.

DMH-The DMH substance use disorder services include both community and inpatient programs.

DMH and Provider Programs- The Mental Health Rehabilitation Services Provider Certification Standards require all DMH and provider programs to screen and assess for substance use disorder, provide documentation in the treatment plan, and provide care coordination. (Criterion 1)

Four (4) DMH certified MHRS providers are also Addiction Prevention Recovery Administration (APRA) certified Substance Abuse Treatment Programs and Facilities. These programs are: 1) Hillcrest Children's Center (youth and adult addiction services); 2) Latin American Youth Center; 3) Neighbors Consejo; and 4) Life Stride.

DMH Mental Health Services Division (MHSD)- The MHSD is responsible for implementing mental health services that include: same day service/urgent care clinic; physician's practice group (adult and child); psychiatric residents' clinic; multicultural services program; deaf/hard of hearing and intellectual disabilities program; outpatient competency restoration program; and pharmacy.

The substance use disorder services were integrated into regular MHSD programs in FY 2010. As an initial step in the assessment process for all individuals who present for treatment, a comprehensive assessment is conducted that includes a protocol for substance use (C.A.G.E., a 6-item brief questionnaire). A positive answer to any of the questions automatically triggers the Mental Illness Drug and Alcohol Screening (MIDAS). The MIDAS is a comprehensive assessment tool used to determine substance use and/or abuse. The results of the MIDAS determine the intervention used to address the substance use findings.

Many of the MHSD consumers are already enrolled in the substance use disorder treatment programs of the agency that referred them. Some of the consumers who are not determined to have a life altering substance use problem, are often treated on site by the clinicians, which includes clinicians from the Psychiatric Residents' Clinic. For other consumers who are determined to have a severe substance use problem, a referral to APRA, is initiated. Consumers are also referred to Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) for support. The substance use/abuse issues become part of the treatment plan.

DMH Comprehensive Psychiatric Emergency Program (CPEP)- The CPEP operates four (4) programs: 1) psychiatric emergency services; 2) extended observation beds; 3) mobile crisis services; and 4) homeless outreach services. The staff within each of these programs attempt to assess, counsel, and treat consumers for substance use issues. There are three (3) Addiction Treatment Specialists working at CPEP. One works for the psychiatric emergency services program and two (2) work in mobile crisis services.

Psychiatric Emergency Services (PES) and Extended Observation Beds (EOB):-Consumers admitted on the PES unit are routinely screened and assessed for substance use, and ultimately staff try to provide comprehensive services that include drug/alcohol treatment.

Screening- Upon admission, consumers are asked to submit to a urine toxicology test and/or breathalyzer. As part of the initial assessment, clinical staff conduct a MIDAS to assess history of drug and alcohol use.

Assessment- Based on the results of the tests and consumer's presentation psychiatrists try to: 1) determine if the substance use has aggravated or caused the current behavior; 2) address these issues during the psychiatric assessment; and 3) try to stabilize the consumer. As necessary, psychiatrists also try to deal with the consumer's withdrawal symptoms (alcohol or narcotics) by providing medications. Consumers that are highly intoxicated or experiencing delirium are sent out for medical clearance first, as there may be underlying medical issues that could be exacerbated with psychotropic medication. As appropriate, psychiatrists will also transfer a dually diagnosed consumer to the Psychiatric Institute of Washington (PIW) for treatment.

CPEP also works cooperatively with inpatient drug treatment centers (e.g., Community Action Group (CAG) Men's Residential Treatment Program) to have their consumers assessed if the consumer is experiencing mental health issues while in treatment. CPEP provides assessments and prescriptions for these consumers, so that they may be returned to the treatment facility as seamlessly as possible.

Support Services- While the consumer is stabilized, CPEP's Addiction Treatment Specialist or Social Workers will work with the consumer to assess, counsel, and (as appropriate) provide referrals for treatment services through APRA's intake unit. Consumers admitted to the EOB unit are also provided with group education and therapy that addresses substance use and mental health.

If the consumer expresses an immediate desire to be linked to treatment services, staff will coordinate with the Mobile Crisis Services team to transport the consumer to APRA's intake unit. If applicable, CPEP will communicate with the consumer's family and/or core service agency (CSA) to make them aware of the issues, and to get support for the consumer's continued treatment.

Mobile Crisis Services (MCS)- Staff assess each consumer for drug use history. If the consumer is found to be intoxicated and needing medical attention, staff will transport the consumer to a hospital or to APRA for detox services. For consumers who do not require hospitalization (medically or psychiatrically), an MCS Addiction Treatment Specialist will work with them to

provide education, counseling, and treatment resources. MCS routinely provides family members with information on treatment resources, as well as resources for their own care (e.g., Al-Anon).

Homeless Outreach Program (HOP)- As part of their outreach efforts HOP staff routinely assess/screen consumers for substance issues, and conduct street “well-care” checks for consumers known to be dually diagnosed. During winter, HOP coordinates with the Hypothermia Van to go out and check on consumers who are dually diagnosed and therefore at-risk for hypothermia.

Staff also will accompany consumers to APRA’s intake unit or PIW for detox services; and on occasion will arrange for a consumer to be admitted to a community treatment facility. Where applicable, staff also communicate with family and/or case workers to inform them of the consumer’s substance issues and needs.

Saint Elizabeths Hospital (SEH)- Co-occurring groups have been conducted at SEH since June 2007. The groups provide a way to address the emotional, behavioral, social, health, and preventive factors associated with mental health and substance use disorder. They also provide information based on the individual’s cognitive level, irrespective of whether or not they are ready to participate in the therapeutic learning centers (TLCs). The co-occurring groups are conducted primarily at SEH in TLCs; aside from the NA and AA meetings there are no outside staff.

SEH conducts a number of groups focusing on co-occurring disorders that are provided in the TLCs and include: 1) anger management; 2) stress reduction; 3) learning about healthy living (focus on nicotine use); 4) quit smoking; 5) Alcoholics Anonymous; 6) Double Trouble and Recovery; 7) Sexual safety and sobriety; and 8) art therapy relapse prevention.

Additionally, the following co-occurring groups are stratified by cognitive level for high and medium functioning individuals in care: 1) stages of change; 2) substance abuse education; 3) self management and recovery training (SMART recovery); 4) relapse prevention; and 5) illness management and recovery.

The hospital’s admission unit conducts stages of change, trauma informed care and substance abuse education groups on the unit for those individuals who are not yet ready to attend the TLC. Specific groups are assigned to individuals based on their strengths, desires, cognitive ability and clinical needs. The individual, clinical administrator and TLC administrator develop their TLC schedule together.

Ida Mae Campbell Wellness and Resource Center- a consumer-run organization offers Double Trouble Groups (mental illness and addiction).

Behavioral Health and Primary Care Services (SAMHSA Strategic Goals 4.1 and 5.5)

Medical and Dental Services: DMH currently provides free medical as well as psychiatric medications to those individuals who do not have Medicaid or other means to purchase them. Due to the change in the Medicaid program eligibility (now 200% of poverty), the number and variety of medications provided by the MHSD pharmacy is down. The 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).

The DMH Mental Health Services Division provides pharmacy services. This involves dispensing medication, medication counseling, and drug interaction counseling. For the period October 2010 through May 2011, pharmacy services were provided to 2,451 unduplicated consumers and 16,091 prescriptions were filled.

Saint Elizabeths Hospital provides health services through medical and dental services clinics. The District's community health system also provides medical services.

The MHRS providers collaborate with the District's Medicaid D.C. Healthy Families program to assure delivery of comprehensive medical and dental services and early periodic screening, diagnosis and treatment (EPSDT) benefits to eligible District children. District children are also eligible to receive Medicaid benefit-level services through the District's Health Program.

The MHRS standards require both health screening and annual physical examinations for mental health consumers. The health status of the consumers of DMH services are to be screened at least every 180 days as part of the assessment process related to 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. There must also be documentation of annual physicals.

DMH Office of Accountability Reviews: These reviews include: 1) a Saint Elizabeths Hospital co-morbidity study of consumers with medical and psychiatric diagnoses; and 2) a DMH provider network quality improvement initiative to increase the number of consumers linked to primary care providers. The details about these reviews are included in the discussion about the CQI Plan in Section F of this Application.

Integration of Mental Health and Primary Health (SAMHSA Strategic Goal 5.5): DMH has been actively involved in the District's efforts to integrate mental health and primary health.

Chronic Care Initiative in Mental Health- The D.C. Chronic Care Initiative (CCI) in Mental Health is a partnership of the George Washington University Medical Faculty Associates and Department of Health Policy, Department of Mental Health, Anchor Mental Health, Green Door, Community Connections, Washington Hospital Center, the Medstar Diabetes Program at the Washington Hospital Center, and Howard University Hospital. The primary goal is to improve the health status of adults with serious mental illness in the District who have chronic disease or who are at high risk for developing chronic illness due to modifiable risk factors. A Nurse Practitioner is located on site at the mental health facility to conduct health screenings (i.e., diabetes) and provide health education.

Integration of Mental Health Services into Primary Care Settings- DMH worked with Georgetown University Department of Psychiatry and the District of Columbia Primary Care

Association (DCPCA), on identifying different strategies to link primary and behavioral health care. A report was issued in December 2010, containing recommendations for developing a sustainable, District-wide partnership between DMH and the District's safety-net primary care clinics to provide needed mental health services to low-income residents and to help mental health providers link up with primary health care settings.

Health Reform (SAMHSA Strategic Goal 5.5): These initiatives include the following:

Health Reform Implementation Committee (HRIC). Initially established in 2010 and reconstituted in 2011, the HRIC was established to oversee the implementation of health reform in the District of Columbia. The HRIC is chaired by the Director of the Department of Health Care Finance (DHCF) and includes the Commissioner of the Department of Insurance, Securities and Banking and the Directors of the Departments of Health, Human Services Mental Health and Disabilities Services. Further details about the collaboration between the various District agencies involved in the HRIC and health reform are set forth in Section N of this Application.

Provision of Recovery Support Service for Individuals with Mental or Substance Use Disorders (SAMHSA Strategic Goals 4.1, 4.2, 4.3 and 4.4)

The recovery support services provided through the DMH Office of Consumer and Family Affairs are described in Section D of the Application. This description includes peer related services provided by consumer-run organizations; consumer employment opportunities; peer specialists certification training; the annual Olmstead Conference; and family and consumer education.

Permanent Housing and Supportive Services (SAMHSA Strategic Goal 4.2): DMH participates in District permanent supportive housing initiatives, as well as operates a Supported Housing Division.

DMH Housing Division: This Division coordinates housing services for children and youth, adults and families. The identified client might be a child or youth, or an adult family member. The Division is responsible for preserving and increasing the supply of affordable permanent supportive housing (PSH) available to mental health consumers in the District. To this end, the Housing Division is allocated District resources for bridge rental housing subsidies and capital fund dollars for housing development. In addition, it obtains resources through local and federal grants and partners with District and other agencies.

Most participants in the DMH Supportive Housing Program are formerly homeless, or in institutions such as Saint Elizabeths Hospital, jail, or living in substandard housing; at the time of referral for DMH housing resources. DMH consumers have extremely low income. The majority receive Supplemental Security Income (SSI) in the amount of \$674 per month and without the availability of DMH supportive housing subsidies, consumers are likely to remain homeless longer.

Housing Subsidies/Vouchers for Affordability- 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. DMH has several Memoranda of

Understanding (MOU) with the D.C. Housing Authority (DCHA) for Federal voucher programs that provide additional housing for consumers.

Housing Liaison Provider Network- Twenty-three (23) CSAs have designated Housing Liaisons who serve as the central point of contact for accessing DMH housing resources and monitoring consumer stability and tenure in housing. Group and individual meetings are held to review monitoring reports, plan and problem solve.

Supported Housing Programs-DMH supported housing programs include: supported independent living (433); The Community Partnership for the Prevention of Homelessness Shelter + Care (144); DMH Shelter + Care Grant (15); Home First (625); DCHA vouchers (2,562), for a total of 3,779 DMH consumers receiving subsidized supported housing.

Residential Programs-A number of consumers reside in community residential facility (CRF) group homes that are supervised 24-hours a day. DMH contracts for 60 transitional living slots and 225 CRF slots. There are also 114 independent CRF operators. All of the CRFs are licensed by DMH.

Capital Funds Used to Leverage Other Public Sources of Housing Funds- The 2007 DMH MOU with Department of Housing and Community Development (DHCD) transferred \$14M in capital funds to develop 300 housing units. There are 125 units on-line with 73 occupied as of June 30, 2011.

D.C. FUSE Project: The project's official start date was November 2010 and the project review is scheduled for 2012. The Corporation for Supportive Housing (CSH) Mid-Atlantic Program is working with partners in the District of Columbia to end homelessness and incarceration for frequent users of jail and shelter. The proposed solution is to offer permanent supportive housing to the most frequent users of jail and shelter systems to keep these men and women off the streets and prevent future criminal justice involvement. The work in the District is based on a model that CSH created in New York City called the Frequent User Service Enhancement (FUSE) Initiative. The participant criteria include: 1) three (3) shelter stays within the last 3 years or shelter stays greater than 180 days; 2) three (3) jail visits within the last 3 years; and 3) diagnosed as seriously and persistently mentally ill (SPMI).

The key partners that include: 1) University Legal Services (ULS) for program administration and legal advocacy services; 2) Department of Corrections (DOC) for data-sharing and providing access to ULS and partners; 3) Department of Mental Health (DMH) for services and needs identification of target population; 4) Department of Human Services (DHS) for coordination of services; 5) D.C. Housing Authority (DCHA) for operating subsidies and shelters and potential housing providers; and 6) Housing and service providers, and shelters that will ultimately serve these users. Other partners include: The Community Partnership for the Prevention of Homelessness, D.C. Public Defender Services and CJA Attorneys, Urban Institute (evaluation including process and outcome), Pathways to Housing-DC and Community Connections both assertive community treatment (ACT) providers and assist with housing.

This project provides enhanced pre-release transition planning and re-entry coordination and identifies housing. The ULS FUSE Housing Coordinator utilizes the GAINS APIC evidence-

based discharge planning model, which develops an individualized transition plan for each participant. The Urban Institute is gathering data on process and outcomes evaluation.

The client profile as of July 18, 2011 includes the following: 17 program participants (16 males and 1 female); all 17 have a co-occurring substance use disorder (some are already in recovery); 9 have trauma history; 15 housing subsidies were awarded with an additional 5 granted in July 2011; and 13 participants are currently housed. The goal is to house 20 individuals by September 30, 2011.

Supported Employment Program (SAMHSA Strategic Goal 4.3): In 2003, DMH began providing 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.

DMH continues to fund six (6) core service agencies (CSAs) to provide specialized supported employment (SE) services: 1) Anchor Mental Health; 2) Community Connections, Inc.; 3) Deaf Reach, Inc.; 4) Green Door, Inc.; 5) Pathways To Housing, Inc.; and 6) Psychiatric Center Chartered, Inc. With the additional funding from the Department on Disability Services (DDS/RSA), each SE provider added one (1) new staff per program and increased its capacity by 20 consumers. This increased the overall capacity of the SE program to 595. Although the capacity is 595, the number of consumers who received a SE service was 650 as of July 2011. DMH expects to serve 700 consumers by the end of FY 2011. The RSA monies fund the initial costs of intake, assessment, job development and placement, job coaching and the first 90 days of employment. This has allowed DMH resources to go towards the longer-term costs of helping people maintain either full or part time jobs.

Youth Vocational Rehabilitation: The Department on Disability Services, Rehabilitation Services Administration (DDS/RSA) works closely with the D.C. Public Schools system to provide vocational rehabilitation transition services for in-school youth with disabilities and those transitioning from school to other activities including employment training and employment. With respect to the latter category, services include career/vocational guidance and counseling and further assessments (as deemed appropriate and based on school findings) including vocational, medical, psychological, and assistive technology. DDS/RSA works with the school system to identify youth, some of whom are referred to the DMH Supported Employment provider network.

Step 1: Assess the strengths and needs of the service system to address the specific populations

Block Grant Program AIM: To promote recovery, resiliency and community integration for adults with serious mental illness (SMI) and children with serious emotional disturbances (SED) and their families

1. Specific Population: Adults with SMI and Children with SED

Program: Mental Health Rehabilitation Services Program

Rationale: DMH is statutorily required to serve adults with SMI and children with SED pursuant to the Department of Mental Health Establishment Amendment Act of 2001 and the Mental Health Rehabilitation Services (MHRS) Provider Certification Standards.

Strengths: DMH certifies a network of providers through the MHRS program to address the mental health needs of children and youth with SED and their families, and adults with SMI. The MHRS program consists of nine (9) service domains, four (4) are core services and five (5) are specialty services. There were 38 MHRS providers in June 2011. The majority (22 or 58%) are child and youth serving agencies. The MHRS providers served approximately 19,829 unduplicated consumers based on a July 11, 2011 data run.

The MHRS program consists of a diverse group of providers who serve populations that include: children, youth and families; adults; persons of various ethnic, cultural and linguistic backgrounds; substance use disorder; homelessness; HIV/AIDS; deaf /hard of hearing; developmental disabilities; and involvement with and/or diversion from the criminal or juvenile justice systems. Five (5) of the MHRS providers are also certified as substance use disorder treatment programs and facilities.

The DMH Office of Accountability conducts Quality Reviews with the MHRS provider programs. These audits consist of site visits and chart abstractions made at each CSA. The samples for these audits are randomly chosen, and based on the size of the client population at a CSA. There are three sample sizes based on the size of the population seen by a CSA. For 0-300 clients 15 charts are reviewed, for 300-1,000 clients 20 charts are reviewed, and for CSAs with over 1,000 clients 25 charts are reviewed. The number of sampled charts is selected based on the population size for a given population (adult or child) at a given CSA, and may be different for adults and children at the same CSA. The Quality Review sample includes records for consumers who had consecutive authorizations for all four (4) quarters of the review period. Fifteen (15) charts is the minimum number of charts examined at each CSA, and if 15 consumers do not meet the above criteria, the rest of the sample is randomly filled with consumers active at the CSA during the review period.

Needs: One of the concerns that has been expressed about the MHRS program is related to the range of services. DMH program staff and providers have found that the current services array is limited in being able to provide flexible services that meet the unique needs of a given consumer.

Also, the results of the Annual Community Services Reviews have shown that services are equally provided to persons with the least and the greatest need.

The RAND Corporation study of the District's behavior health care system (2010) used claims data to describe utilization by MHRS enrollees. These findings are presented under Step 2 of the planning process (identification of the unmet service needs and critical gaps within the current system). The data highlight issues related to the adult and child MHRS provider visits and contacts per year, receipt of intensive services, and gaps in care over a 12-month period. The RAND study also found, based on focus group and stakeholder interviews, concerns about: 1) access to services for those who do not qualify for the MHRS program, and 2) services for targeted populations (geriatric, transition age youth, foreign language speakers, and LGBTQ clients). The RAND Technical Report on Behavioral Health Care in the District of Columbia is available at www.rand.org/pubs/technical_reports/TR914.html.

2. Specific Population: Individuals with Mental and/or Substance Use Disorders Who Are Homeless Or Involved in the Criminal Or Juvenile Justice Systems

Program: Juvenile Behavioral Diversion Program

Rationale: Superior Court of the District of Columbia Administrative Order 10-17 established the Juvenile Behavioral Diversion Program as a problem solving court indicating that: 1) a significant number of juveniles who have a serious mental illness appear before judicial officers in the Superior Court's Family Court; 2) juveniles with mental health illness are at higher risk of re-offending; 3) the Superior Court recognizes the importance of reducing juvenile's behavioral symptoms that result in contact with the court and improving the juvenile's functioning in the home, school, and community; 4) the Superior Court decided with the support of the District of Columbia Department of Mental Health, Court Social Services, the Office of the Attorney General, and the Public Defender Service to develop a juvenile behavioral diversion program that will connect eligible and suitable juveniles and his or her parent, guardian, or custodian to, and intensely monitor engagement with, mental health services and supports in the community; and 5) the Juvenile Behavioral Diversion Program would begin on January 3, 2011.

Strengths: The Juvenile Behavioral Diversion Program (JBDP) is designed to link juveniles and status offenders to, and engage them in, appropriate mental health services and supports in the community in order to reduce behavioral symptoms that result in contact with the court and to improve the juvenile's functioning in the home, school, and community. This pilot program is intended for children and youth under the age of 18 with high-end needs (often multi-system involved) who are at risk of re-offending without the benefit of close monitoring by mental health professionals and court officials to ensure sustained linkage to community mental health services and other important supports such as: family, peers, schools, and educational/vocational programs.

At papering the Office of the Attorney General (OAG) screens case eligibility and identifies the appropriate track (I, II, or III) based on the youth's charge and prior court involvement if any. Meanwhile, during the intake process the Court Social Services Child Guidance Clinic administers the Conners Behavior Rating Scale (CBRS), which provides a comprehensive

overview of child and adolescent disorders and concerns. This process began in March 2011. Since then, there have been approximately 675 screenings using this tool, with 1,500 or so expected by the end of the year.

If the youth is eligible based on charge and is screened to have a high probability of an Axis I diagnosis by the CBRS, the youth is referred to DMH. The DMH JBDP Coordinator researches the youth's prior history in the mental health system. If there is no prior mental health involvement or involvement older than 2 years, he/she is referred to the DMH Physician's Practice Group (PPG) for a brief psychiatric evaluation to determine whether the youth possesses an Axis I diagnosis.

A youth in JBDP will be offered an array of services, including evidence-based treatment in an expedited manner. Two (2) child-serving CSAs, First Home Care and Hillcrest Children's Center, and Youth Villages a third party provider for Multi-Systemic Therapy (MST) participate in the program. The treatment modalities include: Community-Based Intervention (CBI Levels II and III), Functional Family Therapy (FFT), and MST. All youth are assigned a CBI home-based worker. JBDP youth may also access additional services that include: diagnostic/assessment; medication/somatic treatment; counseling and psychotherapy; community support; crisis/emergency; and substance use disorder services.

The juvenile appears before the court for frequent reviews so the court may stay abreast with the progress to commend the juvenile on his/her progress or to admonish the juvenile on his/her lack of compliance. Routine and frequent contact allows the court to address challenges or problems as they arise and for community mental health and treatment partners to provide input on a regular basis. Each juvenile is assigned a probation officer for coordinating case management, community supervision and monitoring to guide and support the youth through this process.

The Court Social Services Child Guidance Clinic is responsible for the research component of the JBDP. A number of variables will be monitored and reported that will include: diagnostic issues, treatment, recidivism and police service areas (PSAs) for neighborhood tracking and associated mental health problems.

Year 1, is the implementation phase and adjustments will be made throughout this period that concludes in January 2012. Also, the frequent reviews before the court create an ongoing monitoring mechanism. Plans are to issue an interim report after the first year of operation and an evaluation report after 2 years of operation.

Needs: The JBDP was created in January 2011 as problem-solving court to meet the mental health needs of juveniles who have a serious mental illness that appear before the court and are at a higher risk of re-offending. The primary need is to determine the extent to which the proposed strategy is effective.

Block Grant Program AIM: To coordinate behavioral health prevention, early identification, treatment and recovery support services with other health and social services.

1. Specific Population: Women Who are Pregnant and Have a Substance Use and/or Mental

Disorder

Program: Healthy Start Project

Rationale: This project is a collaboration between the Department of Health, Maternal and Family Health Administration Healthy Start Program and the DMH Child and Youth Services Division. The Healthy Start Project began in October 2004. The purpose of this program is to: 1) provide needed health and mental health services to pregnant women; 2) reduce infant mortality; and 3) remove barriers to accessing quality health and mental health services for District high risk populations in Wards 5, 6, 7, and 8.

Strengths: The women who participate in this program are of child-bearing age and have children between birth and age 2. They have been assessed for health needs by the Nurses from the D.C. Healthy Start Program, which includes an initial depression screening. The women/mothers identified as having experienced depression during and around pregnancy are candidates for the Healthy Start Project, as this may inhibit their ability to provide critical nurturance and parenting needed to give their infant and toddler a safe and healthy environment.

The staff in the DMH Healthy Start Project perform a diagnostic assessment with the women/mothers. The needs of the children are assessed on an ongoing basis through: observation, assessment and evaluation of the mother-child dyad, and bonding and attachment.

The DMH staff provide the following services: 1) an extensive home visit component to work with parents in their natural environment; 2) individual and family therapy; 3) parenting psychoeducational groups; 4) referral and linkage to community-based programs for services as needed; 5) initial assessment and ongoing review of infant's developmental progress; and 6) psychiatric services including medication management and monitoring.

The program accomplishments include: 1) training in Parents as Teachers (PAT), an evidence-based parenting program and starting a PAT group in April 2011; 2) expanding services to include teen mothers and fathers; and 3) including a significant number of biological fathers in the therapeutic process.

Needs: The program provides monthly statistics to the Department of Health, Maternal and Family Health Administration on variables such as number of referrals and intakes, and the District ward of residence. DMH staff are interested in developing other data that include: the turnaround time between referral and intake; hospitalizations to community hospitals; and the number of children with mothers who have depressive disorder that do not require mental health services. They would also like to conduct a depression screening after 6 months in the program.

The primary need is to develop a data base that will capture process and outcome variables. The outcomes might also include housing and employment. The development of the performance measures and data base will begin in FY 2012.

2. Specific Population: Parents with Substance Use and/or Mental Disorders Who Have Dependent Children

Program: Parent Infant Early Childhood Enhancement Program

Rationale: The 2007 District of Columbia Mayor's Advisory Committee on Early Childhood Development, Health Promotions Subcommittee's Early Childhood Mental Health Task Force call to action was to design and implement a mental health system of care to sustain school readiness by concentrating on the mental health needs of children from birth through age 5. The Parent Infant Early Childhood Enhancement Program was founded in the District in 2010 by a diverse group of mental health clinicians in response to this call. These clinicians were brought together by their shared belief that: 1) many children ages 0-5 in the community lacked comprehensive mental health treatment, and 2) their experience providing mental health services to school-age children in the context of the natural environment (family, social, peer group) and the larger physical and cultural setting.

Strengths: The DMH Child and Youth Services Division launched the Parent Infant Early Childhood Enhancement Program on October 1, 2010, which became fully operational in February 2011. This program provides culturally competent community-based mental health services to infants, toddlers, preschool, and school age children (ages 6 and under), that are responsive to individual family needs. The target group are children with significant emotional/behavioral concerns who are often disruptive in pre-school, early school or home settings. The program provides comprehensive assessments and relies heavily on parental involvement in understanding and learning to manage disruptive child behaviors. The goal is to encourage optimal health and wellness by intervening early with comprehensive services designed to prevent emotional problems and/or reduce stressors within the parent(s) and family from adversely affecting the developing child.

The program capacity is 120. The clinical services provided include: assessment/diagnosis; individual psychotherapy; group-parent psychoeducational and child behavior management groups; family therapy; art/play therapy; developmental/social emotional screenings; crisis intervention; psychological evaluations (only after admission and indicated need); and medication management (through the DMH Physicians' Practice Group). The assessment tools include: Children's Behavior Checklist, and Ages and Stages Questionnaire 3 (cognitive), and SE (social/emotional). The evidence-based practices include: 1) Parent Child Interaction Therapy (PCIT), 12 weeks- parent child observational training, and 2) Incredible Years, 22-weeks and will involve one parent group.

Needs: The program needs to develop key performance measures for: 1) monitoring and tracking program variables; 2) parent child interactions; and 3) child outcomes. This process will begin in FY 2012.

**Detailed Description of Services
Organized by Statutory Criteria and SAMHSA Strategic Initiatives**

Summary of Department of Mental Health Services

The District of Columbia Department of Mental Health (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 specialized community services through the: 1) Mental Health Services Division; 2) School Mental Health Program; and 3) Comprehensive Psychiatric Emergency Program. The Department also provides inpatient services at Saint Elizabeths Hospital.

Mental Health Block Grant Statutory Criteria

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

The DMH programs, services and initiatives described under this criterion are organized by relevant Block Grant Aims and the Substance Abuse Mental Health Services Administration (SAMHSA) Eight Strategic Initiatives.

Block Grant AIM: To promote recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.

SAMHSA Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness

Goal 1.1: With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.

Early Identification and Intervention Services: A number of services are being implemented under the DMH Child and Youth Services Division (CYSD) system of care (SOC). They include services for: 1) women/mothers identified as depressed with children age birth to 2 (Healthy Start Project); 2) children 0-5 in child development centers with a focus on child and family-centered, and program consultation (Healthy Futures); 3) parents and children age 6 and under who have shown emotional and disruptive behavior across various social settings (Parent Infant Early Childhood Enhancement Program); 4) children in grades Kindergarten through First to enhance school related competencies and reduce social, emotional and school adjustment difficulties (Primary Project); and 5) prevention, early intervention, treatment services provided by the School Mental Health Program.

Block Grant AIM: To ensure access to effective culturally and linguistically competent services for underserved populations including Tribes, racial and ethnic minorities, and LGBTQ individuals.

Mental Health Services Division (MHSD): This Division provides specialized mental health services that are not otherwise readily available within the DMH service system or the private sector. The service components include a same day urgent care clinic and pharmacy. The specialty teams are described below.

The specialty teams are Multicultural, Intellectual/Developmental Disabilities, and Deaf/Hard of Hearing. The majority of intake consumers seen are assigned to the private clinics in the DMH provider network for ongoing care, since except for the specialty teams, long-term community support is not provided.

Multicultural Services- This team serves ethnic and regional groups from Asian/Pacific Islands who speak Vietnamese, Chinese and Thai languages. This group makes up 6% of the population served. Ethiopians of different ethnic backgrounds make up 18-20% of the consumer base. The three (3) major Ethiopian languages spoken by consumers are Amharic, Oromo and Tigrinya. Approximately 60% of the multicultural consumers are Spanish speaking from Central and South American countries. The remaining are consumers from other African, American, Middle Eastern and European countries who are English or French bi-lingual.

Some of the DMH certified mental health rehabilitation services (MHRS) providers that serve multicultural and multilingual populations are also Addiction Prevention Recovery Administration (APRA) certified substance abuse treatment programs and facilities. They include:

Latin American Youth Center (LAYC)- serves immigrant Latin youth by operating a regional network of youth centers and public charter schools. LAYC offers multilingual, culturally sensitive programs in five (5) areas: 1) educational enhancement; 2) workforce investment; 3) social services; 4) art and media; and 5) advocacy.

Neighbors' Consejo- serves the Latino community by focusing on chronic homelessness, mental health, terminal disease, domestic violence, and low income individuals. The programs and/or services include: residential; transitional; computer/ESL literacy; employment; civic engagement; life skills; outpatient; case management; environmental stabilization-housing; access to recovery after care; and mental health services.

One DMH MHRS provider that serves individuals from diverse ethnic communities is also a Federally Qualified Community Health Center (FQCHC).

Mary's Center- is an FQCHC serving primarily low-income, immigrant families. It provides comprehensive and integrated health care, education, and social services. A large portion of the services are devoted to pregnant women and their infants in predominantly Latino areas in Ward 1.

Intellectual/Developmental Disability Services (IDD)-This team responds to the psychiatric, rehabilitation, and support service needs of individuals with IDD and mental illness diagnoses. The IDD team focuses on the provision of mental health services and psychiatric treatment to the

adult mentally ill and intellectual/developmentally disabled population in a community-based treatment and supportive care environment as an alternative to institution-based psychiatric care.

This team works closely with the Department on Disability Services (DDS) on joint service planning and currently has a total of 129 consumers being served, 105 of whom are also enrolled in DDS. Altogether, DMH is currently serving 232 individuals in its community system who meet the definition of co-occurring MI/MR, with 187 of those also enrolled in DDS.

Deaf /Hard of Hearing Services- This team ensures that consumers receive the full array of MHRS based on individual need that includes but is not limited to counseling, psychotherapy, community support, medication, etc. They also receive supports such as outreach, home visits, referral to employment, and other services. MHSD staff provides assistance during the diagnostic/crisis screening of children if requested, and provide clinical consultation and education regarding the psychosocial aspects of deafness and the specialized communication needs of deaf/hard of hearing clients/consumers to all components of DMH.

One DMH MHRS provider services individuals who are deaf and hard of hearing.

Deaf-REACH- is committed to maximizing the self-sufficiency of deaf and hard-of-hearing people who need special services. It is the only agency in the District whose mission is specifically to serve deaf individuals facing serious mental illness, developmental disabilities, or other challenges. Programs and services include: community residence facilities, supported independent living, community support, supported employment, HIV prevention, day habilitation, and pre-vocational services.

Sexual Minority Youth Assistance League (SMYAL): Founded in 1984, SMYAL is the only Washington, D.C. metro area service organization solely dedicated to supporting lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. Its mission is to promote and support self-confident, healthy, productive lives for LGBTQ youth ages 13-21 as they journey from adolescence into adulthood. To fulfill this mission, SMYAL addresses five (5) focus areas: 1) life skills and leadership development; 2) counseling and support; 3) health and wellness education; 4) safe social activities; and 5) community outreach and education.

During FY 2011 SMYAL provided training on engagement of LGBTQ youth to two (2) DMH child providers (Hillcrest Children's Center and First Home Care Corporation).

Emergency Services: These DMH operated services include same day urgent care, psychiatric emergency services, and adult mobile crisis services.

Same Day Urgent Care Services- This service, operated by the DMH Mental Health Services Division, is intended to intervene to prevent relapse or full-blown crisis by alleviating presenting problems. Promotion of emotional health is enhanced beyond the services typically provided by a community clinic that serves individuals with major mental illnesses. This is achieved as follows: 1) adult and child consumers for intake may walk-in unscheduled and be evaluated the same day; 2) there is same day access to a psychiatrist; 3) psychotherapy services are available on a scheduled basis through the Residents' Clinic; and 4) there is also an on-site pharmacy that

serves individuals without insurance, all walk-in consumers who see a psychiatrist can also have their prescriptions filled that day.

As of June 30, 2011, the Same Day Urgent Care Clinic served 1,107 consumers. This includes 987 adults and 120 children

Comprehensive Psychiatric Emergency Program (CPEP)- provides emergency psychiatric services for persons 18 years and older. This 24-hour program includes: crisis assessment and stabilization; acute psychiatric and medical screening and assessment; observation and intensive psycho-pharmacological and psychotherapeutic services. There are four (4) components:

1) psychiatric emergency services (PES); 2) extended observation beds (EOB); 3) adult mobile crisis services (MCS); and 4) homeless outreach services (see Criterion 4).

- Psychiatric Emergency Services (PES) and Extended Observation Beds (EOB)- includes two (2) observation beds (used for consumers who may need additional time to stabilize before discharge to the community) and two (2) restraining beds (reserved for persons who present a danger to self or others). These individuals are usually escorted by police 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. As of June 30, 2011, there were 2,946 individuals who received psychiatric emergency services.
- Adult Mobile Crisis Services (MCS)- is staffed by a multidisciplinary team and offers crisis intervention and medical support to adults who are mentally ill in their homes, community facilities, and in the street . The daily hours of operation are 9:00 a.m. - 1:00 a.m. MCS works closely with the police. The primary activities include: 1) respond to adults throughout the District who are experiencing a psychiatric crisis and are unable or unwilling to travel to receive mental health services; 2) spend as much time as needed with consumers to ensure crisis stabilization, make an appropriate disposition, and provide necessary follow-up services; 3) be available to address the concerns of the individual in crisis, family members, concerned citizens, mental health providers, and other referring agencies; and 4) offer a range of services including but not limited to on-site crisis intervention and stabilization, assessment for voluntary and involuntary hospitalization, and linkage to other services such as ongoing mental health care, crisis beds, substance abuse detoxification and treatment, and medical care. As of June 30, 2011, there were 1,585 service responses, of which 1,450 were face-to-face.

In addition to the Same Day Urgent Care Clinic, CPEP adult MCS, the DMH CYSD contracts for child and youth mobile crisis services. DMH also contracts with Children's National Medical Center for child emergency services.

Other Activities Leading to Reduction of Hospitalization: The DMH has a number of programs and initiatives in place that 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). The Access HelpLine also receives referrals for crisis services.

Crisis Beds- The DMH currently funds two (2) providers for a total of 15 crisis beds. These include eight (8) at Jordan House and seven (7) at Crossing Place. At the end of June 2011, total utilization rate was 88.21%.

Local Hospitals for Acute Care- DMH continues to use local hospitals to provide acute care for involuntary patients, as well as voluntary admissions.

Peer Transition Specialists- During FY 2010, the Office of Consumer and Family Affairs, Saint Elizabeths Hospital, and the Integrated Care Division collaborated on the implementation of this initiative aimed at helping consumers leave the Hospital. The role of the Peer Transition Specialists (PTS) is to assist individuals in the care of the Hospital, who have been determined ready for discharge, make a smooth transition to community living. In FY 2010, ten (10) PTS were hired and trained and 8 were working in FY 2011. The PTS are able to draw upon lived experiences as well as their training to provide encouragement and support to those who are returning to the community. This initiative is supported with Olmstead funding.

Assertive Community Treatment (ACT)- This evidence-based practice provides intensive, integrated, rehabilitative, community-based services for adults with SMI. ACT consumers typically have experienced multiple psychiatric crises, housing and employment instability, and have been unable to maintain linkages to traditional clinic-based mental health services. ACT services are provided to consumers in accordance with an IRP developed in collaboration with the consumer, ACT team, and other involved service providers, family members or community support systems. As of June 30, 2011, there were 13 provider ACT teams serving 1,091 consumers.

DMH conducts its own fidelity assessments on an annual basis utilizing the Dartmouth Assertive Community Treatment Scale (DACTS); results are tabulated and provided to ACT providers. Each team must provide an improvement plan for low Fidelity scores and any system related issues identified through the Fidelity process will be addressed in an overall ACT work plan and carried out through the course of the fiscal year.

Integrated Care Division (ICD)- is dedicated to reducing the inpatient census/reducing admissions at Saint Elizabeths Hospital (SEH) by identifying consumers who need a comprehensive array of services that include mental health, non-mental health, and informal supports to integrate to their fullest ability in their communities and families. ICD coordinates, manages, and evaluates the care for these consumers to improve their quality of life and tenure in a community setting. The target population includes: 1) consumers who are discharge ready but who are reluctant to leave and/or have complex needs; 2) consumers who are discharge ready and have been at SEH for 6 months or more; and 3) consumers who have been admitted to an inpatient setting three (3) or more times in the 12-month period immediately prior to the current hospitalization. The overall goal is to reduce the census at SEH by avoiding admissions through more intensive community supports and facilitating discharge for the targeted populations. The

ICD is actively involved in the assessment of SEH consumers who should be referred to community-based ACT teams.

The ICD also oversees the Integrated Community Care Project (ICCP), operated under contract by New Directions at Washington Hospital Center. Intensive discharge planning and coordination is required to develop the most person-centered, comprehensive plan for successful community living. This planning takes 1-4 months including the consumer and the consumer's family/guardian, SEH staff, New Directions, and any community vendors who will also deliver services, with support from the ICD.

Federal and District Performance Indicators- Complying with federal and the Dixon Exit Criteria challenged DMH to establish baseline measures to effect adult and child System of Care improvements to meet the following performance targets: 1) decrease the number of children/youth and adults re-admitted to inpatient care within 30 days of discharge; 2) decrease the number of children/youth and adults re-admitted to inpatient care within 180 days of discharge; and 3) eighty (80%) of children/youth and adults discharged from inpatient care must be seen within seven (7) days in non-emergency outpatient setting.

Community Support vs. Case Management Services: Under the MHRS program DMH and its providers bill for Community Support and not Case Management. DMH strives to create an effective, welcoming, community support system that is based on the consumer's strengths and choices, promotes recovery through the attainment of individualized goals to help the consumer develop the skills to live the best possible quality of life, and provides aggressive outreach to maintain consumers in the community. The DMH provides community support to consumers in a number of ways by both DMH practitioners and private providers and is based on the individual consumer's (child/youth or adult) treatment needs as determined through the individualized recovery planning process where attainable and mutually agreeable goals and objectives are developed. Each consumer is assigned a clinical manager and qualified practitioner to coordinate consumer care, often across multiple provider agencies and to provide rehabilitation services, treatment and supports. The consumer's clinical manager is responsible for assessing with the consumer each of the consumer's major life domains and the areas of need that will be addressed.

Goal 1.2: Prevent or reduce consequences of underage drinking and adult problem drinking.

Four (4) DMH certified MHRS providers (2 child and youth serving CSAs and 2 adult CSAs) are also Addiction Prevention Recovery Administration (APRA) certified Substance Abuse Treatment Programs and Facilities.

Goal 1.3: Prevent suicides and attempted suicides among populations at high risk, especially military families, LGBTQ youth, and American Indians and Alaska Natives.

During FY 2011, a course was offered through the DMH Training Institute by The Trevor Project on "Reducing Suicide among LGBTQ Youth: Research, Public Policy and Educational Programming. There were 23 attendees. Also, the Sexual Minority Youth Assistance League (SMYAL) has received a mini-grant under the DMH SAMHSA State/Tribal Youth Suicide Prevention Grant.

The District's Behavioral Health Assessment and Plan describes suicide prevention initiatives in section J. This description includes the: 1) 2009 Suicide Prevention Plan (Attachment J-1); 2) SAMHSA State/Tribal Youth Suicide Prevention Grant awarded in FY 2010 (Capital CARES); 3) DMH Access HelpLine Suicide Lifeline Network; and 4) collaboration with the Washington Metropolitan Transit Authority (WMATA) to address suicide prevention within the public transportation system.

Goal 1.4: Reduce prescription drug misuse and abuse.

Saint Elizabeths Hospital monitors the use of benzodiazepine prescription use for more than 90 days.

SAMHSA Strategic Initiative #2: Trauma and Justice

Goal 2.1: Develop a comprehensive public health approach to trauma

During FY 2011, five (5) courses were offered through the DMH Training Institute on trauma related issues. They included: 1) creating cultures of trauma informed care; 2) trauma recovery and empowerment profile (TREP); 3) working with adult survivors of trauma; 4) staff support training in trauma informed care; and 5) updates on diagnosis and treatment of psychological trauma. The attendance across the 5 courses ranged from 21-50, for an average of 34 attendees.

Goal 2.2: Make screening for trauma and early intervention and treatment common practice.

In April 2007, Saint Elizabeths Hospital (SEH) launched a Trauma-Informed Care (TIC) Training Initiative with support from Joan Gillece, Ph.D., National Technical Assistance Center National Association of State Mental Health Program Directors (NASMHPD). This initiative involved five (5) mandatory all staff trainings. The events through FY 2011 include the following:

1) TIC training for all clinical staff as part of new employee orientation, required annually for all clinical staff, and added as part of non-clinical staff employee orientation; 2) all nursing shifts trained, Comfort Plan introduced, sensory items provided and consultations with staff and patients provided; 3) Comfort Plan becomes an official Hospital chart document and is completed and updated as needed by nursing staff; 4) all Hospital units have private rooms for patients and a Comfort Room; and 5) NASMHPD conducted training on Trauma, Addiction, Mental Health and Recovery (TAMAR); a 15-session, manualized, supportive and psychoeducational group therapy for trauma survivors focused on affect modulation.

Goal 2.3: Reduce the impact of trauma and violence on children, youth, and families.

Trauma-Focused Cognitive Behavioral (TF-CBT): This psychotherapeutic intervention is designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. The

program can be provided to children 3 to 18 and their parents by trained mental health professionals in individual, family, and group sessions in outpatient settings.

The DMH Child and Youth Services Division (CYSD) launched a TF-CBT initiative in FY 2009 by training 10 providers in this evidence-based model. Many of the providers lost the capacity due to staff turnover. Currently, three (3) core service agencies (CSAs) provide TF-CBT (Community Connections, Latin American Youth Center, and Family Matters). In FY 2011, a new Trauma Learning Collaborative (TLC) project called TLC DC II began for the child and youth Choice Providers. The training timeline includes the: 1) pre-work phase (July-December 2011); 2) learning sessions and action periods (January-September 2012); and 3) evaluation (October-December 2012).

Homicide Survivor Response Project: Mobile Crisis Services (MCS) is partnering with the Executive Office of the Mayor (EOM) Office of Victim Services and the Metropolitan Police Department (MPD) to provide 24-hour response to homicide survivors following homicides in the District. MCS provides homicide survivors with initial non-medical stabilization and mental health assistance, including linkage to ongoing grief and loss counseling and/or other mental health care. If a homicide survivor is experiencing a psychiatric crisis, MCS can assess the individual and link them to the appropriate level of psychiatric care. MCS is able to provide follow-up services including: completing linkages to ongoing grief and loss and/or other mental health care (when appropriate), providing transportation to initial appointments, accompanying family members to the medical examiner's office (when asked), and attending vigils and funerals (when asked).

Goal 2.5: Reduce the impact of disasters on the behavioral health of individuals, families, and communities.

Disaster Mental Health: While DMH responded to local emergencies, disasters or participated in full scale exercises, it did not establish a Director for Disaster Mental Health until 2007. This role ensures DMH's capacity to support 10 of the 16 Emergency Support Functions (ESF) identified in the District of Columbia Response Plan (DRP) and National Response Framework (NRF) in the event of a public emergency or disaster in the District. In addition, the Director oversees DMH safety and continuity of operations.

District agency partners include the Homeland Security and Emergency Management Agency (HSEMA), Department of Health's Health Emergency Preparedness Response Agency (HEPRA), and the Department of Human Services (DHS). In FY 2011 a new partnership was formed with the D.C. State Mental Health Planning Council. This partnership began with the kick-off session that launched the D.C. Mental Health First Aid Program and will continue with funding in FY 2012.

The primary activities include: 1) provide Disaster training for DMH's Emergency Response Teams, and volunteers; 2) develop a Training Plan for DMH Disaster Response and update DMH's All Hazards Response Plan and Continuity Plan; 3) build capacity for a Mental Health response within the FEMA Region III states; and 4) fund Disaster Mental Health training opportunities. Also, a Disaster Mental Health training series was launched in FY 2010 and continued in FY 2011 that included: Advanced Psychological First Aid (PFA) with Special

Populations; Substance Abuse and Suicide Prevention; Intervention and Postvention in Disasters; Stress Management and Self Care; Critical Incident Stress Management (CISM) and Nature and Recognition of Post Traumatic Syndromes; Disaster Mental Health Screening and Assessment; and Core Principles of Crisis Counseling Program.

SAMHSA Strategic Initiative #3: Military Families

Goal 3.3: Promote the behavioral health of military families with programs and evidence-based practices that support their resilience and emotional health and prevent suicide.

Housing and Urban Development (HUD) and Department of Veterans Affairs Supportive Housing (VASH) Program: In 2008, HUD-VASH began a cooperative partnership that provides long-term case management, supportive services and permanent housing to vulnerable veterans who are homeless. The District's effort is led by Department of Human Services (DHS). The 2011 Point in Time Survey identified 515 veterans living in the District. Of that number, 42% report experiencing a mental health issue, 1 in 3 report living with a physical health disability, and 2 in 5 report living with a chronic health condition. In 2010, 105 of the most vulnerable, veterans who were chronically homeless living with serious medical conditions were housed. The VASH-Plus approach customized the process to reduce the wait times for being housed, bringing it in line with the housing first model. Currently, there are approximately 150 units of transitional housing and more than 200 units of permanent supportive housing (PSH) for veterans who are formerly homeless.

The DMH Homeless Outreach Program (HOP) has partnered with DHS to identify eligible veterans who are homeless for the VASH voucher program. DHS received these vouchers through an agreement with the Veterans Administration. HOP's role is to provide outreach, engagement, and referral services.

Veterans Family Reunification Project: This project was implemented by Positive Kinship Bonding (PKB), supported by FY 2010 Mental Health Block Grant funds and implemented in FY 2011. The purpose of the project is to enhance the family reunification process for formerly homeless veterans enrolled at the Southeast Veterans Service Center (SEVSC) through counseling and referral services.

The target population includes both male and female veterans enrolled at the SEVSC and Chesapeake Veterans House. The participants range in age from 25-50.

PKB provides 1:1 counseling, group counseling/therapy and information/educational sessions to discuss various issues facing veterans during the reunification process. Planning meetings are held with veterans to discuss ways to engage family members and friends toward building a strong social network that would provide ongoing support. Events are also planned to bring the veterans together with each other and their significant others. These events include a "dinner for two", sporting events, local recreational activities, movie night and health and fitness activities. The case management staff at SEVSC (where appropriate) will be invited to attend and participate. All events are processed during group therapy/counseling sessions held weekly by the PKB licensed professional staff.

Block Grant Program AIM: To ensure access to a comprehensive system of care, including education, employment, housing, case management, rehabilitation, dental services, and health services, as well as behavioral health services and supports.

SAMHSA Strategic Initiative #4: Recovery Support

Goal 4.1: (Health) Promote health and recovery-oriented service systems for individuals with or in recovery from mental and substance use disorders.

Medical and Dental Services: These services are provided through the DMH provider network, the DMH Mental Health Services Division, Saint Elizabeths Hospital , and the District's community health system. Also, see Strategic Initiative #5 Health Reform, Goal 5.5 that provides information about the integration of primary and behavioral health care.

Goal 4.2: (Home) Ensure that permanent housing and supportive services are available for individuals with or in recovery from mental and substance use disorders.

DMH Housing Division: This Division oversees a range of programs and services to help people with mental illness either obtain affordable housing and/or avoid losing their home. These programs include: 1) development of affordable housing units; 2) supported independent living; 3) transitional living; and 4) community residence facilities. In FY 2011, over 3,700 DMH consumers receive subsidized supported housing through either federal vouchers or District-funded programs.

D.C. FUSE Project: This District initiative offers permanent supportive housing to the most frequent users of jail and shelter systems to keep these men and women off the streets and prevent future criminal justice involvement.

Goal 4.3: (Purpose) Increase gainful employment and educational opportunities for individuals with or in recovery from mental and substance use disorders.

General Educational Services: The educational services for children and youth coordinated through the Office of the State Superintendent of Education, the D.C. Public Schools and the Public Charter Schools. These services for adults are available in the Washington, D.C. community to address individual needs and various disabilities. There is a full range of educational opportunities, from basic literacy through the general equivalency degree (GED) and college. Recently, the University of the District of Columbia has opened a community college, which provides more educational opportunities for District residents.

DMH Training Institute: Provides education and training services on a variety of issues related to the adult and child systems of care. It also offers recurring introductory and overview trainings for, consumers, providers , and DMH staff. These trainings occur on a quarterly to bi-annual basis. The Training Institute is described in Criterion 5. The table below highlights the Consumer Recovery course offerings.

DMH Training Institute Consumer Recovery Courses

Course	Times Offered	Number of Attendees	Average Number of Attendees
History of the Consumer Movement, Peer Recovery Concepts and Peer Specialist Concepts	1	14	14
Self-Advocacy 101	3	28	9.3
Negotiation Skills for Consumers	3	46	15.3
Introduction to Self Determination	1	8	8
Whole Health Training for Peer Specialist	2	53	26.5
Introduction to Intentional Peer Support	2	19	9.5
How to Get and Keep a Job through a Program called Supported Employment	4	No record (2 courses) 13 (2 courses only)	11.5
Supported Employment for Mental Health Providers	3	31	10.3
Self Employment	1	22	22
Introduction to Supported Employment	1	7	7

Youth Vocational Rehabilitation: The Department on Disability Services, Rehabilitation Services Administration (DDS/RSA) works closely with the school system to identify youth, some of whom are referred to the DMH Supported Employment provider network.

DMH Supported Employment Program: DMH continues to contract with six (6) core service agencies (CSAs) to provide specialized supported employment services. As of July 2011, the number of consumers who received a supported employment service was 650.

Goal 4.4: (Community) Promote peer support and the social inclusion of individuals with or in recovery from mental and substance use disorders in the community.

As part of its advocacy role on behalf of consumers and families, the Office of Consumer and Family Affairs (OCFA) has continued to: 1) support consumer-run organizations, 2) consumer employment opportunities, 3) the certified peer specialist certification program, 4) the annual Olmstead Conference; and 5) family and consumer education. Peer specialist programs are further discussed in sections D and L of this Application.

SAMHSA Strategic Initiative #5: Health Reform

Goal 5.1: Ensure that behavioral health is included in all aspects of health reform implementation.

Health Reform Implementation Committee (HRIC): The HRIC was established to ensure the smooth implementation of health reform in the District. The planning efforts related to implementation of the Affordable Care Act will be coordinated and planned through the HRIC and its subcommittees. The HRIC is further discussed in Section N of this Application.

Health Home Planning Initiative: This initiative began in FY 2011 and is a partnership between the Department of Health Care Finance (DHCF), the Department of Health (DOH), and the Department of Mental Health (DMH). The objective is to obtain a planning grant from the Centers for Medicare and Medicaid Services (CMS) to determine the feasibility of implementing a health home in the District. The HRIC and this planning initiative is further discussed in Section N of this Application.

Goal 5.5: Foster the integration of primary and behavioral health care.

Office of Accountability Quality Improvement Initiatives: The DMH Office of Accountability (OA) is implementing two (2) initiatives related to the integration of primary and behavioral health care:

- **Co-morbidity Reviews-** The purpose is to ensure that medical/physical as well as, psychiatric patient care needs are fully integrated and documented in the record of Saint Elizabeths Hospital patients.
- **Quality Improvement Initiative – Medical Co-Morbidity-** The purpose is to increase the number of community consumers linked to primary care providers.

Chronic Care Initiative in Mental Health: The D.C. Chronic Care Initiative (CCI) primary goal is to improve the health status of adults with SMI in the District who have chronic disease or who are at high risk for developing chronic illness due to modifiable risk factors. This project is discussed in more detail in the step 1 of the Plan.

Integration of Mental Health Services into Primary Care Settings: DMH worked with Georgetown University Department of Psychiatry and the District of Columbia Primary Care Association (DCPCA) to identify different strategies to link primary and behavioral health care. This project is discussed in more detail in the step 1 of the Plan.

Mental Health Block Funded Health Related Projects: FY 2010 and FY 2011 funded projects that address mental health and primary health issues include: 1) a health promotion campaign specifically for homeless men and women, 2) mental health services for low income seniors to improve their mental and physical health; 3) trainings on HIV/AIDS/STI and pregnancy prevention for transition age youth and the professionals who work with them; 4) support services for children/youth with SED and co-morbid health issues; 5) combining resiliency principles with culinary arts and dance to promote wellness for youth; and 6) support services

including nutrition and fitness for families with children diagnosed with ADHD who are also obese or at-risk of becoming obese.

Strategic Initiative #6: Health Information Technology

Goal 6.1: Develop the infrastructure for interoperable EHRs, including privacy, confidentiality, and data standards.

The District's strategy for interoperable EHR, including health information exchange and health insurance exchange will be developed under the auspices of the HRIC, which is further described in Section N of this Application. The DMH plans for a new practice management system, which would include an EHR, are described in Section E of this Application.

Goal 6.2: Provide incentives and create tools to facilitate the adoption of HIT and EHRs with behavioral health functionality in general and specialty health care settings.

In 2007, the District of Columbia Regional Health Information Organization (DC RHIO) initiative was launched to create a regional health information exchange (HIE) framework, infrastructure, and system. The core objective of the initiative was to enable multiple hospitals, clinics, and other health care institutions to rapidly and securely access medical history information about patients, so as to yield improvements in the health of the population, enhance the patient experience of care (including quality, access, and reliability); and reduce, or at least control, the per capita cost of care. The DC RHIO was funded via a 3-year grant award from the District and managed by the District of Columbia Primary Care Association (DCPCA).

The Center for Health Information and Decision Systems (CHIDS) at the Robert H. Smith School of Business, University of Maryland College Park developed a multi-dimensional assessment model for the DC RHIO, evaluated its performance along multiple areas and offered a set of recommendations to guide DC RHIOs future evolution. The research and associated recommendations are based on the information and documents provided by key stakeholders of the DC RHIO, an environmental scan of HIE efforts across the nation, best practices published in the literature, and benchmarking with three (3) leading HIE efforts. These activities are described in the September 2010 report, *"The District of Columbia Regional Health Information Organization (DC RHIO) Current Progress and the Road Ahead."*

The District's work on HIT and EHR, will be coordinated through the HRIC as further discussed in section N of this Application. DMH's plans for a practice management system that would include an EHR are described in Section E of this Application. There is legislation pending before the District Council that would amend the District's Mental Health Information Act to facilitate sharing of mental health information with primary and specialty health providers. Once enacted, this will remove a barrier to full participation in the RHIO and other health information exchanges as well as facilitate integration of primary and behavioral healthcare.

Block Grant AIM: To increase accountability for behavioral health services through uniform reporting on access, quality, and outcomes of services.

SAMHSA Strategic Initiative #7: Data, Outcomes, and Quality

Goal 7.1: Implement an integrated approach for SAMHSA's collection, analysis, and use of data.

During FY 2011, DMH continued to engage in data development, integration and tracking activities. One example is the development of the Child and Youth Dashboard. This initiative grew out of the DMH Child and Youth Services Division (CYSD) need to engage in better monitoring of access to services, as well as better monitoring of service delivery.

Also, during FY 2011, the District's Medicaid, health and mental health agencies began a Health Home Planning Initiative. The data development issues involved: 1) identifying the mental health consumers who were frequent users of primary health services (inpatient care facilities except Saint Elizabeths Hospital); 2) their service utilization patterns regarding health problems and medications; 3) service utilization regarding mental health problems including whether they were connected to the DMH Integrated Care Division; and 4) costs associated with mental health and primary health. This is further described in Section N of this Application.

The description of projects that follows is related to SAMHSA collection, analysis and use of data.

Data Infrastructure Grant (DIG): The DIG helps DMH develop the infrastructure needed to support uniform data reporting along other State Mental Health Agencies (SMHAs) and across local agencies for quality improvement. The primary DIG goals are to: 1) ensure data integrity and create an information system storage and retrieval capacity; 2) develop infrastructure to support quantitative planning and service quality improvement; 3) develop a management information system that is compliant with the SAMHSA National Outcome Measures (NOMs) and Uniform Reporting System (URS) requirements; 4) administer an annual Mental Health Statistics Improvement Program (MHSIP) Consumer Perception of Care Survey. This survey is conducted with both adults served by the District's mental health system and parents and guardians of children and adolescents who receive services. Two of the NOMs are derived from the MHSIP, the assessment of Functioning and Social Connectedness.

DMH has made significant progress in increasing the capacity to collect data that has not been collected in the past from independent mental health programs that are not linked to the main information system claims database. Enhancements have been made to capture supported employment, supported housing, employment status, living arrangement, medication status, and evidenced-based practices.

Details about the Mental Health Statistics Improvement (MHSIP) surveys and the CSR surveys are included in Section F of this Application.

Goal 7.2: Create common standards for quality of care, outcomes measurement, and data collection to better meet stakeholder needs.

Community Services Review (CSR): DMH established a Community Services Review Unit within the Organizational Development Division, Office Programs and Policy in FY 2009. This Unit performs a major role in the formal Dixon CSR reviews by providing logistical support for DMH reviewers and helping to provide reviewer training. It has also provided focused reviews and created targeted technical assistance interventions to assist the provider network with clinical practice issues. Details about the FY 2011 reviews are included in Section F of this Application.

Provider Scorecard: In FY 2010, the Office of Accountability (OA) implemented the Provider Scorecard that was piloted in FY 2009. Further details about the Provider Scorecard are found in Section F of this Application.

Applied Research and Evaluation (ARE) Unit: The DMH ARE Unit within Organizational Development has been providing data since October 2009. This Unit implements both measurement and capacity-building activities that enhance the use and application of data to improve system functioning and quality of care. Further details about ARE and its activities are included in Section F of this Application.

Saint Elizabeths Hospital Data Analysis and Reporting: Provides ongoing quantitative data to the hospital, DMH, and other stakeholders in order to enhance the quality of clinical practice and performance. Further details about the Saint Elizabeths Hospital data reporting activities is included in Section F of this Application.

Strategic Initiative #8: Public Awareness and Support

Goal 8.1: Increase public understanding of mental and substance use disorders and how to access treatment and recovery supports for behavioral health conditions.

D.C. Mental Health First Aid Program: During FY 2011, the D.C. State Mental Health Planning Council (D.C. SMHPC) used Mental Health First Aid, a public education program that introduces participants to risk factors and warning signs of mental health problems, their impact, and common treatments; to launch the Judge Aubrey E. Robinson, Jr. Memorial Mental Health Lecture Series. The D.C. SMHPC developed the District of Columbia Mental Health First Aid (D.C. MHFA) Program and partnered with the Department of Mental Health (DMH) on its implementation. The components of the program include: 1) a 4-hour Kick-Off to introduce the concept to up to 100 participants (May 2011); 2) four (4) community orientation sessions throughout the District for up to 50 participants each (June-August 2011); and 3) a 12-hour Certificate Course for up to 30 participants (September 2011). DMH will add a second 12-hour Certificate Course also in September. The National Council for Community Behavioral Healthcare conducts all program components.

The D.C. MHFA Program has been extremely well received. The participants have included: mental health consumers, family members, advocates, faith-based organizations, mental health providers, substance use disorder providers, hospital and other health providers, District agencies

(mental health, human services, aging, child welfare, developmental disabilities, human resources, schools, police, libraries, students, academia, businesses, emergency management, etc.). The District Department of Human Services and the D.C. Public Libraries requested to host target audience sessions.

Department of Human Services (DHS): The DHS/Division of Program Development and Training/Income Maintenance Administration is hosting a Conference for grantees and vendors who serve the Temporary Assistance for Needy Families (TANF) population. This capacity building conference brings the providers together to network, discuss best practices, and expose them to information about services and needs among the target population. The grant programs represented are teen pregnancy prevention, family mentoring home visits for sanctioned customers, employment training, summer health and wellness for youth, and employment programs for job search and development. The D.C. Mental Health First Aid Program will conduct a presentation at this Conference on August 5, 2011.

D.C. Public Libraries: The D.C. Mental Health First Aid Program will conduct a presentation for library services employees at all levels. Most of the District libraries serve many diverse customers because they are a public facility. Individuals who are homeless and/or who have mental health issues constitute a large portion of the library customers. The District Public Libraries want to be able to understand how to interact with these customers, maintain a safe workplace, and provide them with available resources. This presentation will be conducted on August 11, 2011.

D.C. Mental Health First Aid Expansion Program: The D.C. Mental Health First Aid Expansion Program will receive Homeland Security funding in FY 2012. It will include twelve (12), 12-hour courses and one (1) Instructor's Course.

Criterion 2: Mental Health System Data Epidemiology

DMH has reported in the Block Grant the estimates of the need for mental health services based on the original 1999 and 2003 edition of the *Study of Mental Health Need and Services in the District of Columbia*; conducted by the University of Texas. These estimates are based on the National Co-morbidity Survey (NCS) and related surveys and are projected to the District based on data from the U. S. Census. This data is presented under Planning Step 2 in the Application to reference the historical estimation of prevalence.

The study *Behavioral Health in the District of Columbia: Assessing Need and Evaluating the Public System of Care* (RAND 2010) also provides prevalence estimates of mental health. The data sources included national survey data (BRFSS, NSDUH, NSCH, and YRBS), administrative data, claims data, and data from focus groups and stakeholder interviews. The findings are also presented under Planning Step 2 in the Application.

Criterion 3: Children's Services

Children's System of Care Plan: During FY 2011, the DMH Child and Youth Services Division (CYSD) continued its efforts to develop and finalize a 3-5 year plan for children's

mental health services in the District. The broad goal of the planning has been to look not only at traditional mental health service interventions but also at the public health aspects of early detection, health promotion, and prevention. Some of the specific objectives include: 1) reduce the number of youth in out-of-home residential settings and re-invest saved dollars to expand intensive outpatient services; 2) increase services to the 0-5 age group; 3) improve the level of family involvement at all levels of the system; and 4) implement a wider array of evidence-based practices (EBPs). The final draft of this 3-5 year plan has been circulated for comment to stakeholders within the District's child and youth system. The intent is to finalize the plan upon receipt, review, and revision of the feedback provided.

Early Childhood Prevention and Intervention Projects: These projects are presented below.

Early Childhood Mental Health Consultation Project (Healthy Futures)- This project involves child and family-centered, and program consultation for children age 0-5. It is currently serving 24 child development centers throughout the District. One (1) early childhood mental health specialist is placed in each center one (1) day per week to help identify children who need mental health interventions. As of June 30, 2011, the project had achieved the following: 1) 359 Early Childhood Teacher/Staff Consultations ; 2) 71 Early Childhood Parent Consultations ; and 3) 34 Early Childhood Presentations/Trainings. The program outcomes from the inception of this project (May 2010) have been positive. Georgetown University is providing project evaluation services.

Parent Infant Early Childhood Enhancement (P.I.E.C.E.)- This program targets children ages 6 and under with significant emotional/behavioral concerns who are often disruptive in pre-school, early school or home settings. It provides comprehensive assessments, relies heavily on parental involvement, and normally lasts 12-16 weeks for a given child/family. The staff have been trained on two (2) evidence-based practices: Incredible Years and Parent Child Interaction Therapy (PCIT). Social marketing for the program has begun for pre-schools, child care centers, physicians, etc.

Primary Project- This program is targeted to students with mild school adjustment problems and operates in 13 schools. Utilizing a standardized screening assessment, identified students are then connected with trained Child Associates, who work in child led play interventions for 30 minutes per week over 12-15 weeks. The findings for first and second years show significant improvement as measured by the Teacher Child Rating Scale or TCRS (Pre to Post) on all four (4) domains including: Task Orientation, Behavior Control, Assertiveness, and Peer Sociability. The program had to be reduced in scope in School Year 2010/2011 due to funding issues. DMH has continued to fund the overall supervision of the program and expects to restore funding in School Year 2011/2012.

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

School Mental Health Program (SMHP): The SMHP began with a SAMHSA Safe Schools Healthy Students Grant that provided school mental health services to 17 Public Charter Schools. In 2002 when the federal funding ended, DMH funded 10 of the Charter schools and expanded into 16 D.C. Public Schools (DCPS/Spingarn Cluster) with appropriated local dollars. The SMHP continued to expand and during School Year 2010-2011 it operated in 59 schools (50 DCPS and 9 Public Charter).

It operates a 2-tiered staffing model for the 59 schools. The SMHP provides full-time clinician services in the 45 Tier 1 schools and part-time services in the 14 Tier 2 schools. Of the 59 schools, 50 are in D.C. Public Schools (DCPS) and 9 in Public Charter Schools. Decisions about which schools participate in the SMHP program have been made jointly by DMH and staff within the Chancellor's office for the DCPS. These decisions are based largely on school readiness and the availability of other resources (e.g., school counselors and social workers).

The SMHP continues its model of providing not only direct treatment but also intervening via consultations with teachers, parents and others. It also provides general information/presentations to staff that are more focused on primary prevention. For School Year 2010/2011, the total number of referrals seen fell somewhat (6%) but there was a significant jump in some key service areas (e.g., family therapy up 24% and home visits up 79%). There was also a sharp 50% drop in the number of students referred for outside services. This is likely reflective of the degree of professional skill that SMHP staff are providing in a wide array of interventions. Also, being able to bill directly also provides an incentive.

The SMHP began using the Ohio Scales in School Year 2007/2008 to measure changes in problem severity as viewed by the student, the parents and by staff. The data over the past 3 years have consistently shown a significant reduction of behavioral and emotional symptoms after treatment as perceived by these groups.

Wraparound Initiative: This is a family-driven, team-based process for planning and implementing services and supports. Through the Wraparound process, Child and Family Teams create plans that are geared toward meeting the unique and holistic needs of children and youth with complex needs and their families. It is an effort to address the overreliance on the use of psychiatric residential treatment facilities (PRTFs) and non-public school placements for treatment and/or education of youth with intense mental, emotional, or behavioral health needs.

This initiative is a collaboration between DMH and District child-serving agencies that began with the care management contract to DC Choices in June 2008. The purpose of the contract is to implement community-based alternative services for District youth at risk for or returning from an out-of-home (PRTF) placement and for youth who have experienced multiple placements and/or hospitalizations. The D.C. Wraparound program served a total of 228 children/youth for the period of April 1, 2010 – March 31, 2011. Of this total, 177 were part of the DCPS School Wraparound project and the remaining 51 were from the Community Wrap program, which is directly tied to children/youth who can be diverted from PRTFs.

Establishing a Primary Family-Run Organization- DMH has established a partnership with one (1) Family-Run Organization, Total Family Care Coalition, to ensure that there

is a family member as co-trainer in trainings delivered within the DMH System of Care. The Family-Run Organization provides peer-delivered family support to families enrolled in the Wraparound and Child and Family Team process services. The Family-Run Organization will: 1) develop an orientation manual that clearly defines what family voice and choice really mean, and how to maximize the benefits of the Wraparound services for their child; 2) play a key role in the ongoing development of the District Children's System of Care; 3) expand to support and train family advocates for families of children with SED; 4) provide advocates who reflect the cultural and geographic profile of the populations of focus; and 5) serve as a centralized hub for information and referral assistance to families. During FY 2010, Total Family Care Coalition, through a contract with the Children and Youth Investment Corporation Trust, provided peer-delivered family support and 1:1 supervision and coaching for children with SED and their families. The CYSD will continue to offer peer-delivered family support services through Total Family Care Coalition for families enrolled in the Wraparound Child and Family Team process and to support the DMH core service agencies (CSAs) in engaging families.

Residential Treatment Center Reinvestment Program (RTC RP): The RTC RP conducts clinical monitoring for District children and youth placed in PRTFs, which includes DMH, Child and Family Services Agency (CFSA) or any other fee-for-service Medicaid placement. For the past year, DMH has also been monitoring all MCO children and youth after 30 days of placement. The primary activities include: conducting site visits, participating in treatment team meetings, facilitating and supporting discharge planning, and monitoring youth for six (6) months post discharge in the community.

Choice Providers: DMH continues to support the concept of a limited number of Choice Providers. The basic concept is to have more comprehensive and accessible services. The six (6) Choice Providers get some additional contracted dollars (ranging from \$15,000 - \$125,000) that can be used primarily for non-traditional services that are not otherwise covered by Medicaid (flex funds). CFSA has continued to provide funding to support the Choice Provider program in FY 2011.

Child and Youth Mobile Crisis Services: DMH continues to contract with Catholic Charities to provide Children and Adolescent Mobile Psychiatric Services (ChAMPS) for children and youth ages 16-21 and their families living in the District including children and youth in foster care placed in homes in Maryland and Virginia. ChAMPS provides on-site crisis stabilization via rapid response (within 1 hour of a call), and whatever follow-up visits needed to stabilize the family situation and/or connect the family to needed support services. The overall goal of the program is to maintain youth in the community and avert inpatient hospitalization, inappropriate use of emergency room services, and avoid placement-disruptions. As of June 30, 2011, ChAMPS received a total of 751 calls, of which 547 were deployable, and a response was made to 376 calls with an intervention provided.

Juvenile Behavioral Diversion Program (JB DP): The new Juvenile Mental Health Court began in January 2011. JB DP is a mental health based solution or specialty court that provides intensive case management to youth in the juvenile justice system with serious mental health concerns. The juvenile appears before the court for frequent reviews so the court may stay abreast of the progress. Routine and frequent contact allows the court to address challenges or

problems as they arise and for community mental health and treatment partners to provide input on a regular basis. Each juvenile is assigned a probation officer for coordinating case management, community supervision and monitoring to guide and support the youth through this process. DMH will provide mental health services.

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

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

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

Permanent Supportive Housing Plan (Housing First): The District of Columbia embraced the Permanent Supportive Housing (PSH) initiative to end chronic homelessness, and toward this end, DHS was charged with implementing a person-centric approach to implement this policy. Permanent supportive housing is a "housing first" approach and is defined as long-term, community-based housing that has supportive services for homeless persons with disabilities. The District's mental health consumers were also beneficiaries of this PSH initiative.

Housing and Urban Development (HUD) and Department of Veterans Affairs Supportive Housing (VASH) Program: This initiative is described under SAMHSA Strategic Initiative #3, Military Families. The District's Department of Human Services is the lead agency. The DMH Homeless Outreach Program provides outreach, engagement, and referral services for eligible veterans who are homeless that participate in this supportive housing initiative.

Homeless Prevention and Rapid Re-Housing Program: DHS and the Department of Housing and Community Development (DHCD) administer the Homeless Prevention and Rapid Re-Housing Program (HPRP). DHS contracted with four (4) eligibility providers that screen applications for this funding in addition to agencies that will provide case management, housing inspection, and legal assistance. DMH has a Memorandum of Understanding (MOU) with DHS that allows the DMH Homeless Outreach Program (HOP) to do case finding and screening. The individuals are then processed through one of the eligibility centers that provide intake and assistance in obtaining the services for which they qualify. The HPRP funding for DMH/HOP staff is still available and will likely be exhausted by the end of FY 2011. The DMH/HOP will continue to respond to DHS for continuing HPRP needs in particular and for homeless service assessments in general.

DMH Homeless Services: The DMH Homeless Outreach Team works closely with The Community Partnership for the Prevention of Homelessness (TCP). The data from the TCP January 2011 Point in Time Survey indicates that:

- 6,546 homeless singles and individuals in families were counted in the District of

Columbia;

- 2,509 individuals and families were chronically homeless according to the HUD definition;
- 305 were unsheltered on the night of the survey;
- Virtually the same number of persons are homeless who were homeless during the 2010 Point in Time Survey (6,539); and
- 1,274 were identified as having a serious and persistent mental illness.

Homeless Services Activities Programs and Activities: During FY 2011, DMH Homeless Services included the following programs: 1) Homeless Outreach Program (HOP), 2) Psychiatric Residency Program, and 3) Hermano Pedro Drop-In Center.

Homeless Outreach Program-The DMH HOP provides outreach, engagement, linkage, psychiatric treatment and follow-up services to individuals who are homeless. HOP consumers live on the streets, in abandoned vehicles and buildings, in temporary residences as well as low-barrier shelters and transitional programs. Reunification assistance is provided for individuals stranded in the District who are homeless and mentally ill through a collaborative relationship between HOP, Greyhound, and Travelers' Aid.

The HOP data for adults and children engaged for the period October 1, 2010 through June 30, 2011 is presented in the table that follows.

Adults (unduplicated count)	866
Children (unduplicated count)	95
Adults, Children & Families (face-to-face)	2,344

Psychiatry Residency Training- During FY 2011, the Community Psychiatry/Homeless Outreach Rotation was temporarily suspended, though Psychiatric Residents continued to engage homeless residents at the Court Urgent Care Clinic and at CPEP. Planning for resuming the Homeless Outreach Rotation occurred during FY 2011, and fourth year Residents will be placed in community-based settings (homeless shelters programs, drop-in programs, and street outreach programs). They will also participate concurrently in an academic course on Homeless Outreach and Community Psychiatry conducted jointly by Homeless Services and CPEP. Plans for FY 2012 are slated to have two (2) residents work with homeless consumers once a week for 4 hours; each resident would be at this rotation for 3 months and would serve with either DMH/HOP or a fixed-based homeless service site identified by HOP.

Hermano Pedro Day Socialization Program -This program provides a drop in center service for individuals who are homeless to attend during the day when many night shelters are closed. It was designed to offer hospitality services such as laundry facilities, lockers, showers, clothing, breakfast, lunch, service referrals and socialization activities. The referrals include: food stamps, Medicaid, disability benefits, housing referrals, employment and GED, and linking individuals to mental health, health, and substance abuse services. In addition, the program provides counseling, transportation assistance, and socialization groups (anger management, addictions), and social activities (movies, etc.).

Children, Youth and Families-The DMH HOP has hired staff to work with children/youth and their families who are homeless. The activities include but are not limited to the following:

- Regular visits to programs for families and children who are homeless;
- Make referrals and connect parents and children who are homeless to other DMH programs and services, including as appropriate school mental health, Multi-Systemic Therapy (MST), Community-Based Intervention (CBI), etc.;
- Provide training as necessary to family providers and the D.C. Metropolitan Police Department (in collaboration with the DMH Training Institute and The Community Partnership for the Prevention of Homelessness as appropriate);
- Arrange emergency or crisis services as needed;
- Assist with housing resources as appropriate;
- Develop Family Emergency Rounds case coordination activity to meet monthly with all providers of family services working with families who are at risk of losing their children, their housing or in psychiatric or substance abuse crisis;
- Regular participation in monthly meetings (Family Focus Group, DMH Children's Provider meeting); and
- Coordinate care with School Mental Health Program staff, Access HelpLine, Mental Health Rehabilitation Services (MHRS) providers, Children's National Medical Center, etc.

The anticipated result of this work is that DMH will engage 100 or more children/youth who are homeless each year, which is consistent with target for Dixon Exit Criterion #16 – Engagement of Homeless Children and Youth. The Dixon Court Monitor approved this Exit Criterion in the January 2010 Report to the Court; it is now in inactive monitoring status.

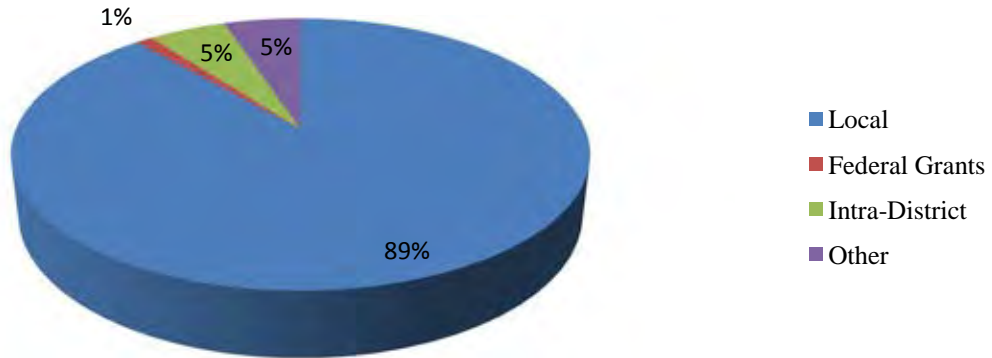
Criterion 5: Management Systems

Financial Resources: The District of Columbia’s approved fiscal year 2012 Program budget for the Department of Mental Health is \$176,110 million dollars. The breakdown of the FY2012 Budget by program category for DMH is as follows:

Mental Health Authority	\$21,634	(12%)
Mental Health Financing/Fee for Services	\$16,554	(9%)
Mental Health Services & Supports	\$57,182	(33%)
Saint Elizabeth’s Hospital	\$80,740	(46%)

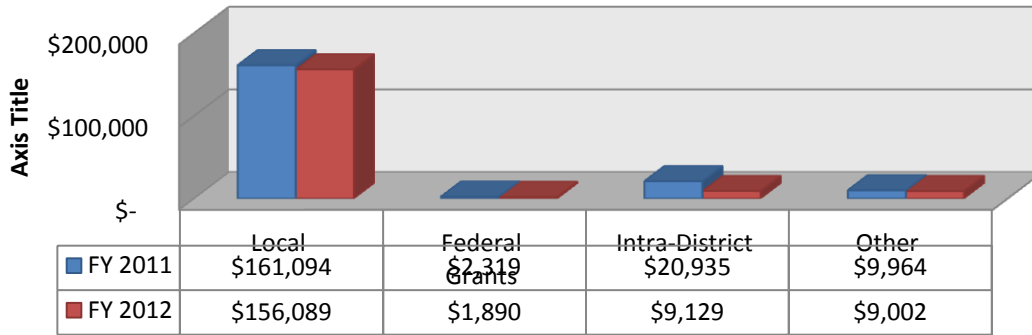
Total Fiscal Year 2012 DMH Program Budget **\$176,110**
(Dollars in millions)

DMH FY 2012 Budget Allocation \$176,110 Million



Revenue to support the budget comes from four major revenue sources. DMH’s **Local** funds are the largest funding source, and accounts for \$156,089 million or 89% of the FY2012 Budget. DMH’s fiscal year 2012 budget also has \$9,129 or 5% in **Intra-Districts**. The **Federal** funds cover \$1,890 or 1% of the budget and **Special Purpose Revenue funds/other** total \$9,002 or 5% of the FY 2012 budget.

**DMH
FY 2011 vs. FY 2012
Budget Comparison
(Dollars in Millions)**



Information Technology Resources: DMH continues to invest in systems that facilitate its role as manager of the public mental health service delivery network, which includes being both a provider and purchaser of services. The DMH Information Technology (IT) includes community systems and inpatient systems. A description of information technology resources is presented in Sections E (Data Information Technology) and M (Use of Technology) of this Application.

Staffing Resources: The total number of DMH staff as of June 30, 2011 is 1,122. This includes: 1) Mental Health Authority = 379, and 2) Saint Elizabeth’s Hospital = 743.

Filling Vacancies in FY 2011: Critical vacancies/positions filled in FY 2011 (October 1, 2010 through June 30, 2011) include the following:

- Psychiatric Nurse (21)
- Supervisory Psychiatric Nurse (4)
- Creative Arts Therapist (2)
- Behavioral Support Technician (1)
- Director of Facilities and Security (1)
- Supervisory Quality Improvement Coordinator (1)
- Quality Improvement Coordinator (1)
- Electrician (1)
- Director of Revenue Management (1)
- Addiction Treatment Specialist (1)
- Social Worker (3)
- Program Manager (1)
- Early Childhood Clinical Specialist (1)

- Supervisory Information Technology Specialist (1)
- Medical Officer (Psychiatry) (1)
- Psychiatric Residential Treatment Facility (PRTF) Coordinator (1)

During the fourth quarter of FY 2011, it is expected that additional key/critical positions will be filled. This will include the following positions:

- Social Worker (5)
- Nurse Practitioner (3)
- Nurse Consultant (1)
- Medical Officer (Psychiatry) (1)
- Senior Recovery Assistant (1)
- Psychiatric Nurse (50)
- Supervisory Psychiatric Nurse (3)
- Clinical Psychologist (4)
- Avatar Positions (10)
- Director of Business Operations (1)
- Supervisory Medical Officer (Psychiatry) (1)
- Supervisory Social Worker (1)
- Medical Officer (Psychiatry) (1)
- Information Technology Specialist (Project Manager) (1)
- Home and Community Based Services Coordinator (1)
- Practice Manager (1)
- PRFT Diversion & Technical Assistance Coordinator (1)

Human Resources Activities in FY 2011: A number of significant human resource development activities were undertaken during FY 2011. These include:

- Completion of the second cycle of the new e-Performance System for all DMH employees
- Management of District initiated Furlough Program for DMH employees
- Management of Reductions-in-Force (RIF's) for DMH employees
- Managed of regulatory ARPP/DEP activities for RIFFED employees
- Management of Early Out Program for DMH Civil Service eligible employees
- Attended Career Fairs for Nursing
- Planned and conducted On-Site Nursing Job Fair
- Conducted RIF counseling sessions for all affected employees
- Planned and coordinated a 6-week Mayor's Summer Youth Employment Program for 90 Summer Youth Participants
- Conducted Benefits Entitlement and Information Sessions for DMH employees
- In conjunction with the D.C. Office of Labor Relations, engaged in bargaining with four (4) DMH unions for re-openers of contracts

- Management of the Mandatory Drug and Alcohol Testing Program for DMH employees serving children and youth
- Actively participated in the District's Classification and Compensation Reform Project as subject matter and human resources experts
- Management of retroactive payment for Recovery Assistant Positions
- Management of the Criminal Background and Traffic Records Check Program for DMH employees

Planned Activities for the Fourth Quarter FY 2011: Some of the activities planned by the end of FY 2010 include:

- Complete Reduction-in-Force activity work
- Conduct ARPP/DEP regulatory activities
- Continue recruitment for identified key/critical positions including 50 direct-care nursing positions
- Manage the completion of the second e-Performance cycle for DMH
- Continue Random and Periodic Drug and Alcohol Testing
- Continue to actively participate in the District's Classification and Compensation Reform Project
- Manage the last phase of the FY 11 Furloughs
- Manage Mayor's Summer Youth Program for DMH
- Continue Criminal Background and Traffic Records Checks for DMH employees

Training Mental Health Service Providers:

DMH Training Institute: This Institute has evolved into a primary mental health workforce development training and community education medium for District agencies, human services providers, consumers, family members, and community residents. The Institute's training series provides a wealth of information on a range of topics. Over the years, partnerships have been established with consumer, family member, community, academic, professional, and federal and local government agencies. An important feature of the DMH Training Institute is the award of continuing education credit for several disciplines. A list of some of the course offerings for the past several years follows.

Service Providers of Emergency Health Services:

1. Disaster Training

- Understanding and Enhancing Cultural Competence in Disaster Mental Health Response (recurring training, offered two times)
- Essentials of Disaster Mental Health
- Stress Management and Self-Care in Disaster Response

- Critical Incident Stress Management (CISM): An Update; Nature and Recognition of Posttraumatic Syndromes
- Disaster Mental Health Screening and Assessment
- Psychological First Aid
- Grief, Loss, Suicide in the Wake of Disasters
- Ethical and Legal Issues in Disaster Mental Health
- Advanced Psychological First Aid
- Advanced Psychological First Aid (PFA) with Special Populations
- Crisis Counseling Program: Core Content Training
- Substance Abuse in Disasters; Suicide Prevention, Intervention and Postvention in Disasters
- National Incident Management System (NIMS) Training

2. Crisis Intervention Officer (CIO) Training

At the heart of the CIO initiative is the identification and development of experienced patrol officers to develop their skills to effectively and appropriately interact with persons who experience mental illness; as well as to work with other mental health and community support services to facilitate appropriate interactions and referrals with this population. A key component of the CIO Initiative is the 40-hour training program for law enforcement officers. This training includes: 1) basic information about mental illnesses and how to recognize them; 2) the local mental health system and local laws; 3) learning first-hand from consumers and family members about their experiences; and 4) verbal de-escalation training, and role-plays.

3. Mental Health and Substance Use Disorder: (Co-Occurring Disorders)

- Co-Occurring Disorders: Basic Principles & Clinical Competencies of Integrated Treatment (recurring training, offered two times)
- Co-Occurring Disorders: Stages of Change (recurring training, offered 3 times)
- Introduction to Co-Occurring Disorders
- Is your Program Co-Occurring Competent?
- Motivational Enhancement and Interviewing (recurring training, offered 2 times)

4. Health:

The NTU Approach to Health and Healing

5. Cultural Issues:

- Culturally and Linguistically Responsive Practice Training
- Diversity Training: Valuing Difference in a Changing Workforce
- Deaf Culture Sensitivity Training
- Cultural Competence in Mental Health Practice: Demystifying the Concept and Committing to the Journey

6. Transgender:

- Transgendered Mental Health Training
- Transgender Cultural Competency
- Addressing the Needs of LGBTQ Youth

7. Suicide:

- Lethality and Risk Assessment Training Providers
- Suicide Prevention & QPR: Question, Persuade and Refer (recurring training, offered 4 times)
- Youth Suicidal Risk Management (recurring training, offered 2 times)
- Suicide Risk Assessment and Treatment Planning for At-Risk Adolescents
- Reducing Suicide among LGBTQ Youth: Research, Public Policy & Educational Programming from The Trevor Project
- ASIST: Applied Suicide Intervention Skills Training (recurring training, offered 2 times)

8. Trauma:

- Creating Cultures of Trauma Informed Care
- The Trauma Recovery and Empowerment Profile (TREP)
- Working with Adult Survivors of Trauma: Key Concepts in Understanding Trauma Dynamics
- Staff Support Training in Trauma-Informed Care
- Updates on Diagnosis and Treatment of Psychological Trauma

9. Criminal Justice:

- Jail Diversion Models and Strategies

10. Child Victimization:

- Helping Keep Children Safe: The Identification and Reporting of Child Victimization

11. Teen Dating Violence:

- Domestic Violence 101: Teen Dating Violence for Teens
- Teen Dating Violence Training for Providers
- How to Talk the Talk: What You Need to Know about Teen Dating Violence
- Dynamics of Teen Dating Violence in a Clinical Setting

12. System of Care (Youth):

- System of Care Basic Training (recurring training, offered 5 times)
- Systemic Conceptualization & Treatment Planning for Youth with Serious Mental Health Challenge
- Effective Management of Severe Behaviors & Collaborating with Schools
- Effective Black Parenting Program Instructor Training Workshop: from the Center for the Improvement of Child Caring
- Chicago Parent Program Group Leader Training
- Child and Adolescent Mobile Psychiatric Services (ChAMPS) Utilization Data Presentation
- Meeting the Mental Health Needs of Youth Receiving Residential Treatment (recurring training, offered 6 times)
- Functional Family Therapy:
 - Introduction to Functional Family Therapy
 - Data Systems for Functional Family Therapy
 - Functional Family Therapy
- Community-Based Intervention :
 - Community-Based Intervention (recurring training, offered 7 times)
 - CBI Booster Training III: Intersystem Collaboration, Strengths and Culture Discovery, and Family Systems
 - CBI- Intensive Home and Community Based Service Philosophy, Parent Engagement and Respect
 - CBI-Intensive Home and Community Based Service Philosophy; Strength-based Engagement, Assessment, and Treatment Planning
 - CBI- Strength- Based Engagement, Assessment, and Treatment Planning and Parenting Skills
 - CBI- Cultural Competency and Family Systems
 - CBI- Differential Diagnosis and Case Conceptualization
 - CBI- Intersystem Collaboration, Child and Family Teaming, and Crisis Stabilization
 - CBI II and III Model Overview
 - CBI II and III: Strength-Based Eco-Systemic Assessment, Contextual Conceptualization and Treatment Planning
 - CBI II & III: Cultural Competency & Strength-Based Engagement; Parenting Youth w/Serous Emotional Disabilities from a Resiliency Perspective
 - CBI II and III: Intersystem Collaboration and Child and Family Teaming; Educational and Vocational Functioning
 - CBI II and III: Risk Assessment, Safety Planning; Family-Centered Assessment and Interventions
- Community and Home Based Intervention Services (CBI) Utilization Data

13. Community Service Review:

- 2009 Dixon Child Youth Review Data Presentation & Practice Development Workshop
- Teaming Formation and Functioning Practice Guidelines Protocol (recurring training, offered 5 times)
- New Child Reviewer Training CSR
- Child Reviewer Refresher Training (CSR)
- New Adult Reviewer Training (CSR)
- CSR Adult Refresher Training (CSR)
- Overview and Child System Performance Indicator Training

14. Diagnostic and Assessment:

- Diagnostic/Assessment Training for Child & Youth Providers
- Child & Adolescent Level of Care Utilization System (CALOCUS) Train-the-Trainer (recurring training, offered 8 times)
- Level of Care Utilization System (LOCUS) Train-the-Trainer (recurring training, offered 6 times)
- Overview of the LOCUS/CALOCUS & the DMH Quality Initiative
- Using the Ohio Scales to Inform Case Conceptualization and Ongoing Treatment Planning (recurring training, offered 3 times)

15. Ethical Practice:

- Ethical Practice in Contemporary Mental Health Practice
- Maintaining Professional Ethics and Boundaries with Consumers and Colleagues (recurring training, offered 2 times)
- Contemporary Clinical Ethics and Risk Management

16. Conflict Management:

- Conflict Management and Coaching for Mental Health Providers (recurring training, offered 8 times)

17. Crisis Intervention:

- Non-violent Crisis Intervention (recurring training, offered 8 times)

18. Crisis Counseling:

- Crisis Counseling Program: Core Content Training

19. Supervisory Skills:

- Strengthening Supervisory Skills (recurring training, offered 2 times)

Saint Elizabeths Hospital Partnership with the D.C. Psychological Association: The course offerings in FY 2011 include the following:

- Ethics in Professional Practice
- Cultural Foundations in Professional Practice

Saint Elizabeths Hospital Continuing Medical Education: The Saint Elizabeths Hospital/DMH, CME ROUNDS is jointly sponsored by MedChi The Maryland State Medical Society. A list of some of the course offerings for the past several years follows.

- Integrating Behavioral Health and Medical Care
- Meeting the Needs of Families: A Randomized Trial of the NAMI Family to Family Education Program
- Psychoeducational Groups for Psychiatric Inpatients
- Chronic Mental Illness and Metabolic Syndrome
- Suicidal Behavior In Prison
- Spring Depression and Suicide
- Suicidal Threats: Meaning and Management
- Principles of Psychodynamic Group Therapy
- The Art and Science of Dialectical Behavior Therapy
- The Therapeutic Use of Canines in Medicine and Psychiatry
- Diagnosis and Treatment of Drug Induced Movement Disorder in Psychiatric Patients
- Schizophrenia: Treatment Resistance
- Psychiatric Disorders in the HIV Clinic
- The Enduring Value of Psychoanalytic Psychotherapy: Survival and Healing in a Quick-Fix Culture
- Recognizing and Exploring Dissociative Processes – Dr. Richard A. Chefetz Learning to Engage a Mind Intent on Not Existing
- Treatment and Management of Sex Offenders
- Medical Treatment of Adult Sex Offenders
- Paranoia and Violence
- Recovery and Rehabilitation in Serious Mental Illness
- Recovering Psychiatry: Toward a New Way to Work
- Reducing Barriers to Treatment for Hepatitis C Infection In Patients with Substance Abuse and Mental Illness
- Respecting Psychiatric Patients' Autonomy
- Improving Treatment for Persons with Schizophrenia: Evidence-Based Practices and Recovery

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system

Page 22 of the Application Guidance

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Historically, as required by Statutory Criterion 2, DMH has reported the estimates of the need for mental health services based on the original 1999 and 2003 edition of the *Study of Mental Health Need and Services in the District of Columbia*; conducted by the University of Texas. These estimates are based on the National Co-morbidity Survey (NCS) and related surveys and are projected to the District based on data from the U. S. Census.

Description of Historical Estimation Methodology: In 1999, the University of Texas conducted a study of mental health need and services in the District of Columbia. 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 1999 through 2000. These estimates are based on the National Co-morbidity Survey (NCS) and related surveys and are projected to the District based on data from the U. S. Census.

The estimates for **Severe Emotional Disturbance (SED)** 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 estimates of **Serious Mental Illness (SMI)** 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 (SPMI)** 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.

RAND Study: As a result of the tobacco litigation settlement, the District retained the RAND Corporation (RAND) to conduct an assessment of the District’s healthcare delivery system mandated by The Community Access to Health Care Amendment Act of 2006. The purpose of the assessment was to: 1) study the health of District residents and the health care delivery system in the District; and 2) provide an informed assessment of policy options for improvement, including through the investment of the tobacco settlement funds. The assessment was originally planned to occur in two phases. RAND issued a Phase 1 report in January 2008 (WR-534) and a Phase 2 report on June 26, 2008 (WR-579). The Phase 2 report, titled “Assessing Health and Health Care in the District of Columbia” provided comprehensive data and recommendations regarding health conditions, needs and health care service delivery throughout the District. It also identified gaps in the knowledge base including inadequate data on mental health status and mental health and substance abuse service needs in the District, as well as, the serious difficulties faced by parents in getting behavioral health care for their children. RAND recommended a phase 3 study focusing solely on the behavioral health system (mental health and substance abuse treatment).

The phase 3 study began in May 2009. It focused on the behavioral health service delivery system including populations served, as well as the financing structure. The purpose of the RAND study is to make recommendations about the investment of the Community Health Care Financing Fund into the improvement of the District’s behavioral health system. RAND issued a Guide to the District’s Behavioral Health System (“Guide”) and its report on Behavioral Health in the District of Columbia: Assessing Need and Evaluating the Public System of Care (“RAND Report”) in October 2010. The Guide and the RAND Report are available on RAND’s website at www.rand.org. The link to the Guide is (http://www.rand.org/pubs/working_papers/WR777/). The link to the RAND Report is http://www.rand.org/pubs/technical_reports/TR914/. RAND identified a number of key findings and made recommendations in five (5) priority areas, which are discussed below. Several key findings related to unmet need and gaps in care for adults and children.

RAND conducted a subsequent study for Children’s National Medical Center, which focused on health and health care delivery among District youth. This study also found unmet need and gaps in care for children with behavioral health needs.

Study Process and Methods: The evaluation of the behavioral health care system builds on RAND's Phase 1 and Phase 2 reports. The approach also blends qualitative and quantitative methods and utilizes data from a wide range of sources, including survey data, administrative data, claims data, and data from focus groups and stakeholder interviews.

To estimate the prevalence of mental health disorders and substance use, RAND primarily used data from four surveys: the Behavioral Risk Factor Surveillance System (BRFSS); the National Survey of Drug Use and Health (NSDUH); the National Survey of Children's Health (NSCH); and the Youth Risk Behavior Survey (YRBS). To evaluate the utilization of behavioral health care services among District residents, administrative data from three (3) sources was used: 1) e-Cura (DMH electronic patient management and billing system); 2) Medicaid managed care claims data from managed care organizations operating in the District; and 3) District of Columbia Hospital Association data. For information about the functioning of the behavioral health care system, stakeholder interviews and focus groups were conducted.

Study Key Findings: The summary of the findings is based on analyses of: 1) the prevalence of mental health disorders, substance use, and substance use disorders among District residents; 2) utilization of public behavioral health services among District residents; and 3) stakeholder interviews and focus groups.

Prevalence of Behavioral Health Disorders: The prevalence of mental health disorders and estimated potential levels of unmet need for specific types of mental health care in the District, was described by using the best data available from a combination of the surveys cited above.

- The prevalence of mental health conditions in the District resembles patterns nationally, among both adults and youth. One exception is that, compared to children nationally, D.C. youth appear to have a higher percentage of parent-reported behavioral problems.
- Suicide attempts among District high school students are more common than among high school students nationally, and prevalence appears to be rising in the District. Among high school students who attempt suicide, District youth are twice as likely to require medical care because of an injury.

Potential unmet need for behavioral health care services:

- The analyses suggest that potentially several thousand District residents have unmet need for mental health care services for severe mental illness, and potentially 60% of adults and 72% of adolescents enrolled in Medicaid managed care who have depression have unmet need for depression services.
- Gaps in surveillance surveys made it impossible to estimate levels of potential unmet need among children with severe mental health conditions.
- Enrollees in the D.C. Healthcare Alliance (Alliance, a public program that provides access to health care to eligible District residents) and uninsured residents have significant mental health needs, with at least 12,000 adults and adolescents potentially having

depression alone. Utilization among these individuals is not captured systematically, and, therefore, the level of unmet need cannot be readily estimated.

Utilization of Public Behavioral Health Care Services: To the extent possible with available data, RAND analyzed the levels and types of service use among District residents served by the public behavioral health care system. Key findings were summarized related to use of services by enrollees in the District's Mental Health Rehabilitation Services (MHRS) programs; by adults and children enrolled in Medicaid managed care; by children with disabling mental health conditions enrolled in the Health Services for Children with Special Needs (HSCSN) program, a specialized managed care plan; and the use of emergency department (ED) services for mental health conditions among all District residents. Key findings relevant to this behavioral health needs assessment include:

- 60% of children and 54% of adults enrolled in MHRS have over 10 visits per year to a core service agency (CSA) treatment facility (a provider that contracts with DMH to provide mental health rehabilitation services).
- Approximately 16% of children and 15% of adults enrolled in MHRS have contact with the MHRS system only one (1) or two (2) times per year. For individuals undergoing active treatment for severe mental illness, such utilization rates are likely to be inadequate.
- 45% of children and 41% of adults enrolled in MHRS have gaps in care that exceed 6 months during a 12-month period, and 19% of children and 18% of adults have gaps of 10 months or longer.
- 11% of children and 17% of adult Medicaid managed care enrollees with mental health disorders who had at least some mental health services use had no outpatient visits over the course of 1 year but had one (1) or more inpatient admissions or visits to an emergency department (ED) during the same period.
- 30-day readmission rates for Medicaid managed care enrollees after a mental health hospitalization were 20% for children and 16% for adults.
- A substantial fraction of children with disabling mental health disorders receiving services through HSCSN had no mental health specialty visits, including nearly three-fourths of children with an emotional disturbance, two-thirds of children with adjustment disorders, more than half of children with a depressive disorder, and one-third of children with an episodic mood disorder.
- Approximately 10% of children with episodic mood disorders and 9% of children with emotional disturbance received care exclusively through the ED. Children with episodic mood disorders were far more likely to have multiple inpatient stays and repeated ED use compared to other HSCSN enrollees.

- The rate of ED use associated with schizophrenia is considerably higher in Wards 7 and 8 compared with all other parts of the District; rates are as much as twice the District-wide rate for most age groups.
- The rate of ED use associated with all mental health conditions among residents of Wards 7 and 8 is much higher than the District average.

Focus Groups and Stakeholder Interviews: Interviews were conducted with a wide range of individuals and organizations to provide insight into the behavioral health safety net system in the District of Columbia. The interviewees included: government employees from behavioral health agencies, providers of mental health and substance abuse services, primary care providers, insurance company executives, representatives of hospitals, local non-profit organizations, and researchers and experts on the delivery of behavioral health care.

Participants highlighted several major challenges to the optimal provision of behavioral health services in the District. Two (2) recurring themes were gaps in care and difficulties in coordination of care for particular populations and particular services. Other themes revolved around challenges related to housing, financing, information technology, and quality measurement.

Priority Areas

The RAND study identifies five (5) high-level priorities for the District and recommendations for addressing each priority. Four are specific to mental health. The five (5) priorities are:

- Work to reduce unmet need for public mental health care.
- Track and coordinate care for individuals in the public system with mental health diagnoses.
- Improve the availability and accessibility of substance abuse treatment services.
- Increase the coordination of care for individuals with co-morbid mental health and substance abuse conditions.
- Fundamentally upgrade the data infrastructure of the public behavioral health care system to allow for improved monitoring of service utilization, quality of care, and patient outcomes.

RAND Recommendations by Priority:

Priority Area 1: Work to reduce unmet need for public mental health care.

- Determine whether the existing patchwork system of care for individuals with mild to moderate mental health disorders who are uninsured or in the Alliance is sufficient for meeting their behavioral health needs.

- Consider investment in:
 - expanded mental health benefits for Alliance enrollees and or
 - free or discounted mental health treatment capacity, including through local clinics or free-standing mental health centers (FSMHCs).
- Establish formal systems to partner with local EDs and other organizations to identify individuals with SMI who are not linked to the MHRS system, to facilitate outreach, follow-up and linkage.

Priority Area 2: Track and coordinate care for individuals in the public system with mental health diagnoses.

- Develop systems to:
 - identify individuals with significant behavioral health problems who are already enrolled in the system via Medicaid, MHRS, or HSCSN;
 - set standards for minimally indicated care based on diagnoses; and
 - track progress toward ensuring that enrollees receive minimally indicated services.

Improvements in this area are likely to require significant care coordination and outreach to enrolled individuals.

Priority Area 3: Improve the availability and accessibility of substance abuse treatment services.

Strategies to address this priority area, include:

- expanding the referral and intake process for substance abuse treatment to additional locations;
- increasing marketing and outreach efforts;
- increasing capacity for providing buprenorphine as a treatment option; and
- leveraging Medicaid funding.

Priority Area 4: Increase the coordination of care for individuals with co-morbid mental health and substance abuse conditions.

Strategies to improve coordination include:

- establishing a unified credentialing system to allow providers with capabilities to serve mental health and substance abuse services to be dually credentialed by APRA and DMH in a streamlined process;
- cross-training providers in both substance abuse and mental health assessment and treatment to increase the number of providers who can treat individuals with co-occurring disorders so that persons with dual diagnoses can obtain quality care in one locale;
- developing a unified billing system in which providers can be reimbursed for mental

health and substance abuse services through a central mechanism, a step which may also encourage providers to become dually certified; and

- developing a uniform consent form that consumers would sign at the time of initial presentation for behavioral services in order to allow information to be shared between substance abuse and mental health providers and help overcome the ambiguities associated with the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA).

Priority Area 5: Fundamentally upgrade the data infrastructure of the public behavioral health care system to allow for improved monitoring of service utilization, quality of care, and patient outcomes.

The District's data infrastructure is not sufficient for tracking services, monitoring quality, and following health outcomes. Data are vital to the District's ability to promote provider efficiency, improve care coordination within and across agencies, and ensure high-quality service. Key issues include the following:

- Develop ways of identifying and tracking individuals with significant mental health disorders in Medicaid and establish consistent and timely analysis of Medicaid data that is received regularly and systematically from DHCF.
- Regular tracking of the prevalence and incidence of behavioral health conditions through continued analysis of population-level surveys (NSDUH, NSCH, and BRFSS) is needed. Consider the permanent addition of mental health screening questions to BRFSS.

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

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Start Year:

2012

End Year:

2013

Number	State Priority Title	State Priority Detailed Description
1	Service Utilization Analysis	Continue and complete the work of the DMH Service Utilization Task Force begun in FY 2011 in response to the RAND Report finding of large gaps in services for high percentages of DMH child and adult consumers in the MHS program.
2	APRA Co-Occurring Certification Project	Continue and complete the work of the DMH APRA Co-occurring Certification Project in response to the RAND Report finding that the care for individuals with co-occurring mental health and substance abuse disorders is not well coordinated.
3	Standardize Reporting Processes	Integrate key performance and outcome measures into standard reporting processes.
4	Juvenile Behavioral Health Diversion Program	Evaluate the Behavioral Health Diversion Program (JBDP), a problem solving court established in FY 2011, to address the mental health service needs of youth with severe mental illness who are at higher risk of re-offending.
5	Healthy Start	Develop performance indicators and database for the Healthy Start Project.
6	Parent Early Childhood Enhancement Program	Develop performance indicators and database for the Parent Early Childhood Enhancement Program.

Footnotes:

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

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Start Year:

2012

End Year:

2013

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
Service Utilization Analysis	Develop regular reports on MHRS service utilization patterns and gaps.	Develop metrics (age, gender, race/ethnicity, diagnostic category, service category, provider, visits prior to service gap, time between visits) for regular reporting and monitoring of service utilization patterns and gaps by September 30, 2012.	Service gaps (time between visits)	Data will be analyzed to evaluate average duration of service gaps, demographic differences, gaps by provider agency and service type. The report will help to investigate the impact of specific phases in care, such as risk factors for gaps in service delivery, including the initial enrollment period and transfers between provider agencies.
		1. Establish a regular meeting schedule during FY 2012. 2. Review legislation regarding staffing requirements for certification;		

<p>APRA Co-Occurring Certification Project</p>	<p>Develop and implement a joint DMH APRA Co-occurring Certification Process.</p>	<p>agency certification regulations; claims payment and utilization issues; co-occurring certifications in other jurisdictions; and other issues during FY 2012 - 2013. 3. Pilot the DMH APRA Co-Occurring Certification by September 30, 2013.</p>	<p>DMH APRA Co-Occurring Certification implemented.</p>	<p>The number of providers certified as "co-occurring enhanced."</p>
<p>Standardize Reporting Processes</p>	<p>Centralize the collection and reporting of program and system-level measures for availability and dissemination to key stakeholders and to inform quality improvement activities.</p>	<p>1. Develop child services data dashboards, containing metrics on service utilization, key program measures, and consumer outcomes for MHRS and other services within the public mental health system by April 2012. 2. Develop process for reporting and tracking data from aforementioned reports and other committee-level data to the Internal Quality Committee (IQC) by January 2012. 3. Develop SharePoint site and begin posting reports by December 2011.</p>	<p>Child service metrics and dashboards are finalized and reports disseminated monthly.</p>	<p>General report metrics to include, but not limited to the following: 1. service utilization year to date 2. number of consumer served by quarter and year to date 3. total annual expenditures for MHRS and locally funded services (jail diversion, integrated care, team meetings) 4. continuity of care 5. LOCUS/CALOCUS compliance 6. Demographic data (race, gender, age) 7. Consumer-level outcomes (e.g. employment, hospitalizations, living situation, change in LOCUS/CALOCUS scores).</p>
		<p>1. Develop both</p>		

Standardize Reporting Processes

Centralize the collection and reporting of program and system-level measures for availability and dissemination to key stakeholders and to inform quality improvement activities.

adult and child services data dashboards, containing metrics on service utilization, key program measures, and consumer outcomes for MHRS and other services within the public mental health system by April 2012. 2. Develop quarterly reports on. 3. Develop process for reporting and tracking data from aforementioned reports and other committee-level data to the Internal Quality Committee (IQC) by January 2012. 4. Develop SharePoint site and begin posting reports by December 2011.

System Performance and URS table metric and report formats are finalized and distributed quarterly.

General report metrics include, but not limited to the following: 1. service utilization year to date 2. number of consumers served by quarter and year to date 3. total annual expenditures for MHRS and locally funded services(jail diversion, integrated care, team meetings) 4. continuity of care (Dixon measure) 5. LOCUS/CALOCUS compliance 6. Demographic data (race, gender, age) 7 Consumer level outcomes (e.g. employment, hospitalizations, living situation, change in LOCUS/CALOCUS scores)

1. Develop both adult services data dashboards, containing metrics on service

<p>Standardize Reporting Processes</p>	<p>Centralize the collection and reporting of system-level measures for availability and dissemination to key stakeholders and to inform quality improvement activities.</p>	<p>utilization, key program measures, and consumer outcomes for MHRS and other services within the public mental health system by April 2012. 2. Develop process for reporting and tracking data from aforementioned reports and other committee-level data to the Internal Quality Committee (IQC) by January 2012. 3. Develop SharePoint site and begin posting reports by December 2011.</p>	<p>Adult service metrics and dashboard formats are finalized and reports disseminated monthly.</p>	<p>Integration of measures into centralized report that can be used by DMH leadership and other stakeholders; integration of reports into a common platform (SharePoint); and data driven decision making by the IQC and DMH programs. General report metrics to include, but not limited to the following: 1. service utilization year to date 2. number of consumer served by quarter and year to date 3. total annual expenditures for MHRS and locally funded services (jail diversion, integrated care, team meetings) 4. continuity of care 5. LOCUS/CALOCUS compliance 6. Demographic data (race, gender, age) 7. Consumer-level outcomes (e.g. employment, hospitalizations, living situation, change in LOCUS/CALOCUS scores).</p>
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<p>Juvenile Behavioral Health Diversion Program</p>	<p>Develop reports to capture the first 2 years of data from the operation of the JBDP</p>	<p>1. The Court Social Services Child Guidance Clinic (CSS-CGC) will develop an interim report on the first year of operation (January 3, 2011 – December 31, 2011) by February 2012. 2. The CSS-CGC will develop an evaluation of the first two years of operation (January 3, 2011 – December 31, 2012) by February 2013.</p>	<p>First year interim report and evaluation of first 2 years</p>	<p>Primary factors include issues related to diagnosis, treatment, and recidivism. Data sources include the screening assessments and other information (gender, age, race/ethnicity, grade, instant offense, violence exposure, Police Service Area for neighborhood tracking and associated mental health problems).</p>
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	<p>1. Develop additional performance</p>	
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Healthy Start	Develop performance indicators and data base for the Healthy Start Project.	measures and data base to be able to report program and outcome measures for the Healthy Start Project by September 30, 2012. 2. Implement data reporting and monitoring the performance measures in FY 2013.	To Be Determined	To Be Determined
Parent Early Childhood Enhancement Program	Increase the monitoring and reporting for the Parent Infant Early Childhood Enhancement (P.I.E.C.E.) Program.	1. Develop additional performance measures and data base to be able to report program and outcome measures for the P.I.E.C.E. Program by September 30, 2012. 2. Implement data reporting and monitoring the performance measures in FY 2013.	To Be Determined	To Be Determined

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 Services Purchased Using Reimbursement Strategy

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Start Year:

2012

End Year:

2013

Reimbursement Strategy	Services Purchased Using the Strategy
Grant/contract reimbursement	The District elected to continue with its past practice in distributing block grant funds, based upon an allocation made by the State Mental Health Planning Council. The Council solicits project proposals from DMH organizational components and community-based organizations. The Council selects projects for funding. The funds for the community-based organizations is issued through a sub-grant and payments are made in two (2) installments. Funding for the DMH programs is transferred in full to the organizational unit and spent down over the course of the project. A list of the funding projects that identifies the amount of the project and the SAMHSA strategic initiative associated with the project is included in the response to section H - Service Management Strategies.

Footnotes:

The awards to the 13 community providers are limited to under \$20,000 each and are intended to provide seed funds to fund new or promising practices, serve identified target populations and address SAMHSA identified priority goals. The bulk of the funding is allocated to DMH-operated programs: expansion of an early intervention program and housing subsidies for adults. \$24,691.00 was reserved for the State Mental Health Planning Council to fund meeting costs and any public education initiatives that are identified by the Council. Details about the projects that were selected is found in the response to section H regarding service management strategies.

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 Projected Expenditures for Treatment and Recovery Supports

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Start Year:

End Year:

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	<ul style="list-style-type: none"> • General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services 	<10% <input type="text" value="6"/>
Engagement Services	<ul style="list-style-type: none"> • Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach 	<10% <input type="text" value="6"/>
Outpatient Services	<ul style="list-style-type: none"> • Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers 	<10% <input type="text" value="6"/>
Medication Services	<ul style="list-style-type: none"> • Medication management • Pharmacotherapy (including MAT) • Laboratory services 	N/A <input type="text" value="6"/>
Community Support (Rehabilitative)	<ul style="list-style-type: none"> • Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services 	26-50% <input type="text" value="6"/>
Recovery Supports	<ul style="list-style-type: none"> • Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care 	<10% <input type="text" value="6"/>
Other Supports (Habilitative)	<ul style="list-style-type: none"> • Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services 	<10% <input type="text" value="6"/>

- Recreational services
- Interactive Communication Technology Devices
- Trained behavioral health interpreters

Intensive Support Services

- Substance abuse intensive outpatient services
- Partial hospitalization
- Assertive community treatment
- Intensive home based treatment
- Multi-systemic therapy
- Intensive case management

N/A 6

Out-of-Home Residential Services

- Crisis residential/stabilization
- Clinically Managed 24-Hour Care
- Clinically Managed Medium Intensity Care
- Adult Mental Health Residential
- Adult Substance Abuse Residential
- Children's Mental Health Residential Services
- Youth Substance Abuse Residential Services
- Therapeutic Foster Care

N/A 6

Acute Intensive Services

- Mobile crisis services
- Medically Monitored Intensive Inpatient
- Peer based crisis services
- Urgent care services
- 23 hour crisis stabilization services
- 24/7 crisis hotline services

N/A 6

Prevention (Including Promotion)

- Screening, Brief Intervention and Referral to Treatment
- Brief Motivational Interviews
- Screening and Brief Intervention for Tobacco Cessation
- Parent Training
- Facilitated Referrals
- Relapse Prevention /Wellness Recovery Support
- Warm line

26-50% 6

System improvement activities

<10% 6

Other

N/A 6

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 Primary Prevention Planned Expenditures Checklist

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Start Year:

End Year:

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Information Dissemination	Selective	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Information Dissemination	Indicated	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Information Dissemination	Unspecified	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Information Dissemination	Total	\$	\$	\$	\$	\$
Education	Universal	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Education	Selective	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Education	Indicated	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Education	Unspecified	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Education	Total	\$	\$	\$	\$	\$
Alternatives	Universal	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Alternatives	Selective	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Alternatives	Indicated	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Alternatives	Unspecified	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Alternatives	Total	\$	\$	\$	\$	\$
Problem Identification and Referral	Universal	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Problem Identification and Referral	Selective	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Problem Identification and Referral	Indicated	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Problem Identification and Referral	Unspecified	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Problem Identification and Referral	Total	\$	\$	\$	\$	\$

Community-Based Process	Universal	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Community-Based Process	Selective	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Community-Based Process	Indicated	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Community-Based Process	Unspecified	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Community-Based Process	Total	\$	\$	\$	\$	\$
Environmental	Universal	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Environmental	Selective	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Environmental	Indicated	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Environmental	Unspecified	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Environmental	Total	\$	\$	\$	\$	\$
Section 1926 Tobacco	Universal	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Section 1926 Tobacco	Selective	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Section 1926 Tobacco	Indicated	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Section 1926 Tobacco	Unspecified	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Section 1926 Tobacco	Total	\$	\$	\$	\$	\$
Other	Universal	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Other	Selective	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Other	Indicated	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Other	Unspecified	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
Other	Total	\$	\$	\$	\$	\$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 Projected State Agency Expenditure Report

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Start Year:

End Year:

Date of State Expenditure Period From:

Date of State Expenditure Period To:

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
2. Primary Prevention	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
3. Tuberculosis Services	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
4. HIV Early Intervention Services	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
5. State Hospital		\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
6. Other 24 Hour Care	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
7. Ambulatory/Community Non-24 Hour Care	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
8. Administration (Excluding Program and Provider Level)	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
9. Subtotal (Rows 1, 2, 3, 4, and 8)	\$	\$	\$	\$	\$	\$
10. Subtotal (Rows 5, 6, 7, and 8)	\$	\$	\$	\$	\$	\$
11. Total	\$	\$	\$	\$	\$	\$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditures Checklist

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Start Year:

End Year:

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment	\$ <input type="text"/>		\$ <input type="text"/>			\$
2. Quality Assurance	\$ <input type="text"/>		\$ <input type="text"/>			\$
3. Training (Post-Employment)	\$ <input type="text"/>		\$ <input type="text"/>			\$
4. Education (Pre-Employment)	\$ <input type="text"/>		\$ <input type="text"/>			\$
5. Program Development	\$ <input type="text"/>		\$ <input type="text"/>			\$
6. Research and Evaluation	\$ <input type="text"/>		\$ <input type="text"/>			\$
7. Information Systems	\$ <input type="text"/>		\$ <input type="text"/>			\$
8. Total	\$	\$	\$	\$	\$	\$

Footnotes:

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

Page 41 of the Application Guidance

Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

DMH does not currently offer any services that meet SAMHSA's definition of participant-directed or self-directed services.

DMH affords consumers "choice" with regard to the selection of community-based providers and individual practitioners. Consumers are encouraged to actively participate in the development of treatment plans. DMH rules and policies relating to consumer choice and participation in treatment planning are attached and marked as Attachments D-1 through D-6.

Consumers are also encouraged to exercise their rights as further described below. However, the DMH system does not currently afford individuals with opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency.

There is a robust consumer grievance system, known as FAIR (Finding Answers, Improving Relationships). FAIR is managed by the Office of Consumer and Family Affairs (OCFA).

DMH funds two (2) consumer-run organizations: 1) the Consumer Action Network (CAN); and 2) the Ida Mae Campbell Wellness and Resource Center. Both CAN and the Ida Mae Campbell Center provide training and advocacy support to consumers. CAN and University Legal Services, the District's PAIMI provide support to consumers in filing and pursuing grievances. DMH also funds the Total Family Care Coalition, which is the family support organization. The roles of CAN, the Ida Mae Campbell Center and the Total Family Care Coalition and their roles within the public mental health system are further described in the response to Section L, Involvement of Individuals and Families.

DMH also contracts with the local chapter of the National Alliance for Mental Illness (NAMI-DC) to provide a range of family and consumer education and training activities as well as family-to-family support and community outreach.

In December 2010, DMH OCFA sponsored its third Annual Olmstead Conference in collaboration with the D.C. Office of Disability Rights. The theme was "Community Inclusion-Building Resources and Safety Nets." Approximately 250 consumers and staff attended. OCFA will work with the D.C. Office of Disability Rights to plan and sponsor another Olmstead Conference in FY 2012.

In 2011, DMH's Training Institute collaborated with the Ida Mae Campbell Foundation to provide additional consumer-focused training. Training topics produced through this collaboration included: Introduction to Intentional Peer Support, Self Employment, Self Advocacy 101, Introduction to Self-Determination, and Introduction to Supported Employment.

Excerpts from 22-A DCMR, Chapter 34

MHRS Certification Standards: Consumer Choice and Treatment Planning

3406. CONSUMER CHOICE

3406.1 Each MHRS provider shall establish and adhere to policies and procedures governing the means by which consumers shall be informed of the full choices of MHRS providers, qualified practitioners and other mental health service providers available, including information about peer support and family support services and groups and how to access these services (MH Consumer Choice Policy).

3406.2 DMH shall review and approve each MHRS provider's MH Consumer Choice Policy during the certification process.

3406.3 The MH Consumer Choice Policy shall comply with applicable federal and District laws and regulations.

3406.4 Each MHRS provider shall:

- (a) Make its MH Consumer Choice Policy available to consumers and their families; and
- (b) Establish and adhere to a system for documenting that consumers and families receive the MH Consumer Choice Policy.

3406.5 Each CSA's MH Consumer Choice Policy shall ensure that each enrolled consumer:

- (a) Requesting MHRS directly from the CSA is informed that the consumer may choose to have MHRS provided by any of the other DMH-certified CSAs;
- (b) Enrolled in the CSA is informed that the consumer may choose to have MHRS provided by any of the DMH-certified sub-providers that have entered into affiliation agreements with that CSA;
- (c) Enrolled in the CSA is informed that the consumer may choose to have MHRS provided by any of the qualified practitioners employed by or contracted by the CSA to provide MHRS, including qualified practitioners providing MHRS through one of the CSA's subcontractors; and
- (d) Enrolled in the CSA is informed that the consumer may choose to have MHRS provided by any of the DMH-certified specialty providers that have entered into affiliation agreements with that CSA.

- 3406.6 Each sub-provider's MH Consumer Choice Policy shall ensure that each consumer:
- (a) Enrolled in a CSA requesting MHRS directly from the sub-provider is directed to that CSA for Diagnostic/Assessment and IRP/IPC development and approval;
 - (b) Not enrolled in a CSA and requesting MHRS directly from the sub-provider is directed to DMH's Consumer Enrollment and Referral System; and
 - (c) Enrolled in a CSA and referred by that CSA to the sub-provider for MHRS is informed that the consumer may choose to have MHRS provided by any of the qualified practitioners employed by or contracted by the sub-provider to provide MHRS, including the sub-provider's subcontractors.

- 3406.7 Each specialty provider's MH Consumer Choice Policy shall ensure that each consumer:
- (a) Enrolled in a CSA requesting MHRS directly from the specialty provider is directed to that CSA for Diagnostic/Assessment and IRP/IPC development and approval;
 - (b) Not enrolled in a CSA and requesting MHRS directly from the specialty provider is directed to DMH's Consumer Enrollment and Referral System; and
 - (c) Enrolled in a CSA and referred by that CSA to the specialty provider for MHRS is informed that the consumer may choose to have MHRS provided by any of the qualified practitioners employed by or contracted by the specialty provider to provide MHRS, including the specialty provider's subcontractors.

3407. TREATMENT PLANNING PROCESS

3407.1 Each CSA shall coordinate the treatment planning process for its enrolled consumers, except that the treatment planning process for consumers authorized to receive:

- (a) CBI shall be coordinated by the consumer's CBI provider; and
- (b) ACT services shall be coordinated by the consumer's ACT provider.

3407.2 The treatment planning process for consumers shall, at a minimum, include:

- (a) The completion of a Diagnostic/Assessment service and required components as described in section 3415;
- (b) Development of an IRP/IPC as described in section 3408; and
- (c) Consideration of the consumer's beliefs, values, and cultural norms in how, what, and by whom MHRS are to be provided.

3407.3 Court-appointed guardians for adults, children and youth and the parents or family members of children and youth shall be involved in the treatment planning process. The families and significant others of adult consumers may participate in the treatment planning process to the extent that the adult consumer consents to the involvement of family and significant others.

3408. IRP/IPC DEVELOPMENT AND IMPLEMENTATION

3408.1 The IRP/IPC shall serve as authorization for the provision of MHRS. Certain services require pre-authorization or authorization by DMH, prior to commencement of the treatment planning process. All services, including those that require pre-authorization or authorization by DMH shall be addressed in the IRP/IPC.

3408.2 The IRP/IPC shall serve as certification that the MHRS are medically necessary as indicated by the approving practitioner's signature on the initial and subsequent IRP/IPC. The approving practitioner's approval of an IRP/IPC shall occur by the fourth visit or within thirty (30) calendar days after the consumer enrolls with the CSA, whichever occurs first.

3408.3 Each CSA shall develop and maintain a complete and current IRP/IPC for each enrolled consumer. The CSA is responsible for coordinating the development of the IRP/IPC with any sub-provider or specialty provider involved in the provision of services.

3408.4 Development of the IRP/IPC shall commence after the first clinical contact with the consumer, so that payment may be made for MHRS delivered consistent with the initial IRP/IPC. Consumers in a crisis situation who are eligible for ACT, CBI or Crisis/Emergency shall receive such services while the IRP/IPC is being developed.

3408.5 The IRP/IPC shall include the following elements:

- (a) A description of the consumer's strengths or assets and challenges and how the consumer's strengths and assets will be utilized in achieving treatment goals.
- (b) A statement of the mutually desired overall long-term results of each intervention, intermediate steps to be taken to achieve those long-term results and the overall treatment being provided for the consumer (Treatment Goals). Treatment Goals shall be based on the consumer's expressed needs and needs identified through Diagnostic/Assessment services, and referral information.
- (c) A statement of the specific consumer or family skills that need to be developed or improved. This statement shall identify services and resources that need to be changed or modified to achieve each Treatment Goal (Objectives). Objectives shall be stated in terms of attainable and measurable results.

Attachment D-1

- (d) A description of the interventions to be used to achieve each Objective and Treatment Goal including, but not limited to:
 - (1) A staff position or service component responsible for the intervention;
 - (2) The names of other agencies (and other human services systems if applicable) providing services for the consumer, a description of the service being provided, identification by name and title of the staff persons of those agencies or systems of care responsible for providing such services, and evidence of interagency service coordination;
 - (3) The intervention by service type, with the IRP/IPC identifying all services related to the provision of mental health services, regardless of the payment source for the service;
 - (4) The frequency and duration of the interventions;
 - (5) For each service, the MHRS provider chosen by the consumer; and
 - (6) A plan for addressing any medical problems that significantly impact or could be expected to affect the consumer's functioning which is to be carried out by either the CSA or another health-providing organization or practitioner.
- (e) Development of psychiatric advance instructions, advance directives, crisis prevention plan, and relapse prevention plan.

3408.6 The clinical manager shall discuss the IRP/IPC with the consumer on an ongoing basis.

3408.7 Specific information describing the consumer's response to, participation in and agreement to the IRP/IPC shall be recorded in the consumer's clinical record.

3408.8 The clinical manager shall document the consumer's participation in the development of the IRP/IPC by obtaining the consumer's signature on the IRP/IPC, and documenting the consumer's own words used to communicate with the Diagnostic/Assessment Team. A court-appointed guardian for adults, children and youth and the parent or family member of children and youth consumers may sign the IRP/IPC, if required by District laws and regulations.

3408.9 In situations where the consumer does not demonstrate the capacity to sign or does not sign the IRP/IPC, the reasons the consumer does not sign shall be recorded in the consumer's clinical record, including each date where signature was attempted

3408.10 The approving practitioner and the clinical manager shall sign the IRP/IPC.

Attachment D-1

- 3408.11 The clinical manager has an affirmative obligation to ask the consumer to document participation and agreement with the IRP/IPC at each subsequent encounter if the consumer did not sign the IRP/IPC.
- 3408.12 Documentation of participation of the consumer's court-appointed guardian, family and significant others in the development of the IRP/IPC shall also be included in the consumer's clinical record, as appropriate.
- 3408.13 Each MHRS provider shall develop policies and procedures for IRP/IPC review (IRP/IPC Review Policy). The IRP/IPC Review Policy shall be part of the MHRS provider's Treatment Planning Policy as required by § 3410.12.
- 3408.14 The IRP/IPC Review Policy shall require that the IRP/IPC be reviewed and updated every one hundred eighty (180) days and at any time there is a significant change in the consumer's condition or situation to reflect progress toward or the lack of progress toward the Treatment Goals. The IRP/IPC may be reviewed more frequently, as necessary, based on the consumer's progress or circumstances.
- 3408.15 Each IRP/IPC review shall include a review of each of the items stated in § 3408.5 including progress on Treatment Goals, re-identification of strengths and progress on Objectives.
- 3408.16 The consumer, the consumer's clinical manager, approving practitioner and other qualified practitioners as necessary or appropriate shall establish new Objectives and modify, add or delete Treatment Goals based on the results of the IRP/IPC review, the consumer's assessment of progress toward meeting Treatment Goals and any new needs, and any other assessments provided by significant others, family or other professionals.
- 3408.17 At least the approving practitioner and the consumer shall participate in the IRP/IPC review.
- 3408.18 At the IRP/IPC review, the approving practitioner shall identify all required MHRS re-authorizations and establish a target date for requesting the re-authorizations well in advance of their expiration dates.
- 3408.19 The approving practitioner shall document the consumer's participation in the IRP/IPC review by obtaining the consumer's signature on the revised IRP/IPC. A court-appointed guardian for adults, children and youth and the parent or family member of children and youth consumers may be required to sign the revised IRP/IPC, if required by District laws and regulations.

Attachment D-1

3408.20 Documentation of participation of the consumer's court-appointed guardian, family and significant others in the review of the IRP/IPC shall also be included in the consumer's clinical record, as appropriate.

3409. IRP/IPC GUIDING PRINCIPLES AND ADDITIONAL REQUIREMENTS

3409.1 Each IRP/IPC shall:

- (a) Be person-centered;
- (b) Include the consumer's self-identified recovery goals; and
- (c) Provide for the delivery of services in the most normative, least restrictive environment that is appropriate for the consumer.

DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Mental Health, pursuant to the authority set forth in section 114 of the District of Columbia Department of Mental Health Service Delivery Reform Act of 2001, effective December 18, 2001 (D.C. Law 14-56; D.C. Official Code §§ 7-1131.01 *et seq.*) (Act), hereby adopts the following new Chapter 3, of Title 22A of the D.C. Code of Municipal Regulations, entitled "Consumer Grievance Procedures." Chapter 3, Title 22A, DCMR sets forth the rules regarding the resolution of complaints and grievances regarding violations of the rights or protections guaranteed to consumers of mental health services and supports.

Earlier versions of these rules were published as proposed rules on February 22, 2002 at 49 D.C. Reg. 1681, on July 26, 2002 at 49 D.C. Reg. 7205, and on January 31, 2003 at 50 D.C. Reg. 1008. Clarifying revisions have been made to the rules since their last publication as proposed rulemaking. These final rules will be effective upon publication in the D.C. Register.

Title 22A DCMR is amended by adding the following new Chapter 3:

CHAPTER 3

**DEPARTMENT OF MENTAL HEALTH
CONSUMER GRIEVANCE PROCEDURES**

300 PURPOSE AND APPLICATION

300.1 The purpose of these rules is to protect and enhance the rights and protections of consumers by establishing the specific procedure for response to and impartial resolution of grievances.

300.2 The rules in this Chapter are applicable to each mental health provider (MH provider) and the Department of Mental Health (DMH). References to DMH may refer to DMH when it is acting in its capacity as the Mental Health Authority for the District of Columbia.

301 CONSUMER RIGHTS AND PROTECTIONS PROCEDURE

301.1 Each MH provider shall establish and adhere to a Consumer Rights Policy. The MH provider's Consumer Rights Policy must be approved by the MH provider's governing authority and DMH, and contain, at a minimum, the following:

- (a) A Consumer Rights Statement published by DMH;
- (b) A copy of the MH provider's Grievance Procedure established in accordance with § 306;
- (c) The telephone number for any independent peer advocacy programs established in accordance with § 302.1; and
- (d) The following statement: "You may also have the option to initiate a grievance with any or all of several outside entities, including but not limited to the Office of Administrative Review and Appeals at the Department of Human Services, the U.S. Department of Health and Human Services, and the District of Columbia's program for the protection and advocacy for persons with mental illness. For further information, contact the Department of Mental Health's Access Hotline or its web site."

301.2

Within one hundred eighty (180) days of the effective date of these rules, each MH provider shall submit to DMH its written Consumer Rights Policy, including the MH Provider Grievance Procedure, for approval. DMH must approve the Consumer Rights Policy of each MH provider in order for the MH provider to be certified and licensed by DMH.

- (a) A MH provider shall submit subsequent substantive changes to its Consumer Rights Policy or MH Provider Grievance Procedure to DMH for approval before implementation of the changes by the MH provider.
- (b) A MH provider may continue to utilize existing consumer grievance policies approved by DMH in the certification process for MH providers, until the MH provider adopts a new procedure consistent with §§ 304 through 306 and approved by DMH as required by this section 301.2.

301.3

Each MH provider shall disseminate its Consumer Rights Policy in ways designed to foster consumer understanding, including, at a minimum:

- (a) A MH provider shall provide a copy of its Consumer Rights Policy to each consumer at his or her initial appointment with the provider or at the next appointment. At the same time the MH provider shall also offer a verbal explanation of the Policy to the consumer and provide such explanation upon request.
- (b) The consumer, and his or her legal guardian if present, shall sign a DMH-approved form acknowledging receipt of the Policy and any

verbal explanation. The receipt form shall be placed in the consumer's clinical record.

- (c) If the consumer elects not to sign the receipt form, the reasons given for not signing shall be recorded on the form.
- (d) In the event of a crisis or other emergency at the initial or next appointment that prevents a written and verbal explanation of the Consumer Rights Policy, the consumer shall be verbally advised of, at a minimum, the consumer's immediately pertinent rights and protections, such as the right to consent to or to refuse the offered treatment and the consequences of that consent or refusal. In such cases, distribution and explanation of the Consumer Rights Policy shall be accomplished at the consumer's next appointment and the reason for the delay shall be documented on the receipt form.
- (e) Each MH provider shall post a copy of the Consumer Rights Policy in strategic and conspicuous locations in each building operated by the provider, and shall make additional copies of the Consumer Rights Policy available to consumers, parents, guardians, family, designated personal representatives and staff upon request.
- (f) Each MH provider shall ensure that every current staff member, including administrative, clerical, and support staff, is knowledgeable about its Consumer Rights Policy when its grievance procedure goes into effect. Each MH provider shall also establish a means of ensuring that all new staff members who are hired in the future are knowledgeable about its Consumer Rights Policy.

302 INDEPENDENT PEER ADVOCACY PROGRAMS

302.1 DMH shall facilitate and provide funding to establish one or more peer advocacy programs independent of all MH providers to assist consumers throughout the grievance process, including filing a grievance, accompanying consumers to meetings, helping consumers gather relevant information, and presenting the information in any subsequent proceedings. A peer advocacy program may provide services to consumers in addition to assistance with grievances.

302.2 The responsibilities of a peer advocacy program established under § 302.1 shall include:

- (a) Recruit and collaborate with DMH to train independent peer advocates;

- (b) Ensure that independent peer advocates abide by all federal and local requirements for the confidentiality of consumer information;
 - (c) Ensure that each independent peer advocate continues to provide services in a satisfactory manner;
 - (d) Provide an intake function that permits consumers to submit requests for assistance twenty-four (24) hours per day, seven (7) days per week; and
 - (e) Ensure that an independent peer advocate is available for individual consultation no later than twenty-four (24) hours after a consumer has submitted a request for assistance pursuant to § 302.2 (d) above.
- 302.3 An independent peer advocate shall not assist a consumer with a grievance against a MH provider from which the peer advocate is currently receiving mental health services or supports, unless the consumer consents in writing to such assistance.
- 302.4 The existence of an independent peer advocacy program is not intended to replace or discourage the use of any consumer advocacy programs a MH provider may offer.
- 303 CORE SERVICES AGENCY TRANSITIONAL PEER ADVOCACY PROGRAM**
- 303.1 Within thirty (30) days from the effective date of these rules and until such time as DMH notifies MH Providers that an Independent Peer Advocacy Program has been established in accordance with § 302, each Core Services Agency (CSA) shall maintain an internal peer advocacy program.
- 303.2 Each CSA shall appoint one or more peer advocates who shall be available to provide information and advice to consumers and to act as representatives of consumers who have filed or contemplate filing a grievance.
- 303.3 Each CSA shall make consumers aware of the availability of peer advocates and shall ensure that consumers have reasonable access to peer advocacy services.
- 303.4 Each CSA peer advocate shall complete a training course provided by DMH.
- 303.5 A CSA may elect to establish a permanent peer advocacy program at any time.

304 GRIEVANCE PROCEDURE – GENERAL PROVISIONS

- 304.1 A grievance is the expression by any individual of his or her dissatisfaction with either DMH or a MH provider, including the denial or abuse of any consumer right or protection provided by applicable federal and District laws and regulations. A grievance will not be entertained if it complains of a specific action that occurred more than six (6) months prior to the filing of the grievance, absent extenuating circumstances.
- 304.2 DMH shall establish a grievance procedure (Grievance Procedure) that complies with applicable federal and District laws and regulations and that is available to all consumers and other interested parties. As part of the Grievance Procedure, each MH provider shall establish and adhere to an internal grievance procedure for its consumers (MH Provider Grievance Procedure) that has been approved by DMH according to § 301.2.
- 304.3 Consumers are not required to utilize the Grievance Procedure. Consumers may pursue other legal, administrative, or informal relief in lieu of or concurrently with filing a grievance.
- 304.4 Any consumer who believes he or she has been denied a service for which the consumer is eligible under Medicaid may file a grievance with the Office of Fair Hearings at the Department of Human Services, pursuant to D.C. and federal law. A Medicaid consumer who has a grievance regarding the receipt, termination, amount, kind, or conditions of Medicaid services is not required to go through DMH or MH Provider Grievance Procedures before filing a grievance with the Office of Administrative Review and Appeals, which is part of the Department of Human Services.
- 304.5 A MH provider's continuing obligations to safeguard the welfare of consumers, including the filing of Unusual Incident reports and other reports of allegations of abuse or neglect, are not affected by the Grievance Procedure.
- 304.6 Mental health services and mental health supports shall continue without limitation, reduction, or termination pending resolution of grievances regarding such mental health services and mental health supports.
- 304.7 Neither DMH nor a MH provider shall retaliate against the consumer or his or her representative in any way because the consumer filed a grievance. An allegation of retaliation shall be treated and filed as a new grievance against the MH provider or DMH.
- 304.8 DMH may institute proceedings to revoke or suspend a MH Provider's certification and/or licensure or to impose other sanctions if:

- (a) DMH substantiates an allegation that the MH provider retaliated against a consumer, or his or her representative, for filing a grievance;
- (b) The MH provider fails to obtain approval of either its MH Provider Grievance Procedure or changes to its MH Provider Grievance Procedure as required by § 301.2;
- (c) The MH provider fails to abide by or implement a final decision by DMH in response to a grievance;
- (d) The MH provider fails to take actions identified to rectify situations that have lead to abuse or neglect of consumers; or
- (e) The MH provider evidences a pattern of untimely or incomplete responses to consumer grievances, or fails to complete action promised by the MH provider in response to a grievance.

304.9 The written explanation of the DMH Grievance Procedure and of each MH Provider Grievance Procedure shall include the language in § 304.7 in a type size and style that stands out from the surrounding text.

305 FILING A GRIEVANCE

305.1 All consumers shall have the right to file a grievance with DMH. If a consumer's grievance involves a specific MH provider, DMH shall ensure that the MH provider has responded to the grievance in a timely manner, before initiating its prompt and impartial review of the grievance. All grievances involving a specific mental health professional shall be treated as involving the MH provider that employs or contracts with the mental health professional.

305.2 Grievances may be expressed orally or in writing. Oral grievances shall be reduced to writing. Each MH provider shall ensure consumers have access to all assistance they need or request in filling out any forms necessary for filing grievances.

- (a) A grievance may be filed by the consumer or the consumer's personal representative, legal guardian, or other party acting on behalf of the consumer, when the consumer is an adult.
- (b) A grievance may be filed by the consumer or the consumer's family member or legal guardian on behalf of the consumer, when the consumer is a child.

- (c) The consumer, or the consumer's family member or legal guardian, when the consumer is a child, must consent to the filing of a grievance by another person in his or her behalf unless the grievance involves an allegation that the consumer is being abused or neglected.
- 305.3 Each consumer may be assisted throughout the grievance process, by any person chosen by the consumer. If the consumer chooses to be assisted by a peer advocate or personal representative, the consumer must designate the advocate or representative in writing and specify what protected mental health information, if any, may be released to the peer advocate or personal representative.
- 305.4 Peer advocates and personal representatives are subject to the requirements of federal and District laws regarding the confidentiality of protected mental health information.
- 305.5 A MH provider shall release information regarding a grievance to any organization or individual upon receipt of a valid authorization for disclosure from the consumer.
- 306 MH PROVIDER GRIEVANCE PROCEDURE**
- 306.1 Consumers with grievances concerning a MH provider from whom they are receiving services shall file the grievances with their provider. Consumers with grievances concerning rules, policies, or actions of employees that are the sole responsibility of DMH may file them with their MH provider but are not required to do so.
- 306.2 Each MH Provider Grievance Procedure shall incorporate, at a minimum, the following elements:
- (a) Consumers shall have the opportunity to file a grievance at any time during the MH provider's normal hours of operation;
 - (b) Consumers shall be protected against having to file or present a grievance to the person complained about in the grievance;
 - (c) Consumers shall have access to peer advocates and shall have the right to representation during each stage of the grievance procedure by a peer advocate or personal representative;
 - (d) The consumer or his or her designee shall receive written acknowledgment of a filed grievance;
 - (e) Time limits shall be set the completion of each step of the Procedure, consistent with § 306.5;

- (f) Prompt steps shall be specified to insure the immediate physical safety of a consumer if the circumstances surrounding a grievance raise a reasonable belief that the consumer's safety is threatened;
- (g) If informal attempts to resolve a grievance are unsuccessful, the chief executive officer of the MH provider shall review the grievance and write a decision in response. The written decision shall be transmitted, with oral explanation, to the consumer or his or her designee along with a reminder of the consumer's right to appeal the grievance to DMH for external review.

306.3 Each MH provider shall establish a permanent group composed of equal numbers of consumers and staff members who shall be responsible for responding to inquiries regarding the grievance process, for attempting to resolve grievances consensually, and for assisting the chief executive officer of the MH provider in providing a response to grievances.

- (a) The group or individual group members may look into individual grievances and work with the consumer filing the grievance and other parties to resolve the grievance consensually, using mediation or other dispute resolution techniques.
- (b) If the grievance cannot be resolved informally, the group or individual group members may fact-find or make advisory recommendations to the chief executive officer of the MH provider.
- (c) Grievances containing allegations of physical or sexual abuse may be forwarded directly to the chief executive officer of the MH provider without action by the group.

306.4 Each MH Provider shall demonstrate that consumers have played a meaningful role in the final design of the Grievance Procedure, and that consumers will be meaningfully consulted in future efforts to monitor and evaluate its effectiveness and decide upon needed modifications. The consumer/staff group required by § 306.3 may be utilized for these functions, or the MH Provider may use other means.

306.5 The chief executive officer of each MH provider shall review, investigate, and provide a substantive response to grievances within the following time frames:

- (a) Within five (5) business days of the date the grievance is filed if it alleges abuse or neglect of a consumer or a denial of service to a consumer, or

- (b) Within ten (10) business days of the date the grievance is filed for all other grievances.

The chief executive officer of a MH provider may request an extension of the time set by paragraph (b) above for a specific number of days. The consumer filing the grievance shall have the option to grant or deny such a request.

306.6 If a consumer is dissatisfied with the response to a grievance by the chief executive officer of the MH provider or his or her designee, the consumer shall have ten (10) business days from the date of verbal notification and explanation of the response within which to appeal the grievance to DMH for external review in accordance with §§ 308 and 309.

306.7 Each MH provider shall submit a copy of each grievance to DMH on the day it is filed and shall submit a copy of any subsequent action concerning the grievance within 24 hours of the action's occurrence. Providers shall submit the information in a manner to be specified by DMH.

306.8 Each MH provider shall ensure that every staff person, including administrative, clerical, and support staff, has a clearly understood responsibility to immediately advise any consumer or other person who is articulating a grievance on behalf of a consumer, of the right to file a grievance and of the means of contacting the peer advocate program.

306.9 Each MH provider may accomplish its responsibilities with regard to implementing the MH Provider Grievance Procedure through utilization of its own staff or board members, as appropriate, or through agreement with outside staff, agencies, or organizations. The utilization of outside persons in the MH Provider Grievance Procedure shall be clearly explained to each consumer filing a grievance and to other parties filing a grievance on behalf of a consumer.

307 DMH REVIEW OF GRIEVANCES

307.1 The Mental Health Authority of DMH shall review grievances that concern:

- (a) The actions of employees of DMH in its capacity as Mental Health Authority for the District of Columbia; or
- (b) Rules or policies that are the sole responsibility of DMH; or
- (c) Grievances involving a MH provider not resolved to the consumer's satisfaction.

- 307.2 Consumers may first file grievances concerning rules or policies that are the sole responsibility of DMH with their MH provider but are not required to do so.
- 307.3 All consumers shall have the right to file a grievance with DMH. If a consumer's grievance involves a specific MH provider, DMH shall ensure that the MH provider has responded to the grievance in a timely manner before initiating its prompt and impartial review of the grievance.
- 307.4 DMH shall refer appeals of consumers' grievances against MH providers to external review as described in § 308 within five (5) business days of receipt of the grievance by DMH.
- 307.5 The Director of DMH or the Director's designee shall respond orally and in writing to the consumer or the consumer's designee within ten (10) business days of receipt of the grievance by DMH, in grievances not involving the appeal of a consumer's grievance against a MH provider. If a consumer is dissatisfied with the DMH response to a grievance, the consumer shall have ten (10) business days from the date of verbal notification and explanation of the response within which to exercise the right to external review of the grievance according to § 308.

308 EXTERNAL REVIEW OF GRIEVANCES

- 308.1 DMH shall contract with one or more external reviewer(s) to provide timely, neutral, and impartial review of grievances that have not been resolved to the consumer's satisfaction. The Director or his or her designee shall select the external reviewer. External reviewers shall serve at the pleasure of the Director of DMH. DMH shall provide consumers with written notice of the method, date, and time of external review, a list of participants, and contact information for the independent peer advocacy program.
- (a) A consumer has the right to representation by a peer advocate, an attorney or a person of the consumer's choice throughout the external review process but DMH shall not appoint, assign or compensate a consumer's representative.
- (b) A consumer, employees or representatives of providers, witnesses, or other participants in a grievance proceeding shall not be compensated by DMH for their time.
- 308.2 All external reviewers shall have experience or appropriate training in mediation, arbitration, and/or alternative dispute resolution.

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- 308.3 The external reviewer may manage an assigned grievance in one of the following ways:
- (a) The external reviewer may attempt to mediate a consensual resolution to the grievance. Mediation may be conducted via individual telephone calls or meetings with interested parties or via a joint meeting. The consumer has the right to representation during mediation. Necessary representatives from the MH provider, as determined by the external reviewer, shall be required to attend the mediation. The consumer may terminate the mediation at any time. If mediation is unsuccessful at resolving the grievance to the consumer's satisfaction, an external reviewer shall prepare a written advisory opinion at the request of any party to the mediation. The external reviewer who prepares a written advisory opinion pursuant to this subsection may or may not be the mediator.
 - (b) The external reviewer may conduct a fact-finding hearing and issue a written advisory opinion. Necessary representatives from the MH provider, as determined by the external reviewer, shall be required to attend the hearing. The consumer has the right to representation during the hearing, and may call witnesses. The MH provider also has the right to representation during the hearing at its expense, and may call witnesses. In some instances, and with the consent of the parties, the external reviewer may attempt to mediate a consensual resolution to a grievance prior to issuing an advisory opinion.
 - (c) The external reviewer may conduct a fact-finding process and issue a written advisory opinion without a hearing, if the consumer elects not to have one. In this case the external reviewer may request written information from the consumer or the MH provider to supplement the record. The external reviewer shall prepare a written advisory opinion based upon the information submitted and any informal conversations held with parties to the grievance.
- 308.4 Within five (5) business days of receipt of a consumer's request for external review, DMH shall assign an external reviewer and secure the earliest practicable date for a mediation or hearing. If a hearing is held, the external reviewer shall submit a written advisory opinion within five (5) business days of the completion of the hearing. An external reviewer may extend the time period for submission of an opinion with the express consent of all parties to the hearing.
- 308.5 Any written advisory opinion prepared by an external reviewer shall include:

- (a) A summary of the evidence gathered during the hearing or document review;
- (b) Applicable federal or District laws and regulations;
- (c) Findings of Fact; and
- (d) Conclusions and recommendations.

308.6 A written advisory opinion prepared by the external reviewer shall be forwarded to the Director of DMH, the chief executive officer of the MH provider (if the grievance originated at or involved the MH provider), and the consumer. A copy of the written advisory opinion shall be provided to the consumer's representative, if authorized pursuant to the Mental Health Information Act of 1978, D.C. Official Code §§ 7-1201.01 *et seq.* Any party to the external review, including the chief executive officer of the MH provider, may, within five (5) business days of receipt of the written advisory opinion, communicate their reaction to the opinion to the Director. The Director shall, in writing, accept in full, accept in part, or reject the recommendations of the external reviewer and set time limits and responsible parties for carrying out any accepted recommendations, within ten (10) business days of receipt of the advisory opinion.

308.7 Any agreement reached in mediation shall be forwarded to the Director of DMH and/or the chief executive officer of the MH provider where the grievance originated, according to which entity has authority over the actions specified in the agreement. The Director or chief executive officer shall set any necessary time limits and responsible parties for carrying out the actions specified by the agreement, within ten (10) business days of receipt of the agreement.

308.8 The external reviewer shall report such information on each grievance as DMH may require and shall provide such information within the time limits and in the manner that DMH requires, except that statements made by parties to mediation shall not be reported.

308.9 Any party to a grievance dissatisfied with the grievance's final determination by DMH may request a fair hearing, pursuant to the D.C. Administrative Procedure Act and federal regulations.

309 DMH MONITORING AND REPORTING

309.1 DMH shall periodically review the implementation of the Consumer Rights Policy, including each MH Provider Grievance Procedure.

309.2 DMH shall ensure that grievances are tracked and that responsible parties carry out actions mandated or agreed to be performed in response to grievances within prescribed time limits.

309.3 DMH shall make publicly available a semi-annual report summarizing the types and dispositions of all grievances filed during the reporting period, including noteworthy trends and patterns and any other statistical information it believes would be helpful in evaluating the operation of the Grievance Procedure.

399 **DEFINITIONS**

"Abuse" - any knowing, reckless, or intentional act or omission by a provider that causes or is likely to cause or contribute to, or which caused or is likely to have caused or contributed to, physical or emotional injury, death, or financial exploitation of a consumer.

"Consumer" - an adult, child or youth who seeks or receives mental health services or mental health supports funded or regulated by DMH. For purposes of this chapter, references to a child or youth consumer include the child's or youth's family or legal guardian.

"Consumer Rights Statement" - a document prepared and distributed by DMH to all MH providers which describes all the consumer rights and protections available under federal and District laws and regulations.

"Core Services Agency" - a community-based provider of mental health services and mental health supports that is certified by DMH in accordance with rules published in the D.C. Register, and acts as the clinical home for consumers of mental health services by providing a single point of access and accountability for mental health rehabilitation services.

"CSA peer advocate" - a person appointed by a core services agency to assist consumers and others in filing a grievance and throughout the grievance process, who

- (a) is a current or former consumer of mental health services or supports; and
- (b) has been trained by DMH.

"DMH" - the Department of Mental Health, the successor in interest to the District of Columbia Commission on Mental Health Services.

"Director" - the Director of DMH.

"External reviewer" - a person or organization with extensive experience in mediation, arbitration and/or alternative dispute resolution, selected by

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the Director, that contracts with DMH to provide neutral and impartial review and resolution of grievances.

"Governing Authority" - the designated individuals or governing body legally responsible for conducting the affairs of the MH provider.

"Grievance" - a description by any individual of his or her dissatisfaction with either DMH or a MH provider, including the denial or abuse of any consumer right or protection provided by applicable federal and District laws and regulations.

"Independent Peer advocate" - a person designated by an independent peer advocacy office established by or with the assistance of DMH to assist consumers and others in filing a grievance and throughout the grievance process, who

- (a) is a current or former consumer of mental health services in the District of Columbia or elsewhere or, in the case of children and youth consumers, a guardian or family member of a current or former child or youth consumer;
- (b) meets minimum qualifications established by DMH; and
- (c) demonstrates knowledge about the Grievance Procedure and relevant MH Provider Grievance Procedures, and District laws and regulations regarding consumer rights and protections.

"Mental Health Authority" - the divisions, offices and employees of DMH involved in the regulatory, administrative, policy, planning, and fiscal responsibilities for the Department, and the Access Helpline or central intake functions of the Department. The Mental Health Authority is not directly involved in providing mental health services or supports and is separate from St. Elizabeths Hospital and the public core services agency. Mental Health Authority offices and divisions include the Director and Director's office, Chief Compliance Officer and Regulatory Counsel, General Counsel, Chief Financial Officer, Public Affairs, Consumer and Family Affairs, Chief Clinical Officer, Organizational Development, Office of Fiscal and Administrative Services, Office of Accountability, and Office of Delivery Systems Management.

"Mental health services" - the services funded or regulated by DMH for the purpose of addressing mental illness or mental health problems.

"Mental health supports" - the supports funded or regulated by DMH for the purpose of addressing mental illness or mental health problems.

"Mental illness" - a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

"MH provider" – (a) any entity, public or private, that is licensed or certified by the District of Columbia to provide mental health services or mental health supports, (b) any entity, public or private, that has entered into an agreement with DMH to provide mental health services or mental health supports, or (c) St. Elizabeths Hospital or the public core services agency.

"Neglect" - any act or omission by a MH provider that causes or is likely to cause or contribute to, or which caused or is likely to have caused or contributed to, injury or death of a consumer.

"Peer advocate" – see "Independent peer advocate" and "CSA peer advocate."

"Personal representative" – a person designated by a consumer as the consumer's personal representative. A personal representative may be a family member, significant other, guardian or attorney.

"Policy" – a written statement developed by a MH Provider that gives specific direction regarding how the MH provider shall operate administratively and programmatically.

"Procedure" – a written set of instructions describing the step-by-step actions to be taken by MH provider staff in implementing a policy of the MH provider.

"Protected mental health information" - means information regulated by the District of Columbia Mental Health Information Act of 1978 effective March 3, 1979 (D.C. Law 2-136, D.C. Official Code §7-1201.1 *et seq.*).

"Service plan" - either the individual recovery plan (IRP) for adults or the individual service plan for children and youth (IPC).

"St. Elizabeths Hospital" – the inpatient psychiatric hospital operated by DMH.

Department of Mental Health
TRANSMITTAL LETTER

SUBJECT Maintaining Children and Youth in Their Homes		
POLICY NUMBER DMH Policy 340.5A	DATE AUG 0 1 2011	TL# 151

Purpose. This policy was generally updated to reflect current terminology and utilization of child and family teaming to assist children and youth as much as possible to remain in their own home (or surrogate home) and to prevent the need for out of home placement for mental health services.

Applicability. Applies to all DMH-certified Mental Health Rehabilitation Services (MHRS) providers and contracted providers who provide mental health services to children and youth; and the Mental Health Authority (MHA).

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate MHA offices.

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

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

ACTION


REMOVE AND DESTROY

DMH Policy 340.5

INSERT

DMH Policy 340.5A


 Stephen T. Baron
 Director, DMH

GOVERNMENT OF THE DISTRICT OF COLUMBIA  DEPARTMENT OF MENTAL HEALTH	Policy No. 340.5A	Date AUG 01 2011	Page 1
	Supersedes: DMH Policy 340.5, same subject, dated April 22, 2005		
Subject: Maintaining Children and Youth in Their Homes			

1. **Purpose.** To require that children and youth are assisted as much as possible to remain in their own home (or surrogate home) and to prevent the need for out of home placement for mental health services.
2. **Applicability.** Applies to all DMH-certified Mental Health Rehabilitation Services (MHRS) providers and contracted providers who provide mental health services to children and youth; and the Mental Health Authority (MHA).
3. **Authority.** Department of Mental Health Establishment Amendment Act of 2001.
4. **Definitions.** For purposes of this policy:
 - 4a. **Own home.** Residing independently or with biological parent(s), stepparent, or legal guardian.
 - 4b. **Surrogate home.** A home other than with one's own natural or adopted parents (i.e., foster home, therapeutic foster home, or home of a family member other than the parents), or other family based home setting.
 - 4c. **Child/Youth Consumer.** A person under 22 years of age, who:
 - (1) Has or is at risk of having, a diagnosable mental, behavioral, or emotional disorder (including those of biological etiology) which substantially impairs the mental health of the person or is of sufficient duration to meet diagnostic criteria specified within the DSM-IV or the ICD-9-CM equivalent (and subsequent revisions), with the exception of substance abuse disorders, mental retardation, and other developmental disorders, or seizure disorders, unless those exceptions co-occur with another diagnosable serious emotional disturbance; and
 - (2) Demonstrates either functional impairments or symptoms that significantly disrupt their academic or developmental progress or family and interpersonal relationships; or
 - (3) Has an emotional disturbance causing problems so severe as to require significant mental health intervention.
 - 4d. **Out of Home Placement.** Any living situation other than a child or youth's own home or surrogate home.
 - 4e. **Psychiatric Residential Treatment Facility (PRTF).** A psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the state in which it is located and provides inpatient psychiatric services for individuals under the age of twenty-two and meets the requirements set forth in §§ 441.151 through 441.182 of Title 42 of the Code of Federal Regulations, and is certified by the District of Columbia to participate in the Medicaid Program.

5. **Background.** Historically, the children/youth of the District of Columbia had severely limited access to in-home and community based mental health services, and were more often sent to out of state residential treatment facilities rather than supported and served in their own homes and communities. DMH has established a community-based system of care, with a sufficient array, quantity and quality of community based services to reduce the need for out of home placements for DC children and youth.

6. **Policy.**

6a. All children/youth enrolled with a DMH-certified provider and engaged in active treatment shall be assisted to the fullest extent possible to remain in their own (or surrogate) home.

6b. Children and families who are at risk for out of home placement will have the opportunity to engage in a child and family teaming process that results in an individualized in-home and community-based plan of care to match the level of the child/youth's clinical need with the level of teaming intensity.

6c. Community-based alternatives to out of home placement must be explored through a family-driven team based process to determine what community supports and services would meet the needs of the child/youth, and to ensure that all diversion opportunities occur prior to referring a child or youth for out of home placement. Also see DMH Policy 340.11, Child/Youth and Family Teaming and DMH Policy 340.10, High Fidelity Wraparound Care Planning Process.

7. **Responsibilities.**

7a. All DMH certified MHRS providers and contracted providers who provide mental health services to children and youth shall:

(1) **Be sufficiently knowledgeable** of the array of services and supports available to children and youth in the community.

(2) **Be sufficiently knowledgeable** about how to access all available services.

(3) **Participate** in a child and family teaming process for service and support planning for children and youth at risk of out of home placement by engaging family members and natural supports to provide a variety of strategies and interventions that could help maintain the child/youth in the home.

(4) **Adhere** to the principle of least restrictive environment while considering the risks and benefits of staying in the home versus being removed from home.

(5) **Participate** in discharge planning meetings from acute, sub-acute, and psychiatric residential care in order to facilitate the return of a child/youth to their home.

7b. Core Services Agencies (CSAs)/Community Based Intervention (CBI) Providers shall:

(1) **Coordinate and facilitate** a child and family teaming process for service and support planning for children and youth at risk of out of home placement by engaging family members and natural supports to provide a variety of strategies and interventions that could help maintain the child/youth in the home.

(2) **Assess** each child/youth's status in accordance with DMH Policy on Level of Care Utilization System (LOCUS/CALOCUS) Evaluations, for the need for increasing or decreasing levels of service(s).

(3) **Make timely referrals** to any needed services that could prevent the need for out of home placement for mental health treatment.

(4) **Request** technical assistance/coaching from the DMH Child and Youth Services Division (CYSD) in the event that an out of home placement is being considered.

7b. The MHA, Office of Programs and Policy shall:

(1) **Provide** all needed supports for the child and family treatment team to perform its responsibilities.

(2) **Provide** all timely authorizations to referrals for children and youth at risk for out of home placement to community based services.

(3) **Ensure** all fee for service admissions, continuing stays, and discharges from Psychiatric Residential Treatment Facilities (PRTFs) and acute hospitalizations are monitored (e.g., to ensure proper utilization of services).

(4) **Provide** ongoing information to all providers on all the in-home and community-based services available to children/youth.


8. **Inquiries.** Any questions regarding this policy may be addressed to the Director, Child and Youth Services Division in the MHA Office of Programs and Policy at (202) 671-2900.

9. **Related References.**

- DMH Policy 300.1C, Level of Care Utilization System (LOCUS/CALOCUS) Evaluations
- DMH Policy 340.4, Services to Children and Youth in Natural Settings
- DMH Policy 340.10, High Fidelity Wraparound Care Planning Process
- DMH Policy 340.11, Child/Youth and Family Teaming

Approved By:

Stephen T. Baron
Director, DMH

 8-1-11

 (Signature) (Date)

Department of Mental Health
TRANSMITTAL LETTER

SUBJECT Community Based Intervention (CBI) Services for Children and Youth		
POLICY NUMBER DMH Policy 340.9	DATE JAN 10 2011	TL# 148

Purpose. To provide the policies, procedures, and practice guidelines for the implementation of CBI.

Applicability. Applies to Department of Mental Health (DMH), certified mental health providers who serve children or youth, and CBI Providers. The policy also provides guidance on how other referring agencies (e.g., Child and Family Services Agency [CFSA], Department of Youth Rehabilitation Services [DYRS], Court Social Services [CSS], and Managed Care Organizations [MCOs]) access CBI services in Section 6 of the policy.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate Mental Health Authority offices.

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

Policy Dissemination and Filing Instructions. Managers/supervisors of DMH must ensure that staff are informed of this policy. Each staff person who maintains policy manuals must ensure that this policy is filed in the DMH Policy and Procedures Manual.

ACTION

REMOVE AND DESTROY


None

INSERT

DMH Policy 340.9



Stephen T. Baron
Director, DMH

GOVERNMENT OF THE DISTRICT OF COLUMBIA  DEPARTMENT OF MENTAL HEALTH	Policy No. 340.9	Date JAN 10 2011	Page 1
	Supersedes: None		

Subject: Community Based Intervention (CBI) Services for Children and Youth

1. **Purpose.** To provide the policies, procedures, and practice guidelines for the implementation of CBI.
2. **Applicability.** Applies to Department of Mental Health (DMH), certified mental health providers who serve children or youth, and CBI Providers. The policy also provides guidance on how other referring agencies (e.g., Child and Family Services Agency [CFSA], Department of Youth Rehabilitation Services [DYRS], Court Social Services [CSS], and Managed Care Organizations [MCOs]) access CBI services in Section 6 of the policy.
3. **Authority.** Department of Mental Health Establishment Amendment Act of 2001 and Title 22-A, DCMR, Chapter 34, Mental Health Rehabilitation Services (MHRS) Provider Certification Standards, as amended.
4. **Definitions.**
 - 4a. **Community-Based Intervention or "CBI".** Time-limited, intensive, mental health intervention services delivered to children, youth, and their family and intended to prevent utilization of an out-of-home therapeutic resource by the consumer. CBI is primarily focused on the development of consumer and family skills and is delivered in the family setting in order for the consumer to function in a family environment.
 - 4b. **CBI Providers.** Agencies certified by DMH to provide CBI services, consistent with the MHRS Standards and the Department of Mental Health Establishment Amendment Act of 2001.
 - 4c. **CBI Team.** The community-based intervention team involved in providing CBI services to child/youth consumers. CBI Team requirements vary according to level of CBI services (Levels I-IV) as outlined in the MHRS Standards.
 - 4d. **CALOCUS.** "Child and Adolescent Level of Care Utilization System" evaluation tool used to measure and track dimensions of functioning of child/youth consumers and provide a level of care recommendation.
 - 4e. **Functional Family Therapy or "FFT".** Research-based prevention and intervention program for at-risk adolescents and their families provided by a team of trained therapists of a DMH certified CBI Level IV provider with FFT site certification.
 - 4f. **Multi-Systemic Therapy or "MST".** An intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions that is used to deliver CBI Level I services by a DMH certified CBI Level I provider.
 - 4g. **Intensive Home and Community-Based Services or "IHCBS".** An intensive home-based model of treatment adopted by DMH as CBI Level II and III to prevent the utilization of restrictive levels of out-of-home treatment for emotionally disturbed children and youth by a DMH certified CBI Level II or III provider.

4h. **IPC.** "Individualized Plan of Care" for children and youth, as defined by the MHRS Standards.

5. **Policy.**

5a. The requirements outlined in the CBI Practice Guidelines (*Exhibit 1*) shall be followed to qualify for CBI services.

5b. DMH will utilize the four (4) levels of CBI services to support child and youth consumers who meet the CBI eligibility criteria in the practice guidelines adopted by DMH and the MHRS certification standards. A provider may be certified to offer one (1) or more levels of CBI services.

5c. All levels of CBI shall consist of services described in 22 DCMR § A3422.7 as medically necessary and clinically appropriate. CBI services shall be individually designed for each child or youth and family to minimize intrusion and maximize independence and primarily provided in natural settings (including the home, school, or other community setting).

5d. DMH will adhere to the following models in the delivery of CBI in order to ensure consistency of CBI services by providers throughout DMH. Refer to *Exhibit 2 - Comparison of CBI Models*.

- **CBI Level I** - services shall be delivered in accordance with the Multi-systemic Treatment (MST) Model.
- **CBI Level II** - services shall be delivered in accordance with the Intensive Home and Community-Based Services (IHCBS) model.
- **CBI Level III** - services shall be delivered in accordance with the IHCBS model for short-term crisis stabilization.
- **CBI Level IV** - services shall be delivered in accordance with the Functional Family Therapy (FFT) model.

Additional information regarding the CBI service delivery models adopted by DMH may be found on the following websites:

- MST <http://www.mstservices.com/>
- IHCBS http://www-dev.rags.kent.edu/CIP_web/
- FFT <http://www.fftinc.com/>

5e. CBI fidelity review tools will be used to assess the adequacy of CBI services and adherence to the identified models. The results of the fidelity assessments will be used for quality improvement. For more information on fidelity review tools refer to the practice guidelines or contact the DMH Child and Youth Services Division (CYSD).

5f. If a consumer is assessed to need CBI, but the parent/legal guardian refuses, the child/youth will be assessed for alternative services.

6. **Responsibilities.** In order to obtain CBI services for children and youth:

6a. **Core Services Agencies (CSAs)** must:

- **Complete** CBI Authorization Event Screen in Provider Connect along with corresponding authorization plan for review by Access Helpline (AHL).
- If CBI is authorized by AHL, the CSA must also **complete** the DMH electronic *CBI Referral Form (Exhibit 3)* and **provide** a copy to the CBI Provider who was authorized by AHL (also see CBI practice guidelines regarding authorization of CBI for more information).

- **Work collaboratively** with the consumer and the CBI Team to ensure continuity of care for the child upon admission, reauthorization, and discharge from CBI services.
- 6b. Child and Family Services Agency (CFSA) shall do the following:
- If the child or youth is not linked to a CSA, the CFSA social worker must **complete** the CFSA referral form and **submit** the form to the CFSA Office of Clinical Practice (OCP) to seek enrollment to a CSA for mental health treatment.
 - CFSA OCP and DMH AHL **review** referral and coordinate initial authorization.
 - If the child or youth is linked to a CSA, CFSA must **contact** the CSA to request CBI services. (See 6a above for CSA responsibilities).
 - A CFSA social worker cannot refer children and youth directly to the AHL.
- 6c. The Department of Youth Rehabilitation Services (DYRS), Court Social Services, and other referring agencies (e.g., MCOs such as Health Services for Children with Special Needs [HSCSN]) must:
- **Complete** the DMH electronic CBI Referral Form and **submit** to AHL/designee for review/authorization if the consumer is not linked to a CSA.
 - If the consumer is in active treatment with a CSA, the case manager/probation officer must **contact** the CSA to request CBI services. (See 6a above for CSA responsibilities).
- 6d. The DMH Access Helpline must **review** the referral, including the clinical presentation and CALOCUS score; and if appropriate, **provide** authorization for CBI services and **assign** the consumer to a CBI Team.
- 6e. All "CBI Providers" must:
- (1) **Comply with and implement** the required activities in the DMH Provider Authorization and Billing Manual, and the MHRs Provider Certification Standards including all MHRs Bulletins and any updates/amendments that may be issued by DMH relating to the provision of CBI services.
 - (2) **Accept and engage** all consumers authorized by DMH for CBI services within forty-eight (48) hours of referral.
 - (3) **Provide** services twenty-four hours, seven days a week (24/7), including after hours, on weekends and holidays (also see CBI Practice Guidelines for CBI Level IV) .
 - (4) **Coordinate** the full array of services and supports required by enrolled consumers to support mental health rehabilitation and stabilization.
 - (5) **Attend** monthly DMH CBI Provider meetings.
 - (6) **Submit** monthly service progress reports to clinical home, and other programmatic reports as deemed necessary by DMH.
 - (7) **Engage** with the child or youth to identify suitable and meaningful daily activities and **facilitate** the consumer's participation in those activities.
 - (8) **Utilize** the team approach and **coordinate** the treatment planning process for all children/youth authorized by DMH to receive CBI and follow the DMH CBI Practice Guidelines, and appropriate treatment model for the level of CBI services rendered (also see Section 5d above).
 - (9) **Provide** AHL with monthly vacancy list and **complete** CBI discharge event in Ecura.

7. Authorization for CBI Services.

7a. Prior authorization from DMH is required for enrollment in CBI and re-authorization is required for continued treatment.

7b. The DMH AHL Clinician must **review** and **approve** as appropriate, initial and reauthorization requests. Questions regarding authorization of CBI should be directed to the DMH Division of Care Coordination Director.

8. Continuity of Care for CBI Consumers.

8a. CBI Providers must engage consumers within 48 hours of authorization of referral and facilitate team meeting to develop treatment plan within fourteen (14) days. Exception: If a child is authorized for CBI upon discharge from an acute care facility or Psychiatric Residential Treatment Facility (PRTF), the team meeting must be facilitated within seven (7) days of discharge.

8b. CBI Providers shall conduct continuity of care planning with consumers and families prior to discharge from any level of CBI services, including facilitating follow-up mental health appointments.

9. Training. DMH will provide CBI training on a quarterly basis.

10. Sanction for Non-Compliance. Non-compliance with the requirements of this policy will result in serious and appropriate action in accordance with DMH policies, applicable rules and any Human Care Agreement or contract between DMH and the provider. See Title 22-A DCMR Chapter 34, Mental Health Rehabilitation Services Provider Certification Standards.

11. Inquiries. Questions related to this policy should be addressed to the DMH Child and Youth Services Division.

12. Related References.

DMH Manual 1000.2, MHRs Provider Authorization and Billing Manual
DMH Policy 300.1C, Level of Care Utilization System (LOCUS/CALOCUS) Evaluations
DMH Policy 200.5, Continuity of Care Practice Guidelines for Children and Youth

13. Exhibits.

Exhibit 1 – CBI Practice Guidelines
Exhibit 2 – Comparison of CBI Models
Exhibit 3 – CBI Referral Form

Approved By:

Stephen T. Baron
Director, DMH


(Signature)


(Date)

CBI Practice Guidelines**Definition/Background**

Community Based Intervention (CBI) services are time limited, intensive, mental health services delivered to children and youth ages six (6) to twenty-one (21). CBI services are meant to help prevent acute care hospitalization, out of home placement or placement in a residential treatment center or a detention of a consumer. CBI services are to be provided in the consumer's natural environment, including school, home, and community settings.

Many of the children/youth referred to this level of care are struggling with emotional and or behavioral issues that have not been addressed via individual therapy, medication or other lower levels of care. The provision of CBI services shall occur in collaboration with pre-existing lower levels of care, including individual counseling, medication management and community support services. The CBI providers' primary responsibility is to provide crisis intervention, care coordination, therapeutic interventions based on treatment goals, and transition consumers to appropriate level of care.

Children/youth referred for CBI services shall have a mental health Axis I or II diagnosis. (Reference MHRS 3403.2). There are four (4) levels of CBI service. These levels do not denote a hierarchy of intensity but more a differing modality of intervention.

CBI Level I is delivered through the Multi-Systemic Therapy (MST) model. MST is an evidence based best practice for children ages ten (10) to seventeen (17) years old that are living with, or returning to, their biological family or other long-term caregivers within 30 days of referral. CBI Level I services are intended for children and youth who are experiencing serious emotional disturbance with either of the following:

A documented behavioral concern with externalizing (aggressive or violent) behaviors (e.g., runaway, verbal and physical aggression, substance use, truancy, illegal activity, oppositional behavior, etc.); or a history of chronic juvenile offenses that has or may result in involvement with the juvenile justice system.

A permanent caregiver must be willing to participate with service providers for the duration of treatment.

CBI Level II is delivered through the In-Home and Community Based Services (IHCBS) model. This level of CBI serves ages six (6) to twenty-one (21) years old. Consumers that are referred to IHCBS have one or a combination of the following:

- a history of involvement with Child and Family Services Agency (CFSA), Court Social Services (CSS), or the Department of Youth Rehabilitation Services (DYRS);

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	<ul style="list-style-type: none"> • a history of negative involvement with schools for behavioral-related issues; or • a history of either chronic or recurrent episodes of negative behavior that have or may result in out-of-home placement. <p><u>CBI Level III is utilized for short term Crisis Stabilization and is also delivered through the IHCBS model.</u> This level of CBI serves ages six (6) to twenty-one (21) years old. Consumers that are referred to CBI Level III shall have one or a combination of the following:</p> <ul style="list-style-type: none"> • Has situational behavioral problems that require short-term, intensive treatment; • Is currently dealing with stressor situations such as trauma or violence and requires development of coping and management skills; • Recently experienced out of home placement and requires development of communication and coping skills to manage the placement change; • Is undergoing transition from adolescence to adulthood and requires skills and supports to successfully manage the transition; • Has been recently discharged from an inpatient setting; i.e. acute hospitalization or psychiatric residential treatment facility; or • Is an adult parent or caregiver with a clinically significant mental health concern and the parent or caregiver will be parenting a child or youth returning from a residential treatment center within the next ninety (90) days. <p><u>CBI Level IV is delivered through the Functional Family Therapy (FFT) model.</u> This level of CBI serves ages ten (10) – eighteen (18) years old. Consumers that are referred to CBI Level IV shall:</p> <ul style="list-style-type: none"> • Have a documented history of moderate to serious behavioral problems which impair functioning in at least one area (such as school or home); • Exhibit significant externalizing behavior which impairs functioning in at least one area (such as school or home); or • Be at risk of a disruption in placement; and • Be: (1) willing to participate with service providers for the duration of CBI Level IV treatment services; and/or (2) involved with a caregiver who is willing to participate with service providers for the duration of CBI Level IV treatment services.
<p>Practice Standards and Benchmarks</p>	<p>Practice standards and benchmarks for Community Based Intervention (CBI) are measured via CBI fidelity review tools. The Therapist Adherence Measures-Revised (TAM) and Supervisor Adherence Measure (SAM) are used to measure adherence to the MST model (Level I); a DMH fidelity review</p>

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	<p>tool is used to assess CBI levels II and III; and a FFT Adherence Tracking System and three specific FFT instruments (OQ-45.2, Y-OQ2.01, and YOQ SR) are used to measure adherence to the FFT model for CBI Level IV.</p>
<p>Staffing Levels Required – Experience & Training</p>	<p>All levels of CBI services must adhere to DMH defined requirements for direct care and supervisory staff. These requirements are as follows:</p> <p><u>Please Note:</u> Per MHRs regulations, CBI qualified practitioners are: psychiatrists, psychologists, LICSW's, APRN's, RN's, LPC's, LISW's, and Addiction Counselors. All credentialed staff, including recovery specialists may provide CBI under the supervision of a qualified practitioner.</p> <p><u>CBI Level I:</u></p> <ul style="list-style-type: none"> • The team shall consist of a full time clinical supervisor, a full time team leader and four to six clinicians. • The team clinical supervisor shall be a Master's level qualified practitioner experienced in providing individual, group, marital or family counseling or psychotherapy in accordance with applicable District laws and regulations, with a minimum of two years of post graduate experience working with behaviorally challenged youth and their families in community-based settings. • The team leader shall be a Master's level clinician with a minimum of one year of post graduate experience working with behaviorally challenged youth and their families in community-based settings. • The team clinicians shall be either Master's level clinicians or Bachelor's level clinicians with a minimum of one year of experience working with behaviorally challenged youth and their families in community-based settings. <p><u>CBI Level II:</u></p> <ul style="list-style-type: none"> • The team shall include a full time clinical supervisor and four to six clinicians. • The team clinical supervisor shall be a Master's level qualified practitioner experienced in providing individual, group, marital or family counseling or psychotherapy in accordance with applicable District laws and regulations, with a minimum of two years of post graduate experience working with behaviorally challenged youth and their families in community-based settings.

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	<ul style="list-style-type: none"> • The team clinicians shall be either Master's level clinicians or Bachelor's level clinicians with a minimum of one year of experience working with behaviorally challenged youth and their families in community-based settings. <p><u>CBI Level III:</u></p> <ul style="list-style-type: none"> • The team shall include a full time clinical supervisor and four to six clinicians. • The team clinical supervisor shall be a Master's level qualified practitioner experienced in providing individual, group, marital or family counseling or psychotherapy in accordance with applicable District laws and regulations, with a minimum of two years of post graduate experience working with behaviorally challenged youth and their families in community-based settings. • The team clinicians shall be either Master's level qualified practitioners or Bachelor's level clinicians with a minimum of two years of experience working with behaviorally challenged youth and their families in community-based settings. <p><u>CBI Level IV:</u></p> <ul style="list-style-type: none"> • The team shall include a full-time clinical supervisor and 3 to 8 full time equivalent clinicians who have completed FFT clinical training, supervisor training if applicable, and on-going clinical and technical assistance. • The team clinical supervisor shall be a Master's level qualified practitioner experienced in providing individual, group, marital or family counseling or psychotherapy in accordance with applicable District laws and regulations, with a minimum of 2 years of post-graduate experience working with behaviorally challenged youth and their families in community-based setting who has satisfied the FFT requirements for a clinical supervisor. • The team clinicians shall be either Master's level clinicians or Bachelor's level clinicians with a minimum of one (1) year of experience working with behaviorally challenged youth and their families in community-based settings, and shall have satisfied the FFT requirements for FFT therapists. • For further information on the FFT model/requirements adopted by DMH, refer to http://www.fftinc.com/
<p>Process Implementation</p>	<p>CBI services are available to any child ages six to twenty one, who are District of Columbia residents and are Medicaid eligible or are committed wards (DYRS/CFSA) of the District.</p>

ENROLLMENT IN DMH SYSTEM OF CARE

Enrollment in the DMH System of Care must be initiated by the parent/legal guardian, a Department of Youth Rehabilitation Services (DYRS) case manager, or a Court Social Services (CSS) probation officer, through the Access Help Line (AHL). When DYRS or CSS calls AHL to enroll a child/youth consumer, the parent/guardian must be present. If the parent/guardian is not available, but agrees to enrollment, DYRS or CSS may submit the MHRs referral to AHL.

For youth that are in the community and are being referred to the DMH System of Care via a parent or legal guardian, CSS, or DYRS, the following must take place:

- Call the Access Help Line and request mental health services for the child, at which time the consumer is enrolled and an intake appointment is made with the chosen Core Services Agency (CSA).

The consumer and caregiver attend the intake appointment and the Diagnostic Assessment is completed. Based on the Diagnostic Assessment, the consumer is referred to mental health services.

See Page 6 and 7 of these guidelines for enrollment procedures when a child/youth is a committed ward of CFSA, or with an MCO such as HSCSN.

AUTHORIZATION OF CBI

If a parent/legal guardian calls AHL requesting CBI for a child/youth that is not enrolled with a CSA, the AHL will assess and offer enrollment with a CSA of choice.

(1) For children/youth enrolled with a CSA - if CBI is identified as a need and the caregiver is in agreement, the CSA will complete the "Community Based Intervention Authorization Event" in Provider Connect within 24 hours. This event should be accompanied by an authorization plan.

- The event must include a detailed clinical presentation that discusses the consumer's need for CBI services based on the current level of functioning in the home, school and community as

CBI Practice Guidelines

	<p>well as any relative background information. <i>Please Note:</i> If CBI services are court ordered, it is the responsibility of the CSA to provide sufficient clinical justification to meet medical necessity to obtain authorization. The event must also include the CALOCUS score of at least 17 (additional justification required if CALOCUS score is less than 17).</p> <ul style="list-style-type: none"> • Once the “Community Based Intervention Authorization Event” is complete and entered into Provider Connect along with the authorization plan, the request will be reviewed within 24 to 48 hours of submission. • Upon approval, the CSA is responsible for forwarding clinical information to the requested CBI provider within 24 hours. This clinical information should include the electronic CBI referral form, most recent Diagnostic Assessment, IPC, and any other pertinent evaluations, assessment and background information. • The CBI provider has 48 hours from the time of notification to initiate CBI services with the consumer. <p><u>(2) For consumers that are under the care of Child and Family Services Agency (CFSA), the following steps should be taken to request CBI services:</u></p> <ul style="list-style-type: none"> • If the consumer is not already enrolled and in active treatment with a CSA, the assigned social worker must submit the Behavioral Services Unit (BSU) referral form to the CFSA Office of Clinical Practice (OCP). Upon receipt in OCP, the referral is reviewed by a DMH co-located clinician to determine that all pertinent information is present and that medical necessity is present. Information that is required for CBI requests include a current placement for the consumer, name address and phone number for foster parent, name and phone number of assigned social worker, mental health Axis I or II diagnosis, medications and any current behaviors or symptoms of concern. • Once the referral has been reviewed, the request is forwarded to the Access Help Line (AHL) designated staff for authorization. The AHL will identify an available CSA and CBI Provider. The consumer will then be enrolled with the chosen CSA and CBI services will be authorized with the identified provider. • The CSA and the CBI provider will be provided with written notification of the enrollment and
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authorization. This notification will include the authorization dates, authorization number, and a brief clinical presentation discussing the referral behaviors/symptoms, diagnosis, medications and contact information.

- If the child is linked to a CSA, CFSA must contact the CSA to request CBI.
- The CBI provider has 48 hours from the time of the notification of authorization to initiate CBI services with the consumer.

(3) Other Referral Sources:

Consumer can also be referred to CBI services from a MCO such as Health Services for Children with Special Needs (HSCSN), Department of Youth Rehabilitation Services (DYRS), Court Social Services (CSS), and upon recommendation from inpatient acute care. Case managers/probation officers can make referrals to CBI by utilizing the following process:

- Referring party must first confer with the legal guardian to gain permission to request the services and to explain the referral process;
- If the consumer is in active treatment with a DMH Core Service Agency (CSA), contact the agency to request CBI services.
- If the consumer is not part of a DMH CSA, submit the DMH CBI Referral form to the designated Access Help Line staff person.
- The referral must include as much clinical information as possible and contact information for the consumer, caregiver, and referring worker. Additionally, if the consumer is part of the CFSA, or Court Social Services, or DYRS system, the assigned worker's contact information must also be a part of the referral.
- Upon review and authorization the referring party will receive a written confirmation from AHL for the consumer's record along with contact information for the authorized CBI provider.
- Inpatient acute care recommendations for CBI must be processed through the assigned active

CBI Practice Guidelines

CSA. If the consumer is not linked to a CSA and is not a ward of CFSA, the hospital must assist the caregiver to call the AHL to request enrollment with a CSA. Clinical documentation should then be forwarded by the acute care facility to the CSA designee with a request for CBI services. Follow (2) on page 6 if the consumer is a ward of CFSA.

- If CBI is identified as a need and the caregiver is in agreement, the CSA will complete the CBI authorization event in provider Connect within 24 hours.
- CBI Providers must engage consumers within 48 hours of notification of authorization of referral.

(4) Reauthorization of CBI Services:

CBI is a prior authorized service. After the first 90 days of service, the CBI provider can request an additional 90 days of service via the CSA. The CSA will enter the reauthorization request into Provider Connect for clinical review and authorization using the following process:

- CBI provider must submit a written clinical justification to the CSA within 2 weeks of the end of the authorization period.
- The presentation will be reviewed by the CSA clinician to ensure that the CSA is clear on consumer's progress, goals, areas of concern and continued need for CBI services.
- If the CSA is in agreement with continued CBI services, the CSA will enter the provided presentation along with a authorization plan to be reviewed by AHL.
- The CBI provider must ensure that the CSA has a copy of the initial IPC.

(5) Referral to a different level of CBI is considered as an "initial authorization".

Discharge Criteria:

A consumer may be discharged from CBI services for the following reasons:

- Consumer and family have met the identified goals of CBI;
- Consumer has been placed in a restrictive environment – i.e. PRTEF;

CBI Practice Guidelines

	<ul style="list-style-type: none"> • Consumer has moved out of state and is not under CFSA or DYRS physical or legal custody; Consumer and/or caregiver refuses service – Refusal must be documented in writing.
<p>Policy Statements <i>References to any applicable policies, including citations.</i></p>	<p>CBI Bulletin MST Bulletin DMH Policy 200.5, Continuity of Care Policy DMH Policy 300.1C, Level of Care Utilization System (LOCUS/CALOCUS) Evaluations DMH 1000.2 MHRS Provider Authorization and Billing Manual DMH Policy 340.9, CBI Services for Children and Youth</p>
<p>Resources and Citations References <i>Information about who to contact for further information/clarification.</i></p>	<p>Questions regarding authorization for CBI should be directed to the DMH Division of Care Coordination Director. All other questions regarding CBI should be directed to the Child and Youth Services Division.</p>

Comparison: MST, IHCBS, and FFT Models Adopted by DMH

	<u>Multi-Systemic Treatment (MST)</u> For CBI Level I	<u>Intensive Home and Community-Based Services (IHCBS)</u> For CBI Level II	<u>Intensive Home and Community-Based Services (IHCBS)</u> For CBI Level III (short-term)	<u>Functional Family Therapy (FFT)</u> For CBI Level IV
Model Description	Intensive home-based treatment for c/youth with complex issues who are at risk for out of home placement due to their behavior. <i>Evidence based practice recognized by SAMSA</i>	Intensive home-based treatment for c/youth due to risk of placement because of some crisis or safety issue.	Intensive home-based treatment for c/youth due to risk of placement because of some crisis or safety issue.	Intensive home based treatment for c/youth that consists of 5 components: Engagement in change, motivation to change, assessment, behavior change, and generalization-multi-systems linking. <i>Evidence based practice recognized by SAMSA</i>
Goals/Primary Responsibility	The 4 basic goals of CBI (all levels) are the same: to provide crisis intervention, care coordination, therapeutic interventions based on treatment goals, and transition consumers to appropriate level of care per 22 DCMR § A3422.6.	The 4 basic goals of CBI (all levels) are the same: to provide crisis intervention, care coordination, therapeutic interventions based on treatment goals, and transition consumers to appropriate level of care per 22 DCMR § A3422.6.	The 4 basic goals of CBI (all levels) are the same: to provide crisis intervention, care coordination, therapeutic interventions based on treatment goals, and transition consumers to appropriate level of care per 22 DCMR § A3422.6.	The 4 basic goals of CBI (all levels) are the same: to provide crisis intervention, care coordination, therapeutic interventions based on treatment goals, and transition consumers to appropriate level of care per 22 DCMR § A3422.6.
Age limits	10 - 17	6 – 21	6 - 21	10 - 18
Diagnosis	Axis I or II mental health diagnosis	Axis I or II mental health diagnosis	Axis I or II mental health diagnosis	Axis I or II mental health diagnosis
Population Served	Children and youth who are experiencing serious emotional disturbance with either of the following:	Children who have one or a combination of any of the following:	Children who have one or a combination of any of the following:	Children and youth with a documented history of serious externalizing behaviors that impair functioning and are at risk of a

	<p>Multi-Systemic Treatment (MST) For CBI Level I</p>	<p>Intensive Home and Community-Based Services (IHCBS) For CBI Level II</p>	<p>Intensive Home and Community-Based Services (IHCBS) For CBI Level III (short-term)</p>	<p>Functional Family Therapy (FFT) For CBI Level IV</p>
	<p>A documented behavioral concern with externalizing (aggressive or violent) behaviors; or a history of chronic juvenile offenses that has or may result in involvement with the juvenile justice system.</p>	<p>(a) A history of involvement with the Child and Family Services Agency (CFSA), Court Social Services (CSS), or the Department of Youth Rehabilitation Services (DYRS);</p> <p>(b) A history of negative involvement with schools for behavioral-related issues; or</p> <p>(c) A history of either chronic or recurrent episodes of negative behavior that have or may result in out-of-home placement.</p>	<p>(a) Has situational behavioral problems that require short-term, intensive treatment;</p> <p>(b) Is currently dealing with stressor situations such as trauma or violence and requires development of coping and management skills;</p> <p>(c) Recently experienced out of home placement and requires development of communication and coping skills to manage the placement change;</p> <p>(d) Is undergoing transition from adolescence to adulthood and requires skills and supports to successfully manage the transition;</p> <p>(e) Has been recently discharged from an inpatient setting; i.e., acute hospitalization or psychiatric residential treatment facility; or</p> <p>(f) Is an adult parent or caregiver with a clinically significant mental health concern</p>	<p>disruption in placement. Child/youth must be willing to participate in service.</p>

	Multi-Systemic Treatment (MST) For CBI Level I	Intensive Home and Community-Based Services (IHCBS) For CBI Level II	Intensive Home and Community-Based Services (IHCBS) For CBI Level III (short-term)	Functional Family Therapy (FFT) For CBI Level IV
			and the parent or caregiver will be parenting a child or youth returning from a residential treatment center within the next ninety (90) days.	
Family Participation	Have a permanent caregiver willing to participate for duration of Level I treatment.	Encouraged, but not required for c/youth to receive services.	Encouraged, but not required for c/youth to receive services.	Involved with a permanent caregiver who is willing to participate with service providers for the duration of Level IV treatment.
Treatment Duration	up to 6 months	up to 6 months	Not to exceed 90 days	up to 6 months
Intensity of Services	Multiple sessions/weekly contacts that are flexible and convenient to family.	Multiple sessions/weekly contacts that are flexible and convenient to family.	Multiple sessions/weekly contacts that are flexible and convenient to family.	Averages one visit per week, frequency determined by family's need.
Availability	24/7	24/7	24/7	Must ensure that there is a crisis plan in effect for the consumer to ensure access to needed services 24/7, when the FFT therapist is not available.
Location of Service	home, school, & community	home, school, & community	home, school, & community	home, school, & community
Exclusions	Child/youth is not eligible for CBI services if	Child/youth is not eligible for CBI	Child/youth is not eligible for CBI	Child/youth is not eligible for CBI

	Multi-Systemic Treatment (MST) For CBI Level I	Intensive Home and Community- Based Services (IHCBS) For CBI Level II	Intensive Home and Community- Based Services (IHCBS) For CBI Level III (short-term)	Functional Family Therapy (FFT) For CBI Level IV
	<p>at least one of the following applies:</p> <ul style="list-style-type: none"> • C/Youth¹ does <u>not</u> have a primary Axis I or II mental health diagnosis; • C/Youth in long-term residential treatment facility or other inpatient setting and not being discharged within 30 days; • C/Youth in full-service group home; • C/Youth is in need of crisis psychiatric hospitalization or stabilization; • C/Youth has moderate/severe/profound mental retardation or any moderate/severe/profound disorder on the autism spectrum; • C/Youth where substance abuse or sex offending behavior is the <u>primary</u> reason for referral; or • C/Youth is in an emergency or respite placement/ independent living or not returning to their biological home or long term placement within 30 days of referral. 	<p>services if at least one of the following applies:</p> <ul style="list-style-type: none"> • C/Youth does <u>not</u> have a primary Axis I or II mental health diagnosis; • C/Youth in long-term residential treatment facility or other inpatient setting and not being discharged within 30 days; • C/Youth in full-service group home; • C/Youth is in need of crisis psychiatric hospitalization or stabilization; • C/Youth has moderate/severe/profound mental retardation or any moderate/severe/profound disorder on the autism spectrum; • C/Youth where substance abuse or sex offending behavior is the <u>primary</u> reason for referral. 	<p>services if at least one of the following applies:</p> <ul style="list-style-type: none"> • C/Youth does <u>not</u> have a primary Axis I or II mental health diagnosis; • C/Youth in long-term residential treatment facility or other inpatient setting and not being discharged within 30 days; • C/Youth in full-service group home; • C/Youth is in need of crisis psychiatric hospitalization or stabilization; • C/Youth has moderate/severe/profound mental retardation or any moderate/severe/profound disorder on the autism spectrum; • C/Youth where substance abuse or sex offending behavior is the <u>primary</u> reason for referral. 	<p>services if at least one of the following applies:</p> <ul style="list-style-type: none"> • C/Youth does <u>not</u> have a primary Axis I or II mental health diagnosis; • C/Youth in long-term residential treatment facility or other inpatient setting and not being discharged within 30 days; • C/Youth in full-service group home; • C/Youth is in need of crisis psychiatric hospitalization or stabilization; • C/Youth has moderate/severe/profound mental retardation or any moderate/severe/profound disorder on the autism spectrum; • C/Youth where substance abuse or sex offending behavior is the <u>primary</u> reason for referral; or • C/Youth is in an emergency or respite placement/ independent living or not returning to their biological home or long term placement

¹ C/Youth – Child/Youth

	<p><u>Multi-Systemic Treatment (MST)</u> For CBI Level I</p>	<p><u>Intensive Home and Community-Based Services (IHCBS)</u> For CBI Level II</p>	<p><u>Intensive Home and Community-Based Services (IHCBS)</u> For CBI Level III (short-term)</p>	<p><u>Functional Family Therapy (FFT)</u> For CBI Level IV</p>
	<p>C/Youth who are actively suicidal, homicidal, or psychotic w/o medication stabilization.</p>	<p>C/Youth who are actively suicidal, homicidal, or psychotic w/o medication stabilization.</p>	<p>C/Youth who are actively suicidal, homicidal, or psychotic w/o medication stabilization.</p>	<p>within 30 days of referral.</p> <p>C/Youth who are actively suicidal, homicidal, or psychotic w/o medication stabilization.</p> <p>C/youth active with any other level of CBI or clinic based family therapy should not enroll in FFT until the other services are complete.</p>

	<p>Multi-Systemic Treatment (MST) For CBI Level I</p>	<p>Intensive Home and Community-Based Services (IHCBS) For CBI Level II</p>	<p>Intensive Home and Community-Based Services (IHCBS) For CBI Level III (short-term)</p>	<p>Functional Family Therapy (FFT) For CBI Level IV</p>
<p>Staffing</p>	<p>FT Clinical Supervisor – Masters level qualified practitioner² & 2 years post-graduate experience working with behaviorally challenged youth and families in community based settings.</p> <p>FT Team Leader – Master’s level with min. of 1 year post-grad experience working with behaviorally challenged youth and families in community based settings.</p> <p>4 – 6 Clinicians – either Master’s level clinicians or Bachelor’s level with min. of 1 year experience working with behaviorally challenged youth and families in community based settings.</p> <p><i>(AND must be licensed MST providers)</i></p>	<p>FT Clinical Supervisor - Master's level qualified practitioner experienced in providing individual, group, marital or family counseling or psychotherapy in accordance with applicable District laws and regulations, with a minimum of two (2) years of post-graduate experience working with behaviorally challenged youth and their families in community-based settings.</p> <p>4-6 Clinicians - either Master's level clinicians or Bachelor's level clinicians with a minimum of one (1) year of experience working with behaviorally challenged youth and their families in community-based settings.</p>	<p>FT Clinical Supervisor - Master's level qualified practitioner experienced in providing individual, group, marital or family counseling or psychotherapy in accordance with applicable District laws and regulations, with a minimum of two (2) years postgraduate experience working with behaviorally challenged youth and their families in community-based settings</p> <p>4-6 Clinicians - either Master's level qualified practitioners or Bachelor's level clinicians with a minimum of two (2) years of experience working with behaviorally challenged youth and their families in community-based settings.</p>	<p>FT Clinical Supervisor – Master’s level qualified practitioner experienced in providing individual, group, marital or family counseling or psychotherapy in accordance with applicable District laws and regulations, with a minimum of 2 years of post-graduate experience working with behaviorally challenged youth and their families in community-based setting who has satisfied the FFT training requirements for a clinical supervisor.</p> <p>3 to 8 FT equivalent Clinicians - either Master’s level clinicians or Bachelor’s level clinicians with a minimum of one (1) year of experience working with behaviorally challenged youth and their families in community-based settings, and shall have satisfied the FFT training requirements for FFT therapists.</p> <p><i>(AND must have current site certification as FFT provider)</i></p>

² **Qualified Practitioner (QP)** – psychiatrists, psychologists, LICSW, APRN, RN, LPC, LISW, and addiction counselor.

	<u>Multi-Systemic Treatment (MST)</u> For CBI Level I	<u>Intensive Home and Community-Based Services (IHCBS)</u> For CBI Level II	<u>Intensive Home and Community-Based Services (IHCBS)</u> For CBI Level III (short-term)	<u>Functional Family Therapy (FFT)</u> For CBI Level IV
Caseload	4-6 consumers for each FT team member (per 22 DCMR § A3422.31)	4 to 6 consumers for each full-time team member (per 22 DCMR § A3422.32)	4 to 6 consumers for each full-time team member (per 22 DCMR § A3422.33)	10-12 consumers for each full-time therapist (per 22 DCMR § A3422.34)
Primary Focus	Multi-systems including family, school, community, and peers to assist youth in being successful.	The focus of treatment is the youth – in context of the family, school, neighborhood, and community.	The focus of treatment is the youth – in context of the family, school, neighborhood, and community.	Multi-system risk and protective factor view addressed through a “family first” focus, eventually integrating with influencing systems.
Minimum Training	MST 5-day orientation training Quarterly Booster trainings	For new IHCBS providers – IHCBS initial training required for FT Clinical Supervisor, at a minimum. Periodic booster training thereafter. Weekly telephone consultations provided for additional support	For new IHCBS providers – IHCBS initial training required for FT Clinical Supervisor, at a minimum. Periodic booster training thereafter. Weekly telephone consultations provided for additional support	FFT Site Certification is a 3-phase process: <u>Phase 1 Clinical Training</u> for all clinicians, telephone consultation, and follow-up training sessions; <u>Phase 2 Supervision Training</u> , that includes phone consultation and follow-up training; and <u>Phase 3 Maintenance Phase</u> , that includes follow-up training and monthly phone consultation. For further information on the FFT training /model, refer to http://www.fftinc.com/



Department of Mental Health

Referral for Community Based Intervention (CBI)



EXCLUSIONARY CRITERIA for CBI Services

DMH Policy 340.9
Exhibit 3 – 6a

Child/Youth is **not eligible** for CBI services if at least one of the following applies:

- C/Youth does not have a primary Axis I or II mental health diagnosis;
- C/Youth in long-term residential treatment facility or other inpatient facility and not being discharged within 30 days;
- C/Youth in full-service group home;
- C/Youth is in need of crisis psychiatric hospitalization or stabilization;
- C/Youth has moderate/severe/profound mental retardation or any moderate/severe/profound disorder on the autism spectrum;
- C/Youth where substance abuse or sex offending behavior is the **primary** reason for referral; or
- C/Youth is in an emergency or respite placement/independent living or not returning to their biological home or long term placement within 30 days of referral (for MST or FFT only).

ONLY complete referrals, with sufficient clinical documentation attached, will be accepted.

Sufficient clinical documentation includes:

- A detailed clinical presentation describing behaviors exhibited within the last 60 days,
- Diagnostic/Assessment, Individualized Plan of Care, IEP if applicable,
- Hospital reports, and/or any additional psychiatric/psychological evaluations or assessments completed in the last 12 months.

If the youth is linked to a CSA/Clinical Home: CSA/Clinical Home should send a copy of the referral and supporting clinical documentation directly to CBI provider within 24 hours of authorization.

If the youth is not linked to a CSA/Clinical Home: The DYRS case manager, Court Social Services probation officer, or MCO care manager should send the referral and supporting clinical documentation to the DMH Access Helpline for review/authorization.

If youth is involved with CFSA and not linked to a CSA/Clinical Home: **DO NOT USE THIS FORM.**

The CFSA Social Worker must submit CFSA Behavioral Health Services referral form to the CFSA Behavioral Services Unit (BSU) in the Office of Clinical Practice.

Please submit the electronically completed referral form to AHL.auths@dc.gov.



Department of Mental Health

Referral for Community Based Intervention (CBI)

Client Name: _____ Date of Birth: _____
 SS#: _____ Medicaid #: _____ eCura ID# (if known): _____
 MCO Name: _____ Care Manager: _____

Gender (circle): Male Female Primary Language: _____
 Race (check): African-American Hispanic Caucasian Asian Native American Other: _____

Current Living Environment: (bio home, foster home, group home, PRTE/RTC etc): _____

Parent/Caretaker (and relationship): _____

Child/Youth Address: _____

Phone # (home): _____ Work: _____ Cell: _____

Legal Guardian & Contact information (if different from above):

Family Commitment	Yes	No	Comments
Is the family willing to have regular weekly services in their home?	<input type="checkbox"/>	<input type="checkbox"/>	
Has the caretaker agreed to be an active participant in treatment?	<input type="checkbox"/>	<input type="checkbox"/>	

Is the child or youth involved with: (check all that apply) CFSA DYRS Court Social Services

Is this referral court ordered? Yes No

If yes, please attach a copy of the court order.

Judge: _____ Guardian a litem (GAL): _____

Referral Source:

Referring Worker: _____ Phone: _____ Cell: _____

Title: _____ Agency: _____

Supervisor: _____ Phone: _____ Cell: _____

Other Involved Team members:

Agency/Program	Team Member Name	Office Phone	Cell Phone
CFSA			
DYRS			
Court Social Services/Probation			
PASS			
Wraparound			
School-Based Mental Health			



Referral for Community Based Intervention (CBI)

Is the youth currently receiving mental health services? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, where? Is youth linked to a Core Service Agency? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, CSA Name:	Is the youth receiving substance abuse treatment/counseling? Y <input type="checkbox"/> N <input type="checkbox"/> Name of Agency:
Clinical : Phone #: Community Support Worker: Office #:	Substance Abuse Counselor: Office #: Agency/Program:
Primary Care Physician: Office#:	Medications:(List all)

List all acute care inpatient hospitalizations and major psychiatric interventions within last two years, if any:

Month/Year	Hospital/ Program Name	Reason	Length of Treatment

List all arrests and detentions within last two years, if any:

Month/year	Detention Center/Program	Reason	Court Order

Psychiatric Diagnosis:

Axis I: (List all, identify Primary)

Axis II: (List all)

Most recent CALOCUS Score (if known):



Referral for Community Based Intervention (CBI)

Identifying Problems: *(Check all that apply)*

Symptomologies/Behaviors	Yes	No	Suspected	Last 30 days	Last 6 months	Last 12 months
Aggressive, oppositional and/or antisocial behaviors (i.e., verbal/physical aggression, fire setting, animal cruelty)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional disorders (anxiety, depression)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At risk for home placement disruption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School (truancy, suspensions, expelled)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At risk for RTC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Returning from RTC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abscondance/Chronic runaway	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal/Homicidal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Reactive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Offending Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gang Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychosis/Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self Mutilation/Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal Charges Pending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Reason for Referral: *Concisely explain the identifying issues selected above that justify a referral to Community Based Intervention (CBI) services for this child/youth.*

Name & Title of the person completing this form: (Please Print)

Date

Please submit the electronically completed referral form to AHL.auths@dc.gov.



Referral for Community Based Intervention (CBI) Face Sheet

Community Based Intervention (CBI) services are time-limited, intensive, mental health services delivered to children and youth ages six (6) through twenty-one (21). A child/youth is eligible for CBI services if they have a primary Axis I or II mental health diagnosis and the following:

- *Individual or family needs, or a combination of the two, that are unmanageable and require intensive coordinated clinical behavioral interventions; and*
- *Insufficient or severely limited individual & family resources or skills to cope with an immediate crisis.*

CBI Levels

(You may request a specific level for the child/youth but DMH Access Help Line will make final determination based on the information submitted in the referral)

Level I: Multi-Systemic Therapy (MST)	Level II: Intensive Home & Community Based Services (IHCBS)	Level III: Crisis Stabilization (short term) (IHCBS)	Level IV: Functional Family Therapy (FFT)
<input type="checkbox"/> 10-17 years old <input type="checkbox"/> has a documented behavioral concern with externalizing (aggressive or violent) behaviors; or has a history of chronic juvenile offenses that has or may result in involvement with the juvenile justice system. <input type="checkbox"/> has a permanent caregiver who is willing to participate with service providers for the duration of treatment.	<input type="checkbox"/> 6-21 years old <input type="checkbox"/> has a history of involvement with the Child and Family Services Agency (CFSA), Court Social Services (CSS), or the Department of Youth Rehabilitation Services (DYRS); <input type="checkbox"/> has a recent history of negative involvement with schools for behavioral-related issues; or <input type="checkbox"/> has a history of either chronic or recurrent episodes of negative behavior that have or may result in out-of-home placement.	<input type="checkbox"/> 6-21 years old <input type="checkbox"/> has situational behavioral problems that require short-term, intensive treatment; <input type="checkbox"/> is currently dealing with stressor situations such as trauma or violence and requires development of coping and management skills; <input type="checkbox"/> recently experienced out of home placement and requires development of communication and coping skills to manage the placement change; <input type="checkbox"/> Is undergoing transition from adolescence to adulthood and requires skills and supports to successfully manage the transition; or <input type="checkbox"/> Has been recently discharged from an inpatient setting, i.e., acute hospitalization or psychiatric residential treatment facility.	<input type="checkbox"/> 10-18 years old <input type="checkbox"/> has a documented history of moderate to serious behavior problems which impair functioning in at least one area (e.g., school, home); <input type="checkbox"/> Exhibits significant externalizing behavior which impairs functioning in at least one area (e.g., school, home); or <input type="checkbox"/> be at risk of a disruption in placement; and be willing to participate with service providers for duration of level IV treatment; and/or involved with a caregiver who is willing to participate with service providers for the duration of level IV services.

Department of Mental Health
TRANSMITTAL LETTER

SUBJECT High Fidelity Wraparound Care Planning Process		
POLICY NUMBER DMH Policy 340.10	DATE AUG 0 1 2011	TL# 153

Purpose. To outline the high fidelity wraparound process for children and youth and their families.

Applicability. Department of Mental Health (DMH) Mental Health Authority, DMH-certified Core Services Agencies (CSAs), Community Based Intervention (CBI) providers, and DMH contracted wraparound providers who serve children or youth and their families.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate MHA offices.

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

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

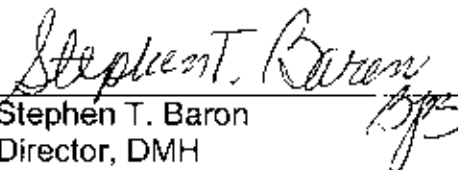
ACTION


REMOVE AND DESTROY

None

INSERT

DMH Policy 340.10


Stephen T. Baron
Director, DMH

<p style="text-align: center;">GOVERNMENT OF THE DISTRICT OF COLUMBIA</p>  <p style="text-align: center;">DEPARTMENT OF MENTAL HEALTH</p>	<p>Policy No. 340.10</p>	<p>Date AUG 0 1 2011</p>	<p>Page 1</p>
	<p>Supersedes None</p>		

Subject: High Fidelity Wraparound Care Planning Process

1. **Purpose.** To outline the high fidelity wraparound process for children and youth and their families.
2. **Applicability.** Department of Mental Health (DMH) Mental Health Authority, DMH-certified Core Services Agencies (CSAs), Community Based Intervention (CBI) providers, and DMH contracted wraparound providers who serve children or youth and their families.
3. **Authority.** Department of Mental Health Establishment Amendment Act of 2001.
4. **Background.** High Fidelity Wraparound is a process, not a treatment *per se*. (see Section 6a below). The wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that results in plans that are more holistic than traditional care plans in that they are designed to meet the identified needs of caregivers and siblings and to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of the young people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.
5. **Policy.** DMH shall utilize contracted wraparound providers to provide high fidelity wraparound care coordination services to children and youth with the most complex needs. Wraparound providers must abide by specific requirements and timelines as outlined in their contracts, and based on the National Wraparound Initiatives (NWI) phases and activities of the wraparound process.
6. **Definitions.** For the purposes of this policy:
 - 6a. **High Fidelity Wraparound Process (Wrap)** - Although wrap is often referred to as a treatment within the District of Columbia, high fidelity wraparound is a care coordination service, and is defined as: A collaborative team-based care planning process where the family and the team implement, track, and adapt an individualized Plan of Care (POC), working toward the youth and family's long term vision for the purpose of achieving positive outcomes in the home, school, and community. The process is coordinated and facilitated by a team leader (Wraparound Care Coordinator) who is trained in the child and family team (CFT) process. The CFT works to engage the youth and family in a needs-based care planning and service delivery process. The CFT also understands the youth and family's strengths, needs, and culture, and leverages community based and natural supports/resources.
 - 6b. **Wraparound Care Coordinator** - The Wraparound Care Coordinator is responsible for developing and organizing the Child and Family Team (CFT) process that focuses on the development of an individualized POC for children/youth with complex emotional and/or

behavioral health needs and their families. The Wraparound Care Coordinator serves as the team leader and coordinates and facilitates the wraparound CFT process.

6c. Child and Family Team (CFT) - A group of individuals who the family believes can help them develop and implement a plan that will assist the child and family in realizing and achieving their vision of the future. At a minimum it includes the child and his/her family, a mental health representative, court involved partners, and any individuals important in the child's life and who are identified and invited to participate by the child and family. This may include, for example, teachers, extended family members, friends, family support partners, healthcare providers, relevant experts, coaches, representatives from churches, synagogues or mosques, and representatives from other child-serving systems like Child and Family Services Agency (CFSA), Department of Youth Rehabilitation Services (DYRS), DC Public Schools (DCPS), and Court Social Services (CSS). The size, scope and intensity of involvement of the team members is determined by level and complexity of need.

6d. Family Support Partner (FSP) – A team member who is a formal member of the CFT whose personal experience/journey is critical to earning the respect of the family and establishing a trusting relationship that the family values. The FSP's role is to empower the child and the family, help them engage and actively participate in the CFT process, and make informed decisions that drive the process. FSPs have a strong connection to the community and are very knowledgeable about resources, services, supports, and policies for families.

6e. CALOCUS - Child and Adolescent Level of Care Utilization System (CALOCUS) instrument is a method of quantifying the clinical severity and service needs of children and adolescents with psychiatric disorders, substance use disorders, or developmental disorders, and has the ability to integrate these as overlapping clinical issues. The overall CALOCUS score guides the level of care assignment.

6f. Family - The primary care-giving unit, including a biological, adoptive or self-created unit of people who may or may not be residing together and consisting of adult(s) and children, with adult(s) performing duties of parenthood for the children. Persons within this unit share bonds, culture, practices, and significant relationships. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family.

6g. Family Vision – The family's vision should identify the long term family goals which can encompass where the child and family like to reside, educational and vocational aspirations, and the building of relationships.

6h. Natural Supports - Natural supports are people who are informal supports and know or are related to the youth/family, but do not provide a paid service (such as a grandparent or neighbor who is connected to the youth/family). Natural supports can also be found in the youth/family's community, such as the faith community, neighborhood, school, or community organizations.

6i. Individualized Plan of Care (IPC) – The individualized plan of care for children and youth, which is the result of the Diagnostic/Assessment. The IPC includes the consumer's treatment goals, strengths, challenges, objectives, and interventions. The IPC is based on the consumer's identified needs as reflected by the Diagnostic/Assessment, the consumer's expressed needs, and referral information. The IPC shall include a statement of the specific, individualized objectives of each intervention, a description of the interventions, and specify

the frequency, duration, and scope of each intervention activity. The IPC is the authorization of treatment, based on certification that the MHRS are medically necessary by the approving practitioner. *The IPC is maintained by the consumer's CSA (or CBI provider when the child or youth is receiving CBI service), and should reflect the same overall vision and goals as the mental health section of the Plan of Care (POC). Also see Section 6j below.*

6j. Plan of Care (POC) - A written document that is developed by the child, family, and other wraparound CFT members to meet the needs of both the child and family. Essential elements include: demographic information, family vision, strengths, needs, outcomes, action items, responsible parties, date of completion of action items, updates, and a crisis and safety plan (predicted behaviors, triggers, solutions, responses to the crisis, communication tree, and hospitalization plan). *The mental health section of the POC should reflect the same goals as the IPC that is maintained by the consumer's CSA/CBI provider (see Section 6i above).*

6k. Strengths, Needs, and Cultural Discovery (SNCD) – An interview and assessment process where the Wraparound Care Coordinator (sometimes in partnership with the Family Support Partner) listens to the youth and family's journey in order to identify strengths across multiple life domains, understand the family's culture, assist the family in articulating the family's vision, identify areas of need, and begin the preparation of the CFT. A SNCD document is created based on this process, sent to the team members with the family's permission, and utilized to drive the initial stages of the CFT process and development of the child/youth's POC.

6l. Mental Health Rehabilitation Services (MHRS) – mental health rehabilitative or palliative services provided by a DMH-certified community mental health provider (CSAs, subproviders and specialty providers) to consumers in accordance with the District of Columbia State Medicaid Plan, the MAA/DMH Interagency Agreement, and the MHRS Provider Certification Standards.

6m. Core Services Agency (CSA) – a DMH-certified community-based MHRS provider that has entered into a Human Care Agreement with DMH to provide specified MHRS. A CSA shall provide at least one core service directly and may provide up to three core services via contract with a sub-provider or subcontractor. A CSA may provide specialty services directly if certified by DMH as a specialty provider.

6n. CBI Provider – Agencies certified by DMH to provide CBI services, consistent with the MHRS Standards and the Department of Mental Health Establishment Amendment Act of 2001. CBI providers shall be responsible for the treatment planning process while the child or youth is receiving CBI services (including the update of the IPC as necessary).

7. Access to the High Fidelity Wraparound.

7a. An individual, agency, or CSA/CBI provider can refer a child and family who have been identified as having the most complex needs for wraparound coordination services by contacting the DMH PRTF Diversion, Technical Assistance (TA) and Coaching for Children's Mental Health department at PRTF.Diversion@dc.gov to request a referral packet. The packet will include an instruction sheet and contact information.

(1) Complex needs may include, but are not limited to: multiple system involvement, multiple risk factors across many life domains, severe functional impairments, risk of or recent return from residential placement, or hospitalization.

(2) Trigger events that could lead to a referral to wrap may include placement change, level of care transition, excessive truancy, abscondance, release from detention, risk of probation violation, or hospitalization.

7b. Upon receipt of a completed packet, a Child and Youth Services Division staff member will review the referral packet for appropriateness for high fidelity wrap and if appropriate, notify the referral source of the assigned wraparound provider.

7c. Assignment to a wraparound provider does not shift the overall responsibility of the CSA (or CBI provider if applicable) for treatment planning and maintenance of the IPC when a child or youth is receiving wraparound services. Also see sections 6i and 6j above.

8. Wraparound Provider Responsibilities.

8a. **Wraparound Providers** shall:

(1) **Follow** the National Wraparound Initiatives (NWI) Phases and Activities of the Wraparound Process as outlined in Exhibit 1.

- For the NWI 1.3.a activity, "Explore strengths, needs, culture, and vision with the child/youth and family", that is listed in Exhibit 1, the Wraparound Care Coordinator will develop a SNCD and present to the Child and Family Team (CFT) as a summarized document no later than the first CFT meeting.

(2) **Ensure** the Wraparound Care Coordinator completes the initial CALOCUS within thirty (30) days of receiving a referral from DMH, and upon discharge from wraparound services.

8b. **Wraparound Providers** shall adhere to the following timelines and teaming activities of the Wraparound CFT process:

(1) **Meet** with the youth and family within 24-72 hours of enrollment for the initial engagement, orientation to the CFT process, and to begin the Strengths, Needs, and Cultural Discovery (SNCD) assessment process.

(2) **Ensure** that the CFT is assembled for the first CFT meeting within two (2) weeks of enrollment.

(3) **Ensure** that an initial Plan of Care (POC) is developed and implemented by the CFT within two (2) weeks of enrollment.

(4) **Ensure** that each family has a written SNCD document within two (2) weeks of enrollment and that it is disseminated to the CFT members for review.

(5) If a family is in crisis, the Wraparound Care Coordinator and/or the family support partner shall **work** to de-escalate the crisis situation and **assure** necessary supports are in place. Within forty-eight (48) hours, a crisis and safety plan shall be developed with the family.

(6) **Ensure** the Wraparound Care Coordinator and/or family support partner makes face-to-face contact at least once per week, and **ensure** that CFT meetings are conducted every thirty (30) days.

(7) **Ensure** that the CFT meeting is facilitated, the POC is documented and distributed to the team members, and that the CFT members adhere to the POC, thus assuring that all elements of the POC are delivered.

(8) **Ensure** that the approach to services is aligned with System of Care values (as reflected in Exhibit 2, District of Columbia Children's System of Care Guiding Principles; and the ten (10) Principles of Wraparound as outlined by the National Wraparound Initiative <http://www.rtc.pdx.edu/PDF/TenPrincWAProcess.pdf>

(9) **Ensure** that the POC includes a customized mix of services that is responsive to the family's needs using both formal and informal (natural) supports.

(10) **Submit** monthly and quarterly reports to the DMH Child and Youth Services Division as required by DMH.

9. Evaluation, Monitoring, and Training.

9a. The DMH PRTF Diversion, Technical Assistance and Coaching for Children's Mental Health department will conduct targeted observations of the CFT process for ongoing monitoring of fidelity to the wraparound model. An annual report on the fidelity to the phases and activities will be developed and provided to the Child and Youth Services Division leadership for quality improvement.

9b. Technical assistance, consultation, and training will be provided by DMH as needed to support wraparound services to ensure adherence to the high fidelity wraparound model.

10. Related References.

DMH Policy 340.5A, Maintaining Children and Youth in their Homes

DMH Policy 340.11, Child/Youth and Family Teaming

11. Exhibits.

Exhibit 1 – NWI Phases and Activities of the Wraparound Process

Exhibit 2 – DC Children's System of Care Guiding Principles

Approved By:

Stephen T. Baron
Director, DMH


(Signature) 8-1-11
(Date)

AUG 01 2011

Phase and Activities of the Wraparound Process



Phases and Activities of the Wraparound Process



Phases and Activities of the Wraparound Process: Phase 1

AUG 0 1 2011

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 1: Engagement and team preparation		
<p><i>During this phase, the groundwork for trust and shared vision among the family and wraparound team members is established, so people are prepared to come to meetings and collaborate. During this phase, the tone is set for teamwork and team interactions that are consistent with the wraparound principles, particularly through the initial conversations about strengths, needs, and culture. In addition, this phase provides an opportunity to begin to shift the family's orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. The activities of this phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as quickly as possible.</i></p>		
<p>1.1. Orient the family and youth GOAL: To orient the family and youth to the wraparound process.</p>	<p>1.1 a. Orient the family and youth to wraparound In face-to-face conversations, the facilitator explains the wraparound philosophy and process to family members and describes who will be involved and the nature of family and youth/child participation. Facilitator answers questions and addresses concerns. Facilitator describes alternatives to wraparound and asks family and youth if they choose to participate in wraparound. Facilitator describes types of supports available to family and youth as they participate on teams (e.g., family/youth may want coaching so they can feel more comfortable and/or effective in partnering with other team members).</p>	<p>This orientation to wraparound should be brief and clear, and should avoid the use of jargon, so as not to overwhelm family members. At this stage, the focus is on providing enough information so that the family and youth can make an informed choice regarding participation in the wraparound process. For some families, alternatives to wraparound may be very limited and/or non-participation in wraparound may bring negative consequences (as when wraparound is court ordered); however, this does not prevent families/youth from making an informed choice to participate based on knowledge of the alternatives and/or the consequences of non-participation.</p>
	<p>1.1 b. Address legal and ethical issues Facilitator reviews all consent and release forms with the family and youth, answers questions, and explains options and their consequences. Facilitator discusses relevant legal and ethical issues (e.g., mandatory reporting), informs family of their rights, and obtains necessary consents and release forms before the first team meeting.</p>	<p>Ethical and legal considerations will also need to be reviewed with the entire team as described in phase 2.</p>

Phases and Activities of the Wraparound Process

Phases and Activities of the Wraparound Process: Phase 1

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 1: Engagement and team preparation		
<p><i>During this phase, the groundwork for trust and shared vision among the family and wraparound team members is established, so people are prepared to come to meetings and collaborate. During this phase, the tone is set for teamwork and team interactions that are consistent with the wraparound principles, particularly through the initial conversations about strengths, needs, and culture. In addition, this phase provides an opportunity to begin to shift the family's orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. The activities of this phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as quickly as possible.</i></p>		
<p>1.1. Orient the family and youth</p> <p>GOAL: To orient the family and youth to the wraparound process.</p>	<p>1.1 a. Orient the family and youth to wraparound</p> <p>In face-to-face conversations, the facilitator explains the wraparound philosophy and process to family members and describes who will be involved and the nature of family and youth/child participation. Facilitator answers questions and addresses concerns. Facilitator describes alternatives to wraparound and asks family and youth if they choose to participate in wraparound. Facilitator describes types of supports available to family and youth as they participate on teams (e.g., family/youth may want coaching so they can feel more comfortable and/or effective in partnering with other team members).</p>	<p>This orientation to wraparound should be brief and clear, and should avoid the use of jargon, so as not to overwhelm family members. At this stage, the focus is on providing enough information so that the family and youth can make an informed choice regarding participation in the wraparound process. For some families, alternatives to wraparound may be very limited and/or non-participation in wraparound may bring negative consequences (as when wraparound is court ordered); however, this does not prevent families/youth from making an informed choice to participate based on knowledge of the alternatives and/or the consequences of non-participation.</p>
	<p>1.1 b. Address legal and ethical issues</p> <p>Facilitator reviews all consent and release forms with the family and youth, answers questions, and explains options and their consequences. Facilitator discusses relevant legal and ethical issues (e.g., mandatory reporting), informs family of their rights, and obtains necessary consents and release forms before the first team meeting.</p>	<p>Ethical and legal considerations will also need to be reviewed with the entire team as described in phase 2.</p>

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Phases and Activities of the Wraparound Process: Phase 1 (CONTINTUED)

MAJOR GOALS	ACTIVITIES	NOTES
<p>1.2. Stabilize crises GOAL: To address pressing needs and concerns so that the family and team can give their attention to the wraparound process.</p>	<p>1.2 a. Ask family and youth about immediate crisis concerns Facilitator elicits information from the family and youth about immediate safety issues, current crises, or crises that they anticipate might happen in the very near future. These may include crises stemming from a lack of basic needs (e.g., food, shelter, utilities such as heat or electricity).</p> <p>1.2 b. Elicit information from agency representatives and potential team members about immediate crises or potential crises Facilitator elicits information from the referring source and other knowledgeable people about pressing crisis and safety concerns.</p> <p>1.2 c. If immediate response is necessary, formulate a response for immediate intervention and/or stabilization Facilitator and family reach agreement about whether concerns require immediate attention and, if so, work to formulate a response that will provide immediate relief while also allowing the process of team building to move ahead.</p>	<p>The goal of this activity is to quickly address the most pressing concerns. The whole team engages in proactive and future-oriented crisis/safety planning during phase 2. As with other activities in this phase, the goal is to do no more than necessary prior to convening the team, so that the facilitator does not come to be viewed as the primary service provider and so that team as a whole can feel ownership for the plan and the process.</p> <p>Information about previous crises and their resolution can be useful in planning a response in 1.2.c.</p> <p>This response should describe clear, specific steps to accomplish stabilization.</p>
<p>1.3. Facilitate conversations with family and youth/child GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning.</p>	<p>1.3 a. Explore strengths, needs, culture, and vision with child/youth and family. Facilitator meets with the youth/child and family to hear about their experiences; gather their perspective on their individual and collective strengths, needs, elements of culture, and long-term goals or vision; and learn about natural and formal supports. Facilitator helps family identify potential team members and asks family to talk about needs and preferences for meeting arrangements (location, time, supports needed such as child care, translation).</p>	<p>This activity is used to develop information that will be presented to and augmented by the team in phase 2. Family members should be encouraged to consider these topics broadly.</p>



Phases and Activities of the Wraparound Process

AUG 01 2011

Phases and Activities of the Wraparound Process: Phase 1 (CONTINUED)

MAJOR GOALS	ACTIVITIES	NOTES
<p>1.3. Facilitate conversations with family and youth/child</p> <p>GOAL: To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning. <i>(Continued from previous page)</i></p>	<p>1.3 b. Facilitator prepares a summary document</p> <p>Using the information from the initial conversations with family members, the facilitator prepares a strengths-based document that summarizes key information about individual family member strengths and strengths of the family unit, as well as needs, culture, and vision. The family then reviews and approves the summary.</p>	
<p>1.4. Engage other team members</p> <p>GOAL: To gain the participation of team members who care about and can aid the youth/child and family, and to set the stage for their active and collaborative participation on the team in a manner consistent with the wraparound principles</p>	<p>1.4 a. Solicit participation/ orient team members</p> <p>Facilitator, together with family members if they so choose, approaches potential team members identified by the youth and family. Facilitator describes the wraparound process and clarifies the potential role and responsibilities of this person on the team. Facilitator asks the potential team members if they will participate. If so, facilitator talks with them briefly to learn their perspectives on the family's strengths and needs, and to learn about their needs and preferences for meeting.</p>	<p>The youth and/or family may choose to invite potential team members themselves and/or to participate in this activity alongside the facilitator. It is important, however, not to burden family members by establishing (even inadvertently) the expectation that they will be primarily responsible for recruiting and orienting team members.</p>
<p>1.5. Make necessary meeting arrangements</p> <p>GOAL: To ensure that the necessary procedures are undertaken so the team is prepared to begin an effective wraparound process.</p>	<p>1.5 a. Arrange meeting logistics</p> <p>Facilitator integrates information gathered from all sources to arrange meeting time and location and to assure the availability of necessary supports or adaptations such as translators or child care. Meeting time and location should be accessible and comfortable, especially for the family but also for other team members. Facilitator prepares materials—including the document summarizing family members' individual and collective strengths, and their needs, culture, and vision—to be distributed to team members.</p>	

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Phases and Activities of the Wraparound Process: Phase 2

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 2: Initial plan development		
<p><i>During this phase, team trust and mutual respect are built while the team creates an initial plan of care using a high-quality planning process that reflects the wraparound principles. In particular, youth and family should feel, during this phase, that they are heard; that the needs chosen are ones they want to work on, and that the options chosen have a reasonable chance of helping them meet these needs. This phase should be completed during one or two meetings that take place within 1-2 weeks, a rapid time frame intended to promote team cohesion and shared responsibility toward achieving the team's mission or overarching goal.</i></p>		
<p>2.1. Develop an initial plan of care GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles</p>	<p>2.1 a. Determine ground rules Facilitator guides team in a discussion of basic ground rules, elicits additional ground rules important to team members, and facilitates discussion of how these will operate during team meetings. At a minimum, this discussion should address legal and ethical issues—including confidentiality, mandatory reporting, and other legal requirements—and how to create a safe and blame-free environment for youth/family and all team members. Ground rules are recorded in team documentation and distributed to members.</p>	<p>In this activity, the team members define their collective expectations for team interaction and collaboration. These expectations, as written into the ground rules, should reflect the principles of wraparound. For example, the principles stress that interactions should promote family and youth voice and choice and should reflect a strengths orientation. The principles also stress that important decisions are made within the team.</p>
	<p>2.1 b. Describe and document strengths Facilitator presents strengths from the summary document prepared during phase 1, and elicits feedback and additional strengths, including strengths of team members and community.</p>	<p>While strengths are highlighted during this activity, the wraparound process features a strengths orientation throughout.</p>
	<p>2.1 c. Create team mission Facilitator reviews youth and family's vision and leads team in setting a team mission, introducing idea that this is the overarching goal that will guide the team through phases and, ultimately, through transition from formal wrap-around.</p>	<p>The team mission is the collaboratively set, long-term goal that provides a one or two sentence summary of what the team is working towards.</p>



Phases and Activities of the Wraparound Process

Phases and Activities of the Wraparound Process: Phase 2 (CONTINTUED) AUG 0 1 2011

MAJOR GOALS	ACTIVITIES	NOTES
<p><i>2.1. Develop an initial plan of care</i></p> <p>GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wrap-around principles (Continued from previous page)</p>	<p><i>2.1 d. Describe and prioritize needs/goals</i></p> <p>Facilitator guides the team in reviewing needs and adding to list. The facilitator then guides the team in prioritizing a small number of needs that the youth, family, and team want to work on first, and that they feel will help the team achieve the mission.</p>	<p>The elicitation and prioritization of needs is often viewed as one of the most crucial and difficult activities of the wraparound process. The team must ensure that needs are considered broadly, and that the prioritization of needs reflects youth and family views about what is most important. Needs are not services but rather broader statements related to the underlying conditions that, if addressed, will lead to the accomplishment of the mission.</p>
	<p><i>2.1 e. Determine goals and associated outcomes and indicators for each goal</i></p> <p>Facilitator guides team in discussing a specific goal or outcome that will represent success in meeting each need that the team has chosen to work on. Facilitator guides the team in deciding how the outcome will be assessed, including specific indicators and how frequently they will be measured.</p>	<p>Depending on the need being considered, multiple goals or outcomes may be determined. Similarly, for each goal or outcome determined by the team for measurement, multiple indicators may be chosen to be tracked by the team. However, the plan should not include so many goals, outcomes, or indicators that team members become overwhelmed or tracking of progress becomes difficult.</p>
	<p><i>2.1 f. Select strategies</i></p> <p>Facilitator guides the team in a process to think in a creative and open-ended manner about strategies for meeting needs and achieving outcomes. The facilitator uses techniques for generating multiple options, which are then evaluated by considering the extent to which they are likely to be effective in helping reach the goal, outcome, or indicator associated with the need; the extent to which they are community based, the extent to which they build on/incorporate strengths; and the extent to which they are consistent with family culture and values. When evaluating more formal service and support options, facilitator aids team in acquiring information about and /or considering the evidence base for relevant options.</p>	<p>This activity emphasizes creative problem solving, usually through brainstorming or other techniques, with the team considering the full range of available resources as they come up with strategies to meet needs and achieve outcomes. Importantly, this includes generating strategy options that extend beyond formal services and reach families through other avenues and time frames. These are frequently brainstormed by the team, with the youth and family and people representing their interpersonal and community connections being primary nominators of such supports. Finally, in order to best consider the evidence base for potential strategies or supports, it may be useful for a wraparound team or program to have access to and gain counsel from a point person who is well-informed on the evidence base.</p>

Phases and Activities of the Wraparound Process: Phase 2 (CONTINUED) AUG 01 2011

MAJOR GOALS	ACTIVITIES	NOTES
<p><i>2.1. Develop an initial plan of care</i></p> <p>GOAL: To create an initial plan of care using a high-quality team process that elicits multiple perspectives and builds trust and shared vision among team members, while also being consistent with the wraparound principles (Continued from previous page)</p>	<p><i>2.1 g. Assign action steps</i></p> <p>Team assigns responsibility for undertaking action steps associated with each strategy to specific individuals and within a particular time frame.</p>	<p>Action steps are the separate small activities that are needed to put a strategy into place, for example, making a phone call, transporting a child, working with a family member, finding out more information, attending a support meeting, arranging an appointment. While all team members will not necessarily participate at the same level, all team members should be responsible for carrying out action steps. Care should be taken to ensure that individual team members, particularly the youth and family, are not overtaxed by the number of action steps they are assigned.</p>
<p><i>2.2. Develop crisis/safety plan</i></p> <p>GOAL: To identify potential problems and crises, prioritize according to seriousness and likelihood of occurrence, and create an effective and well-specified crisis prevention and response plan that is consistent with the wraparound principles. A more proactive safety plan may also be created.</p>	<p><i>2.2 a. Determine potential serious risks</i></p> <p>Facilitator guides the team in a discussion of how to maintain the safety of all family members and things that could potentially go wrong, followed by a process of prioritization based on seriousness and likelihood of occurrence.</p> <p><i>2.2 b. Create crisis/safety plan</i></p> <p>In order of priority, the facilitator guides team in discussion of each serious risk identified. The discussion includes safety needs or concerns and potential crisis situations, including antecedents and associated strategies for preventing each potential type of crisis, as well as potential responses for each type of crisis. Specific roles and responsibilities are created for team members. This information is documented in a written crisis plan. Some teams may also undertake steps to create a separate safety plan, which specifies all the ways in which the wraparound plan addresses potential safety issues.</p>	<p>Past crises, and the outcomes of strategies used to manage them, are often an important source of information in current crisis/safety planning.</p> <p>One potential difficulty with this activity is the identification of a large number of crises or safety issues can mean that the crisis/safety plan "takes over" from the wraparound plan. The team thus needs to balance the need to address all risks that are deemed serious with the need to maintain focus on the larger wraparound plan as well as youth, family, and team strengths.</p>
<p><i>2.3. Complete necessary documentation and logistics</i></p>	<p><i>2.3 a. Complete documentation and logistics</i></p> <p>Facilitator guides team in setting meeting schedule and determining means of contacting team members and distributing documentation to team members.</p>	



Phases and Activities of the Wraparound Process

Phases and Activities of the Wraparound Process: Phase 3

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MAJOR GOALS	ACTIVITIES	NOTES
PHASE 3: Implementation		
<p><i>During this phase, the initial wraparound plan is implemented, progress and successes are continually reviewed, and changes are made to the plan and then implemented, all while maintaining or building team cohesiveness and mutual respect. The activities of this phase are repeated until the team's mission is achieved and formal wraparound is no longer needed.</i></p>		
<p>3.1. Implement the wraparound plan</p> <p>GOAL: To implement the initial plan of care, monitoring completion of action steps and strategies and their success in meeting need and achieving outcomes in a manner consistent with the wrap-around principles.</p>	<p>3.1 a. Implement action steps for each strategy</p> <p>For each strategy in the wraparound plan, team members undertake action steps for which they are responsible. Facilitator aids completion of action steps by checking in and following up with team members; educating providers and other system and community representatives about wraparound as needed; and identifying and obtaining necessary resources.</p>	<p>The level of need for educating providers and other system and community representatives about wraparound varies considerably from one community to another. Where communities are new to the type of collaboration required by wraparound, getting provider "buy in" can be very difficult and time consuming for facilitators. Agencies implementing wraparound should be aware of these demands and be prepared to devote sufficient time, resources, and support to this need.</p>
	<p>3.1 b. Track progress on action steps</p> <p>Team monitors progress on the action steps for each strategy in the plan, tracking information about the timeliness of completion of responsibilities assigned to each team member, fidelity to the plan, and the completion of the requirements of any particular intervention.</p>	<p>Using the timelines associated with the action steps, the team tracks progress. When steps do not occur, teams can profit from examining the reasons why not. For example, teams may find that the person responsible needs additional support or resources to carry out the action step, or, alternatively, that different actions are necessary.</p>
	<p>3.1 c. Evaluate success of strategies</p> <p>Using the outcomes/indicators associated with each need, the facilitator guides the team in evaluating whether selected strategies are helping team meet the youth and family's needs.</p>	<p>Evaluation should happen at regular intervals. Exactly how frequently may be determined by program policies and/or the nature of the needs/goals. The process of evaluation should also help the team maintain focus on the "big picture" defined by the team's mission: Are these strategies, by meeting needs, helping achieve the mission?</p>
	<p>3.1. d. Celebrate successes</p> <p>The facilitator encourages the team to acknowledge and celebrate successes, such as when progress has been made on action steps, when outcomes or indicators of success have been achieved, or when positive events or achievements occur.</p>	<p>Acknowledging success is one way of maintaining a focus on the strengths and capacity of the team and its members. Successes do not have to be "big", nor do they necessarily have to result directly from the team plan. Some teams make recognition of "what's gone right" a part of each meeting.</p>

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Phases and Activities of the Wraparound Process: Phase 3 (CONTINUED)

MAJOR GOALS	ACTIVITIES	NOTES
<p><i>3.2. Revisit and update the plan</i></p> <p>GOAL: To use a high quality team process to ensure that the wraparound plan is continually revisited and updated to respond to the successes of initial strategies and the need for new strategies.</p>	<p><i>3.2. a. Consider new strategies as necessary</i></p> <p>When the team determines that strategies for meeting needs are not working, or when new needs are prioritized, the facilitator guides the team in a process of considering new strategies and action steps using the process described in activities 2.1.f and 2.1.g.</p>	<p>Revising of the plan takes place in the context of the needs identified in 2.1.d. Since the needs are in turn connected to the mission, the mission helps to guide evaluation and plan revisions.</p>
<p><i>3.3. Maintain/build team cohesiveness and trust</i></p> <p>GOAL: To maintain awareness of team members' satisfaction with and "buy-in" to the process, and take steps to maintain or build team cohesiveness and trust.</p>	<p><i>3.3 a. Maintain awareness of team members' satisfaction and "buy-in"</i></p> <p>Facilitator makes use of available information (e.g., informal chats, team feedback, surveys—if available) to assess team members' satisfaction with and commitment to the team process and plan, and shares this information with the team as appropriate. Facilitator welcomes and orients new team members who may be added to the team as the process unfolds.</p>	<p>Many teams maintain formal or informal processes for addressing team member engagement or "buy in", e.g. periodic surveys or an end-of-meeting wrap-up activity. In addition, youth and family members should be frequently consulted about their satisfaction with the team's work and whether they believe it is achieving progress toward their long-term vision, especially after major strategizing sessions. In general, however, this focus on assessing the process of teamwork should not eclipse the overall evaluation that is keyed to meeting identified needs and achieving the team mission.</p>
	<p><i>3.3 b. Address issues of team cohesiveness and trust</i></p> <p>Making use of available information, facilitator helps team maintain cohesiveness and satisfaction (e.g., by continually educating team members—including new team members—about wraparound principles and activities, and/or by guiding team in procedures to understand and manage disagreement, conflict, or dissatisfaction).</p>	<p>Teams will vary in the extent to which issues of cohesiveness and trust arise. Often, difficulties in this area arise from one or more team members' perceptions that the team's work—and/or the overall mission or needs being currently addressed—is not addressing the youth and family's "real" needs. This points to the importance of careful work in deriving the needs and mission in the first place, since shared goals are essential to maintaining team cohesiveness over time.</p>
<p><i>3.4. Complete necessary documentation and logistics</i></p>	<p><i>3.4 a. Complete documentation and logistics</i></p> <p>Facilitator maintains/updates the plan and maintains and distributes meeting minutes. Team documentation should record completion of action steps, team attendance, use of formal and informal services and supports, and expenditures. Facilitator documents results of reviews of progress, successes, and changes to the team and plan. Facilitator guides team in revising meeting logistics as necessary and distributes documentation to team members.</p>	<p>Team documentation should be kept current and updated, and should be distributed to and/or available to all team members in a timely fashion.</p>



Phases and Activities of the Wraparound Process

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Phases and Activities of the Wraparound Process: Phase 4

MAJOR GOALS	ACTIVITIES	NOTES
PHASE 4: Transition		
<p><i>During this phase, plans are made for a purposeful transition out of formal wraparound to a mix of formal and natural supports in the community (and, if appropriate, to services and supports in the adult system). The focus on transition is continual during the wraparound process, and the preparation for transition is apparent even during the initial engagement activities.</i></p>		
<p>4.1. Plan for cessation of formal wraparound GOAL: To plan a purposeful transition out of formal wraparound in a way that is consistent with the wraparound principles, and that supports the youth and family in maintaining the positive outcomes achieved in the wraparound process.</p>	<p>4.1 a. Create a transition plan Facilitator guides the team in focusing on the transition from wraparound, reviewing strengths and needs and identifying services and supports to meet needs that will persist past formal wraparound.</p>	<p>Preparation for transition begins early in the wraparound process, but intensifies as team meets needs and moves towards achieving the mission. While formal supports and services may be needed post-transition, the team is attentive to the need for developing a sustainable system of supports that is not dependent on formal wraparound. Teams may decide to continue wraparound—or a variation of wraparound—even after it is no longer being provided as a formal service.</p>
	<p>4.1 b. Create a post-transition crisis management plan Facilitator guides the team in creating post-wraparound crisis management plan that includes action steps, specific responsibilities, and communication protocols. Planning may include rehearsing responses to crises and creating linkage to post-wraparound crisis resources.</p>	<p>At this point in transition, youth and family members, together with their continuing supports, should have acquired skills and knowledge in how to manage crises. Post-transition crisis management planning should acknowledge and capitalize on this increased knowledge and strengthened support system. This activity will likely include identification of access points and entitlements for formal services that may be used following formal wraparound.</p>
	<p>4.1 c. Modify wraparound process to reflect transition New members may be added to the team to reflect identified post-transition strategies, services, and supports. The team discusses responses to potential future situations, including crises, and negotiates the nature of each team member's post-wraparound participation with the team/family. Formal wraparound team meetings reduce frequency and ultimately cease.</p>	<p>Teams may continue to meet using a wraparound process (or other process or format) even after formal wraparound has ended. Should teamwork continue, family members and youth, or other supports, will likely take on some or all of the facilitation and coordination activities.</p>

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Phases and Activities of the Wraparound Process: Phase 4 (CONTINUED)

MAJOR GOALS	ACTIVITIES	NOTES
<p>4.2. Create a "commencement"</p> <p>GOAL: To ensure that the cessation of formal wrap-around is conducted in a way that celebrates successes and frames transition proactively and positively.</p>	<p>4.2 a. Document the team's work</p> <p>Facilitator guides team in creating a document that describes the strengths of the youth/child, family, and team members, and lessons learned about strategies that worked well and those that did not work so well. Team participates in preparing/reviewing necessary final reports (e.g., to court or participating providers, where necessary)</p>	<p>This creates a package of information that can be useful in the future.</p>
	<p>4.2 b. Celebrate success</p> <p>Facilitator encourages team to create and/or participate in a culturally appropriate "commencement" celebration that is meaningful to the youth/child, family, and team, and that recognizes their accomplishments.</p>	<p>This activity may be considered optional. Youth/child and family should feel that they are ready to transition from formal wraparound, and it is important that "graduation" is not constructed by systems primarily as a way to get families out of services.</p>
<p>4.3. Follow-up with the family</p> <p>GOAL: To ensure that the family is continuing to experience success after wraparound and to provide support if necessary.</p>	<p>4.3 a. Check in with family</p> <p>Facilitator leads team in creating a procedure for checking in with the youth and family periodically after commencement. If new needs have emerged that require a formal response, facilitator and/or other team members may aid the family in accessing appropriate services, possibly including a reconvening of the wraparound team.</p>	<p>The check-in procedure can be done impersonally (e.g., through questionnaires) or through contact initiated at agreed-upon intervals either by the youth or family, or by another team member.</p>

District of Columbia Children's System of Care Guiding Principles

DMH Policy 340.10
Exhibit 2 - 8b(8)

- 1. Family Driven & Youth Guided:** A holistic approach that supports and recognizes all family members involved in a youth's care and upbringing, with the end goal of providing services that are successful and meaningful to the youth. Families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children. Youth and families have the right to be empowered, educated, and given a decision-making role. Youth and families are full participants in service planning, service delivery as well as the program procedures and policy development governing their care.
- 2. Individualized & Needs-Based:** Services and activities are customized, tailored, and guided by an individualized service plan that is comprehensive and based on the unique needs and strengths of the youth and their family.
- 3. Array of Services & Supports:** A comprehensive network of services and supports are readily accessible to youth and families to address the physical, emotional, social, developmental, and educational needs of youth. Clinically appropriate services exist along a continuum of care from early identification and early intervention through transition to adulthood.
- 4. High Quality:** Service delivery incorporates evidence-based, promising, and best practices in meeting the complex needs of youth and families. The rights of youth and families are protected and effective advocacy efforts are promoted.
- 5. Community-Based:** Community-based service options are fully explored so that services and supports take place in the most inclusive, normative, and least restrictive setting possible. The DC System of Care will continuously develop the capacity of the community to care for its youth and families, maximizing traditional and natural community resources.
- 6. Cultural Competence:** Policies and service delivery will demonstrate respect for the unique and diverse roles, values, beliefs, race, ethnicity, culture and gender of the youth, family, and their community.
- 7. Early Identification & Intervention:** Early identification and intervention is promoted to identify and address social, emotional, physical, and educational needs, enhance the likelihood of improved outcomes, and lessen the need for more intensive and restrictive services as adolescents and young adults.
- 8. Integrated Care:** Child-serving agencies will systematically coordinate efforts and blend resources to enhance the availability of traditional services, natural supports, and community resources and to avoid duplication of services and gaps in care. Agencies collaborate to ensure appropriate and clear transitions between levels of care and between youth and adult systems of care.
- 9. Strengths-Based:** Assessments comprehensively identify and services build on the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.
- 10. Outcomes-Based:** Goals and objectives identified in the individualized service plan are clearly understood and measurable, with supports and services helping youth to live with their families, achieve success in school, and avoid delinquency. Outcomes are used to drive decisions to further improve services for youth at the system and practice level.
- 11. Least Restrictive:** Services and supports are provided in the most inclusive, normative and least restrictive setting possible, to increase the likelihood of successful integration into family, home and community life.

Department of Mental Health

TRANSMITTAL LETTER

SUBJECT Child/Youth and Family Teaming		
POLICY NUMBER DMH Policy 340.11	DATE AUG 01 2011	TL# 152

Purpose. To establish the Core Services Agencies (CSA) and Community Based Intervention (CBI) provider requirements for the teaming process for Department of Mental Health (DMH) enrolled children and youth and their families.

Applicability. DMH Mental Health Authority, DMH-certified CSAs who serve children or youth and their families and CBI providers.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate MHA offices.

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

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

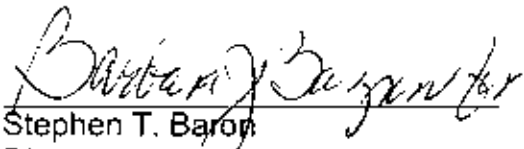
ACTION

REMOVE AND DESTROY

None

INSERT

DMH Policy 340.11


Stephen T. Baron
Director, DMH

<p style="text-align: center;">GOVERNMENT OF THE DISTRICT OF COLUMBIA</p> <p style="text-align: center;">*** [Redacted]</p> <p style="text-align: center;">DEPARTMENT OF MENTAL HEALTH</p>	<p>Policy No. 340.11</p>	<p>Date AUG 01 2011</p>	<p>Page 1</p>
	<p>Supersedes None</p>		
<p>Subject: Child/Youth and Family Teaming</p>			

1. **Purpose.** To establish Core Services Agencies (CSA) and Community Based Intervention (CBI) provider requirements for the teaming process for Department of Mental Health (DMH) enrolled children and youth and their families.
2. **Applicability.** DMH Mental Health Authority, DMH-certified CSAs who serve children or youth and their families, and CBI providers.
3. **Authority.** Department of Mental Health Establishment Amendment Act of 2001.
4. **Background.** In the 1980s the System of Care concept was developed in order to address the lack of integrated care for children with complex emotional/behavioral health needs and their families. During this time it was recognized that many children and youth were receiving fragmented services and not involved in their care planning process, resulting in poor outcomes. This national movement was initiated to strategically support family-driven and youth-guided service planning and delivery that was coordinated in a team-based framework.
5. **Goal.** To ensure that DMH CSAs and CBI Providers are able to provide child/youth and family teaming.
6. **Policy.** CSAs/CBI Providers shall ensure that all DMH enrolled children or youth and their families receive collaborative service planning.
7. **Definitions.** For the purposes of this policy:
 - 7a. **Child and Family Team (CFT)** - A group of individuals who the family believes can help them develop and implement a plan that will assist the child and family in realizing and achieving their vision of the future. The team should include the child and his/her family, a mental health representative, court involved partners, and any individuals important in the child's life and who are identified and invited to participate by the child and family. This may include, for example, teachers, extended family members, friends, community support workers, healthcare providers, relevant experts, coaches, representatives from churches, synagogues or mosques, and representatives from other child-serving systems like Child and Family Services Agency (CFSA), Department of Youth Rehabilitation Services (DYRS), DC Public Schools (DCPS), and Court Social Services (CSS). The size, scope and intensity of involvement of the team members is determined by level and complexity of need.
 - 7b. **Core Services Agency (CSA)** - a DMH-certified community-based MHRS provider that has entered into a Human Care Agreement with DMH to provide specified MHRS. A CSA shall provide at least one core service directly and may provide up to three core services via contract with a sub-provider or subcontractor. A CSA may provide specialty services directly if certified by DMH as a specialty provider.

7c. CBI Provider – Agencies certified by DMH to provide CBI services, consistent with the MHRS Standards and the Department of Mental Health Establishment Amendment Act of 2001. CBI providers shall be responsible for the treatment planning process while the child or youth is receiving CBI services (including the update of the IPC as necessary).

7d. CSA/CBI Teaming - A staff member shall be identified as the responsible person for coordinating service planning and the teaming process for each child/youth and family. Also see Section 8 for teaming elements, and guidance on who convenes the team if the child or youth is involved with another child servicing agency (e.g., DYRS, CFSA, or CSS).

7e. Individualized Plan of Care or "IPC" - The individualized plan of care for children and youth, which is the result of the Diagnostic/Assessment. The IPC is maintained by the consumer's CSA (or the CBI provider when a child is receiving CBI services). The IPC includes the consumer's treatment goals, strengths, challenges, objectives, and interventions. The IPC is based on the consumer's identified needs as reflected by the Diagnostic/Assessment, the consumer's expressed needs, and referral information. The IPC shall include a statement of the specific, individualized objectives of each intervention, a description of the interventions, and specify the frequency, duration, and scope of each intervention activity. The IPC is the authorization of treatment, based on certification that the MHRS are medically necessary by the approving practitioner.

7f. Family - The primary care-giving unit, including a biological, adoptive or self-created unit of people who may or may not be residing together and consisting of adult(s) and children, with adult(s) performing duties of parenthood for the children. Persons within this unit share bonds, culture, practices and significant relationships. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family.

7g. Wraparound services - services provided by trained contracted DMH providers that are provided to children and youth with the most intensive level of needs. Wraparound providers must abide by specific requirements and timelines as outlined in their contracts, and based on the National Wraparound Initiatives (NWI) Phases and Activities of the Wraparound Process and DC Children's System of Care Guiding Principles (see DMH Policy 340.10, High Fidelity Wraparound Care Planning Process).

8. CSA/CBI Teaming Elements. At a minimum, CSA/CBI teaming must include the following essential elements:

8a. Team Formation. Persons needed for planning are engaged and included in the teaming process. Also see Section 7a above.

8b. Team Functioning. Team members must communicate with each other based on the needs of the child and family to ensure service planning and delivery is coordinated. If there is a significant incident or event, team members may need to meet or convene a conference call with all essential parties.

- If another agency (e.g., DYRS, CFSA, or CSS) is not involved, the CSA/CBI provider will convene/facilitate/coordinate and document team meetings.
- If another agency (e.g., DYRS, CFSA, or CSS) is involved, the CSA/CBI provider will ask that agency to convene/facilitate/coordinate and document team meetings, and the CSA/CBI provider will attend and participate.

8c. Family Vision – The family's vision should identify the long term family goals which can encompass where the child and family like to reside, educational and vocational aspirations, and the building of relationships.

9. **Responsibilities.**

9a. **CSAs/CBI Providers** shall:

(1) **ensure** that a staff member is identified as the mental health team leader to coordinate mental health service planning and delivery that includes the family.

(2) **ensure** that the mental health teaming process is in accordance with the level of the child/youth and family's need, which will guide the frequency of contact, the sharing of information, and most appropriate responses needed to integrate clinical intervention with supports and resourcing.

(3) **ensure** that the child and family teaming process includes the teaming elements outlined in Section 8 above.

(4) **ensure** that team members are assigned individual tasks and held accountable for those tasks.

(5) **refer** children or youth with the most intensive level of needs for high-fidelity wraparound services when indicated. Also see DMH Policy 340.10, High Fidelity Wraparound Care Planning Process.

- A child and family may be referred for WRAP by contacting the DMH PRTE Diversion, Technical Assistance (TA), and Coaching for Children's Mental Health department at PRTE.Diversion@dc.gov to request a referral packet. The packet will include an instruction sheet, and contact numbers.

9b. **The Child and Youth Services Division, PRTE Diversion, TA, and Coaching for Children's Mental Health department.** Upon receipt of a completed referral packet, a staff member will review the referral packet for appropriateness for wraparound services and if appropriate, notify the referral source of the assigned wraparound provider.

10. **Evaluation and Monitoring and Training.**

10a. The DMH Community Services Review (CSR) department shall monitor and evaluate CSA/CBI provider adherence to the CSR indicators for team formation and team functioning through periodic, targeted case reviews conducted in accordance with the DMH CSR Protocol.

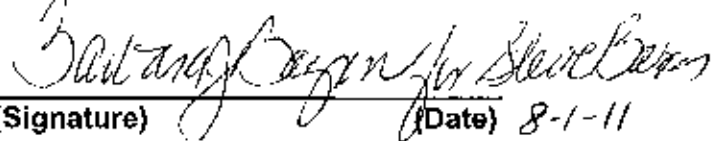
10b. Training on the child and family teaming process will be provided as needed by the Child and Youth Services Division.

11. Related References.

DMH Policy 340.5A, Maintaining Children and Youth in Their Homes
DMH Policy 340.10, High Fidelity Wraparound Care Planning Process

Approved By:

Stephen T. Baron
Director, DMH


(Signature) (Date) 8-1-11

IV: Narrative Plan

E. Data and Information Technology

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Narrative Question:

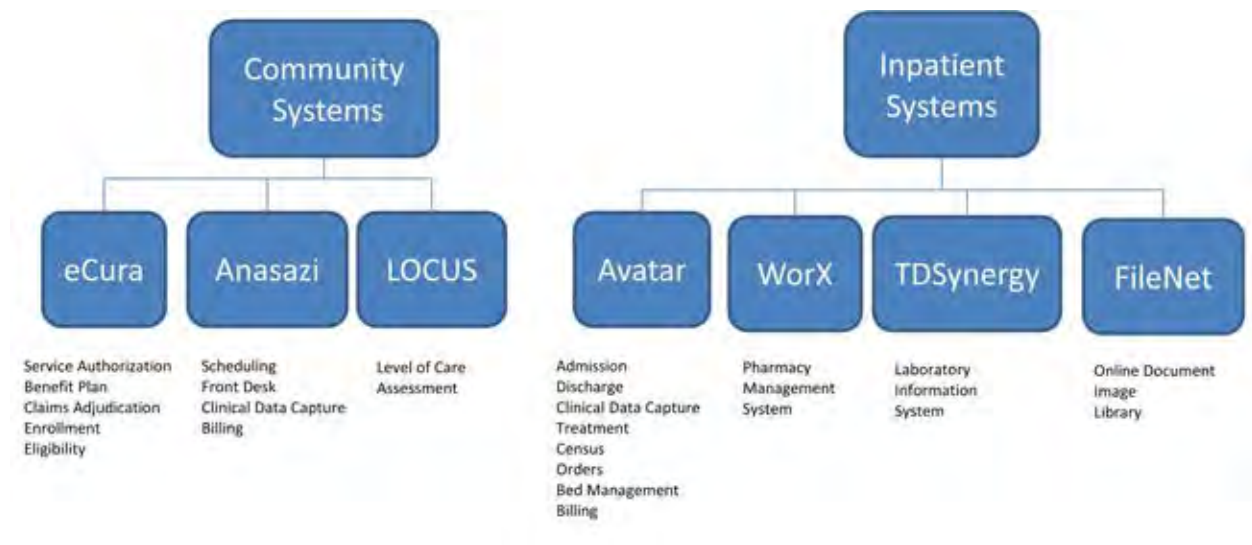
Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
 - Provider characteristics
 - Client enrollment, demographics, and characteristics
 - Admission, assessment, and discharge
 - Services provided, including type, amount, and individual service provider
 - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
 - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
 - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
 - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
 - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
 - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
 - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
 - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
 - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
 - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
 - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

The DMH IT system includes the following components:



The DMH IT topology is comprised of an integrated WAN of routers connecting multiple locations on a single protected network within the District of Columbia's infrastructure. Each location can access any of the servers, printers or shared resources within that topology.

Community Systems.

The community systems include eCura, Anasazi (a Client Data System for the Mental Health Services Division) and LOCUS/CALOCUS (a web-based application used to determine consumer functioning levels and identify appropriate level of care). In addition, the program staff use a number of small-specialized databases that can be accessed on the network or across the Internet. This provides the capability to record data on defined and specified measures included in the system. The DMH IT infrastructure utilizes state-of-the-art networking technology, data warehousing and mining technology, relational database management systems, all of which facilitate easy incorporation of data elements for recordation and reporting.

1. eCura

eCura is a managed care application that is used for enrollment, eligibility determinations, service authorization and claim adjudication. It tracks the majority of the outpatient services provided by public and private community agencies. Each provider qualified/certified to provide mental health services to DMH has a contract that specifies an agreed upon dollar value for Local funds, provider demographic data, and rates for services provided. All contracted providers within the District's mental health system utilize eCura through a web-based data portal call Provider Connect.

The system serves as the driving force for centralized claims processing, contracts management, provider payment, Medicaid reimbursement, budget and accounts management. eCura has been augmented with a Data Event Screen that captures mental health statistical data including demographic and clinical information that meets the

requirements of the URS and NOMS. The Quarterly Performance Data Event Screen requires providers to update client/consumer data every 180 days. The provider cannot request authorization for services until the required event data are completed. eCura complies with HIPAA regulations and adjudicates claims based on specific data rules. eCura uses a relational database structure. A data warehouse module has been implemented to facilitate comprehensive ad hoc reporting on any field in the database as well to allow data mining of all statistical data to support outcome analysis. Data reporting is available through eCura and is used to generate reporting for URS, NOMS and other business purposes, including compliance with the Dixon Consent decree and the LaShawn A. Consent decree.

The eCura validates Medicaid eligibility by matching enrollment data against the DHCF data in a bi-weekly update tape of matching data, to facilitate enrollment and serves as payer of last resort. eCura is designed to conform to HIPAA regulations and adjudicate claims based on certain valid data rules. Once a claim is adjudicated and approved, if the recipient is Medicaid-eligible, the claim is submitted to the Department of Health Care Finance (DHCF)¹ for payment. The system will also process claims for Medicaid non-reimbursable services, paying providers using locally appropriated funds.

In early FY2012 e-Cura will be updated with ANSI 5010 software that will allow eCura to continue to process claims received in the ANSI 4010 format but be capable of billing out in the ANSI 5010 format until such time as all providers are able to bill using the latest 5010 format. This implementation shall be phased and fully implemented by January 1, 2012.

2. Anasazi

An application called Anasazi by Anasazi Software is used by the Mental Health Services Division for its business processing needs and PanceaRX for ambulatory pharmacy management. The Mental Health Services Division encompasses the various government operated services offered by DMH, except for the crisis emergency services programs and Saint Elizabeth's Hospital. Anasazi is a practice management application that includes scheduling, treatment, and billing. Anasazi generates HIPAA compliant 837 claims files that are processed for payment through eCura

3. LOCUS/CALOCUS

DMH has adopted the Level of Care Utilization System (LOCUS) and the Child and Adolescent LOCUS (CALOCUS) to measure and track dimensions of functioning for mental health consumers. The LOCUS/CALOCUS was developed by American Association of Community Psychiatrists. Deerfield Behavioral Health developed a web-based application for clinicians to use in scoring the instrument.

DMH policy requires the completion of LOCUS and CALOCUS to assess initial and continuing authorization of certain services, and as a decision-support tool for Assertive

¹ The Department of Health Care Finance is the District's single state Medicaid agency.

Community Treatment (ACT), Community-Based Intervention (CBI) and Community Residence Facilities (CRFs).

Standard reports are available from the web-based application for both DMH and the providers. In addition, DMH has worked with the vendor to develop several highly customized reports, including an agency-level utilization report and a high-end service utilization and variance report for use by DMH staff and providers, which are discussed below in the section describing reporting capabilities.

4. Other Databases.

There are many small databases that exist to support programs and are maintained on individual work stations and although networked, result in a significant amount of data that is being collected outside of the core IT systems. During FY 09, DMH completed a resource map that identified and cataloged their data elements; however, for the most part, data reported from these systems only serves a relatively narrow group of stakeholders. Examples include: the housing database; the PRTF placement database; the Office of Accountability databases that track major unusual incidents, complaints, certification and licensure data; and the Office of Consumer and Family Affairs grievance database.

DMH, as part of its overall system redesign planning has developed specifications for a practice management system that would replace eCura and Anasazi, as well as incorporate some of the data currently collected and maintained on individual programs, further described below in the section discussing future plans.

Inpatient Systems -- AVATAR System.

AVATAR is the clinical management information system used to capture patient care services at Saint Elizabeths Hospital (SEH). The internet-based Avatar System has three integrated functions: (1) it serves as an electronic medical record and practice management system; (2) a laboratory database system; and (3) a pharmacy database system for St Elizabeths Hospital. All clinical units at the hospital report directly into the database, including adult acute care, adult continuing care and forensic inpatient service programs. Data is mined and developed into a report format by an Information Systems staff person.

In early 2011, the IBM FileNet document management system was implemented. The hospital scanned the paper records of the active patients into that application to allow all clinicians secure, online access to historical documentation. Reporting was also improved with the addition of a Crystal Reports Server that allows secure web based access to the hospitals frequently used reports.

Saint Elizabeths Hospital moved into a 450,000 state of the art facility in June 2010. This new facility provided a new VOIP telephone system, a fully wireless environment and speeds of up to 1 GB to the desktop – improving the overall infrastructure for the staff. Currently the hospital is looking to integrate automatic dispensing systems, and point-of-service scanning.

Reporting Capabilities.

Provider and client identifiers in the DMH IT system allow for linkage with Medicaid provider identifiers and provide the ability to aggregate Medicaid and non-Medicaid provider information.

Reports using Medicaid data or Medicaid data linked to DMH data are generated routinely. Such reports include the MHRS Service Utilization Report and the Provider Enrollment Report. DMH also receives regular extracts of MCO encounter data, which is linked with eCura data using Medicaid ID to develop an unduplicated count of persons receiving publicly funded mental health services.

DMH uses eCura ID numbers to prepare reports linking eCura and LOCUS/CALOCUS data. For example, ACT and CBI program managers are currently receiving data spreadsheets that present both client-level eCura claims data and LOCUS data from the web-based application to monitor overall utilization of these services, based on LOCUS/CALOCUS scores. A customized "High-end Service Utilization Variance Report," has been developed to identify consumers who may be over-utilizing or under-utilizing ACT or CBI services based on variance in recommended levels of care. The report is intended to assist the DMH to more effectively monitor access to these high-end services.

DMH is also currently receiving a customized report that details variance in LOCUS score in comparison to DMH housing program requirements. This report is being used by staff working in the Division of Adult Services to help determine if consumers receiving housing in DMH contracted CRFs are placed in the appropriate level of care.

Future Plans.

DMH plans to issue the RFP for an off the shelf practice management application by late FY 11. This practice management system is intended to replace eCura and Anasazi, as well as the Office of Consumer and Family Affairs grievance database and some of the Office of Accountability databases. Personnel for the effort are presently being recruited. The new practice management system is scheduled for modification and implementation in late FY 13. Legacy applications will operate in parallel as the new system is prototyped, built, tested and implemented. All providers will be required to use the new practice management system, which will include an electronic health record.

DHCF is also planning for implementation of an Administrative Services Organization (ASO) in FY 12. DMH staff participate in meetings about the ASO implementation.

DHCF received \$1 million under the State Planning and Establishment Grants for the Affordable Care Act's (ACA's) Exchanges. DHCF is the lead agency developing the HIT strategy for the District. DMH IT representatives participate in the meetings convened by DHCF regarding the District's health information exchange, interoperability, electronic health records and federal IT requirements.

In addition, the District recently received a Level 1 grant to develop a health insurance exchange. DMH staff will participate in the workgroup that will develop the exchange. The impact of this workgroup on existing plans is unknown at this time.

Barriers to Implementing an Encounter/Claims Based Approach to Payment.

The District already uses an encounter/claims based approach to payment for the MHRS program (both Medicaid and locally funded services). However, some locally funded services, such as supported employment and supported housing, are paid through an invoicing system and are not currently part of the encounter/claims based approach to payment. Payment for supported housing services will transition to eCura effective October 1, 2011.

Technical Assistance Needs.

DMH has a huge reporting deficit within its existing system. There are a number of stand-alone databases which contribute to concerns about data integrity and data management. Other areas where technical assistance is needed include:

- General reporting
- Refinement of performance and outcome measures
- Technical training on the use of electronic health records and new systems
- User documentation – implementing the “how tos” of system redesign
- Computer based training videos

IV: Narrative Plan

F. Quality Improvement Reporting

Page 43 of the Application Guidance

Narrative Question:

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

The DMH Office of Accountability (OA) ensures that service standards are upheld according to the DMH vision, mission, values and performance objectives and that mental health care practices adhere with District and federal standards and national state-of-the-art practices and evidence-based practices. OA also implements the compliance plan mandated by the Deficit Reduction Act (DRA). OA includes the Division of Quality Improvement (DQI), which is the organizational unit responsible for organizing, directing and coordinating quality improvement of services and supports.

DMH does not have a formally adopted CQI plan. However, there is an established quality improvement framework that is used by OA and DQI to organize, direct and coordinate quality improvement of services and supports. That framework is described below.

Quality Improvement Committees:

There are two standing Quality Improvement Committees at DMH. The first is the Internal Quality Committee (IQC), which was established in 2007. This committee is chaired by the DMH Deputy Director for Accountability and meets monthly. The IQC is made up of representatives from the Mental Health Services Division, the Comprehensive Psychiatric Emergency Program, Saint Elizabeths Hospital, and the Division of Quality Improvement. The IQC is responsible for the ongoing examination of quality improvement issues in the following areas:

- LOCUS/CALOCUS
 - Use of this tool for quality improvement in service delivery
- MHSIP
 - Use of consumer satisfaction data for Quality Improvement Initiatives
- Critical Incident Mortality Review Committee
 - Trending of mortality data with related recommendations for best practices
- Annual Quality Improvement Initiatives (QII): quarterly and yearly results
 - Covering defined areas
 - Data submitted by providers
- Provider Scorecard
 - Reflects performance of providers in the areas of Quality, Compliance and Financial
 - Trending analysis
 - Reflects various aspects of consumer utilization across the service delivery system

The second standing committee is the DMH Quality Council, which was established in 2003. This committee is chaired by the Director of Quality Improvement and its members consist of Quality Improvement Directors from DMH providers. The Quality Council meets quarterly and

receives direction and information from the IQC. The Quality Council focuses on the following areas:

- Sharing of quarterly QII results
- Analyzes LOCUS/CALOCUS data provided by OA
- Provider reports on quality activities
- Quarterly provider presentations of significant quality activities and best practice

The DMH quality improvement initiatives are guided by the Institute of Medicine (IOM) 2001 report, “Crossing the Quality Chasm: A New Health System for the 21st Century” which examined the quality of the healthcare system in the United States. The Quality Chasm report developed a framework and strategies for improvements in quality and identified six aims for high quality healthcare and ten rules for the redesign of the healthcare system. The Six Aims are:

- **Safe**—avoiding injuries to patients from the care that is intended to help them.
- **Effective**—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- **Patient-centered**—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that consumer values guide all clinical decisions.
- **Timely**—reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient**—avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable**—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic locations, and socioeconomic status.

A copy of the letter announcing the 2011 Quality Initiatives is attached and marked as Attachment F-1.

Recent Quality Improvement Activities

1. Health and Wellness (Integration of Physical Health and Mental Health)

Co-morbidity Reviews- In 2008, OA began a hospital co-morbidity study of consumers with medical and psychiatric diagnoses. The Co-morbidity Reviews are part of the effort to achieve the highest quality of care possible for patients at Saint Elizabeths Hospital by ensuring that medical/physical, as well as, psychiatric patient care needs are fully integrated and documented in the record. The initial audits involved chart reviews and showed some improvement in the integration of medical and psychiatric information in documentation and treatment planning. It

was determined that the information needed for the audits was transferred from the chart to the AVATAR electronic medical record.

The auditors were trained on how to locate information critical to the co-morbidity review (i.e., progress notes, assessments, treatment plans, lab results, vital signs, nursing assessment, psychiatric assessment, physical exam, risk assessments for falls, choking, dementia, and bowel obstruction, and referrals for outside medical treatment). During this process it was discovered that some of the information required for the co-morbidity review was either not present in the electronic record or not fully recorded in the record due to the evolving functionality of this system. The co-morbidity reviews using the AVATAR system were scheduled to resume in June 2011.

Quality Improvement Initiative – Medical Co-Morbidity- **This** QI Initiative to increase the number of consumers linked to primary care providers began in 2009. In FY 2011, the QI Initiative requires CSAs to track two (2) groups of consumers, using a sample provided by DMH. The first group is a random sample of 15 consumers that providers monitor across all four (4) quarters. The second group is a random sample of consumers proportional to the size of the agency. The consumers in the second group will change each quarter. Each CSA reviews these records on a quarterly basis to ascertain whether:

- a) The CSA has any current documentation on the consumer's general medical condition from the primary care provider and;
- b) The CSA's IRP includes a plan for addressing medical problems identified on Axis III. This includes the utilization of Schizophrenia Quality Improvement Plan (SQIP) brochures, posters, and handbooks for health teaching.

For the purposes of this QI Initiative, general medical conditions should be listed on Axis III. Examples of current documentation from the primary care provider include: a physical examination performed within the year, laboratory results from the primary care provider within the year, current list of medications from the primary care provider. CSAs with consumers in the sample who have an Axis III diagnosis and do not meet criteria (a) or (b) should request the primary care treatment records and revise the IRP to include a plan for addressing medical problems by the following quarter.

FY 2010 data for consumers linked to a primary care physician (PCP) shows that during the first quarter 84% were linked, and by year end 97% of consumers had been linked to a PCP. FY 2011 data for the second quarter shows that 73% of consumers had a physical examination in a year, 51% had lab results within a year, and 72% had a current list of medication from the PCP.

2. Provider Scorecard

In FY 2010, the OA implemented the Provider Scorecard that was piloted in FY 2009. This process included revision of the tools used to collect data for the Scorecard, as well as site visits and other data collection activities. The OA staff conducted chart reviews at 22 core service agencies (CSAs) in order to collect data for the Quality Review section of the Scorecard. The

Provider Scorecards assess three (3) domains for each provider: Quality, Financial, and Compliance with regulations. The results of assessments in these areas allow DMH to give each CSA a rating on a Five Star scale.

Only providers who could be assessed across all domains were issued a Scorecard in FY 2010. Sixteen (16) providers were assessed across all three (3) domains, and were issued an overall Scorecard score for FY 2010. The overall Scorecard score for each CSA was published among all providers on February 28, 2011. The FY 2011 Scorecard will incorporate revisions based on feedback from DMH Senior Staff and community providers. It will be published to the general public in January or February 2012.

Data Reporting Capabilities and Quality Improvement Activities

In addition to the work of OA and DQI, as well as the IQC and QC, there are other programs within DMH generating data that is used for quality improvement purposes.

Applied Research and Evaluation (ARE) Unit: The DMH ARE Unit within Organizational Development has been providing data since October 2009. This Unit implements both measurement and capacity-building activities that enhance the use and application of data to improve system functioning and quality of care. The Director is also the principal investigator for the DIG. ARE facilitates the use of data within DMH and addresses specific questions with research and evaluation methodology. That is, to understand the nature of the data currently being collected, refine and enhance its quality, aggregate it into meaningful new configurations and to design targeted, small scale studies. ARE is comprised of a multidisciplinary team of individuals with a primary emphasis on collecting and using data from particular DMH program areas. By looking at the data across programs, program staff will be able to identify resources and strategies being used by other programs to enhance their data collection, utilize methods and IT infrastructure, or collaborate with other program areas.

The primary activities include: 1) conduct data analyses and develop reports for federal, state and local programs; 2) keep abreast of the literature and national trends; 3) provide accurate and timely reports; and 4) support quality improvement efforts. Enhancements have been made to capture data for the following programs and/or activities: Care Coordination; School Mental Health Program; Child and Family Services Agency (CFSA) initiatives; Housing; Supported Employment; Psychiatric Residential Treatment Facility; Community-Based Intervention; and evidence-based practices.

ARE has developed a data reports and deliverable schedule to provide the following reports on a monthly, quarterly or annual basis: LOCUS/CALOCUS; Key Performance Indicators; Client Level Outcomes Assessment; Child and Youth Services Division Reports; CFSA Utilization; ChAMPS Performance Statistics; Child and Youth Services Dashboard; Crisis Intervention Officer Monitoring; Integrated Care Evaluation; Mental Health Statistics Improvement Program (MHSIP); and URS Tables. The analysis of the MHSIP and the CSR data are included as Attachment F-2.

Saint Elizabeths Hospital Data Analysis and Reporting: Provides ongoing quantitative data to the hospital, DMH, and other stakeholders in order to enhance the quality of clinical practice and performance. The data analysis and reporting activities include: 1) risk management and unusual incident investigations; 2) hospital wide data collection; 3) database development and management; 4) data analysis and presentation; 4) in-depth studies; 5) performance improvement initiatives and implementation; and 6) audit development and implementation.

Reports include:

- PRISM Report- monthly data publication which documents 12-month trends in 17 key performance indicators in the areas of: census, unusual incidents, medication, and clinical practice.
- Trend Analysis-yearly data publication that presents trends in census, admission, discharge and transfer information, demographic characteristics of the individuals in care, length of stay, readmissions, clinical profile captured in all five (5) axes of DSM-IV-TR, medication related data, and unusual incidents. Analysis results are presented visually in charts or tables, along with bullet points describing key findings and interpretations in every section.
- Clinical Audits- there are a total of 25 monthly audits, each of which has 12 to 50 indicators. In some audits, the sample size is 20 % while in others; the sample size is two (2) per clinician. Audits include:
 - IRP and multi-disciplinary practice audits- IRP observation, clinical chart audit, discharge, and transfer;
 - Disciplinary audits: initial/update assessments and progress note of each discipline (psychiatry, psychology, medical, nursing, social work, and rehabilitation); and
 - Other treatment related audits: treatment mall facilitation, therapeutic progress note, COD, involuntary emergency medication, tardive dyskinesia, and restraint/seclusion.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH



December 16, 2010

Dear MHRS Quality Improvement Director:

As we discussed at the last quarterly DMH Quality Council meeting, the Department is launching new mandatory community based quality initiatives for FY 2011. The FY 2011 Quality Improvement Initiatives were derived from the Office of Accountability's analysis of trends in major reportable incidents, mortality reviews, major investigations, quality reviews, and the FY 10 QI initiative outcomes. The 2011 QI Initiatives also include recommendations from the DMH Internal Quality Committee. The FY 2011 Quality Improvement Initiatives are as follows:

(1) Medical Co-Morbidity:

We will be continuing our medical co-morbidity QI initiative, but we will change the way we sample this cohort. While in the past providers have chosen their own random sample, this year DMH will provide the sample to providers from their consumer roster. You are required to track two groups for this initiative in FY 2011. The first group is a random sample of fifteen (15) consumers that you will monitor across all four quarters. The second group is a random sample of consumers proportional to the size of your agency. The consumers in the second group will change each quarter. The Office of Accountability will provide you with the sample for both groups.

Each core service agency will internally review these records on a quarterly basis to ascertain whether:

- a. The CSA has any current documentation on the consumer's general medical condition from the primary care provider *and*;
- b. The CSA's IRP includes a plan for addressing medical problems identified on Axis III. This includes the utilization of SQIP brochures, posters, and handbooks for health teaching.

For the purposes of this QI Initiative, general medical conditions should be listed on Axis III. Examples of current documentation from the primary care provider include: a physical examination performed within the year, laboratory results from the primary care provider within the year, current list of medications from the primary care provider.

CSAs with consumers in the sample who have an Axis III diagnosis and do not meet criteria (a) or (b) should request the primary care treatment records and revise the IRP to include a plan for addressing medical problems by the following quarter.

(2) Clinical Supervision:

Thirty (30) clinical records will be reviewed quarterly by each CSA for (a) documentation of clinical supervision on the consumer's medical record, and (b) documentation of clinical supervision in the personnel file for the credentialed staff providing services to the consumer.

(3) LOCUS/CALOCUS DOMAINS AND TREATMENT PLANNING:

This QI initiative is designed to foster integration of level of care data with ongoing treatment planning. Thirty (30) clinical records will be reviewed twice during the year by each Core Service Agency to ascertain whether LOCUS/CALOCUS dimension score data (for dimension scores of three (3) or above) are being used to inform the treatment planning process. Demonstrated use will be evidenced by incorporation of the consumer's dimension scores into the treatment plan goals, objectives, and/or intervention. The Office of Accountability will provide you with the sample.

These initiatives will be monitored during the next twelve months. Report your quarterly data findings on these initiatives to the Office of Accountability (OA). The due dates for quarterly data submissions to OA are as follows:

FY 2010 Quarter Data Range	Date for Submission to OA
Q1: 11/1/10 – 12/31/10	February 1, 2011
Q2: 1/1/11 – 3/31/11	May 1, 2011
Q3: 4/1/11 – 6/30/11	August 1, 2011
Q4: 7/1/11 – 9/30/11	November 1, 2011

If you have any questions about these QI Initiatives, then please contact me at (202) 673-2255 or andrew.pollock@dc.gov. The next meeting of the Quality Council will be held on March 17, 2011 at 9:30 a.m. I look forward to seeing you there to review the data submissions for the 1st quarter of FY 2010.

Sincerely,

Andrew Pollock
Acting Director of Quality Improvement
DMH Office of Accountability

MHSIP and CSR Analysis
(SAMHSA Strategic Goals 7.1 and 7.2)

Mental Health Statistics Improvement Program (MHSIP) Surveys–Adults:

2011 MHSIP Survey- DMH is in discussion with the Consumer Action Network (CAN) to conduct the 2011 adult MHSIP Survey and the Youth Services Survey for Families (YSS-F).

2010 MHSIP Survey- This survey was conducted between October 1, 2010 and December 30, 2010. Random sampling (probability sample) was used with adult consumers who received two (2) or more mental health rehabilitation services (MHRs) during the period December 1, 2009 through June 30, 2010. In an attempt to mitigate low response rates and inaccurate contact data, oversampling was used. Also, in order to encourage the best possible response rates an incentive (\$10.00 gift card) was given. Translation services included bi-lingual Spanish/English surveyors and Language Access Line services were also available.

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

Sample: The sample overview includes: 1) overall eligible sample 12,843; 2) over-sample 1,119; 3) optimal sample for 95% confidence level (+/-5) 373; 4) surveys completed 355; 5) overall response rate 31% (number of surveys/over-sample); 6) telephone survey 9% success rate per call (2,465/227); and 6) mail survey 30% success rate per mailing (395 mailed/50 returned to sender/120 surveys).

Demographics: The adult demographics include the following: 1) gender (n=347) with 204 males and 143 females; 2) ethnicity (n=347) with 6 Hispanic and 341 non-Hispanic; 3) race (n=347) with 314 African-American, 7 Caucasian, 18 Other, and 2 Asian; 4) age (n=347) with an age range of 18-78 and the mean = 47.

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

Positive Responses: The adult consumer percentage of positive responses includes: 1) Overall = 81%; 2) Access = 80%; 3) Quality and Appropriateness = 84%; 4) Outcomes =70%; 5) Participation in Treatment = 78%; 6) General Satisfaction = 83%; 7) Functioning =76%; and 8) Social Connectedness =75%.

Differences by Demographics and Diagnosis: There were no significant gender differences on the MHSIP domains. There were no significant age differences on MHSIP domains. A trend was observed for differences in participation in treatment. Individuals in the 65-84 age group perceived less participation in their treatment than other age groups. Consumer ratings of satisfaction in this area tend to decline with age. There was no significant difference between African-American and the “Other” ethnic group on MHSIP domains. Individuals with psychotic disorders rate the “Quality and Appropriateness” of their care significantly lower than individuals with mood disorders. They also tend to perceive lower “Participation in Treatment.”

Differences in Perception of Care and Outcomes by Providers: A highly significant difference between providers emerged on ratings of “General Satisfaction,” with the difference between the largest provider (Community Connections) and other small providers accounting for this difference. A trend emerged on “Access” to services with consumers from Life Stride and Community Connections rating “Access” the highest, and consumers from Washington Hospital Center (WHC) and “Other” providers the lowest. A trend was observed for overall survey results, with Community Connections and Life Stride receiving the most positive average ratings overall, and McClendon Center, WHC, and the “Other Provider” group receiving lower ratings.

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

Mental Health Statistics Improvement Program (MHSIP) Survey- Youth:

2010 MHSIP Survey- The Youth Services Survey for Families (YSS-F) used the same procedures as the adult survey related to: 1) time period of survey; 2) random sampling procedure; 3) oversampling; 4) incentive for participation; 5) translation services; 6) mixed methods design; and 7) contractor.

Sample: The sample overview includes: 1) overall eligible sample 2,698; 2) over-sample 1,011; 3) optimal sample for 95% confidence level (+/-5) 337; 4) surveys completed 278; 5) overall response rate 27% (number of surveys/over-sample); 6) telephone survey 12% success rate per call (1,418/167); and 6) mail survey 29% success rate per mailing (386 mailed/34 returned to sender/111 surveys).

Demographics: The child demographics include the following: 1) gender (n=273) with 169 males and 104 females; 2) ethnicity (n= 272) with 12 Hispanic and 260 non-Hispanic; 3) race (n= 272) with 255 African-American, 3 Other, and 2 Caucasian; 3) age (n=267) with an age range of 5-18 and the mean = 11.27.

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

Positive Responses: The parent/guardian percentage of positive responses includes: 1) Overall = 76%; 2) Access =76%; 3) Satisfaction with Services =75%; 4) Outcomes = 63%; 5) Participation in Treatment = 75%; 6) Cultural Sensitivity = 90%; 7) Social Connectedness = 83%; and 8) Functioning = 64%. Overall survey scores are lower than the scores for adults, at 76%.

Differences by Demographics and Diagnosis: There were no significant gender, age and diagnosis differences on the YSS-F domains. Ratings of “Cultural Sensitivity” varied significantly by provider. Community Connections and First Home Care had the highest mean ratings. Launch and Scruples had the lowest mean ratings. Ratings of “Social Connectedness” varied significantly by provider.

Type and Amount of Service Predictors for Parental Perceptions of Care: Higher frequency of Community-Based Intervention (CBI) contacts predicted lower ratings on: Access, Participation in Treatment, Cultural Sensitivity, Outcomes, Functioning and Overall perception of care and outcomes. Higher frequency of Counseling contacts predicted lower ratings on

Participation in Treatment. Higher frequency of Community Support contacts predicted higher ratings on General Satisfaction.

Recommendations for Quality Improvement: Rates of perceived progress in achieving outcomes and improved functioning have increased, but continue to be the lowest rated domains for both children and adults. Parental perceptions of involvement in treatment have decreased from 84% in 2009 to 75% in 2010. Additional analysis is needed to determine characteristics of consumers who perceive greater or less involvement in treatment. Also, specific providers should be targeted to improve teaming and engagement in treatment.

Certain providers consistently received higher ratings across domains, relative to others. This pattern was particularly pronounced within the adult sample. MHSIP results mirror the Community Services Review (CSR) results. There is a need to: 1) identify and disseminate best practices for high performing agencies, and 2) develop peer learning communities to support development in key areas of practice. Higher rating of CBI significantly predicted lower ratings on most YSS-F domains. Additional data needs to be collected to: 1) analyze provider level data; 2) conduct quality reviews of CBI services; and 3) analyze additional CSR data on CBI consumers.

Community Services Review (CSR):

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

Summary of Children/Youth Findings- The Child/Youth CSR was completed in May 2011 – with a total of 87 cases reviewed. Trained DMH staff reviewed 33% of the cases. Human Systems and Outcomes (HSO) provided case judging for most of the cases reviewed, including all of the cases that were reviewed by DMH staff to ensure inter-rater reliability.

In terms of child status, DMH scored at a 77% level, which is highly consistent with past reviews. Areas of strength continued to be child safety (82%), appropriate home and school placement 91% and physical well-being (97%).

The Dixon performance standard measures system performance – with a requirement for an 80% positive rating. For 2011, DMH scored at a level of 59%, which is considerable improvement over prior years – 49% (2010) and 48% (2009). Some of the major areas of weakness in past child/youth reviews showed marked improvement, including service team formation (59% vs. 45% for last year), service team functioning (49% vs. 33%) and long-term guiding view (48% vs. 32%).

As in prior years, there is large variability in scores across the individual CSAs. It is clear that the targeted training interventions have had a positive impact on lower performing CSAs, but the issue of consistency continues to be elusive, particularly for the smaller CSAs. Staff turnover is an issue, as it underscores DMH efforts to create a certification process for the Community Support Worker (CSW) positions within CSAs. Turnover supports the need for continued emphasis on clinical supervision and feedback to CSWs and therapists. Overall, the child review is encouraging but with continued efforts needed.

Summary of Adult Findings- The Adult CSR Review was conducted in February 2011 and included intensive reviews of 78 adult consumers of mental health services. HSO continued to oversee the quality and integrity of individual reviews via the case judging process. The overall FY 2011 results for consumer status was that 80% of the cases had an acceptable rating, which is exactly the same as last year. There were three (3) areas that continued to show high marks in the measurement of consumer status; with safety at 88%, living arrangements at 83%, and satisfaction with services at 91%. Areas of social network (65%), education/work (46% and 61%, respectively) and economic security (69%) were identified as areas that need continued improvement.

The FY 2011 result for system performance was at 78%, which is very consistent with last year's performance of 77% and slightly below the Court requirement of 80% for system performance. The overall functioning of service teams was up somewhat from last year (63% vs. 60%); Individualized Recovery Plans (IRPs) were acceptable in 78% of the cases, an increase of 4% from 2010. As in 2010, the larger agencies (with a larger sample size) were much more likely to score well. Green Door and Community Connections were singled out as providing "considerable amounts of quality services." The key factor to success appears to be internal CSR commitment and capacity to measure and improve quality practice. HSO made an important finding in noting that for the first time, the problem issues that were frequently identified were more unique to a given CSA as opposed to the system as a whole.

IV: Narrative Plan

G. Consultation With Tribes

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Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

There are no Tribes located within the District of Columbia. No consultation is required.

IV: Narrative Plan

H. Service Management Strategies

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Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

The District of Columbia expects to receive \$752,000 in Mental Health Block Grant funds in FY 2012. Five percent (5%) of the award (\$37,600.50) is allocated for administrative costs, leaving a total of \$ 714,409.50 available to fund services. Given the amount of funding available, DMH elected to use sub-grants to make awards to non-DMH projects and transfer funds for DMH-operated programs to those programs via journal entry. Subgrantees are required to report quarterly on the services rendered, including the number of persons served by the program. DMH operated programs are required to submit quarterly reports to the State Mental Health Planning Council as well as report on performance indicators developed for the individual programs. Some of the DMH performance indicators are included in the DMH Annual Performance Management Plan (a set of performance initiatives and indicators that is reported to the Office of the Mayor and the Council of the District of Columbia, as well as the U.S. Congress).

In accordance with past practice, the State Mental Health Planning Council issued a request for projects in June 17, 2011. A copy of the request for projects is attached and marked as Attachment H-1. Applicants were asked to identify the SAMHSA Strategic Goal associated with their individual proposal.

The projects selected for funding are as follows:

Organization	Project Name	SAMHSA Initiative	SAMHSA Goal	Target Population	Purpose	Funding
Miriam's Kitchen	Therapeutic Thursdays	Strategic Initiative #1 - Prevention of Substance Abuse and Mental Illness	Goal 1.1: With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.	Chronically homeless men and women	Improve access to healthcare, physical and behavioral health	\$15,000.00
Mary's Center for Maternal and Child Care, Inc.	Mary's Center SBIRT (Screening, Brief Intervention and Referral to Treatment) Pilot Program	Strategic Initiative #1 - Prevention of Substance Abuse and Mental Illness	Goal 1.1 With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.	Ages 13 -21	Pilot SBIRT to increase access to mental health and substance use disorder care	\$15,000.00
Time Dollar Youth Court, Inc.	Youth Court Substance Abuse Assessment Program	Strategic Initiative #1 - Prevention of Substance Abuse and Mental Illness	Goal 1.1 With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.	36 Youth 12-17	Implement substance use disorder assessment program, also identify behavior issues	\$15,000.00
Institute of Urban Living, Inc.	The Hyacinth's Place Project	Strategic Initiative #1 - Prevention of Substance Abuse and Mental Illness	Goal 1.1 With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.	15 women who are homeless with mental health diagnosis	Provide home and support services	\$15,000.00

Organization	Project Name	SAMHSA Initiative	SAMHSA Goal	Target Population	Purpose	Funding
Advocates for Survivors of Torture and Trauma	Strengths Based Model Psychotherapy Groups for Torture Survivors	Strategic Initiative #2 - Trauma and Justice	Goal 2.2 Make screening for trauma and early intervention and treatment common practice.	50-60 torture survivors	Provide 2-hour weekly psychotherapy sessions, women group and co-ed group	\$18,000.00
The Spoken Word	Lens and Pens Creative Expression Project	Strategic Initiative #2 - Trauma and Justice	Goal 2.4 Address the needs of people with mental disorders, substance use disorders, or co-occurring disorders and with associated histories of trauma in the criminal and juvenile justice systems.	10-20 Adults with SMI in Forensic Unit at Saint Elizabeths Hospital	Explore creative talents and skills to support community re-integration	\$9,000.00
N Street Village	N Street Village Trauma-Informed Care Project	Strategic Initiative #2 - Trauma and Justice	Goal 2.1: Develop a comprehensive public health approach to trauma.	Women with multiple issues: homeless, SMI, addiction, trauma, criminal justice	Provide 20 women TREM model	\$17,500.00
So Others Might Eat (SOME) Behavioral Health Services	STOP: Standardizing Trauma Informed Opportunities Project	Strategic Initiative #2 - Trauma and Justice	Goal 2.2: Make screening for trauma and early intervention and treatment common practice. Goal 2.3: Reduce the impact of trauma and violence on children, youth, and families.	Homeless, chronically ill, unemployed, SMI, SUD, co-occurring disorders	Assessment of capacity to deliver trauma-informed behavioral health care; evaluate at client level	\$15,000.00
La Clinica del Pueblo	<i>Mi Familia</i> (My Family)	Strategic Initiative #2 - Trauma and Justice	Goal 2.3: Reduce the impact of trauma and violence on children, youth, and families.	Latinos with PTSD, depression, and anxiety; Children, adolescents and families. Family mental health therapy with 20 children, adolescents and parents; 10 families	Hire Family Therapist to provide 1-on-1 couples and family therapy for children, teens and their parents	\$15,000.00
FamilyLinks Outreach Center, Inc.	FamilyLinks Outreach Center	Strategic Initiative #4 – Recovery Support	Goal 4.1: (Health) Promote health and recovery-oriented service systems for individuals with or in recovery from mental and substance use disorders.	Adults SMI age 50-85	Foster self-esteem, actively engage in good health practices and the world around them	\$15,000.00

Organization	Project Name	SAMHSA Initiative	SAMHSA Goal	Target Population	Purpose	Funding
The Women's Collective	LIFTing Women Coping with HIV, Trauma and Substance Use	Strategic Initiative #4 – Recovery Support	Goal 4.1: (Health)	Low income African American women 18 and over living with HIV/AIDS, trauma, substance use disorder	Reduce barriers to access, therapy, unprotected sex, substance use	\$7,718.00
Open Arms Housing, Inc.	Open Arms Housing Peer Support	Strategic Initiative #4 – Recovery Support	Goal 4.4: (Community) Promote peer support and the social inclusion of individuals with or in recovery from mental and substance use disorders in the community.	16 adult women living on the streets, middle age to elderly, MI, SUD, health issues, PTSD	Hire Peer Support Counselor	\$15,000.00
Family Voices of D.C.	The C.O.D. Initiative: Public Awareness Education-Best and Promising Practices for a Stronger System of Care for Children and Youth with Co-Occurring Disorders	Strategic Initiative #5 – Health Reform Strategic Initiative #7 – Data, Outcomes and Quality Strategic Initiative #8 – Public Awareness and Support	5.1: Ensure that behavioral health is included in all aspects of health reform implementation. 7.4: Improve the quality and accessibility of surveillance, outcome and performance, and evaluation information for staff, stakeholders, funders, and policymakers. 8.1: Increase capacity for Americans to understand and to access treatment and recovery supports for behavioral health conditions 8.4: Get information to the workforce. 8.5: Increase social inclusion and reduce discrimination.	Children with developmental disorders and co-occurring mental disorders	Public awareness campaign to promote education and awareness of children with co-occurring disorders and resources available	\$17,500.00
D.C. State Mental Health Planning Council						\$24,691.50
DMH Projects						
Child/Youth Services Division	Primary Project in the Community Schools and Supervision	Strategic Initiative #1 - Prevention of Substance Abuse and Mental Illness	Goal 1.1: With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.	Expands existing program to include Pre-K and Kindergarten children in the child development centers, age 3 to 5	This project will enhance the emotional and behavioral readiness of children entering the District public school system.	\$200,000.00

Organization	Project Name	SAMHSA Initiative	SAMHSA Goal	Target Population	Purpose	Funding
Housing Division	Permanent Supportive Housing for Special Populations	Strategic Initiative #4 – Recovery Support	Goal 4.2: (Home) Ensure that permanent housing and supportive services are available for individuals with or in recovery from mental and substance use disorders.	Fifteen (15) transition age youth (18-26); 15 persons being released from jail; and 22 consumers enrolled in ACT programs	Assist DMH continue to provide “bridge” rental subsidies to transition age young, persons being released from jail, and persons in need of intensive services to remain in the community.	\$300,000.00
TOTAL						\$714,409.50

**DISTRICT OF COLUMBIA
STATE MENTAL HEALTH PLANNING COUNCIL**



REQUEST FOR PROJECTS

The **District of Columbia State Mental Health Planning Council** is seeking projects for funding consideration under the FY 2012 Community Mental Health Services Block Grant. The projects should reflect the Substance Abuse and Mental Health Services Administration (SAMHSA) focus on behavioral health (mental health and substance use disorder), primary health, and the SAMHSA eight strategic initiatives. These initiatives include: 1) Prevention of Substance Abuse and Mental Illness; 2) Trauma and Justice; 3) Military Families; 4) Recovery Support; 5) Health Reform; 6) Health Information Technology; 7) Data, Outcomes and Quality; and 8) Public Awareness and Support. The Planning Council recommends reviewing these initiatives on the SAMHSA website (<http://www.samhsa.gov/>).

Who Can Apply?

Projects must be from:

- A. District-based, nonprofit organizations in good standing with the District government, and the Internal Revenue Service.
- OR-
- B. Individuals or non-incorporated groups must have a registered agent (who must be District-based and in good standing with the District government and the Internal Revenue Service) to receive funds on their behalf.
- C. Projects from District academic settings such as colleges and universities can also apply.

The projects funded under this initiative must be:

- Innovative in nature
- Incorporate elements of the recovery model for adults with serious mental illness (SMI), i.e., wellness and crisis planning, strong support system, self-advocacy; and resiliency principles for children/youth with serious emotional disturbances (SED), i.e., related to activities, school, social, and strengths.

Only 5% of the total project budget can be spent on administrative costs.

Projects are also encouraged to utilize best or promising practices and/or evidence-based practices. Consumer focused, consumer-run, and family member programs (that serve family members of adults or children/youth) can submit projects.

How to Apply?

The project format is attached. A few projects will be funded ranging from \$5,000- \$20,000. To discuss the request for projects you may contact Effie Smith at (202) 842-0001, Lynne M. Smith at (202) 671-4071 or Juanita Reaves at (202) 671-4080.

All projects must be submitted by July 8, 2011. They can be mailed to: District of Columbia State Mental Health Planning Council, c/o Juanita Reaves, Ph.D., Department of Mental Health, 64 New York Avenue, N.E., Fifth Floor, Washington, DC 20002, emailed to: juanita.reaves@dc.gov or faxed to Dr. Reaves at: (202) 673-7053.

**PROJECT REQUEST FORMAT
FY 2012 COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT**

If the request for funding is for an existing project, clearly indicate how these funds will be used to implement a new initiative. The project description should follow the format below and be **concisely written between 5-10 pages or fewer**.

1. **SAMHSA Strategic Initiative-** Identify the number, name and definition for the initiative related to the proposed Project.
2. **SAMHSA Strategic Initiative Goal-** Identify the goal number and definition under the identified initiative related to the proposed Project.
3. **Project Title-** Indicate the name of the Project.
4. **Project Target Population-** Describe the characteristics of the target population for proposed Project.
5. **Project Description-** Describe the proposed Project and its intent, include some background information on the problem/issue being addressed and why it is important.
6. **Purpose of Project-** Explain how the proposed Project will benefit its participants and how the Project will help to improve the delivery of behavioral health (mental health and substance use disorder) and/or primary health services in the District of Columbia.
7. **Project Goals-** Indicate what the proposed Project will accomplish both short-term and long-term. Create goals that are specific, measurable, attainable, realistic, and time-sensitive (S.M.A.R.T. goals). Example: The Older Adult Committee will develop a plan for serving older adults with mental illness and chronic health issues by June 30, 2012.
8. **Project Measurable Outcomes-** Identify the tool/method that will be used to measure the success of the proposed Project. Example: Youth with high scores on the Anger Management Scale will participate in a six (6) week Anger Management Course and be re-tested to see if their scores are lower.
9. **Project Timeline-** Indicate the development of the proposed Project for FY 2012 in terms of activities/schedule of events and their durations; milestones and their completion dates. The status will be reported in the Quarterly Report.
10. **Project Team-** Indicate the Project manager and responsibilities/roles of persons who are likely to work on the proposed Project with the applicant.
11. **Project Evaluation Plan-** Identify key performance indicators that demonstrate Project outcomes (e.g., results from people participating in a program, group, activity/event, or receiving an intervention). Include the method of data tracking that will be used and reported in the Quarterly Report.

FY 2012 Quarters	1 st Quarter (10/1/11-12/31/11)	2 nd Quarter (1/1/12-3/31/12)	3 rd Quarter (4/1/12-6/30/12)	4 th Quarter (7/1/12-9/30/12)
Number of Persons Referred				
Number of Persons Served				
Type of Services Provided				
Outcomes Achieved				

12. Project Budget- Indicate the anticipated cost of the proposed Project by associating costs with activities and services. Report project expenditures in the Quarterly Report.

FY 2012 Funded Category	Funded Amount	Vendor Point of Contact (name, address, phone number)	Activity/Services	Amount Paid	Amount Carried Over to Next Quarter

13. Project Sustainability- Indicate how the proposed Project will continue after the requested funding period ends and how it will be funded.

14. Previous Block Grant Funding- Indicate the Project name, date and funding amount for all Projects that received Department of Mental Health Block Grant funds from FY 2006 - FY 2011. For all Projects similar to proposed Project, indicate how the Projects are different.

15. Dissemination of Project Results- In addition to the requested Project Quarterly Status Reporting, Project Measurable Outcomes Tracking, and Project Evaluation, indicate how the Project Final Report will be communicated.

All funded Projects are required to: 1) submit quarterly reports including expenditures to the D.C. State Mental Health Planning Council (SMHPC) and 2) submit a request to the SMHPC to make any substantial change in Project implementation prior to making any changes.

IV: Narrative Plan

I. State Dashboards (Table 10)

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Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year:

Priority	Performance Indicator	Selected
Service Utilization Analysis	Service gaps (time between visits)	€
APRA Co-Occurring Certification Project	DMH APRA Co-Occurring Certification implemented.	€
Standardize Reporting Processes	Child service metrics and dashboards are finalized and reports disseminated monthly.	b
Standardize Reporting Processes	System Performance and URS table metric and report formats are finalized and distributed quarterly.	€
Standardize Reporting Processes	Adult service metrics and dashboard formats are finalized and reports disseminated monthly.	b
Juvenile Behavioral Health Diversion Program	First year interim report and evaluation of first 2 years	€
Healthy Start	To Be Determined	€
Parent Early Childhood Enhancement Program	To Be Determined	€

Footnotes:

Child/Youth and Adults Performance Measures: Goals, Targets and Action Plans

SAMHSA Required Measures

The performance measures that are reported in this section include the SAMHSA required National Outcome Measures (NOMs) and District measures. The NOMs include: 1) reduced utilization of psychiatric inpatient beds (children/youth and adults discharged and re-admitted within 30 days and 180 days of discharge); 2) use of evidenced based practices (children/youth and adults); and 3) client perception of care (Youth Services Survey for Families and Mental Health Statistics Improvement Program Survey social connectedness and level of functioning).

State Measures

The District performance measures that have been reported in the Mental Health Block grant are related to the 19 Exit Criteria and performance targets to vacate the longstanding Dixon Court Order. At the end of July 2011, fourteen (14) of these criteria had been moved to an inactive monitoring status as depicted in the chart that follows.

STATUS OF DIXON EXIT CRITERIA

Dixon 19 Exit Criteria	Court Required Performance Level	Active vs. Inactive Status
1. Consumer Satisfaction Method(s)	Methods + Demonstrated Utilization of Results	Inactive Status January 2011
2. Consumer Functioning Method(s)	Methods + Demonstrated Utilization of Results	Inactive Status July 2011
3. Consumer Reviews (Adult)	80% for System Performance	Active Status
4. Consumer Reviews (Child/Youth)	80% for System Performance	Active Status
5. Penetration (C/Y 0-17 Years)	5% of District C/Y Population	Inactive Status January 2011
6. Penetration (C/Y with SED)	3% of District C/Y Population	Inactive Status July 2010
7. Penetration (Adults 18 + Years)	3% of District Adult Population	Inactive Status July 2010
8. Penetration (Adults with SMI)	2% of District Adult Population	Inactive Status January 2009
9. Supported Housing	70% Served within 45 Days of Referral	Active Status
10. Supported Employment	70% Served within 120 Days of Referral	Active Status
11. Assertive Community Treatment	85% Served within 45 Days of Referral	Inactive Status January 2011
12. Newer -Generation Medications	70% of Adults with Schizophrenia	Inactive Status July 2007
13. Homeless Services Adults	150 Served + Comprehensive Strategy	Inactive Status January 2009
14. C/Y in Natural Setting	75% SED Served + SED Penetration Rate 2.5%	Inactive Status July 2010
15. C/Y in Own or Surrogate Home	85% SED Served + SED Penetration Rate 2.5%	Inactive Status January 2011
16. Homeless Services C/Y	100 Served + Comprehensive Strategy	Inactive Status January 2009
17. Continuity of Care Adults & C/Y	80% Inpatient Discharges Seen with 7 Days in Non-Emergency Outpatient Setting	Active Status
18. Community Resources	60% of DMH Expenses for Community Services	Inactive Status July 2008
19. Medicaid Utilization	49% of MHRS Billings Paid by Medicaid	Inactive Status January 2008

During FY 2011, the District and the plaintiffs began the process of negotiating a Settlement Agreement. The terms of this agreement are not likely to be final prior to the submission of the FY 2012-2013 Mental Health Block Grant Application. The District is not able to specify new targets that are likely to be set for the five (5) remaining Dixon Exit Criteria until the agreement is

approved. They include: 1) community service reviews for adults and children/youth (criteria #3 and #4); 2) supported housing (criterion #9); 3) supported employment (criterion #10); and 4) continuity of care for adults and children/youth (criterion #17).

It is anticipated that this process will become final by early FY 2012 and that reporting on the new targets will begin. The new measures will be included in subsequent Mental Health Block Grant reports.

Criterion 1: FY 2012 Performance Goals, Targets and Action Plans

Goal 1: Reduced Utilization of Psychiatric Inpatient Beds

**DISTRICT OF COLUMBIA
FY 2012 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

Name: Improve Continuity of Care

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

NOM: Reduced Utilization of Psychiatric Inpatient Beds

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

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Target: Establish percent of children/youth re-admitted to inpatient care within 30 days at 8.0% in FY 2012

Performance Indicator Value:

Numerator: Number of children/youth re-admitted to inpatient care within 30 days of discharge in FY 2012

Denominator: Number of children/youth discharged from inpatient care in FY 2012

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

Significance: SAMHSA required National Outcome Measure

Special Issues: FY09 and FY10 data was based on 12 area hospitals not just those that DMH contracts with, as reported in previous years. A discharge during FY09 and FY10 for children/youth (age 0-17) for the 12 providers was considered in the analysis. In FY11 the analysis was based on 11 hospitals.

Action Plans: DMH has continued the “linkage meetings” between various child-serving agencies and other stakeholders regarding linkages between providers and inpatient care facilities, residential treatment, etc. These meetings serve as a forum for discussion of continuity of care issues and problem resolution (i.e., re-admission to inpatient care, and service linkage leading to discharge). DMH also continued to try to reach the Dixon Performance Target that 80% of children/youth discharged from inpatient care must be seen within seven (7) days

Name of Performance Indicator: Improve Continuity of Care					
	Population: Children with SED in the District of Columbia			Criterion 1: Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Projected	FY 2012 Target
Performance Indicator (Value)	2.56%	6.47%	10.34%	7.56%	8.0 %
Numerator	2	27	46	27	---
Denominator	78	417	445	357	---

**DISTRICT OF COLUMBIA
FY 2012 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

Name: Improve Continuity of Care

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

NOM: Reduced Utilization of Psychiatric Inpatient Beds

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

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Target: Establish percent of children/youth re-admitted to inpatient care within 180 days at 22.0% in FY 2012

Performance Indicator Value:

Numerator: Number of children/youth re-admitted to inpatient care within 180 days of discharge in FY 2012

Denominator: Number of children/youth discharged from inpatient care in FY 2012

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

Significance: SAMHSA required National Outcome Measure

Special Issues: FY09 and FY10 data was based on 12 area hospitals. A discharge during FY09 and FY10 for children/youth (age 0-17) for the 12 providers was considered in the analysis. In FY11 the analysis was based on 11 hospitals.

Action Plans: Same as children/youth re-admitted to inpatient care within 30 days of discharge

Name of Performance Indicator: Improve Continuity of Care					
	Population: Children with SED in the District of Columbia			Criterion 1: Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Projected	FY 2012 Target
Performance Indicator (Value)	6.85%	21.82%	26.07%	16.8%	22.0%
Numerator	5	91	116	60	---
Denominator	73	417	445	357	---

Note: FY11 data based on August 19, 2011 data run.

**DISTRICT OF COLUMBIA
FY 2012 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 (SEH) within 30 days of discharge

Target: Establish the percent of adults re-admitted to SEH within 30 days of discharge at 7.0% in FY 2012

Performance Indicator Value:

Numerator: Number of adults re-admitted to SEH within 30 days of discharge in FY 2012

Denominator: Number of adults discharged from SEH in FY 2012

Sources of Information: Hospital Management Information System (AVATAR)

Significance: SAMHSA required National Outcome Measure and DMH has a SEH Census Reduction Initiative

Special Issues: AVATAR was launched in July 2008 and there were data conversion issues. Also, instability of the previous system (STARS) raised questions about data accuracy prior to FY 2009.

Act Plans: DMH strategies to support adult consumers in the least restrictive setting and reduce the number of beds at SEH include continue: 1) emphasis on the Continuity of Care Policy Practice Guidelines that assure every inpatient is seen within 48 hours of admission; 2) meetings held between Hospital, Authority and Core Service Agency staff to review all clients in the Hospital 30 days or longer; 3) housing priority to place individuals leaving the Hospital; 4) ACT services placement priority for individuals leaving the Hospital; 5) Integrated Care Project to address the needs of some of the most clinically challenging inpatients to support them in the community; 6) Peer Transition Specialist Project where peers provide encouragement and support to consumers leaving the Hospital; and 7) try to reach the Dixon Performance Target that 80% of adults discharged from inpatient care must be seen within seven (7) days in a non-emergency outpatient setting.

Name of Performance Indicator: Improve Continuity of Care					
	Population: Adults with mental illness in the District of Columbia			Criterion 1: Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Projected	FY 2012 Target
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Projected	FY 2012 Target
Performance Indicator (Value)	10.04%	11.36%	6.82%	4.7%	7.0%
Numerator	49	41	33	16	---
Denominator	488	361	484	340	---

Note: FY11 data is based on October 2010 through June 2011.

**DISTRICT OF COLUMBIA
FY 2012 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS)**

Name: Improve Continuity of Care
Goal: Reduce number of adults re-admitted to hospital within 180 days
NOM: Reduced Utilization of Psychiatric Inpatient Beds
Population: Adults with mental illness in the District of Columbia
Criterion 1: Comprehensive Community-Based Mental Health Service Systems
Indicator 2: Number of Adults re-admitted to Saint Elizabeths Hospital (SEH) within 180 days of discharge
Target: Establish the percent of adults re-admitted to SEH within 180 days of discharge at 25.0% in FY 2012

Performance Indicator Value:

Numerator: Number of adults re-admitted to SEH within 180 days of discharge in FY 2012

Denominator: Number of adults discharged from SEH in FY 2012

Sources of Information: Hospital Management Information System (AVATAR)

Significance: SAMHSA required National Outcome Measure and DMH has a SEH Census Reduction Initiative

Special Issues: AVATAR was launched in July 2008 and there were data conversion issues. Also, instability of the previous system (STARS) raises questions about data accuracy prior to FY 2009.

Act Plans: Same as discharged and re-admitted within 30 days

Name of Performance Indicator: Improve Continuity of Care					
	Population: Adults with mental illness in the District of Columbia			Criterion 1: Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Projected	FY 2011 Target
Performance Indicator (Value)	23.36%	31.15%	23.26%	20.5%	25.0%
Numerator	114	57	70	30	---
Denominator	488	183	301	146	---

Note: FY11 data is based on October 2010 through June 2011.

Goal 2: Use of Evidence-Based Practices

DMH Child and Youth Services Use of Evidence-Based Practices: The table below lists the evidence-based practices (EBPs) used by the DMH child-serving programs.

DMH

CYSD Program	Number of EBPs	Number of Unique EBPs	Name of EBPs
Parent Infant Early Childhood Enhancement (P.I.E.C.E.) Program	3	1	Parent Child Interaction Therapy (PCIT) Parents as Teachers (PAT) Incredible Years
Healthy Futures	2	1	Incredible Years Child Treatment Group Incredible Years Parenting Program
School Mental Health Program	7	5	Botvins Life Skills, Signs of Suicide (SOS), Too Good For Violence, Incredible Years Child Treatment Group, Parenting Wisely, Cognitive-Behavioral Intervention for Trauma in Schools (CBITS), Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
CFSA Mental Health Program Manager	6	4	Multi-Systemic Therapy (MST), Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Functional Family Therapy (FFT), Parent Child Interaction Therapy (PCIT), Multi-Systemic Therapy for Youth with Problem Sexual Behavior (MST-PSB), Child Parent Psychotherapy for Family Violence (CPP-FV)
TOTAL		11	

Adult Services Use of EBPs: The primary EBPs used by the DMH adult serving programs are Assertive Community Treatment (ACT) and Supported Employment.

Issues Related to the Use of EBPs: The District’s reporting of EBPs has been somewhat limited in part because the majority of the practices implemented are not Medicaid covered services. The Department of Health Care Finance (DHCF), state Medicaid agency, has submitted and/or is in the process of submitting State Plan Amendments (SPAs) to cover several EBPs. This includes the submission of a SPA to the Centers for Medicare and Medicaid Services (CMS) for Medication Assisted Treatment (MAT), if approved, will allow for blended funding from Medicaid and Department of Health. Also, proposed SPAs include: 1) Medication Management; 2) Family Psychoeducation; and 3) Screening Brief Intervention and Referral to Treatment (SBIRT).

Some of the efforts related to trying to implement EBPs include: 1) collaboration between the Department of Health and DHCF to create a framework for adult substance abuse services that will allow future coverage of EBPs; and 2) collaboration between Department of Mental Health and DHCF to develop and implement Functional Family Therapy (FFT) and Clubhouse services as Medicaid-covered services. Some of the challenges include: 1) difficulty translating EBPs into a fee-for-service Medicaid service; and 2) inadequate provider networks (e.g., shortage of qualified child psychiatrists willing to participate in Medicaid, poor retention of providers trained in EBPs).

Goal 3: Client Perception of Care

The performance measures reported are the SAMHSA required measures related to social supports/social connectedness and level of functioning. These measures for children and youth are derived from the Youth Services Survey for Families (YSS-F) and for adults the Mental Health Statistics Improvement Program (MHSIP) Survey.

**DISTRICT OF COLUMBIA
FY 2012 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES**

Name: Child - Increased Social Supports/Social Connectedness
Goal: Improve child and youth social supports/social connectedness
Population: Children and youth with mental health issues in the District of Columbia
Criterion 1: Comprehensive Community-Based Mental Health Service Systems
Target: Establish social connectedness at 85%

Performance Indicator Value:

Numerator: Positive responses to social supports/social connectedness questions
 Denominator: Number of responses to social supports/social connectedness questions

Source of Information: Youth Services Survey for Families (YSS-F)

Significance: SAMHSA requires client perception of care reporting.

Special Issues: The FY 2010 YSS-F was completed in FY 2011 and the FY 2011 YSS-F will be completed in FY 2012.

Action Plans: RightSources LLC served as the contractor for the FY 2009 YSS-F and the FY 2010 YSS-F.

Name of Performance Indicator: Improve Access to Evidence-based Practices					
	Population: Children with mental health issues in the District of Columbia			Criterion 1: Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Target
Performance Indicator (Value)	92.30%	89.37%	88.05%	TBD Completed in FY 2012	TBD Completed in FY 2012- FY2013
Numerator	683	227	973	---	---
Denominator	740	254	1,105	---	---

Note: The FY 2011 YSS-F will be completed in FY 2012 and factored into the FY 2012 YSS-F target to be completed between FY 2012 -FY 2013.

**DISTRICT OF COLUMBIA
FY 2012 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES**

Name: Child – Improved Level of Functioning

Goal: Improve child/youth outcomes by improving level of functioning

Population: Children and youth with mental health issues in the District of Columbia

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Target: Increase level of functioning to 75%

Performance Indicator Value:

Numerator: Positive responses to the level of functioning questions

Denominator: Number of responses to the level of functioning questions

Source of Information: Youth Services Survey for Families (YSS-F)

Significance: SAMHSA requires client perception of care reporting.

Special Issues: The FY 2010 YSS-F was completed in FY 2011 and the FY 2011 YSS-F will be completed in FY 2012.

Action Plans: RightSources LLC served as the contractor for the FY 2009 YSS-F and the FY 2010 YSS-F.

	Name of Performance Indicator: Improve Access to Evidence-based Practices				
	Population: Children with mental health issues in the District of Columbia			Criterion 1: Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Target
Performance Indicator (Value)	72.86%	73.23%	68.67%	TBD Completed in FY 2012	TBD Completed in FY 2012-FY 2013
Numerator	674	186	1,131	---	---
Denominator	925	254	1,647	---	---

Note: The FY 2011 YSS-F will be completed in FY 2012 and factored into the FY 2012 YSS-F target to be completed between FY 2012 -FY 2013.

**DISTRICT OF COLUMBIA
FY 2012 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES**

Name: Adult - Increased Social Supports/Social Connectedness

Goal: Improve consumer outcomes related to social supports/social connectedness

Population: Adults with mental illness in the District of Columbia

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Target: Increase to 85% adults who report positively about social connectedness

Performance Indicator Value:

Numerator: Number of adults with positive responses to social supports/social connectedness questions

Denominator: Number of adults who respond to social supports/social connectedness questions

Source of Information: Mental Health Statistics Improvement Program (MHSIP) Survey

Significance: SAMHSA requires client perception of care reporting.

Special Issues: The FY 2010 MHSIP Survey was completed in FY 2011 and the FY 2011 MHSIP Survey will be completed in FY 2012.

Action Plans: RightSources LLC served as the contractor for the FY 2009 MHSIP Survey and the FY 2010 MHSIP Survey.

	Name of Performance Indicator: Improve Access to Evidence-based Practices				
	Population: Adults with mental illness in the District of Columbia			Criterion 1: Comprehensive Community-Based Mental Health Service Systems	
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Actual	FY 2012 Target
Performance Indicator (Value)	78.83%	77.08%	81.15%	TBD Completed in FY 2012	TBD Completed in FY 2012-FY 2013
Numerator	633	222	1,119	---	---
Denominator	803	288	1,379	---	---

Note: The FY 2011 MHSIP will be completed in FY 2012 and factored into the FY 2012 MHSIP target to be completed between FY 2012 -FY 2013.

**DISTRICT OF COLUMBIA
FY 2012 STATE PLANNING AND MONITORING
MENTAL HEALTH NATIONAL OUTCOME MEASURES**

Name: Adult – Improved Level of Functioning
Goal: Improve consumer level of functioning
Population: Adults with mental illness in the District of Columbia
Criterion 1: Comprehensive Community-Based Mental Health Service Systems
Target: Increase level of functioning to 85%

Performance Indicator Value:

Numerator: Number of adults with positive responses to the level of functioning questions
 Denominator: Number of adults who respond to the level of functioning questions

Source of Information: MHSIP Survey

Significance: SAMHSA requires client perception of care reporting.

Special Issues: The FY 2010 MHSIP Survey was completed in FY 2011 and the FY 2011 MHSIP Survey will be completed in FY 2012.

Action Plans: RightSources LLC served as the contractor for the FY 2009 MHSIP Survey and the FY 2010 MHSIP Survey.

Name of Performance Indicator: Improve Access to Evidence-based Practices					
	Population: Adults with mental illness in the District of Columbia				Criterion 1: Comprehensive Community-Based Mental Health Service Systems
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Actual	FY 2011 Projected	FY 2012 Projected
Performance Indicator (Value)	76.12%	78.35%	75.33%	TBD Completed in FY 2012	TBD Completed in FY 2012-FY 2013
Numerator	612	228	1,313	---	---
Denominator	804	291	1,743	---	---

Note: The FY 2011 MHSIP will be completed in FY 2012 and factored into the FY 2012 MHSIP target to be completed between FY 2012 -FY 2013.

**DISTRICT OF COLUMBIA
FY 2012 STATE PLANNING AND MONITORING
MENTAL HEALTH PERFORMANCE INDICATORS**

Name: Improve Services for Homeless Populations

Goal: Increase engagement of adults with SMI who are homeless

Population: Adults with SMI who are homeless

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Target: Engage 300 adults with SMI who are homeless quarterly in FY 2012

Source of Information: DMH Authority Homeless Outreach Program Database

Significance: This measure represents a goal set by the DMH Homeless Outreach Program.

Special Issues: The DMH Homeless Outreach Program (HOP) would like to increase its engagement of adults who are homeless to 300 per quarter in FY 2012.

Action Plans: The HOP will continue to provide outreach, engagement, linkage, psychiatric treatment and follow-up services to individuals who are homeless. It will also continue to work with the homeless services programs in the District.

Name of Performance Indicator: Improve Services for Homeless Populations					
Population: Adults with SMI who are homeless in the District of Columbia			Criterion 4: Targeted Services to Rural and Homeless Populations and Older Adults		
(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2011 1st Quarter	FY 2011 2nd Quarter	FY 2011 3rd Quarter	FY 2011 4th Quarter	FY 2012 Target Per Quarter
Performance Indicator	409	397	375	175	300

Note: FY 2011 fourth quarter data is through July 31, 2011.

IV: Narrative Plan

J. Suicide Prevention

Page 46 of the Application Guidance

Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

DMH developed a Suicide Prevention Plan in 2009 in collaboration with the District of Columbia Public Schools and the DC Suicide Prevention Coalition. The Suicide Prevention Plan was organized in accordance with the eleven (11) goals of the National Strategy. A copy is included with this application as Attachment J-1. Although the Suicide Prevention Plan is youth-focused, it is not exclusive to children and youth.

DMH was awarded a 3-year SAMHSA State/Tribal Youth Suicide Prevention Grant beginning in FY 2010. The focus is to bring together public and private partners to address youth suicide for ages 10-24. This program has both public and private partners participating in the D.C. Youth Suicide Prevention Coalition. Public partners include police, schools, foster care, juvenile justice, the medical examiner, parks and recreation, and health. Private partners include non-profit organizations that have been given mini-grants from the Capital CARES program to conduct evidence-based suicide prevention programs with at-risk youth as well as other community organizations, representatives from local universities and suicide prevention organizations, and survivors. Other private partners include organizations who work with Lesbian, Gay, Bisexual Transgender and Questioning (LGBTQ) youth. Activities include:

- Award of nine (9) mini-grants for non-profits and schools to conduct evidence-based suicide prevention activities;
- Trained thirty-four (34) people as trainers in Question, Persuade and Review (QPR) so that there will be sustainability in their host organizations as these trainers conduct most internal trainings for their agencies;
- Trained over 1,000 people as gatekeepers;
- Screened over 150 youth with approximately 30% referred for an additional evaluation; and
- Scheduled the D.C. Youth Suicide Prevention Conference: Strengthening Communities to Promote Resilience for September 16, 2011. Conference objectives include:
 - building support for youth suicide prevention programs in the District;
 - improving knowledge of services available and how to access treatment;
 - developing increased awareness for suicide prevention programming/protocols within agencies; and
 - understanding how suicidal behaviors manifest in different populations.

Social marketing materials have been developed as part of the CAPITAL CARES grant. A website called "IamthedifferenceDC.org" has been developed. Social marketing materials include print ads/posters to be placed in community settings and in public locations such as schools and Parks and Recreation sites, radio PSAs, wallet cards and postcards for youth, as well as brochures for parents. Both the website and the print ads focus on helping a friend who is in crisis as well as getting help for yourself if you feel this way. The website and materials will be available by the end of August 2011.

As a part of the 2009 DMH Suicide Prevention Plan, the Access HelpLine (AHL) became a provisionally certified Suicide Lifeline Network provider for the District in April 2009 and became fully certified by the American Association of Suicidology (AAS) in April 2011. AHL provides Suicide Lifeline Network callers with 24-hour suicide prevention via telephone access.

The activities include: 1) response to callers who access the Suicide Prevention Lifeline Network; 2) provision of suicide intervention; and 3) dispatching mobile crisis services when necessary. During the period of provisional certification there were 122 calls to this designated crisis line. It should be noted that the majority of calls received from District residents were routed to a regional center until DMH's AccessHelpline was fully certified to perform this service. A total of 137 calls have been received since April 2011.

In FY 2010, DMH established a collaborative relationship with the Washington Metropolitan Area Transit Authority (WMATA) to address suicide prevention within the metropolitan area for the public transportation system (METRO trains and buses). The purpose of this project is to provide suicide crisis counseling and intervention including access to mobile crisis services for METRO riders in the District, Maryland and Northern Virginia. The goals of this suicide prevention strategy are to:

- provide training to a core group of staff of the Department of Mental Health and WMATA's Medical Services and Compliance Branch who will serve as master trainers with the ability to train front-line WMATA and DMH staff;
- provide suicide prevention training to all 529 WMATA supervisors, transit police officers, special officers, platform workers, and bus/train operators; and
- Develop and implement a workflow process and dedicated telephone line to link individuals identified as being at risk of suicide to mental health services through DMH's Access HelpLine and the DMH National Suicide Prevention Lifeline.

In October 2010 DMH in partnership with WMATA conducted Applied Suicide Intervention Skills Training (ASIST) as the initial step in the process designed to establish a suicide prevention training team in the District. ASIST is an internationally recognized suicide prevention training program that prepares participants to integrate intervention principles into everyday practice. The two-day workshop is a skills-based program developed by LivingWorks Education, Inc., a Canadian public service company dedicated to the prevention of suicide. The session is designed to reduce attitudinal barriers which hinder the ability of the trainees to be direct and comfortable with suicidal situations. Participants receive information that dispels myths about suicide, identifies the indicators and provides a framework for assessing suicidal risks. LivingWorks was contracted by WMATA to deliver this training. A total of 22 people participated in the session. The training group consisted of 14 DMH clinicians, 4 members of the WMATA police force and 4 WMATA mental health clinicians.

All but one individual successfully completed the ASIST training. Those individuals were invited to participate in the Training of Trainers (TOT) session designed to establish to group of trainers who would be assigned to deliver suicide prevention instruction to front line workers. The TOT was conducted in November 2010. Twenty-one people attended this session. LivingWorks provided participants with instruction in safeTALK, a suicide alertness training program. This one-day training is designed to prepare suicide alert staff with the information needed to recognize possible warning signs of suicide, use the primary element of suicide risk assessment and to connect persons with thoughts of suicide to suicide first aid or clinical resources. All of the session participants successfully completed this course.

Over the past few months, DMH and WMATA have worked together to develop the workflow and response plan that will be used to address the mental health needs of individuals identified as being at-risk for suicide by the train operators, platform workers and/or supervisors. A dedicated suicide prevention line (1800-273-TALK) has been established within the DMH AccessHelpline to receive these calls. A mental health clinician will answer the calls, provide crisis counseling, intervention and referral services. The DMH Mobile Crisis Unit will be deployed as required to provide on-site support which includes counseling, evaluation and transport to a hospital for in-patient care when required. Each person who calls will be referred or linked to a DMH mental health provider for emergency services based upon their mental health needs. Care coordination follow up services will be provided to ensure that the individuals who call the AccessHelpline have accessed and received crisis support.

WMATA and DMH have developed a Memorandum of Understanding that formalizes their collaborative working relationship. In accordance with this agreement, WMATA will provide funding to DMH to provide project management, crisis intervention and training during FY 2012 to support this suicide prevention effort.

D.C. Suicide Prevention Plan

Goal 1: Promote awareness that suicide is a serious public health problem and that many suicides are preventable		
• Objectives	• Activities	• Outcomes
<ul style="list-style-type: none"> • Create culturally competent social marketing campaign on risk factors for suicide and depression 	<ul style="list-style-type: none"> • Create a series of multilingual (Spanish, English, Aramaic etc) posters, brochures to be distributed to schools, recreation centers, collaborative centers, boys/girls’ clubs, barber shops, shopping centers, churches, hospitals, detention centers, pediatrician’s offices, health fairs, emergency rooms, workshop sites. • Distribute information about suicide prevention through an advertising campaign utilizing billboards, radio ads, television in Spanish and English 	<ul style="list-style-type: none"> • By 2010, 10% of residents of D.C. will have been exposed to some suicide prevention materials • By 2011, 25% of residents of D.C. will have been exposed to suicide prevention materials • By 2015, all residents of D.C. will have been exposed to some suicide prevention materials • Increased # parents will consent for screening. • Increased # groups will request materials.
<ul style="list-style-type: none"> • Provide information about suicide prevention and awareness to established groups 	<ul style="list-style-type: none"> • Present DC suicide plan and information on suicide prevention to local working groups such as interfaith boards, Mayor’s Reconnecting Disconnected Youth Board, School Health Work Group, relevant Boards and Commissions • Collaborate with local mental health associations to reach DC residents (NAMI DC, Mental Health America DC, Mental Health Association of DC) 	<ul style="list-style-type: none"> • Present to established groups by 2010 • Present yearly to update groups and expand efforts
<ul style="list-style-type: none"> • Collaborate with local conferences and forums and provide awareness and education about suicide prevention and intervention 	<ul style="list-style-type: none"> • Present at local conferences or meetings • Seek out conferences that incorporate faith community as well as Latino, GLBT, school officials. 	<ul style="list-style-type: none"> • Present at local events each year
<ul style="list-style-type: none"> • Collaborate and partner with other community health programs such as community outreach workers on substance abuse, HIV 	<ul style="list-style-type: none"> • Present jointly at local forums • Train community outreach workers in signs and symptoms of suicide as well as risk factors 	<ul style="list-style-type: none"> • Present at least three local forums or trainings each year
Goal 2: Develop broad based support for suicide prevention		
• Objectives	• Activities	• Outcome
<ul style="list-style-type: none"> • Establish task force to address youth suicide and to initiate goals of this plan. 	<ul style="list-style-type: none"> • Expand the STOP Suicide Advisory Board to include representatives from other agencies including: Mayor’s Executive Group, DMH, DOH, DJJ, Chancellor’s Office, MPD, DOES, DCPS, residential programs, Universities, primary care, suicide organizations such as AAS and SPAN, community providers, parents, youth. 	<ul style="list-style-type: none"> • Task force will be created and meet at least quarterly

Attachment J-1

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<ul style="list-style-type: none"> Increase the number of professional, volunteer, faith community, and other groups that integrate suicide prevention activities into their ongoing activities and adopt policies to prevent suicide 	<ul style="list-style-type: none"> Develop community/neighborhood partnerships Identify organizations who can outreach to parents, youth Reach out to church groups (Health Ministries) 	<ul style="list-style-type: none"> # of groups who request materials, trainings # groups who incorporate suicide prevention activities into their organizations
<p>Goal 3: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services</p>		
<ul style="list-style-type: none"> Objectives 	<ul style="list-style-type: none"> Activities 	<ul style="list-style-type: none"> Outcome
<ul style="list-style-type: none"> Address belief systems of residents and consumers in D.C. to reduce stigma associated with receiving mental health and substance abuse services 	<ul style="list-style-type: none"> Develop outreach materials and social marketing campaign that is culturally competent Create suicide prevention/health and wellness materials for distribution in physicians offices, schools Materials will be available in multiple languages Emphasize neurobiological basis of many mental disorders and promote effective medicines and therapies 	<ul style="list-style-type: none"> 50% of DC youth referred for therapy by screening program will stay in treatment for at least two appointments Materials will be distributed during all well visits. There will be an increase in the percent of parental consents received for screening and education in suicide.
<ul style="list-style-type: none"> Provide education for families of youth involved in the mental health system for suicide, substance abuse or other mental health issues Work with Medicaid Managed Care Organizations to increase identification of covered services for the Medicaid population 	<ul style="list-style-type: none"> Materials and support groups will be available for families Work through the local Income Maintenance Administration to develop an MOU to increase oversight of interventions on behalf of the Medicaid population 	<ul style="list-style-type: none"> At least 2 new support groups will be established in different regions of the city through churches, hospitals, community based organizations or mental health agencies
<ul style="list-style-type: none"> Increase the number of suicidal youth with underlying mental health disorders who receive appropriate mental health treatment 	<ul style="list-style-type: none"> Identify youth through screening and education and link to treatment 	<ul style="list-style-type: none"> 33% of schools will provide screening by 2013 Schools will sustain screening year to year Increased # of parents who provide consent for screening and treatment. Increased # of youth referred for mental health services for depression and suicide. Improved satisfaction with treatment services. Referred youth will attend more appointments.
<ul style="list-style-type: none"> Imbue cultural competence in all prevention strategies 	<ul style="list-style-type: none"> Identify differences in the ways unique communities in DC respond to suicide prevention and mental health promotion 	<ul style="list-style-type: none"> All suicide prevention programming will be culturally competent
<ul style="list-style-type: none"> Promote resilience 	<ul style="list-style-type: none"> Incorporate wellness programs into DCPS health curriculum Help promote use of youth external supports, inner-strengths, and interpersonal and problem-solving skills 	<ul style="list-style-type: none"> All schools will conduct health and wellness prevention programs as part of Health classes by 2011 Families of youth with mental health needs will receive support

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Goal 4: Identify, develop, implement and evaluate youth suicide prevention programs		
• Objectives	• Activities	• Outcome
<ul style="list-style-type: none"> Develop technical support activities to build the capacity across the District to implement and evaluate suicide prevention programs 	<ul style="list-style-type: none"> Establish collaborations with local stakeholders to share in training, education, and evaluation 	<ul style="list-style-type: none"> Key positions and coalition will be established
<ul style="list-style-type: none"> Create policy changes to increase suicide prevention programming and education 	<ul style="list-style-type: none"> Work with DCPS to incorporate suicide prevention into health curriculum Establish a policy that makes suicide prevention training mandatory for all school personnel Make suicide prevention training available to police, recreation staff and other frontline workers 	<ul style="list-style-type: none"> Suicide prevention will be taught in all health classes for middle and high school youth All school personnel will receive at least 2 hours annually in suicide prevention Auxilliary personnel and frontline workers will receive training at least one time annually. Screening will be incorporated into primary care settings.
<ul style="list-style-type: none"> Develop public/private partnerships with local organizations who work with youth at risk for related risk factors for suicide. 	<ul style="list-style-type: none"> Develop partnership with National Campaign to Prevent Teen Pregnancy, Metro Teen AIDS, Latin American Youth Center 	<ul style="list-style-type: none"> # organizations who partner Provide training and/or screening annually. There will be an increase in help seeking behaviors by youth affiliated with these organizations.
<ul style="list-style-type: none"> Identify youth at risk for suicide, suicidal behavior, and related risk factors 	<ul style="list-style-type: none"> Conduct universal screening of depression and suicide in middle and high schools. Conduct screening through local organizations such as Health ministries Conduct suicide screening for youth in juvenile detention centers Conduct suicide screening for youth in CFSA Conduct suicide screening for youth enrolled in substance abuse treatment through APRA . 	<ul style="list-style-type: none"> Increased # of youth screened for depression and suicide annually. # of settings conducting screening # people trained to screen # screenings held At least 500 youth screened per year
<ul style="list-style-type: none"> Train youth in signs and symptoms suicide and how to talk to friends at risk 	<ul style="list-style-type: none"> Conduct education based prevention program in schools, community, churches Train staff of organizations with youth workers such as teen pregnancy, HIV prevention in signs of suicide and how to incorporate into their prevention programming . 	<ul style="list-style-type: none"> There will be an increase in help seeking behaviors by youth for mental health services. # youth who receive training # sites conducting training
<ul style="list-style-type: none"> Train medical providers to conduct suicide assessments 	<ul style="list-style-type: none"> Provide training to pediatricians, managed care organizations, school nurses, ER staff on suicide warning signs and risk factors . 	<ul style="list-style-type: none"> All youth will be asked about thoughts of suicide and depression during well visits # youth identified through screenings in primary care settings.
<ul style="list-style-type: none"> Ensure availability of suicide hotlines 	<ul style="list-style-type: none"> Encourage Department of Mental Health Access Helpline to become a certified crisis line through AAS 	<ul style="list-style-type: none"> DMH will be a certified crisis hotline for 1800/273-TALK by 2009

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Goal 5: Promote efforts to reduce access to lethal means and methods of self-harm		
• Objectives	• Activities	• Outcome
<ul style="list-style-type: none"> Reduce deaths by passive suicidal means 	<ul style="list-style-type: none"> Develop partnerships with organizations to reduce risk factors for passive suicidal behavior such as through violence, HIV exposure, substance abuse Incorporate training on risk factors related to suicide such as exposure to violence, substance abuse when working with youth, families, schools, and community partners 	<ul style="list-style-type: none"> Increased # youth and families will recognize risk factors related to suicide behaviors At least 1000 youth annually participate in these activities
Goal 6: Implement training for recognition of at-risk behavior and delivery of effective treatment		
• Objectives	• Activities	• Outcome
<ul style="list-style-type: none"> Identify individuals to be trained as “Certified QPR Trainers” 	<ul style="list-style-type: none"> Establish group of individuals to be trained from diverse agencies within DC – including DCPS, DOH, DMH, DJJ, DOES, MPD, DCPS, CFSA, DYRS, organizations that serve charter schools, church representatives, parents, school nurses, neighborhood/community groups Identify staff in programs who work with high risk youth to receive training through programs such as Metro TeenAIDS, Campaign to Prevent Teen Pregnancy, GLBT programs, Latino community 	<ul style="list-style-type: none"> 50 individuals will be trained as certified QPR trainers Pre/Post tests by trainees will show increase in knowledge and skills acquisition Within 5 years, 75% of staff at each of these agencies will have received QPR training. 1000 people annually will receive QPR gatekeeper training
<ul style="list-style-type: none"> Train medical professionals in signs and symptoms of suicide and depression 	<ul style="list-style-type: none"> Train pediatricians in signs and symptoms of suicide Train hospital emergency room workers in signs and symptoms of suicide Train mobile outreach groups (dental, pediatrics, maternal/child) in signs and symptoms of suicide 	<ul style="list-style-type: none"> Train at least 100 individuals yearly involved in well visits
Goal 7: Develop and promote effective clinical and professional practices		
• Objectives	• Activities	• Outcome
<ul style="list-style-type: none"> Enhance the abilities of providers to provide culturally competent, evidence-based management of youth in crisis 	<ul style="list-style-type: none"> Provide training to DMH, CFSA, DJJ, CSAs and private providers, physicians, nurses Provide training to all providers of mental health services in the management youth in a suicidal crisis All training will be based on culturally competent principles 	<ul style="list-style-type: none"> At least 500 individuals will receive training per year
<ul style="list-style-type: none"> Establish group of individuals who have received training in suicide prevention and identification in schools 	<ul style="list-style-type: none"> Encourage schools to apply for school-based accreditation through AAS 	<ul style="list-style-type: none"> At least 5 schools per year will receive accreditation in suicide prevention
<ul style="list-style-type: none"> Promote therapeutic support for victims of violence and sexual abuse as risk factor for suicidal behavior 	<ul style="list-style-type: none"> Identify youth who are victims of violence or sexual abuse Promote linkage between violence and suicide Youth with histories of violence or sexual abuse will be identified and providers working with these youth will incorporate screening for suicide and depression 	<ul style="list-style-type: none"> 10% more youth yearly will be identified to mental health providers or receive prevention programming from community based organizations with histories of exposure to violence or sexual abuse

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Goal 8: Improve access to and community linkages with mental health and substance abuse services		
Objectives	Activities	Outcome
<ul style="list-style-type: none"> Ensure timely and accurate compliance with referrals of all youth referred to local mental health providers. 	<ul style="list-style-type: none"> Create database and reporting mechanisms for data regarding screening, referral, and compliance with recommendations Monitor and track length of time from referral to first appointment 	<ul style="list-style-type: none"> 50% of youth will be linked to services within one month of screen 75% of youth will be linked to service within six months of screen
<ul style="list-style-type: none"> Determine length of treatment 	<ul style="list-style-type: none"> Assess whether youth stays in treatment for at least two appointments 	<ul style="list-style-type: none"> Collaborate with treatment providers to obtain follow-up data on at least 50% of youth referred for treatment
<ul style="list-style-type: none"> Ensure satisfaction of services rendered 	<ul style="list-style-type: none"> Conduct parent satisfaction surveys. 	<ul style="list-style-type: none"> 50% of parents with youth referred for treatment will complete Satisfaction Survey
<ul style="list-style-type: none"> Compile and update a guide to DC suicide prevention resources and services 	<ul style="list-style-type: none"> Update resource list to include local, state, and national organizations with a focus on suicide awareness, prevention, intervention, and aftercare. Distribute list widely. 	<ul style="list-style-type: none"> Guide will be available at schools, mental health centers, local organizations, pediatricians by 2012
Goal 9: Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media		
Objectives	Activities	Outcome
<ul style="list-style-type: none"> Increase the number of local television programs and news reports that observe recommended guidelines in the depiction of suicide and mental illness 	<ul style="list-style-type: none"> Provide guidelines from AAS to local media outlets 	<ul style="list-style-type: none"> Local news agencies will make changes to their reporting
Goal 10: Promote and support research on suicide and suicide prevention		
Objectives	Activities	Outcome
<ul style="list-style-type: none"> Promote youth suicide prevention research 	<ul style="list-style-type: none"> Develop partnerships with universities to collect, analyze, and disseminate data on youth suicide prevention and training 	<ul style="list-style-type: none"> Data and activities of the DC Suicide Prevention Coalition will be analyzed annually and distributed
<ul style="list-style-type: none"> Evaluate prevention programs 	<ul style="list-style-type: none"> Gather data on universal suicide prevention programs on numbers of youth identified with suicidality, depression, substance abuse Gather data on numbers of youth linked effectively to treatment for mental health services following screening Gather data on numbers of youth identified as suicidal as a result of gatekeeper training Gather data on numbers of youth identified through classroom-based peer prevention programs 	<ul style="list-style-type: none"> Data and activities of the DC Suicide Prevention Coalition will be analyzed annually and distributed Data will be presented at national and local conferences

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Goal 11: Improve and expand surveillance systems		
• Objectives	• Activities	• Outcome
<ul style="list-style-type: none"> • Synthesize suicide data for the District 	<ul style="list-style-type: none"> • Obtain data from all relevant stakeholders (hospitals, Child Fatality Review Committee, police, schools, crisis response teams, Access Helpline) with regard to youth suicide (completions, attempts, hotline calls) in the District • Determine STIPDA representative for District • Encourage DC to establish National Violent Death Reporting System 	<ul style="list-style-type: none"> • Stakeholders will provide data to central repository • DC will contribute to NVDRS
<ul style="list-style-type: none"> • Increase the number of hospitals and local service providers that code for external cause of injuries 	<ul style="list-style-type: none"> • Encourage hospitals to code for suicidal behaviors • Encourage police to report on transporting suicide victim 	<ul style="list-style-type: none"> • Hospitals will use codes for external causes of injury
<ul style="list-style-type: none"> • Produce an annual report on youth suicide 	<ul style="list-style-type: none"> • Present findings to District leaders (Mayor, City Council) and recommend changes 	<ul style="list-style-type: none"> • Annual report will be distributed yearly

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IV: Narrative Plan

K. Technical Assistance Needs

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Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

Prevalence Estimates

In 1999, a *Study of Mental Health Need and Services in the District of Columbia* was conducted by the University of Texas. The 2003 edition of this study provided updates of prevalence estimates for children and youth with serious emotional disturbances (SED), and adults with serious mental illness (SMI) and serious and persistent mental illness (SPMI). These estimates are based on the National Co-morbidity Survey (NCS) and related surveys and are projected to the District based on data from the U. S. Census. This data has been reported in the District's Mental Health Block Grant.

The 2010 *Behavioral Health in the District of Columbia: Assessing Need and Evaluating the Public System of Care* conducted by the RAND Corporation, also provides prevalence estimates of mental health. The data sources included national survey data (BRFSS, NSDUH, NSCH, and YRBS), administrative data, claims data, and data from focus groups and stakeholder interviews.

The RAND analysis suggested that potentially several thousand District residents have unmet need for mental health care services for severe mental illness. In order to quantify this finding more specifically, DMH will seek technical assistance through the National Research Institute (NRI), National Association of State Mental Health Program Directors (NASMHPD), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Activities that Support Consumers in Directing Services

As discussed in section D, DMH does not currently offer consumers the option to self-direct care. Technical assistance from SAMHSA regarding opportunities within the existing service delivery system for adopting a pilot to allow consumers to self-direct care would be helpful.

Data & Information Technology

As discussed in section E, DMH has a huge reporting deficit within its existing system. There are a number of stand-alone databases which contribute to concerns about data integrity and data management. Other areas where technical assistance is needed include:

- General reporting
- Refinement of performance and outcome measures while identifying benchmarks specific to each measure
- Technical training on the use of electronic health records and new systems
- User documentation – implementing the “how tos” of system redesign
- Computer based training videos

IV: Narrative Plan

L. Involvement of Individuals and Families

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Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coaches and or peer specialists)?
- Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

The DMH Office of Consumer and Family Affairs (OCFA) advises DMH leadership on issues about consumers receiving services in the mental health system. OCFA advocates for education and support of consumer and family member needs for self-management and recovery through budget initiatives, conferences, employment and other appropriate activities. As discussed briefly in section D, the OCFA manages the DMH grievance program, which is known as FAIR (Finding Answers, Improving Relationships).

The OCFA devises and encourages initiatives to support peer counseling, wellness/recovery living, crisis planning and family support and has introduced consumer-run programs through various budget and grant initiatives.

Consumer-Run/Family Organizations

DMH funds two (2) consumer-run organizations: 1) the Consumer Action Network (CAN); and 2) the Ida Mae Campbell Wellness and Resource Center. Both CAN and the Ida Mae Campbell Center provide training and advocacy support to consumers.

- CAN is an Independent Peer Advocacy Program. CAN's goal is to help guide mental health consumers through the process by promoting recovery and self advocacy. The primary activities include: 1) rights and recovery training; 2) direct advocacy; and 3) grievance resolution. CAN has also provided support to DMH with regard to other services, including consumer satisfaction surveys, consumer self-advocacy, training and outreach.
- The Ida Mae Campbell Wellness and Resource Center (WRC) is a contracted consumer-run, self-help center. In FY 2011, the WRC provided a variety of supports to consumers including:
 - training (financial literacy, computer);
 - workshops (self-advocacy, intentional peer support, self determination and self employment, WRAP);
 - an annual mental health day that includes HIV/AIDS testing on site;
 - Mind Body and Soul HIV/AIDS Support Group;
 - Syringe, Treatment, Advocacy, Resources and Training (START) that reflects the core elements of the harm reduction philosophy adopted by the Westminster Presbyterian Church in the District, and
 - "Double Trouble", a program for addressing issues of both mental illness and addiction.

DMH has established a partnership with the Total Family Care Coalition, a family-run organization. Total Family Care Coalition provides peer-delivered family support and 1:1 supervision and coaching for children with SED and their families enrolled in the Wrap Around and Child-Family Team process, through trained family support partners. *See* Attachments D- 3, D-4, D-5 and D-6 for further details about DMH policies regarding services to children, youth and families as well as the role of the family support partners in the delivery of services. In addition, DMH contracts with two (2) of the six (6) Healthy Families/Thriving Communities

Collaboratives (Georgia Avenue and Far Southeast) to provide Psychiatric Residential Treatment Diversion utilizing the Child and Family Team process. Each of the professional teams includes a Family Support Partner to provide peer-delivered services to families and their children.

DMH also contracts with the local chapter of the National Alliance for Mental Illness (NAMI-DC) to provide a range of family and consumer education and training activities as well as family-to-family support and community outreach. NAMI, along with DMH and the District Metropolitan Police Department (MPDC), participated in the Crisis Intervention Collaborative, which was established to improve the outcomes of police interactions with people with mental illnesses. The Crisis Intervention Collaborative addresses the diverse professional development needs of officers at various levels of their law enforcement careers. The Crisis Intervention Officer (CIO) Initiative's framework is based on a survey of crisis intervention response initiatives from law enforcement jurisdictions across the country. Since its beginning in the spring of 2009, a total of 287 MPDC officers have participated in the 40-hour training and are now fully certified (of which 266 are still active). The goal is to train approximately 15%-20% of the MPDC patrol officers; currently 8% of patrol officers have been certified. A major part of this training is to help ensure that everyone receiving emergency calls understands why and how to dispatch mental health calls to a CIO-certified officer.

In December 2010, DMH OCFA sponsored its third Annual Olmstead Conference in collaboration with the D.C. Office of Disability Rights. The theme was "Community Inclusion-Building Resources and Safety Nets." Approximately 250 consumers and staff attended. OCFA will collaborate with the D.C. Office of Disability Rights to plan another Olmstead Conference in FY 2012.

Peer Specialists/Recovery Specialists/Transition Specialists

The OCFA currently contracts with twelve (12) consumers who work in different areas of DMH. This includes: 1) three (3) in administrative support roles, 2) eight (8) working as Peer Transition Specialists with the Integrated Care Division; and 3) one (1) with the Office of Accountability who has conducted satisfaction surveys for the D.C. Community Services Agency transition process.

The Peer Transition Specialists work with consumers who are transitioning from Saint Elizabeths Hospital back to the community, providing support and skill-building activities to facilitate a smooth transition that will result in extended community tenure for the transitioning consumer.

DMH has also developed a certification program for peer specialists. The curriculum and program were developed over an 18-month period by a group of stakeholders primarily comprised of consumers with extensive technical assistance, coordination and support from the Division of Policy Support. The first training class convened in June 2011. Twelve (12) consumers were selected for the first class, by a selection committee consisting entirely of consumers, most of who are working in peer counselor or peer specialist roles within the public mental health system. The certification program requires 70 hours of classroom work and 80 hours of field practicum. At the successful completion of the classroom work and field

practicum, individuals will be fully certified to work as peer specialists. The certification rules are currently pending a legal sufficiency review.

DMH plans to access Medicaid funding for certified Peer Specialists by using a billing modifier on existing service codes (e.g., ACT, Community Support, and CBI). The current state plan allows for credentialed, unlicensed staff to bill for specific components of MHRs under supervision of a qualified practitioner. The DMH certification program is designed to satisfy the credentialing requirement as well as the CMS requirements for billing for peer specialist services. DMH plans to offer the certification training annually.

IV: Narrative Plan

M. Use of Technology

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Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

- a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
- b. What specific applications of ICTs does the State plan to promote over the next two years?
- c. What incentives is the State planning to put in place to encourage their use?
- d. What support systems does the State plan to provide to encourage their use?
- e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
- f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
- g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
- h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

M. Use of Technology

The District does not have a formalized plan to use interactive communication technologies (ICTs) to deliver various health care and recovery support services or to allow individuals to report health information and outcomes.

Currently, DMH has the capability to use Bluetooth technology to coach parents/caregivers receiving psychotherapeutic services at 821 Howard Road. Monitors are also available. Monitoring equipment is scheduled for installation at 35 K Street during the FY 2012.

In addition, the following initiatives are in the early stages and relate to the use of technology.

- DMH has issued a request for proposals (RFP) seeking a vendor to provide a learning management system. The learning management system (LMS) is intended to provide training for DMH and provider agency staff using. Contract award is anticipated in early FY 2012 (October 2011). DMH plans to offer web-based training through the LMS, which would include training for certified peer specialists and consumers, as well as training for employees. This will provide web-based support for case managers and other practitioners.
- A scope of work for a contract to provide physician testimony in probable cause hearings via videoconference has been developed. A date for issuing an RFP to search for a vendor has not been established as of the date of this report.

Saint Elizabeths Hospital also has a proposed pilot of an “alert system” at Saint Elizabeths which would notify practitioners via text message about laboratory testing results, changes in dietary orders and changes in medications for individuals in care who are part of the practitioners case load.

The main barrier to further development of ICTS is funding and resources for implementation (staffing, training, etc).

IV: Narrative Plan

N. Support of State Partners

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Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

DMH has developed partnerships and collaborative relationships with a number of state and federal agencies. These partnerships and collaborative relationships are discussed in detail in section A of this application, as well as sections D, E, F, J, L, M and O.

One of the most significant developments in FY 2011, was the issuance of Mayoral Order 2011-106, by Mayor Gray. Mayoral Order 2011-106 reconstitutes the District Healthcare Reform Implementation Committee and includes the Directors of the Departments of Mental Health and Disabilities Services as full committee members. The HRIC is chaired by the Director of the Department of Health Care Finance (DHCF) and includes the Commissioner of the Department of Insurance, Securities and Banking and the Directors of the Departments of Health, Human Services Mental Health and Disabilities Services as full committee members.

The HRIC developed a sub-committee structure that includes interested members of the public to address issues delegated by the full committee. The HRIC has three sub-committees: (1) Eligibility and Medicaid Expansion; (2) Insurance; and (3) Service Delivery. The sub-committee meetings are open to the public.

Service Delivery Subcommittee. Representatives from DMH and APRA are participating in the Service Delivery subcommittee, which began meeting regularly in July 2011. The focus of the Service Delivery subcommittee is to develop specific demonstration proposals for the Centers for Medicare and Medicaid Services (CMS) which offer new service delivery models in the District for serving both fee-for-service and managed care beneficiaries. As these proposals will be designed to take advantage of the funding benefits offered through the federal health reform legislation, we plan to focus on the concepts of medical homes and accountable care organizations for a yet-to-be determined range of beneficiaries. The District's planning efforts related to implementation of the Affordable Care Act will be coordinated and planned through the HRIC and its subcommittees. This includes the Health Home Planning Initiative, which began in May 2011. DMH partnered with the Department of Health Care Finance (DHCF), the Department of Health (DOH) to develop a request for a planning grant from the Centers for Medicare and Medicaid Services (CMS) to determine the feasibility of implementing a health home in the District. The planning funds will be used to develop a health profile of people with at least one (1) psychiatric admission in order to identify high end users who would be good candidates for specific interventions in order to: 1) reduce total health costs, 2) improve health care delivery, and 3) improve quality of life. The planning will build upon a data analysis project that DMH initiated in January 2011, which examined data from DHCF about Medicaid funded psychiatric admissions to all District hospitals with psychiatric units, except the public operated psychiatric inpatient facility Saint Elizabeths Hospital.

Eligibility and Medicaid Expansion Subcommittee. Representatives from DMH and APRA are also participating in the Eligibility and Medicaid Expansion Subcommittee, which began meeting in early August 2011.

Health Insurance Exchange. On August 12, 2011, the District was awarded an 8.2 million dollar Level One Establishment grant by HHS. DHCF will administer the grant. The District plans to use the funds to continue and complete current planning and implementation efforts that would enable the District to establish a certified and functioning insurance exchange by January 2014.

The District estimates that approximately 225,000 of the District's residents are expected to utilize District Exchange Services. The District's Exchange project development staff has been working to establish a planning and requirements gathering framework for designing an Exchange that is representative of the unique health insurance needs of District residents and that reflects the preferences of stakeholders. This Level One funding is intended to leverage the data, information and indicators gathered in the preliminary planning effort into a comprehensive project design document to be used to stand up the exchange in Level Two. The health insurance exchange project will be implemented under the overall direction of the HRIC. DMH staff have been invited to participate on the workgroup that will be implementing the Level One Establishment grant.

A list of the various partnerships and collaborative arrangements is below. Letters of Support, Memoranda of Understanding, Memoranda of Agreement and other documentation describing existing partnerships and collaboration are attached, to the extent available.

No.	Name of Partner Agency (ies)	Nature of Partnership or Collaboration	Federal or District Agency	Letter of Support, Memorandum of Agreement or Memorandum of Understanding
1.	Departments of Health Care Finance, Health, Human Services, Insurance , Securities and Banking, and Disabilities Services	Healthcare Reform Implementation Committee	District	Attachment N-1, Mayoral Order 2011-106
2.	Child and Family Services Agency	Partnership on wraparound pilot, Choice Providers, evidence-based practices	District	Attachment N-2, Letter of Support
3.	Department of Health	Collaboration on Healthy Start, Project Launch, co-occurring disorders, healthcare reform implementation activities	District	Attachment N-3, Letter of Support
4.	Department of Health Care Finance	Delegation of authority regarding MHRS program, MCO and mental health services, State Optional Payment Program, healthcare reform implementation activities, Membership on State Mental Health Planning Council	District	Attachment N-4, Letter of Support
5.	Department of Human Services	Homeless Services Collaboration, Membership on State Mental Health Planning Council, negotiation of supported employment project for TANF recipients; participation in healthcare reform implementation activities	District	Attachment N-5, Letter of Support
6.	District of Columbia	Juvenile Behavioral Diversion	Federal	Attachment N-6, Superior

No.	Name of Partner Agency (ies)	Nature of Partnership or Collaboration	Federal or District Agency	Letter of Support, Memorandum of Agreement or Memorandum of Understanding
	Superior Court	Court		Court of the District of Columbia Administration Order 10-17
7.	Court Services and Offender Supervision Agency (CSOSA) and Pre-Trial Services Agency (PSA)	Coordination of services for defendants/offenders with major mental illnesses under the supervision of CSOSA and PSA.	Federal	Attachment N-7, MOU between CSOSA, PSA and DMH
8.	Executive Office of the Mayor, Office of Victim Services and other District and Federal Agencies	DC Lethality Assessment Project	Federal and District	Attachment N-8, MOU between OVS, DMH and other partners
9.	Metropolitan Police Department	General Order – Crisis Intervention Officer Initiative	District	Attachment N-9, MPD General Order SO-10-07, effective September 13, 2010
10.	Executive Office of the Mayor, Office of Victim Services	Homicide Survivor Response Project	District	Attachment N-10, MOU between OVS and DMH
11.	Executive Office of the Mayor, Office of Victim Services	Trauma-focused Cognitive Behavioral Therapy (CBT) Learning Collaborative	District	Attachment N-11, MOU between OVS and DMH
12.	District of Columbia Public Schools ¹	Provision of prevention, assessment and treatment services to DCPS students in 48 schools	District	Attachment N-12, MOU between DCPS and DMH
13.	Office of the State Superintendent of Education	Wrap-Around Program in Full Service Schools	District	Attachment N-13, MOU between OSSE and DMH
14.	District of Columbia Department of Housing and Community Development	Development of affordable, supportive housing for persons with mental illness	District	Copy not attached, available upon request
15.	District of Columbia Housing Authority	Administration of the DMH Home First bridge subsidy program	District	Copy not attached, available upon request

¹ DMH also has individual agreements with the local educational authorities responsible for operating 10 public charter schools that participate in the School Mental Health Program. Copies of those MOUs are not attached to this application. The format of these individual agreements is identical the format of the MOU with DCPS.

No.	Name of Partner Agency (ies)	Nature of Partnership or Collaboration	Federal or District Agency	Letter of Support, Memorandum of Agreement or Memorandum of Understanding
16.	Metropolitan Police Department	Coordination between agencies to provide services to people experiencing both mental health and physical health crises in the community.	District	Copy not attached, the current MOU has expired and the parties are negotiating a new agreement while continuing to operate under the terms of the existing agreement.
17.	District of Columbia Fire and Emergency Services	Coordination between agencies to provide services to people experiencing both mental health and physical health crises in the community.	District	Copy not attached, available on request
18.	Catholic Charities	Coordination between the DMH mobile crisis services program and the Catholic Charities contracted mobile crisis service for children regarding the provision of services.	Private agency	Copy not attached, available upon request
19.	Department of Corrections	Purchase of pharmaceuticals for the DC Jail through the DMH arrangement with the Department of Defense	District	Copy not attached, available upon request.
20.	Department of Youth Rehabilitative Services	Funds for wraparound pilot	District	Copy not attached, available upon request
21.	Department of Youth Rehabilitation Services	Targeted CSR	District	Copy not attached, available upon request
22.	Child and Family Services Agency	Coordination of CSR	District	Copy not attached, available upon request
23.	Homeland Security and Emergency Management Agency	Funding for disaster mental health training and mental health first aid course	District	This is for funding for FY 12 and the agreement with regard to transfer of funds has not yet been finalized.
24.	Metropolitan Police Department	Covers the cost of required criminal background checks for employees, volunteers and persons considered for employment with DMH	District	Copy not attached, available upon request
25.	Department of Human Resources	Covers the cost of required drug testing for employees, volunteers and persons considered for employment with DMH	District	Copy not attached, available upon request

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order 2011-106
June 7, 2011

SUBJECT: Establishment – Mayor's Health Reform Implementation Committee

ORIGINATING AGENCY: Office of the Mayor

By virtue of the authority vested in me as Mayor of the District of Columbia by section 422(11) of the District of Columbia Home Rule Act, approved December 24, 1973, 87 Stat. 790, Pub. L. 93-198, D.C. Official Code §1-204.22(11) (2010 Supp.), it is hereby **ORDERED** that:

I. ESTABLISHMENT

There is hereby established in the Executive Branch of the Government of the District of Columbia, the Mayor's Health Reform Implementation Committee ("Committee").

II. PURPOSE

The Committee shall advise and make recommendations to the Mayor on implementation of the federal Patient Protection and Affordable Care Act, approved March 23, 2010 (Pub. L. 111-148; 124 Stat. 119), and the Health Care and Education Reconciliation Act of 2010, approved March, 30, 2010 (Pub. L. 111-152; 124 Stat. 1029).

III. FUNCTIONS

The functions of the Committee shall include advising the Mayor on implementation of federal health reform and coordination of health reform in the District of Columbia.

IV. COMPOSITION

A. The Committee shall be composed of the following members who shall be appointed by the Mayor and who shall serve at the pleasure of the Mayor;

1. Director, Department of Health, or his or her designee;
2. Director, Department of Health Care Finance, or his or her designee;
3. Director, Department of Human Services, or his or her designee;
4. Director, Department of Disability Services, or his or her designee;

5. Director, Department of Mental Health, or his or her designee;
 6. Commissioner, Department of Insurance, Securities and Banking, or his or her designee; or
 7. Individuals representing any other agency within the Executive Branch of the District government, as designated by the Mayor.
- B. Members of the Committee shall serve only during their tenure as employees of the District government.
- C. Members of the Committee shall serve without compensation.

V. OVERSIGHT

The Deputy Mayor for Health and Human Services shall have oversight responsibility for the work of the Committee. All reports and recommendations shall be submitted through the Deputy Mayor.

VI. ORGANIZATION

- A. The Committee shall be chaired by the Director of the Department of Health Care Finance.
- B. The Director of the Department of Health and the Commissioner, Department of Insurance, Securities and Banking, shall serve as co-vice chairpersons of the Committee.
- C. The Committee may elect other officers as it may deem necessary, and may determine rules of procedure, subject to the approval of the Mayor or a designee.
- D. The Committee shall operate through the following subcommittees:
1. The subcommittee on "*Eligibility and Medicaid Expansion*" which shall be chaired by the Director of the Department of Human Services;
 2. The subcommittee on "*Insurance*" which shall be chaired by the Commissioner, Department of Insurance, Securities and Banking;
 - a. The areas of focus of this subcommittee shall include:
 - i. Health insurance exchange;
 - ii. Regulations; and

- iii. Other matters as necessary.
- 3. The subcommittee on "*Health Delivery System*" which shall be chaired by the Director, Department of Health;
 - a. The areas of focus for this subcommittee shall include:
 - i. Integration of prevention into the delivery system;
 - ii. Patient safety;
 - iii. Quality of care improvement;
 - iv. Health care delivery options; and
 - v. Manpower Training.
- E. The Committee may establish other subcommittees as needed, which may include persons who are not members of the full Committee, provided that each subcommittee shall be chaired by a member of the Committee.

VII. ADMINISTRATION

- A. Administrative, clerical and technical support to the Committee shall be provided by the agencies represented on the Committee.
- B. Agencies of the subcommittee chairs shall provide appropriate staffing and administrative support on substantive issues in their areas of responsibility

VIII. SUNSET


The Committee shall sunset and cease to exist on January 31, 2014.

IX. RESCISSIONS

Mayor's Order 2010-97, dated May 28, 2010, is superseded and rescinded in its entirety.

X. EFFECTIVE DATE: This order shall become effective *nunc pro tunc* to May 4, 2011.


VINCENT C. GRAY
MAYOR

ATTEST: 
CYNTHIA BROCK-SMITH
SECRETARY OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency



OFFICE OF THE DIRECTOR

August 22, 2011

Virginia Simmons, Grants Management Officer
Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20857

Re: *Support for the District of Columbia's Community Mental Health Block Grant Application (CMHS FY 2012)*

Dear Ms. Simmons:

On behalf of the Child and Family Services Agency (CFSA), I am writing to confirm our support of the District of Columbia's Department of Mental Health's application for the Fiscal Year 2012 Community Mental Health Block Grant (MHBG).

CFSA is the District of Columbia's public child welfare agency (Title IV-E and IV -B) that protects child victims and children at risk of abuse and/or neglect. Services include family stabilization, reunification, foster care, adoption, and supportive community-based services to enhance the safety, permanence and well-being of abused, neglected, and at-risk children and their families in the District of Columbia. In this capacity, CFSA has established and maintained a close and positive working relationship with the Department of Mental Health (DMH).

CFSA is committed to working with DMH and its partner agencies to enhance or improve the District of Columbia's existing mental health system for children and youth, and to the development and implementation of evidence-based and promising practices.

Support with Compliance with the *LaShawn* Amended Implementation Plan (AIP)

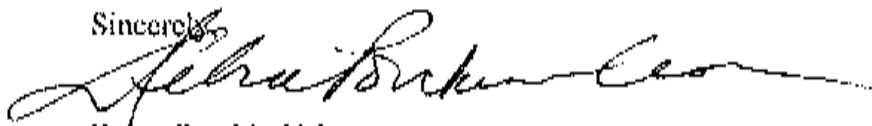
DMH continues to co-locate staff at CFSA as part of the overall compliance with the *LaShawn* AIP. For the time period of April 1, 2010 to March 31, 2011, the Child and Youth Clinical Practice Unit (CYCPU) clinicians co-located at CFSA conducted 199 mental health screens out of 647 total children/youth that entered foster care. Of the 199 referrals, 156 (79%) were determined to be in need of mental health services.

CFSA also provides funding for a dedicated staff member in the Division of Care Coordination who is responsible for ensuring linkages to mental health services and authorizing specialty services (e.g., MST, FFT and CBI) for children and youth referred by CFSA.

CFSA submitted a letter of support for DMH's recent *System of Care Planning Grant* application. If awarded, CFSA will participate on the governance committee and work closely with DMH to implement the work plan and achieve the required deliverables. Likewise, DMH provided a letter of support to CFSA with regard to CFSA's recent application for funding under *Integrating Trauma-Informed and Trauma-Focused Practice in Child Protective Service (CPS) Delivery* opportunity. If awarded, CFSA expects that DMH will have a significant role in the grant implementation activities.

The Child and Family Services Agency strongly supports the DMH application for the 2012 MIIBG and will continue to work collaboratively with DMH. We are pleased to submit this letter in support of DMH's application. If you have any questions or require additional information, please do not hesitate to contact Loren Ganoe, Chief of Staff at (202) 442-6160.

Sincerely,



Debra Porchia-Usher
Interim Director

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Office of the Director



August 26, 2011

Virginia Simmons, Grants Management Officer
Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20857

Re: Support for the District of Columbia's Community Mental Health Block Grant Application
(CMHS FY 2012)

Dear Ms. Simmons:

The purpose of this letter is to express the support of the Department of Health (DOH) for the Department of Mental Health's application for the FY 2012 Community Mental Health Block Grant (MHBG).

DOH is responsible for promoting and protecting the health, safety and quality of life of residents, visitors and those doing business in the District of Columbia. Our responsibilities include identifying health risks; educating the public; preventing and controlling diseases, injuries and exposure to environmental hazards; promoting effective community collaborations; and optimizing equitable access to community resources.

The Department of Health's Addiction, Prevention and Recovery Administration (APRA) is responsible for establishing a substance abuse prevention, treatment and recovery support system of care for District residents and families coping with the disease of addiction or at risk of becoming addicted to alcohol and illicit drugs.

Substance Abuse Treatment and Recovery Initiatives

COSIG. In 2005, the District was awarded a five (5) year COSIG from SAMHSA. DMH was the lead agency for the grant, which required the establishment of cross-agency collaboration between DMH and APRA. One of the most significant achievements of the COSIG project was the development of a sustainable competency training course for practitioners. Over 150 individual practitioners were trained during the course of the grant. DMH offers the training annually and APRA has incorporated some of the training modules into its course offerings.

Court Urgent Care Clinic. Earlier this year, APRA entered into an MOU with DMH to expand the operation of the DMH-funded Court Urgent Care clinic (CUCC) to include substance use disorder assessment and referral services. The CUCC is operated by the Psychiatric Institute of Washington under contract with DMH.

Co-Occurring Joint Certification. APRA and DMH staff have recently initiated a planning process to develop and implement a co-occurring joint certification program for providers. Activities planned for FY 2012

899 North Capitol Street, N.E., 5th Floor, Washington, D.C. 20002 • Phone: (202) 442-5955, Fax: (202) 442-4795

include a review of existing regulations regarding staffing, requirements for certification, claims payment and utilization issues, as well as co-occurring certifications in other jurisdictions.

Early Intervention and Prevention Initiatives

DOH has a successful partnership with the DMH on the implementation of Project Launch, a five (5) year SAMHSA grant awarded in October 2009. Funding through Project Launch has allowed for the expansion of the DMH early intervention program known as the Primary Project and for implementation of an evidence-based program, The Incredible Years (curriculum). Funds have also been used to expand the mental health consultation project known as "Healthy Futures" to several additional sites. DOH and DMH are also partnering to implement Part B (Early Stages) and Part C (DC Early Intervention Program).

DOH also collaborates with DMH on the Health Start Program. DOH provides some funding to DMH for the provision of services to women of child bearing age who have children between birth and age 2, identified as having experienced depression during and around pregnancy. This includes services to enhance the emotional health of the women/mothers as well as their interactions with their children. The purpose of this program is to: 1) provide needed health and mental health services to pregnant women; 2) reduce infant mortality; and 3) remove barriers to accessing quality health and mental health services for District high risk populations in Wards 5, 6, 7, and 8.

Chronic Care Initiative in Mental Health

In 2009, DOH awarded grant funds to the D.C. Chronic Care Initiative (CCI) in Mental Health, a partnership of the George Washington University Medical Faculty Associates and Department of Health Policy, Department of Mental Health, Anchor Mental Health, Green Door, Community Connections, Washington Hospital Center, the Medstar Diabetes Program at the Washington Hospital Center, and Howard University Hospital. The primary goal of the CCI in Mental Health project is to improve the health status of adults with serious mental illness in the District who have chronic disease or who are at high risk for developing chronic illness due to modifiable risk factors. A Nurse Practitioner is located on site at the mental health facility to conduct health screenings (i.e., diabetes) and provide health education. DMH provided some supplemental funding for the project during FY 2011.

Health Reform

In 2011, Mayor Gray reconstituted the Health Reform Implementation Committee (HRIC) to ensure the smooth implementation of health reform in the District of Columbia. The HRIC is chaired by the Director of the Department of Health Care Finance. Other HRIC members include the Commissioner of the Department of Insurance, Securities and Banking and the Directors of the Departments of Health, Human Services, Mental Health and Disabilities Services. There are three (3) subcommittees of the HRIC: (1) Eligibility and Medicaid Expansion; (2) Insurance; and (3) Service Delivery.

In May 2011, DMH, DOH and the Department of Health Care Finance began to develop a request for a planning grant from CMS to determine the feasibility of implementing a health home in the District.

The Department of Health strongly supports the DMH application for the 2012 MHBG and will continue to work collaboratively with DMH to further strengthen the District's healthcare delivery system.

Sincerely,



Mohammad N. Akhter, M.D., M.P.H.
Director

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance



Office of the Director

August 31, 2011

Ms. Virginia Simmons
Grants Management Officer
Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20857

Re: Support for the District of Columbia's Community Mental Health Block Grant Application
(CMHS FY 2012)

Dear Ms. Simmons:

The purpose of this letter is to express the Department of Health Care Finance's (DHCF) support for the Department of Mental Health's application for the FY 2012 Community Mental Health Block Grant (MHBG). DHCF serves as the single state Medicaid agency for the District of Columbia and has a longstanding partnership with the Department of Mental Health (DMH). The DHCF-DMH partnership relates to Medicaid, the State Optional Payment program, the State Mental Health Planning Council, Money Follows the Person, and health care reform. The information below highlights our longstanding relationship and continued support for DMH.

Medicaid and the State Optional Payment Program

In 2001, DHCF delegated authority to administer the mental health rehabilitation services (MHRS) program to DMH. This arrangement is memorialized in a memorandum of understanding between our agencies. Another memorandum of understanding sets forth the relationship between DHCF and DMH with regard to the conduct of claims audits and joint recoupment. DMH budgets for the local match portion of Medicaid eligible MHRS and transfers the funds to DHCF, which is responsible for payment of Medicaid claims.

DHCF also contracts with several Medicaid managed care organizations (MCOs). In 2009, DHCF and DMH entered into a memorandum of understanding outlining the relationship between the agencies with regard to mental health services provided by the MCOs.

In January 2010, DHCF enacted a rule designating DMH as the Level of Care Agent for all Medicaid Psychiatric Residential Placement, which also includes Continuity of Care in Psychiatric Residential Placements for all District children. My staff have worked closely with DMH to implement the processes required to implement this rule over the past two years.

Ms. Virginia Simmons
Page Two

DHCF and DMH have also entered into a memorandum of understanding with regard to the Optional State Payment program for adults who live in "eligible adult foster care homes" as defined by the Social Security Administration. DMH is responsible for certifying eligibility for the Optional State Payment.

State Mental Health Planning Council Participation

Maude Holt, the DHCF Health Care Ombudsman continues to serve as the DHCF representative to the State Mental Health Planning Council.

Money Follows the Person

A representative from DMH participates in the monthly Money Follows the Person steering committee meetings. DMH is also working with the MFP coordinator to amend the protocol to include persons with mental illness discharged from nursing homes and psychiatric residential treatment facilities.

Health Reform

In 2010, the Mayor established the Health Reform Implementation Committee (HRIC) to ensure the smooth implementation of health reform in the District of Columbia. Mayor Gray reconstituted the HRIC in 2011. I chair the HRIC. The other members of the HRIC are the Commissioner of the Department of Insurance, Securities and Banking and the Directors of the Departments of Health, Human Services, Mental Health and Disabilities Services.

The HRIC has three sub-committees: (1) Eligibility and Medicaid Expansion; (2) Insurance; and (3) Service Delivery. The sub-committee meetings are open to the public. My Deputy Director, who also serves as the Medicaid Director, chairs the Service Delivery Subcommittee, which includes representatives from DMH. The Service Delivery subcommittee focuses on the development of specific demonstration proposals for the Centers for Medicare and Medicaid Services (CMS) that offer new service delivery models in the District for serving both fee-for-service and managed care beneficiaries. As these proposals will be designed to take advantage of the funding benefits offered through the federal health reform legislation, we plan to focus on the concepts of health homes and accountable care organizations for a yet-to-be determined range of beneficiaries. The District's planning efforts related to implementation of the Affordable Care Act will be coordinated and planned through the HRIC and its subcommittees.

In May 2011, DMH, DHCF and the Department of Health (DOH) began to develop a request for a planning grant from CMS to determine the feasibility of implementing a health home in the District. The request was submitted to CMS on July 14, 2011.

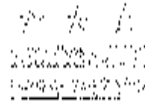
The Department of Health Care Finance strongly supports the DMH application for the 2012 MHBG and will continue to work collaboratively with DMH further strengthen the District's health care delivery system.

Sincerely,



Wayne Turnage
Director

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES**



Office of the Director

25

Virginia Simmons
Grants Management Officer
Division of Grants Management
Substance Abuse and Mental Health
Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20857

Re: Support for the District of Columbia's Community Mental Health Block Grant
Application (CMHS FY 2012)

Dear Ms. Simmons:

The purpose of this letter is to express the support of the Department of Human Services (DHS) for the Department of Mental Health's application for the FY 2012 Community Mental Health Block Grant (MHBG). DHS is the District agency responsible for coordinating and providing a range of services that collectively create the enabling conditions for economic and socially challenged residents of the District of Columbia to enhance their quality of life and achieve greater degrees of self-sufficiency. DHS includes the Income Maintenance Administration (IMA) and the Family Services Administration (FSA).

The Income Maintenance Administration (IMA) determines eligibility for benefits under the Temporary Assistance for Needy Families (TANF), Medical Assistance, Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), Child Care Subsidy, Burial Assistance, Emergency Rental Assistance, Interim Disability Assistance, and Refugee Cash Assistance programs. In addition, IMA's Food Stamp Employment and Training Program (FSET) provides employment and training services to able-bodied adults without dependents who receive food stamps. IMA also performs monitoring, quality control and reporting functions required by federal law and court orders.

The FSA provides protection, intervention and social services to meet the needs of vulnerable adults and families to help reduce risk and promote self-sufficiency. FSA administers the following social services programs: (1) Adult Protective Services; (2) D.C. Fatherhood Initiative; (3) Homeless Services, including emergency shelter, temporary shelter and transitional shelter; (4) Homelessness Prevention and Rapid Re-housing Program; (5) Hypothermia program; and (6) Permanent Supportive Housing Program.

Letter to Virginia Simmons
Page Two

Homeless Services

The District of Columbia Interagency Council on Homelessness (ICH) is a group of cabinet-level leaders, providers of homeless services, advocates, homeless and former homeless leaders that come together to inform and guide the District's strategies and policies for meeting the needs of individuals and families who are homeless or at imminent risk of becoming homeless in the District of Columbia.

The ICH was established by the Homeless Service Reform Act of 2005 for the purpose of facilitating interagency, cabinet-level leadership in planning, policymaking, program development, provider monitoring, and budgeting for the Continuum of Care of homeless services (HSRA, Sec. 4 (a)). The ICH is chaired by the City Administrator. Steve Baron, the Director of DMH is a member of the Council along with other District agency officials and members of the public.

The DMH Homeless Outreach Program also works collaboratively with my staff on the following initiatives:

- Outreach, engagement, and referrals to the Homelessness Prevention and Rapid Re-housing Program (HPRP);
- Identification of homeless veterans eligible for the VASH (Veterans Affairs Supportive Housing) voucher program;
- Outreach assistance to homeless encampments and participation when a decision is made that these encampments need to be cleaned up and/or removed from public property; and
- The development of the Winter Plan which provides information on shelter and services for the homeless during hypothermia season.

My staff also participate in the DMH monthly Emergency Rounds meetings and assist in the coordination of care for the most vulnerable homeless individuals living on the street.

TANF

DMH and DHS-IMA are developing a partnership to collaborate and coordinate resources, services, and expertise to better serve TANF customers with mental illness who face barriers to employment. Key areas of collaboration and service coordination include:

- Mental Health screening and assessment;
- Providing Mental Health Rehabilitation Services through enrollment in CSA's;
- Refer and enrolling TANF customers in supported employment;
- Cross-training of IMA and CSA personnel; and
- Data coordination and sharing between DMH and DHS-IMA.

Letter to Virginia Simmons
Page Three

State Mental Health Planning Council Participation

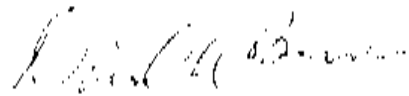
Peggy Massey continues to serve as the DHS representative to the State Mental Health Planning Council.

Health Reform

In 2011, Mayor Gray reconstituted the Health Reform Implementation Committee (HRIC) to ensure the smooth implementation of health reform in the District of Columbia. The HRIC is chaired by the Director of the Department of Health Care Finance. Other HRIC members include the Commissioner of the Department of Insurance, Securities and Banking and the Directors of the Departments of Health, Human Services, Mental Health and Disability Services. There are three (3) subcommittees of the HRIC: (1) Eligibility and Medicaid Expansion; (2) Insurance; and (3) Service Delivery. I chair the Eligibility and Medicaid Expansion subcommittee. Representatives from DMH participate on the subcommittee.

The Department of Human Services strongly supports the DMH application for the 2012 MHBG and will continue to work collaboratively with DMH to further strengthen the District's healthcare delivery system.

Sincerely,



David A. Berns
Director

DAB/kr

**SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
ADMINISTRATIVE ORDER 10-17**

Juvenile Behavioral Diversion Program

WHEREAS, a significant number of juveniles who have a serious mental illness appear before judicial officers in the Superior Court's Family Court; and

WHEREAS, juveniles with mental health illness are at higher risk of reoffending; and

WHEREAS, the Superior Court recognizes the importance of reducing juvenile's behavioral symptoms that result in contact with the court and improving the juvenile's functioning in the home, school, and community; and

WHEREAS, the Superior Court decided with the support of the District of Columbia Department of Mental Health, Court Social Services, the Office of the Attorney General, and the Public Defender Service to develop a juvenile behavioral diversion program that will connect eligible and suitable juveniles and his or her parent, guardian, or custodian to, and intensely monitor engagement with, mental health services and supports in the community; and

WHEREAS, in order to implement the program, an additional calendar will need to be added to the Family Court;

NOW, THEREFORE, it is by the Court,

ORDERED, that an additional Family Court Calendar (Juvenile Behavioral Diversion Program) be and hereby is established; it is further

ORDERED, that all judges presiding over Family Court Calendars where juvenile matters are assigned may certify cases to the Juvenile Behavioral Diversion Program; it is further

ORDERED, that the Juvenile Behavioral Diversion Program shall be administered in accordance with the attached memorandum, which provides a detailed description of the program; and it is further

ORDERED, the Juvenile Behavioral Diversion Program shall begin on January 3, 2011, although referrals to the program can be made and assessments for the program can be

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

Juvenile Behavioral Diversion Program Description

Introduction

It is estimated that between 65 to 70% of juveniles involved in the delinquency system are diagnosed with a mental health disorder.¹ In addition, many juveniles re-offend, even while they are involved with the juvenile justice system. A diversion program would help connect juveniles with a mental disorder to appropriate mental health services and supports and increase public safety. It is agreed that “it is crucial that we deal not only with the specific behavior or circumstances that bring [juveniles] to our attention, but also with their underlying, often long-term mental health and substance abuse problems.”² Moreover, a diversion program is consistent with the policy underlying juvenile court, which is the care and rehabilitation of children who violate the law, while protecting the community.

In May 2010, Chief Judge Lee F. Satterfield established an implementation group to develop the criteria and procedures for a juvenile behavioral diversion program. Representatives from the Family Court, the Department of Mental Health (DMH), the Office of the Attorney General (OAG), the Public Defender Service (PDS), Court Social Services (CSS), and the D.C. Courts’ Research and Development Division (R&D) met several times to develop criteria and procedures for the program. Based on its

¹ Teplin, Abram, McClelland, Dulcan and Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher and Santos, 2002; Wasserman, Ko, and McReynolds, 2004.

² Shay Bilchik, Office of Juvenile Justice and Delinquency Protection, U.S. Department of Justice, *Mental Health Disorders and Substance Abuse Problems Among Juveniles* (July 1998), available at www.childrensprogram.org/media/pdf/mentalhealthdisorders.pdf.

discussions and information of other jurisdictions' programs, the implementation group developed the following criteria and process.

The Juvenile Behavioral Diversion Program (JBDP) is established as a problem-solving court. The R & D Division will evaluate the program at the end of its first year of operation to determine its effectiveness. The Program is an intensive non-sanction based program designed to link juveniles and status offenders to, and engage them in, appropriate mental health services and supports in the community in order to reduce behavioral symptoms that result in contact with the court and to improve the juvenile's functioning in the home, school, and community. Priority for admission to JBDP will be provided to juveniles. The Program is voluntary.

Program Goals

The program's goals are as follows:

- To connect the juvenile and status offender with appropriate mental health services in the community;
- To provide support for and involve the respondent's parents, guardian, or custodian in mental health treatment for their child;
- To provide a period of engagement with mental health services that is monitored by the court in order to increase treatment engagement by respondents and their families;
- To increase the number of respondents able to remain in the community with the appropriate mental health services and supports and to reduce the number of respondents who otherwise without such services and support might be detained;

- To reduce the individual's contact with the criminal justice system as a juvenile and later as an adult; and
- To reduce crime in the community and protect public safety by reducing the number of times that juveniles with mental disorders reoffend.

Eligibility Criteria

The initial hearing judge, respondent's counsel, CSS officer, or the Assistant Attorney General (AAG) may identify a respondent who may be eligible for certification from the juvenile calendar judge to the JBDP. The juvenile calendar judge may also identify a respondent who may be eligible. The attorney appointed to represent the respondent at the initial hearing shall remain the attorney for the respondent in the Program. In order for the respondent to participate in the Program, he or she must be available to participate in community-based services. It is not a disqualification if the respondent is in respite care or is placed in shelter care.

Age

The respondent may be any age under 18 years old.

Clinical Criteria

In order to participate in the program, the juvenile or status offender must have an Axis I mental health disorder or be at significant risk of receiving an Axis I diagnosis. The respondent may also have an Axis II developmental disability, if he or she is able to participate in the program, but he cannot solely have an Axis II diagnosis.

The Court has available for its consideration prior evaluations of the respondent. The program will rely on prior diagnoses and recognizes that various assessment instruments may have been used to make a diagnosis. CSS administers a risk assessment for all respondents who have contact with the court system. If CSS identifies a respondent who is at risk of mental illness and there is no available prior assessment, DMH shall conduct a further assessment of the respondent. This assessment will be completed by DMH at its Howard Road child psychiatry group. Based on its consideration of prior or current assessments for a mental disorder, DMH shall determine whether the respondent has or is at risk of having a qualifying diagnosis. No information learned from the respondent during the course of the CSS screen and the DMH assessment shall be discoverable.

Criminal Criteria

The OAG will review the following information regarding the respondent: any prior contacts with the court; the nature and circumstances of the prior contacts; the nature and circumstances of the present contact; and any relevant social factors. If a respondent's charges involve certain offenses, he or she is ineligible to participate in the Program. Attachment A lists the excluded offenses. A respondent may have been adjudicated delinquent in prior cases. However, in the prior cases, if the respondent was found to be involved in the listed excluded offenses, he or she is ineligible to participate in JBPD. The OAG reserves the right, based upon the individual factors in a respondent's case, to override any criminal eligibility factor either to permit or decline to allow a respondent to enter any program track.

There are three tracks (Track I, Track II, and Track III). Track I is available for the charges listed on Attachment B. The respondent does not enter a plea on this Track. A respondent may enter a consent decree and be eligible to enter on Track I. In addition, generally, the individuals who would be eligible for this Track must have no prior convictions or have entered any consent decrees in prior cases. The OAG, however, will always review prior convictions and consent decrees to determine whether the nature and circumstances underlying the conviction or consent decree, including whether appropriate mental health services and supports were provided to the respondent, support a determination that the individual remains eligible for Track I.

Attachment C lists the charges for which a respondent would be eligible for certification to the JBDP in Track II. This Track involves a respondent who enters a plea and is certified to the program pre-disposition by the juvenile calendar judge.

Attachment D lists the charges for which a respondent would be eligible for certification to the JBDP in Track III. This Track involves a respondent who is certified to the program by the juvenile calendar judge at disposition or after a motion to revoke probation has been filed.

Certification to the Juvenile Behavioral Diversion Program

Prior to certification to the JBDP, the OAG and DMH shall have determined that the respondent meets their respective eligibility criteria. CSS will screen in the Juvenile New Referrals courtroom. Based on that screening, CSS will recommend to the judge in New Referrals whether the respondent should be further assessed by DMH. If a further assessment is recommended, the respondent will be ordered to attend a further

assessment and a date shall be set in the New Referrals courtroom for the assessment at Howard Road. The Court may also order a parent, guardian, or caretaker to attend the assessment. CSS will also notify the OAG of the identification of the respondent based on its screen. The OAG will then review the case to determine whether the respondent meets criminal eligibility criteria. The DMH assessment and OAG's review will be completed prior to the first status before the juvenile calendar judge. If both the OAG and DMH report to the juvenile calendar judge that the juvenile meets eligibility criteria, the juvenile judge will then certify the case to the JBDP judge and schedule the matter for a status before the JBDP judge within seven (7) days.

If a juvenile is identified as a candidate for the JBDP when the case is pending before the juvenile calendar judge, and after adjudication or a plea or post disposition if the juvenile is on probation, the OAG will review the case to determine whether the respondent meets criminal eligibility criteria and the DMH will review the case to determine if an assessment is required. DMH shall schedule a mental health assessment at Howard Road, if one is needed. The OAG and DMH review and DMH assessment will be completed within ten (10) days. If the OAG and DMH report to the juvenile calendar judge that the juvenile meets eligibility criteria, the juvenile judge will then certify the case to the JBDP judge and schedule the matter for a status before the JBDP judge within seven (7) days.

When a respondent is deemed eligible for the JBDP, the Suitability Committee will review the case to determine if the juvenile is suitable to participate, including, but not limited to, amenability to treatment and community support. The Suitability Committee shall have all available information regarding the respondent's history

(criminal, medical, educational and social). The Committee will be composed of the following: a CSS officer, a psychiatrist or psychologist, a DMH representative and an APRA representative, as appropriate. Neither the JBDP judge nor counsel shall be present for or participate in the Suitability Committee's review. The Committee shall meet two (2) times a week, or as needed, to review eligible candidates for the JBDP. The Committee shall meet prior to the first status before the JBDP judge. The Committee shall provide the judge and counsel with its determination of whether the juvenile is suitable or unsuitable for the Program. If the Committee determines the respondent is not suitable, it shall suggest appropriate treatment or service alternatives. The JBDP judge will then certify the respondent back to the juvenile calendar judge with the specific recommendations from the Committee.

Diversion Supervision

The program involves a multi-disciplinary approach. Collaboration between involved agencies is critical. The Program team will determine an appropriate individual plan for the respondent. The plan will be made part of a Participation Agreement entered into by the respondent, respondent's counsel, respondent's parent, guardian, or custodian, the Assistant Attorney General, and the JBDP judge. The plan will include participation in mental health treatment and reporting to CSS. It may also include substance abuse treatment and drug testing, if appropriate. The judge may order the parents and other caretakers of respondents into parenting classes, family counseling, medical and psychiatric treatment, or other appropriate programs. In addition, if appropriate, the

judge will appoint an Education Attorney to assist in addressing the educational needs of the respondent.

The JBDP judge will hold status hearings every two weeks to determine the respondent's compliance with treatment. The constant reviews make sure that services are in place and service adjustments can be made quickly, as appropriate. The frequency of hearings may change based on the juvenile's compliance. The judge will make every effort not to schedule a court hearing more than once a month that would require the respondent to be absent from school. At the hearing, the following will be present: respondent; parent, guardian, or custodian; AAG; CSS officer; respondent's counsel; and a DMH integration coordinator (a cross-trained clinician). No statements made by a respondent in the JBDP shall be discoverable or used against the respondent in any prosecution. The respondent's participation or lack of participation in the program will be used to determine the respondent's compliance in the program and may be used at any detention or disposition hearing.

Prior to the hearing, CSS will provide a written report on the respondent's compliance with the Participation Agreement. The JBDP judge shall determine whether the respondent has successfully completed the program for Track I and II, based on the judge's judgment that the respondent has substantially complied with the Participation Agreement and any court orders. The respondent's participation in the program shall generally be for a four (4) to six (6)-month period from the date the formal agreement is entered, but no longer than twelve (12) months. The judge may shorten or lengthen the period, depending on the compliance and engagement of the respondent with services and supports.

For respondents who were certified to the Program's Track I, at the time the JBDP judge determines that the respondent has completed the Program, the case will be dismissed with prejudice and the proceedings shall thereupon terminate. For respondents who were certified to the Program's Track II, upon successful completion of the program, the Assistant Attorney General will dismiss the case pursuant to Superior Court Juvenile Rule 48(a). For respondents who were on probation when they were certified to the Program's Track III, CSS may recommend that the judge terminate the order of probation at any time it determines that the purpose of the order has been achieved.

Termination Criteria

A juvenile who is rearrested on probable cause for any delinquent offense may be terminated from the diversion program. A charge does not necessarily require termination. The OAG will review the nature and circumstances of the offense and exercise discretion as to whether the juvenile should be terminated.

A juvenile may also be terminated from the program if he or she has failed to comply with the diversion program requirements for at least 30 days, or if he or she has lost contact with his service provider or CSS for at least 30 days, or a petition to revoke probation has been filed.

If the respondent is terminated from the program or decides to terminate her or himself from the Program, the case(s) will be certified back to the juvenile calendar judge. A respondent terminated from Track I will be certified to a juvenile calendar judge for a status hearing. A respondent who is terminated from Track II will be certified to the juvenile calendar judge for disposition. A respondent who is terminated from

Track III will be certified to the juvenile calendar or judge from which the referral was made for whatever action deemed appropriate by the judge assigned to that calendar. This certification may be made instead of, prior to, or after a probation revocation hearing and disposition is held.

Evaluation of Juvenile Behavioral Diversion Program

The R&D Division shall establish performance measures to evaluate the Program. The R&D Division shall conduct a one-year evaluation of the Program that will consider various measures to assess the identified goals, including re-arrests during the period of supervision and after the period of supervision ended, compliance with mental health treatment during the period of supervision and after the period of supervision ended, attendance at court hearings, completion of program, and school attendance. The Program will be reviewed to determine whether protocols and/or processes should be modified in an effort to better serve the best interests of each child, their families, and the community.

MEMORANDUM OF UNDERSTANDING

BY AND BETWEEN

**THE COURT SERVICES AND OFFENDER SUPERVISION AGENCY
FOR THE DISTRICT OF COLUMBIA,**

THE PRETRIAL SERVICES AGENCY FOR THE DISTRICT OF COLUMBIA,

AND

THE DISTRICT OF COLUMBIA DEPARTMENT OF MENTAL HEALTH

I. INTRODUCTION

This Memorandum of Understanding (MOU) is entered into by and between the Court Services and Offender Supervision Agency (CSOSA), the Pretrial Services Agency for the District of Columbia (PSA), and the District of Columbia Department of Mental Health (DMH), hereinafter collectively referred to as "the Parties."

II. BACKGROUND

- This MOU updates and renews the previous MOU that was executed between the Parties on March 28, 2005. DMH is the District of Columbia government agency responsible for ensuring access to treatment and services for District residents diagnosed with mental illness, and PSA and CSOSA are the federal entities responsible for pretrial and post-conviction supervision in the District of Columbia, respectively. As key stakeholders with interdependent interests, DMH, PSA, and CSOSA endeavor to coordinate their respective systems for the stated goal of helping individuals with mental illness who are involved in the criminal justice system to succeed under supervision. In addition, this MOU recognizes that releasing authorities such as D.C. Superior Court, U.S. District Court (PSA only) and the U.S. Parole Commission (CSOSA only) usually impose specific conditions of release regarding ongoing treatment for mentally ill defendants and offenders. Defendants/offenders with major mental illnesses under the supervision of CSOSA and PSA require services that are well coordinated, flexible and offered in a timely manner to assist them in maintaining compliance with the conditions of their release.

III. OBJECTIVES OF THE PARTIES

PSA, CSOSA, and DMH can better fulfill their respective statutory mandates and agency missions by developing specific approaches to supervision, service provision and case management for defendants/offenders with mental health and dual diagnosis conditions (an Axis I mental disorder co-occurring with substance dependence). PSA and CSOSA seek to enhance and expand their ability to be more effective in identifying, case managing, and supervising this population. In order to accomplish this, both PSA and CSOSA have established special supervision options for mentally ill defendants and offenders:

- PSA and CSOSA have developed specialized supervision units within their respective operations to supervise and case manage adult defendants and offenders with any of the following conditions: 1) severe, persistent, and chronic mental illness; 2) mental retardation; and 3) co-occurring substance use and mental disorders. These specialized units are dependent on DMH and its provider network to best serve individuals under the supervision of PSA and/or CSOSA supervision.
- CSOSA's Reentry and Sanctions Center (RSC), serving the needs of individuals supervised by PSA and CSOSA, provides a 28-day intensive assessment and pre-treatment program for defendants and offenders deemed to be at high risk for recidivism due to long histories of substance abuse and criminal activity. Two units within the RSC are designated for males diagnosed with co-occurring disorders; one additional unit serves women with co-occurring disorders.
- DMH seeks to provide timely evaluations and treatment for District residents involved in the justice system who are identified as being in need of mental health services. DMH also seeks to identify more expeditiously those individuals who are already connected with DMH and providers within DMH's network so that their criminal justice-related requirements can be coordinated more effectively with their treatment needs.

All parties agree and understand that the D.C. Mental Health Information Act (D.C. Official Code §§7- 1201.01 *et seq.*) requires that before DMH or a mental health provider can share mental health information of a defendant/offender with PSA and/or CSOSA, the defendant/offender must have authorized the release of information, a court order must have been issued authorizing such release of information, or other exception recognized by law must be satisfied.

IV. TERMS AND CONDITIONS

A. PSA and CSOSA Responsibilities

1. Once a determination is made that a defendant or offender has a mental illness and needs some form of mental health treatment to be provided by a DMH mental health provider, the Pretrial Services Officer (PSO) or Community Supervision Officer (CSO) will obtain from the defendant or offender an authorization for disclosure of protected health information as required by the federal Privacy Act, the Health Insurance Portability and Accountability Act (HIPAA), the D.C. Mental Health Information Act, and/or the alcohol and drug abuse treatment regulations (collectively "privacy/confidentiality laws"), so that the DMH mental health provider may report to the PSO or CSO information on the person's treatment. In those instances where the defendant/offender is unwilling to authorize the disclosure, the PSO/CSO will take the necessary steps to secure a court order that will permit the DMH mental health provider to disclose information to the PSO/CSO and to the releasing authority.
2. Upon a determination that a defendant or offender is currently linked to a provider within DMH's network, PSA/CSOSA will attempt to obtain a signed release of information from the defendant/offender and contact that provider to identify the individual's case manager/primary counselor. During this introductory call, the PSO or CSO will initiate a referral, using the standard referral form (Attachment A), and confirm that the mental health provider has the following information:
 - a. PSO/CSO's phone and fax numbers;
 - b. PSO/CSO's alternative/emergency telephone number;
 - c. PSO/CSO's current work site address;
 - d. PSO/CSO's e-mail address and
 - e. Supervisor's phone and fax numbers.

If the defendant is convicted and sentenced and the case is to be supervised by CSOSA, the PSO will ensure that the mental health provider contact information is transmitted to CSOSA.

3. If an individual is identified as needing DMH evaluation and/or services, but is not currently linked to a mental health provider, PSA/CSOSA will attempt to obtain a signed release of information from the defendant/offender, initiate a referral, using the standard referral form (Attachment A), and will provide the following information as part of the referral package:

- a. All PSO/CSO contact information identified above;
 - b. Defendant/offender's criminal justice status;
 - c. Defendant/offender's employment status;
 - d. Defendant/offender's address;
 - e. Circumstances leading to the referral;
 - f. Relevant criminal/social history information;
 - g. Copy of signed release of information form.
4. During the defendant's/offender's period of supervision, the PSO/CSO will maintain contact with his/her mental health provider for the purposes of effective case management and implementation of the treatment plan as follows:
- a. The PSO/CSO will prepare and send to the mental health treatment provider a monthly supervision status report, utilizing the Supervision Compliance Form on an as needed basis (Attachment B).
 - b. The PSO/CSO will make on-site and/or telephonic contact with the mental health provider for routine treatment staffings as necessary.
 - c. The PSO/CSO will brief the mental health provider staff on any pertinent criminal justice matters that may impact the defendant/offender's treatment, to the extent permitted by the applicable privacy/confidentiality laws.
 - d. The PSO/CSO will obtain information on the defendant/offender's progress in treatment, through the provider's submission of the Mental Health Treatment Compliance Form (Attachment C), in accordance with applicable privacy/confidentiality laws.
5. As long as the defendant/offender remains under criminal justice supervision PSA/CSOSA will participate in-person or telephonically, as necessary, in any staffings that involve material changes to the defendant's/offender's current treatment plan or transition to the next phase of treatment.
6. PSA/CSOSA will collaborate with DMH to ensure that defendants/offenders are referred to the most appropriate service available in the District to meet the individual's mental health needs, achieve stabilization, prevent decompensation and optimize the individual's potential to remain safely in the community.

7. PSA/CSOSA will develop ongoing criminal justice/mental health training coordinated by PSA's and CSOSA's mental health supervision staff to train select DMH staff, staff of mental health providers, and other community providers to work more effectively with the mentally ill defendant/offender population. These trainings will be held at least twice annually or more often if needed.

B. DMH Responsibilities

1. DMH will maintain a full-time liaison stationed at D.C. Superior Court to screen and evaluate defendants in the D.C. Superior Court and U.S. District Court being considered for mental health-related pretrial release conditions and related supervision, and who is available to work with PSA/CSOSA staff.
2. If the PSO/CSO has not already obtained a release of information from the defendant or offender, the mental health provider will seek to obtain a release of information from the defendant or offender at the initial appointment. The release of information will authorize the mental health provider to disclose protected health information concerning the defendant/offender to PSA/CSOSA consistent with all applicable privacy/confidentiality laws.
3. An eligible defendant/offender who requires the services of a mental health provider will be able to access those services by contacting the DMH Access Helpline or the mental health provider directly if previously or currently connected with that CSA. When contacting the Access Helpline or a mental health provider in the presence of the PSO/CSO, the defendant/offender may give verbal consent for the mental health provider or DMH to verbally provide enrollment, appointment, and participation information to the PSO/CSO. When consent is given, the DMH or CSA representative agrees to provide that information immediately if the information is readily available.
4. DMH will collaborate with PSA/CSOSA to ensure that the appropriate mental health services are provided to defendants and offenders supervised by PSA/CSOSA.
5. If a defendant/offender is incarcerated and unable to contact the DMH Access Helpline directly, the PSO/CSO can contact DMH's Forensic Services Coordinator, who will facilitate contact with the DMH Access Helpline. The PSO/CSO will be permitted to relay individual preferences regarding the selection of a mental health provider when the individual is incarcerated and unable to contact the Access Helpline directly.

6. The following time frames for service access are agreed upon:

While PSA and CSOSA may refer eligible defendants/offenders to any of the DMH mental health providers, the time period before the first appointment can be scheduled is determined by each provider's availability. DMH provides two walk-in/same day service sites for those identified by PSA or CSOSA as needing assessments or medications immediately.

- a. The Court Urgent Care Clinic is available at D.C. Superior Court for consumers requiring immediate medications and assessments and receives referrals from PSA on a regular basis.
 - b. The 35 K Street Clinic also provides immediate medications and assessments and receives referrals from both PSA and CSOSA on a regular basis.
7. DMH will establish a procedure with PSA and CSOSA to ensure that defendant/offender referrals for intake and services can be made within **one (1) business day** of release. PSA defendants requiring immediate connection or services following court appearances will be referred to the DMH Urgent Care Clinic at DC Superior Court. CSOSA offenders requiring immediate connection or services following appearance before releasing authority or change in status will be referred to the walk-in clinic at the Mental Health Services Division (35 K Street).
8. Defendants not connected to a mental health provider who are Options-eligible will be referred to the designated Options mental health provider or other designated forensic provider as appropriate, which will be contacted to arrange that a case manager meets the defendant at the Court or at PSA's Specialized Supervision Unit (SSU) upon release for transport to the mental health provider for intake.
9. Individuals assigned to PSA/CSOSA who are in the District of Columbia are eligible to request immediate crisis intervention through the DMH's Mobile Crisis Unit (MCU).
10. DMH will request that mental health providers contact the PSO/CSO within **one business day** following the intake appointment for each client involved in the criminal justice system. The mental health provider will submit to PSO/CSO:

- a. Counselor's telephone and fax number;

- b. Counselor's alternate/emergency contact information;
- c. Counselor's current work site address;
- d. Counselor's e-mail address; and
- e. Supervisor's telephone and fax numbers.

Mental health provider personnel will use the contact information contained in the referral package and may make this contact by phone or e-mail.

11. Mental health providers will work with PSA/CSOSA to develop appropriate transition plans for individuals moving to different levels of care including community based services, housing, supported employment and others.
12. DMH and its mental health providers will ensure that the defendant/offender's need for housing is assessed as part of intake, and that efforts will be made to assist in finding appropriate housing. As of the date of this MOU, DMH anticipates that it will continue to fund the housing slots currently available in the Options program, subject to availability of funds.
13. DMH will request that the mental health providers complete monthly compliance reports for clients under PSA or CSOSA supervision. Mental health providers will use the PSA/CSOSA Mental Health Treatment Compliance Form (Attachment B) for the monthly compliance report. Mental health providers will submit a written or verbal update **five (5) business days** prior to each scheduled court date at the PSO/CSO's initiation.
14. DMH will require mental health providers to notify PSA/CSOSA of any proposed or major changes in a defendant/offender's treatment plan within **three (3) business days** of the following: reassignment, disenrollment, hospitalization and/or changes in medication regimen.
15. Appropriate DMH staff and providers designated to work with defendants in pretrial status will participate in scheduled program meetings.
16. DMH will require mental health providers working with clients involved in the criminal justice system to attend training coordinated by PSA/CSOSA.

C. Joint Responsibilities of All Parties

DMH/PSA/CSOSA will participate in regular meetings convened by PSA's Office of Research, Analysis, and Development to establish performance measures related to this MOU, aid in the coordination, analysis, and dissemination of data resulting from this MOU, and help inform decision-makers and improve service delivery. The first meeting will be convened within 30 days of execution of this MOU.

V. MISCELLANEOUS

A. Duration of MOU

The period of this MOU shall be from February 2011, through February 2016, unless terminated in writing by the Parties prior to the expiration, consistent with Section J below.

B. MOU Evaluation

The Parties will evaluate this MOU one year from the date this MOU is executed and on a semi-annual basis thereafter to determine its continuance. The Parties shall maintain a close liaison and consult, on at least a quarterly basis, on all matters pertaining to this MOU. Moreover, the Parties agree to work together in fulfilling the terms of this MOU.

C. MOU Funding and Anti-Deficiency Considerations

1. Each party shall bear the cost of its obligations under the terms of this MOU. No funds are to be exchanged between parties in furtherance of this MOU.
2. The Parties acknowledge and agree that their respective obligations to fulfill financial obligations of any kind pursuant to any and all provisions of this MOU, or any subsequent agreement entered into by the parties pursuant to this MOU, are and shall remain subject to the provisions of the federal Anti-Deficiency Act, 31 U.S.C. §§ 1341 et seq. (federal and D.C. parties); and the District of Columbia Anti-Deficiency Act, D.C. Official Code §§ 47-355.01-355.08 (2001), D.C. Official Code § 47-105 (2001), and D.C. Official Code § 1-204.46 (2006 Supp.) (DC party only), as the foregoing statutes may be amended from time to time, regardless of whether a particular obligation has been expressly so conditioned.

D. Applicable Laws

The Parties shall comply with all applicable laws, regulations, and rules, whether in force at the time of the execution of this MOU or subsequently

enacted or promulgated during the period this MOU is in effect, including federal and D.C. laws governing the disclosure of drug/alcohol treatment records, mental health, and other sensitive and personally identifiable information. Nothing in this MOU shall be construed as in any way impairing the general powers of the Parties for supervision, regulation, and control of their respective property.

E. Publicity and Media

Publicity releases and/or media interviews in connection with the activities credited to this MOU shall not be undertaken by any of the Parties without the prior written approval by CSOSA through its Office of Legislative, Intergovernmental, and Public Affairs, and by PSA through its Office of the Director, and by DMH through its Public Affairs Office, as appropriate.

F. Anti-Discrimination Policy

The Parties shall ensure that the activities associated with this MOU are undertaken in accordance with the applicable provisions of the Americans with Disabilities Act and the Rehabilitation Act of 1973, as well as other applicable laws prohibiting discrimination.

G. No Rights Created

This agreement does not, and shall not be construed to create any rights, substantive or procedural, enforceable at law by any person in any matter, civil or criminal.

H. Liability

Each Party is responsible for its own conduct under this MOU and retains all defenses, including immunities, available under federal and District of Columbia law. No Party agrees to insure, defend, or indemnify another.

I. Modification

Modification of this MOU shall be based upon the mutual agreement of the Parties and shall be made in writing as an addendum to this MOU.

J. Termination

This MOU may be terminated, in whole or in part, by any Party hereto upon thirty (30) business days advance written notice

K. No Third-Party Beneficiary

This MOU shall not and is not intended to benefit or to grant any right or remedy to any person or entity that is not a party to this MOU.

L. Existing Obligations Not Affected

This MOU is not a substitute for any statutory, regulatory or policy obligation a Party may have. Any such obligations a Party may have are still binding on that Party.

M. Notice

The following individuals are the contact points for each Party under this MOU:


Department of Mental Health
ALEXIS HAYNES
Director, Adult Services
64 New York Ave., NE, 4th Floor
Washington, DC 20002
Phone 202-673-4443
Alexis.Haynes@dc.gov

Court Services and Offender Supervision Agency
LORENZO HARRIS
Branch Chief, Substance Abuse and Treatment Branch
300 Indiana Avenue, N.W., Room 2042
Washington, DC 20001
Phone 202-585-7457

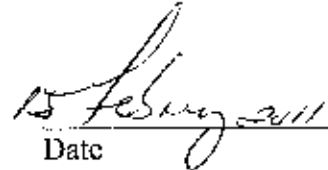
Pretrial Services Agency
TERRENCE WALTON
Program Director, Treatment
633 Indiana Avenue, N.W., Suite 920
Washington, DC 20004
Phone 202-220-5510

IN WITNESS WHEREOF, the Parties hereto have executed this MOU as of the last date written below.

**Court Services and Offender Supervision Agency
for the District of Columbia:**




Adrienne R. Poteat, Deputy Director

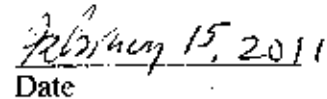


Date

Pretrial Services Agency for the District of Columbia:



Susan W. Shaffer, Director

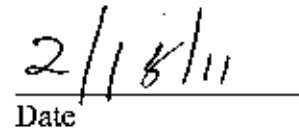


Date

District of Columbia Department of Mental Health:



Stephen T. Baron, Director



Date

- Attachment A: Referral for Mental Health Services
- Attachment B: Supervision Status Report
- Attachment C: Mental Health Treatment Compliance Report



**Pretrial Services Agency for the District of Columbia (PSA)
Court Services and Offender Supervision Agency (CSOSA)**



REFERRAL FOR MENTAL HEALTH SERVICES

This form is to be used when referring defendants/offenders to the mental health provider. (MHP)

Referring Supervision Agency: <input type="checkbox"/> PSA OR <input type="checkbox"/> CSOSA			
Mental Health Provider (MHP):			
Referral Date: <input type="checkbox"/> New Referral <input type="checkbox"/> Currently Receiving Services <input type="checkbox"/> Currently connected, but inactive			
Name: Alias:		DOB:	PDID:
Address: Telephone: Homeless: <input type="checkbox"/> Yes <input type="checkbox"/> No Emergency Contact Name/Telephone:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Other
Does individual have physical impairments? <input type="checkbox"/> Yes <input type="checkbox"/> No Type of impairment: <input type="checkbox"/> Speech <input type="checkbox"/> Hearing <input type="checkbox"/> Sight <input type="checkbox"/> Mobility		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Other:	Does individual require translation services? <input type="checkbox"/> Yes <input type="checkbox"/> No Language:
Highest Level of Education: Employment: <input type="checkbox"/> Yes <input type="checkbox"/> No		Insurance: <input type="checkbox"/> Yes Name: <input type="checkbox"/> IDA <input type="checkbox"/> Medicaid <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> SSI <input type="checkbox"/> Medicare	
Defendant/Offender Supervision Assignment/Status:			
<input type="checkbox"/> PSA SSU (non-Options)	<input type="checkbox"/> PSA Mental Health Court	<input type="checkbox"/> PSA Treatment Team 2	<input type="checkbox"/> PSA General Supervision
<input type="checkbox"/> PSA SSU (Options)	<input type="checkbox"/> PSA Treatment Team 1	<input type="checkbox"/> PSA Treatment Team 3	<input type="checkbox"/> PSA HISP <input type="checkbox"/> PSA Other
<input type="checkbox"/> CSOSA Jail <input type="checkbox"/> CSOSA Bail	<input type="checkbox"/> CSOSA Civil Protection Order (CPO) <input type="checkbox"/> CSOSA Work Release	<input type="checkbox"/> CSOSA Probation <input type="checkbox"/> CSOSA Parole	<input type="checkbox"/> CSOSA Supervised Release <input type="checkbox"/> CSOSA Detention
CSOSA Special Supervision: <input type="checkbox"/> Sex Offender <input type="checkbox"/> Mental Health <input type="checkbox"/> Developmental Disabilities <input type="checkbox"/> Domestic Violence			
CSOSA Date of Termination/Expiration:		Charges:	
Current Charges:			
Mental Health/Medical Diagnosis: <input type="checkbox"/> Unknown <input type="checkbox"/> Known (list dx): Date diagnosed (if known): Self-Reported (list dx):		Medication (Psychotropic/Medical):	History of MH Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If yes, last known provider):
Currently testing positive for illicit substances <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please specify type of substance)			
Reason(s) for referral (check all that apply):			
<input type="checkbox"/> Treatment/Evaluation Needed <input type="checkbox"/> Self Reported Mental Health Problems <input type="checkbox"/> History of Mental Illness <input type="checkbox"/> History Suicidal <input type="checkbox"/> History Homicidal Behavior		<input type="checkbox"/> Questionable Behavior and/or Mood <input type="checkbox"/> Altered Mental Status <input type="checkbox"/> Medication Issues (Non-Compliance/Side Effects) <input type="checkbox"/> Other:	
Brief Description of Symptoms and/or History of Mental Illness:			
Referral Source			
PSO/CSO Name: Supervisor Name: Address:		PSO/CSO Telephone: Fax: Email: Supervisor Telephone:	

Provider: Please contact the Pretrial Services Officer (PSO) or Community Supervision Officer (CSO) listed on this form as soon as possible to notify the supervising agency of the results of this referral. Thank you.



**Pretrial Services Agency for the District of Columbia (PSA)
Court Services and Offender Supervision Agency (CSOSA)**



SUPERVISION STATUS REPORT

This form is to be completed by the Pretrial Services Officer (PSO)/Community Supervision Officer (CSO) and submitted to the defendant's /offender's case manager at the Mental Health Provider (MHP)

Reporting Supervision Agency: <input type="checkbox"/> PSA OR <input type="checkbox"/> CSOSA			
Mental Health Provider(MHP):			
Defendant/Offender Name:		eCura#: (if known)	DOB:
			SSN:
Defendant/Offender Address: Telephone: Homeless: <input type="checkbox"/> Yes <input type="checkbox"/> No		Service Needs: <input type="checkbox"/> Housing <input type="checkbox"/> Medication <input type="checkbox"/> Food Stamps <input type="checkbox"/> Insurance Assistance	
PSO/CSO Name: Supervisor Name: Agency/Address:	PSO/CSO Telephone: Supervisor Telephone: Fax: Email:	MHP Case Manager Name: MHP Team Leader Name: Agency/Address:	MHP Case Manager Telephone: MHP Team Leader Telephone: Fax: Email:

SUPERVISION STATUS: Pretrial Release Probation Parole Supervised Release

Next Court Date/Time/Courtroom Number: _____

Medication(s)			
Reportedly on Psychotropic Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Observed Side Effects: Explain:	Reports compliance to medications (i.e., taking medications as prescribed): <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	
Criminal Justice Supervision Plan			
Currently meets with PSO or CSO as required (indicate frequency):	<input type="checkbox"/> Yes <input type="checkbox"/> 1x/wk <input type="checkbox"/> bi-weekly <input type="checkbox"/> 1x/month <input type="checkbox"/> Other:		<input type="checkbox"/> No
Compliant with supervision requirements: (If no, please elaborate in "additional comments" below.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Court Ordered Mental Health Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No Special Conditions: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please indicate conditions under additional comments)	
Supervision compliance level:	<input type="checkbox"/> Compliant <input type="checkbox"/> Non-compliant <input type="checkbox"/> Loss of Contact <input type="checkbox"/> Bench Warrant <input type="checkbox"/> Incarcerated: <input type="checkbox"/> DC Jail <input type="checkbox"/> CTF <input type="checkbox"/> John Howard <input type="checkbox"/> Halfway House Date Incarcerated: _____ <input type="checkbox"/> Other non-compliance:		
Urine Screening Results: (If positive, indicate dates/substance since last report)	<input type="checkbox"/> Negative Dates/Substances:	<input type="checkbox"/> Positive: Dates/Substances:	<input type="checkbox"/> See Attached Report for Drug Testing Results
Observed Changes to behavior since last report? (If yes, please describe.)	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain:		
Changes to Supervision plan? (If yes, please describe.)	<input type="checkbox"/> Yes <input type="checkbox"/> No Change:		
Additional Comments:			

PSO/CSO Signature: _____ Date: _____

Defendant/Offender Signature: (optional) _____ Date: _____



**Pretrial Services Agency for the District of Columbia (PSA)
Court Services and Offender Supervision Agency (CSOSA)**



MENTAL HEALTH TREATMENT COMPLIANCE REPORT

This form is to be completed by the mental health provider (MHP). Please complete and submit this form by fax or e-mail to the Pretrial Services Officer (PSO) or Community Supervision Officer (CSO) as designated below.

Receiving Supervision Agency: <input type="checkbox"/> PSA OR <input type="checkbox"/> CSOSA			
Mental Health Provider (MHP):			
Defendant/Offender Name:		eCura #:	DOB:
Defendant/Offender Address:		Telephone:	
Homeless: <input type="checkbox"/> Yes <input type="checkbox"/> No			
PSO/CSO Name:	Agency/Address:		PSO/CSO Telephone:
Supervisor Name:			Supervisor Telephone:
		Fax:	
MHP Case Manager (CM) Name:	Agency/Address:		MHP CM Telephone:
MHP Team Leader (TL) Name:			MHP TL Telephone:
		Fax:	
Medication(s)			
Currently on Psychotropic Medications (if yes, please list names of medications):		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reports compliance with medication regimen:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any recent changes with medication regimen: (If yes, provide date of change and names of new medications):		<input type="checkbox"/> Yes Date: Meds:	<input type="checkbox"/> No
Mental Health Treatment Regimen			
Attended Scheduled Appointments (If no, indicate dates of missed appointments):		<input type="checkbox"/> Yes	<input type="checkbox"/> No Dates of Missed Appts:
Currently receiving individual therapy: (If yes, indicate frequency)		<input type="checkbox"/> Yes <input type="checkbox"/> 1x/wk <input type="checkbox"/> bi-weekly <input type="checkbox"/> 1x/month <input type="checkbox"/> Other:	<input type="checkbox"/> No
Currently meets with psychiatrist: (If yes, indicate frequency)		<input type="checkbox"/> Yes <input type="checkbox"/> 1x/wk <input type="checkbox"/> bi-weekly <input type="checkbox"/> 1x/month <input type="checkbox"/> Other:	<input type="checkbox"/> No
Currently meets with case manager: (If yes, indicate frequency)		<input type="checkbox"/> Yes <input type="checkbox"/> 1x/wk <input type="checkbox"/> bi-weekly <input type="checkbox"/> 1x/month <input type="checkbox"/> Other:	<input type="checkbox"/> No
Treatment participation level:		<input type="checkbox"/> Active <input type="checkbox"/> Variable <input type="checkbox"/> Minimal <input type="checkbox"/> None	
Treatment compliance:		<input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Low <input type="checkbox"/> Noncompliant	
Response to treatment:		<input type="checkbox"/> Stable <input type="checkbox"/> Improving <input type="checkbox"/> Decompensating <input type="checkbox"/> Unstable <input type="checkbox"/> Other <input type="checkbox"/> Hospitalization (dates/location/reason)	
Current Diagnosis:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes to diagnoses? (If yes, describe)		Change:	
Changes to treatment plan? (If yes, describe)		<input type="checkbox"/> Yes Change: <input type="checkbox"/> No	
Additional Comments:			

Person Completing Report: _____
Print Name/Title (please initial)

Date:

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
EXECUTIVE OFFICE OF THE MAYOR**



Memorandum of Understanding

WHEREAS, **The Office of Victims Services (OVS), Survivors and Advocates for Empowerment (SAFE), Washington Hospital Center (WHC), Department of Mental Health (DMH), Child and Family Services Agency (CFSA), the Metropolitan Police Department (MPD), the federal Court Services and Offender Supervision Agency (CSOSA), and the DC Superior Court (DCSC)** have come together to collaborate and to make an application for the OVW Fiscal Year 2011 **Grants to Encourage Arrest Policies and Enforcement of Protection Orders Program** to further the **DC Lethality Assessment Project's** goals of screening for potential high lethality in domestic violence cases and providing enhanced safety measures and resources for victims in those cases.

WHEREAS, the partners listed below have agreed to enter into a collaborative agreement in which **The Office of Victim Services** will be named applicant and the other agencies will be partners in this application; and

WHEREAS, the partners herein desire to enter into a Memorandum of Understanding setting forth the services to be provided by the collaborative; and

WHEREAS, the application prepared and approved by the collaborative through its partners is to be submitted to the Office on Violence Against Women on or before **February 24, 2011**.

1) Description of Partner Agencies

Office of Victim Services

The Office of Victim Services (OVS) is situated under the Deputy Mayor Of Public Safety and Justice of the Office of the Mayor and is the lead agency for administering federal funds such as the STOP (Services_Training_Officers_Prosecutors) Violence Against Women Formula Grant Program and the Crime Victims Assistance Grant (VOCA) as well as local funds to assist victims of violent crimes in the District of Columbia (DC). OVS administers victim services related to reducing and preventing future victims of crime and funding programs that provide victims of violent crime in the District with care and support during traumatic periods of their lives.

In 2010, OVS funded fifty-four projects and programs in the District that afforded crisis response, counseling, advocacy, case management, court accompaniment, shelter, and assistance with victim compensation to over 28,000 victims and family members. While the office is

relatively small, consisting of only six staff members, it has the capacity to develop and institutionalize a comprehensive response to the needs and concerns of crime victims in the District. OVS staff members have expertise in the development, management, and administration of local and federal grant programs in the areas of domestic violence, sexual assault, stalking and dating violence. The Office of Victim Services is the mechanism by which DC Government resources are leveraged to bridge gaps in victim services.

Survivors and Advocates for Empowerment (SAFE):

Survivors and Advocates for Empowerment, Inc. is a non-profit organization that provides immediate crisis intervention services to more than 5,000 victims of domestic violence each year through the Domestic Violence Intake Centers at DC Superior Court and United Medical Center and its 24-hour On Call Advocacy Program (OCAP) Response Line. SAFE conducts a lethality assessment with each victim they encounter to deliver tailored services that include: safety planning, legal information, assistance writing pro se petitions for Civil Protection Orders, access to the Emergency Civil Protection Order process when the Court is closed, as well as immediate crisis shelter, transportation and other emergency financial assistance. Since its creation in 2006, SAFE has collaborated with the Metropolitan Police Department to provide crisis intervention services to victims who have called police.

Washington Hospital Center (WHC)

Washington Hospital Center (WHC) is a non-for-profit, 926-bed acute care teaching and research hospital based in northwest DC. It is the largest private medical center in the nation's capital and consistently ranks among the nation's top hospitals in the research and treatment of cardiovascular and kidney diseases, cancer, stroke, endocrine disorders, neurological injury and illness and geriatric and respiratory care. WHC is also home to MedSTAR Trauma and Transport and is the region's burn facility. The Emergency Department provides care to over 80,000 patients annually and is the designated anchor site for the District's Sexual Assault Nurse Examiner (SANE) Program in partnership with the Office of Victim Services. WHC has expertly served victims in this function since the program's inception in October 2008.

Department of Mental Health (DMH)

The DC Department of Mental Health's Mobile Crisis Services Unit is part of its Comprehensive Emergency Psychiatric Program Mobile Crisis Services and is staffed by a multidisciplinary team of mental health workers including: peer counselors, mental health counselors, mental health specialists, addiction treatment specialists, social workers, and psychiatrists. The staff is available from 9am-1am, seven days a week to respond to adults throughout the District who are experiencing a psychiatric crisis and are unable or unwilling to travel to receive mental health services, to be available to address the concerns of the individual in crisis, family members, concerned citizens, mental health providers, and other referring agencies and to offer a range of services including but not limited to onsite crisis intervention and stabilization, assessment for voluntary and involuntary hospitalization, and linkage to other services such as ongoing mental health care, crisis beds, substance abuse detoxification and treatment, and medical care.

Child and Family Services Agency (CFSA)

The District's Child and Family Services agency's Office of Clinical Practice provides domestic violence assessments when needed and coordinates education about domestic violence for CFSA staff working with families to investigate and resolve reports of child abuse and neglect. CFSA works closely with domestic violence service providers to provide access to other services for adult and teen parents as well as teens under the agency's supervision. Since 2008, CFSA has had a memorandum of understanding with SAFE, Inc. to provide direct referrals from their social workers to SAFE, Inc.'s OCAP Response Line to provide immediate support to victims with co-occurring child abuse and neglect issues in the home.

Metropolitan Police Department (MPD)

The Domestic Violence Unit serves as a liaison among the Metropolitan Police Department (MPD), the US Attorney's Office, other law enforcement agencies, victim service agencies, victim advocates and the community in the Washington, D.C. area. The unit conducts ongoing community outreach and education, provides ongoing training for the members of MPD, and monitors the activities of the District Domestic Violence Investigators and District Patrol Officers. The unit has direct supervision of the Domestic Violence Intake Center Officers and their investigations. The Domestic Violence Unit is part of the MPD's Investigative Services Bureau, Superintendent of Detectives Division, District Investigative Branch.

Court Services and Offender Supervision Agency (CSOSA)

The Court Services and Offender Supervision Agency (CSOSA) provides supervision for adults on probation or parole in the District. CSOSA's mission is to increase public safety, prevent crime, reduce recidivism, and support the fair administration of justice in close collaboration with the community. Through its Community Supervision Program, CSOSA provides programming and supervision for many domestic violence offenders each year and conducts the Domestic Violence Intervention Program to which many are sentenced. As the agency responsible for reducing recidivism and ensuring public safety through supervision of offenders, their staff are in direct contact with the Courts, the Metropolitan Police Department, the Domestic Violence Intake Centers at DC Superior Court, and Advocates to ensure that information is transmitted about new offenses and victim safety. CSOSA is a member of the Domestic Violence Intake Center's Implementation Committee.

DC Superior Court (DCSC)

DC Superior Court's Domestic Violence Unit consists of four dedicated judges and one magistrate judge responsible for hearing civil and criminal domestic violence cases in a coordinated way. This unit also contains the Domestic Violence Intake Centers where most victims seeking legal relief begin the legal process. Since 1996, the Domestic Violence Unit has served as a national model for the administration of justice in domestic violence cases. In coordination with prosecutors, the defense bar, police, and victim advocates, the unit hears over 8,000 cases each year.

II) History of Relationship

In spring 2009, the DC Office of the City Administrator requested that the Office of Victim Services (OVS) develop a program to effectively engage and serve individuals who are high risk

for lethality as a result of domestic abuse. OVS met with Survivors and Advocates for Empowerment (SAFE), the Metropolitan Police Department (MPD) Domestic Violence Unit and other criminal justice stakeholders to explore the feasibility of employing a lethality assessment tool, utilizing SAFE's 24/7 hotline and the On-Call Advocacy (OCAP) Program. OCAP is a collaborative effort with the MPD to provide advocates to victims who contact law enforcement outside of normal business hours.

A Lethality Assessment Project (LAP) team was formed to develop and pilot: a protocol for conducting the lethality assessment tool; an enhanced response to the backlog of current cases assessed high for lethality at the Domestic Violence Intake Centers (DVICs); a protocol for actions to be taken following high lethality assessments conducted by MPD first responders and/or domestic violence advocates to increase safety and reduce abuser access to the victim; and a protocol among social service agencies and not for profit organizations to information share, discuss options and deliver appropriate services within 24 hours following high lethality assessments. Criminal justice stakeholders that joined the team include Court Services and Offender Supervision Agency (CSOSA) and the DC Superior Court (DCSC). Social service agencies that joined the team include Department of Mental Health, Department of Human Services and Child and Family Services.

In November, 2009, the LAP team received technical assistance from the Maryland Network Against Domestic Violence Lethality Assessment for First Responder Program to discuss best practices that would be appropriate to the District of Columbia and consulted with other experts in the field. The team developed an assessment tool to be used by MPD first responders and OCAP advocates; and obtained training for first responders and advocates on sensitive delivery of the assessment tool and follow-up protocols.

The LAP pilot was first introduced in January 2010 in two police Public Service Areas (PSAs) where volume of 911 calls for domestic abuse is high. In July 2010, LAP coverage was doubled. In September 2010, OVS purchased a secure, confidential web-based data tracking system where LAP team points of contact can upload and share critical information about current cases. More recently, MedSTAR at Washington Hospital Center (WHC) has joined the LAP team. WHC medical personnel will pilot the LAP to assess non reporting victims presenting at the hospital with physical injuries to provide them with a SAFE advocate before they leave the hospital. OVS and SAFE will work with other emergency services in the District to extend the LAP program once the hospital protocol is tested and refined.

III) Development of Application

Development of the coordinated response to domestic violence victims at high risk for lethality has been a progression in three phases: 1) the creation of a collaborative program with common goals and objectives that has strong agency and organizational commitment, which has already occurred; 2) training and technical assistance for primary and secondary responders; and 3) streamlined confidential data sharing. The next phase of the LAP will be program enhancement with emphasis placed on compliance to the protocols, expanded training, and victim engagement in wraparound services. Currently, eighty-one percent (81%) of the victims who screen into the project as high lethality seek additional services through the LAP and the LAP Advocate at

SAFE. By increasing the training for first responders, advocates and service providers, as well as broadening the scope for screening, the project can reach more high risk victims in need.

LAP members communicate daily to share information about each case and to coordinate resources. Because of the nature of the information sharing, project partners are in the process of finishing the creation and setup of the confidential database purchased by OVS which will provide additional security and data sharing opportunities on a daily basis. SAFE is coordinating this effort that will link each point of contact and preserve client confidentiality. Team members teleconference on a monthly basis to discuss improvements to the protocols, information sharing, and current cases. Because of the amount of information being shared among multiple agencies and through varying internal processes, an ongoing goal is to produce group recommendations for protocol changes and system process changes to increase victim safety.

In this Memorandum of Understanding, members of the LAP project agree to collaborate to further the LAP's goals of screening for potential high lethality in domestic violence cases and providing enhanced safety measures and resources for victims in those cases. This includes expanded training for participating partners, increased first responder compliance with LAP protocols, increased victim engagement in wraparound services and decrease in number of victims assessed high for lethality who continues to call 911 for domestic abuse after receiving LAP wraparound services.

IV) Roles and Responsibilities

NOW, THEREFORE, it is hereby agreed by and between the partners as follows:

1. As grant administrator, **Office of Victim Services** will be in charge of fiscal and administrative responsibilities, project oversight and programmatic reporting.
2. **Survivors and Advocates for Empowerment** agrees to provide a dedicated Advocate for purposes of case management and advocacy in high lethality cases; to act as the facilitator of the information sharing process; and to coordinate services from various agencies collaborating in this process. In addition, SAFE agrees to add necessary agencies and services to the collaborative dictated by the needs of high lethality victims. To that end, SAFE, Inc. agrees to provide:
 - 24-hour access to advocacy services on SAFE's Response Line for any domestic violence or stalking victim referred by the Metropolitan Police Department, the US Attorney's Office, Child and Family Services Agency, or any other collaborating agency in the manner identified respectively for those agencies;
 - Screening of every referred client using the lethality assessment tool developed in collaboration with the Metropolitan Police Department and the US Attorney's Office.
 - Hotel placement in cases where emergency shelter is required until the next business day when the Crime Victim's Compensation Program can place the family or other shelter resources become available.

- Transportation for callers who require immediate crisis intervention services to place them in a safe shelter location and to transfer them to longer-term services.
 - Assistance filing an Emergency Temporary Protection Order outside of normal business hours if required and appropriate.
 - Legal information and appointment of a Lethality Assessment Project Advocate to coordinate services to victims who score high on the lethality assessment;
 - Information sharing with project partners to facilitate enhanced service provision as allowed by local and federal laws;
 - Frequent communication and process review as needed through regular meetings to ensure that the process is working properly;
 - Engagement in joint outreach efforts to ensure that agency partners and the public are aware of services available. This may include jointly produced written information.
3. **The Metropolitan Police Department** agrees to provide enhanced training for personnel in the identified Public Safety Areas (PSAs) where the LAP has been implemented; to ensure compliance with the screening protocol; to coordinate with SAFE, Inc. to provide increased outreach in those PSAs; to review data with SAFE, Inc. regarding the calls for service in the PSAs; and to help devise plans for addressing identified cases.
 4. **The Department of Mental Health** agrees to continue to collaborate with agency partners about high lethality cases and provide both long-term and emergency psychiatric care as needed to victims, as well as cross-training for its staff at 35K Street and its mobile unit regarding domestic violence and for SAFE staff regarding mental illness and available services through DMH. Per the separate MOU with SAFE, DMH's mobile unit may also refer victims of domestic violence encountered first by them to the SAFE Response Line thus initiating lethality screening for those clients and placing them within this project.
 5. **The Washington Hospital Center** agrees to participate in screening for domestic violence in Emergency Room triage and refer those cases that assess high risk to SAFE, Inc. for services through the Lethality Assessment Project.
 6. **Child and Family Services Agency** agrees to collaborate with this project in accordance with both the Lethality Assessment Project and the individual MOA entered into with SAFE allowing social workers to utilize the SAFE Response Line as a partner agency. CFSA agrees to expand training opportunities about this project and process to its personnel to include Child Protective Services workers and hotline call takers.
 7. **Court Services and Offender Supervision Agency (CSOSA)** agrees to assign a Lethality Assessment Project point person to circulate information about cases obtained from SAFE, Inc. to its personnel to maximize coordination between those supervising suspects in domestic violence cases and those assisting the victim for purposes of enhancing victim safety. CSOSA also agrees to provide joint training opportunities with SAFE, Inc. to inform their personnel about the project.

- 8. DC Superior Court** agrees to provide an opportunity for SAFE to educate Court personnel about Lethality Assessments and the project itself, as well as to communicate regarding case processing within the proper boundaries of the Court's role.

9. Administrative Provisions

a. Insurance, Indemnification and Agency

- The non-government parties will indemnify, and will hold harmless the other parties, for the intentional and negligent acts of its employees.
- SAFE maintains sufficient malpractice and accidental injury/death insurance coverage for its employees, as applicable by law.
- Government agencies are self-insured and are governed by Anti-Deficiency laws noted below.
- Neither party intends by virtue of this agreement to bestow any powers of agency upon the other. All parties hereby agree that neither it, nor any of its employees, respectively, will act as an agent or employee for the other, in any capacity, to include explicit, implicit or apparent authority.
- Each party shall bear the cost of its obligations under the terms of this MOU. No funds are to be exchanged between parties in furtherance of this MOU.
- The Parties acknowledge and agree that their respective obligations to fulfill financial obligations of any kind pursuant to any and all provisions of this MOU, or any subsequent agreement entered into by the parties pursuant to this MOU, are and shall remain subject to the provisions of the federal Anti-Deficiency Act, 31 U.S.C. §§ 1341 et seq. (federal and D.C. parties); and the District of Columbia Anti-Deficiency Act, D.C. Official Code §§ 47-355.01-355.08 (2001), D.C. Official Code § 47-105 (2001), and D.C. Official Code § 1-204.46 (2006 Supp.) (DC party), as the foregoing statutes may be amended from time to time, regardless of whether a particular obligation has been expressly so conditioned.

b. Confidentiality:

- All data gathered from this project regarding victims shall be maintained as confidential information according to the policies of the participating agencies respectively, except where immediate danger to the victim is thought to exist.
- The agencies shall not disclose a victim's identity and/or specifics about the victim's circumstances without the written consent of the victim, unless required by local or federal law.
- A victim must sign a "Release of Information Form" prior to the exchange of information regarding the victim with anyone outside of this agreement except where allowed by the policies of individual agencies.
- Copies of the original, signed "Release of Information Forms" shall be kept at the SAFE offices and are available for review by any signatory agency to this MOU.

c. Effective Administration and Execution of This MOU

- Effective execution of this MOU can be achieved only through continuing communication and dialogue between the parties. It is the intent of the parties that they will directly, verbally communicate for the resolution of questions, misunderstandings or complaints that may arise that are not specifically addressed in this MOU.
- Personnel from Signatory Agencies shall meet, regularly and as necessary to share information regarding individual cases and to generally discuss and review the quality of services provided to clients.
- Each party represents that the individual signing this MOU has the authority to enter this agreement on behalf of her/his organization. The signature represents complete understanding of this MOU and of approval of its terms and conditions.

d. General:

This MOU does not limit or modify existing agreements, formal or informal, between the parties. This MOU provides guidance and documents an agreement for collaboration between the parties.

- In entering into this agreement, both parties agree to the following guidelines in provision of services: The terms of this memorandum of understanding will become effective from the date of signature and will be effective for a two year period.
- The rights of all clients will be respected without regard to race, creed, religion, ethnicity, sexual orientation, nationality, health or disability.
- Continuation of this program is contingent on the availability of resources and funding.

e. No Rights Created

This agreement does not, and shall not be construed to create any rights, substantive or procedural, enforceable at law by any person in any matter, civil or criminal.

f. Liability

Each Party is responsible for its own conduct under this MOU and retains all defenses, including immunities, available under federal and District of Columbia law.

g. Modification

Modification of this MOU shall be based upon the mutual agreement of the Parties and shall be made in writing as an addendum to this MOU.

h. No Third-Party Beneficiary

This MOU shall not and is not intended to benefit or to grant any right or remedy to any person or entity that is not a party to this MOU.

i. Existing Obligations Not Affected

This MOU is not a substitute for any statutory, regulatory or policy obligation a Party may have. Any such obligations a Party may have are still binding on that Party.

V) Planning and Development Team

Melissa Hook, Office of Victim Services Director, will serve as the responsible fiscal and administrative agent for this project.

Jennifer Pollitt-Hill , Office of Victim Services Program Manager will serve as the project director, assisting in the coordination, conceptualization and implementation of project activities.

Elisabeth Olds, Co-Executive Director of SAFE, Inc. will be responsible for coordinating SAFE, Inc.'s collaboration. She will be responsible for managing SAFE personnel and ensuring all services provided by SAFE, Inc. as required, and ensuring as well as the coordination of the confidential database.

Chief Cathy Lanier, Metropolitan Police Department will oversee MPD collaboration. She will be responsible for ensuring the collaboration of the Metropolitan Police Department and ensures the participation of personnel the four Public Safety Areas designated for this project.

Lt. Michele Robinson, Metropolitan Police Department will coordinate MPD collaboration. She will be responsible for assisting with collaboration and training for first responders within the police department.

The Honorable Judge Jose Lopez, Presiding Judge Domestic Violence Unit, DC Superior Court will coordinate DC Superior Court collaboration. He will assist with providing training opportunities for the Court about this project, and assistance with information about proper handling of information and case disposition in accordance with the Court's role.

Fred Swan, Director of Family Services Administration, Department of Human Services will coordinate DHS collaboration. He will be responsible for designating and managing DHS case and information management and ensuring that all information is shared and services are provided as required.

Luis Vasquez, Director of Mobile Crisis Services Unit, Department of Mental Health will coordinate DMH collaboration. He will be responsible for managing DMH personnel's information sharing and services provided as required.

Loren Gano, Chief of Staff, Child and Family Services will coordinate CFSA's collaboration. She will be responsible for managing CFSA staff providing direct services and information for the project.

Valerie Collins, Court Services and Offender Supervision Agency will coordinate CSOSA's collaboration. She will manage CSOSA's point of contact for the project for information sharing and CSOSA response to information provided by the project for offender accountability.

V) Timeline

The roles and responsibilities described above are contingent on the Office of Victim Services receiving funds requested for the project described in the OVW/GTEAP grant application. Responsibilities under this Memorandum of Understanding would coincide with the grant period, anticipated to be **10/01/2011** through **09/30/2013**.

VI) Commitment to Partnership

- 1) The collaboration service area includes underserved communities in Southeast Washington of Wards Five, Seven and Eight and patients at Washington Hospital Center in Ward Four.
- 2) The partners agree to collaborate and provide information, training, and services pursuant to the program narrative of the grant application attached to this agreement.
- 3) Compensation for [non-lead] partners' contribution to this project will be provided as outlined in the attached OVW budget detail worksheet.
- 4) We, the undersigned have read and agree with this MOU. Further, we have reviewed the proposed project and approve it.

By Melissa Hook
Melissa Hook
Director, Office of Victim Services (EOM)
Date 2.22.2011

By Elisabeth Olds
Elisabeth Olds
Director, Survivors and Advocates for Empowerment (SAFE), Inc.
Date 2.22.11

By Cathy L. Lanier
Cathy L. Lanier
Chief of Police, Metropolitan Police Department
Date 2-22-11

By Stephen T. Bacon
Stephen T. Bacon
Director, Department of Mental Health
Date 2/22-11

By Dr. Roque Gerald
Dr. Roque Gerald
Director, Child and Family Services Agency
Date 2/22/11

By Anne B. Wicks
Anne B. Wicks
Executive Officer of District of Columbia Courts
Date 2/22/11

By Adrienne Poteat
Adrienne Poteat
Deputy Director, Court Services and Offender Supervision Agency
Date 2/23/11

By William Frohna
Dr. William Frohna
Chairman, Department of Emergency Medicine, Washington Hospital Center
Date 2/23/2011

SPECIAL ORDER



DISTRICT OF COLUMBIA

Subject	Crisis Intervention Officer Initiative
Number	SO-10-07
Effective Date	September 13, 2010
Related to:	GO-OPS-308.04 (Processing of Persons Who May Suffer From Mental Illness) GO-OPS-309.01 (Barricade/Hostage Situations and Other Unusual Incidents) SO 00-19 (Compliance with Title II of the Americans with Disabilities Act) SO 03-09 (Juvenile Mental Health Services), TT 03-076-10 (Transportation of Juveniles in Need of Mental Health Services), effective date 03/23/10
Rescinds:	TT 06-073-10 (Crisis Intervention Officer Initiative) effective date 06/22/10

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I. BACKGROUND

The Metropolitan Police Department (MPD) created the Crisis Intervention Officer Initiative to provide skills to members that are necessary to effectively deal with persons of diminished mental capacity and to provide professional assistance to these individuals.

The Crisis Intervention Officer Initiative does not require members to make a diagnosis of whether subjects are mentally ill or what form of mental illness subjects may have, but rather to use reasonable judgment to recognize behavior which is outside the norm in which subjects pose a danger to themselves or others, and their behavior appears to the average person to be caused by mental illness.

II. POLICY

It is the policy of the MPD when handling incidents involving persons of diminished capacities to de-escalate the situation and encourage professional resource intervention to resolve the encounter in the safest possible manner in the best interest of all the involved parties. Proper intervention techniques can assist in resolving the immediate implications of the encounter and hasten the intervention by professional resource personnel.

III. DEFINITIONS

For the purpose of this order, the following terms shall have the meanings designated:

1. Crisis Intervention Officer – Sworn member trained and certified by the MPD to deal with persons of diminished mental capacity.
2. Diminished Mental Capacity – Impaired mental condition that is caused by trauma or disease. It encompasses all persons who exhibit unusual behaviors commonly referred to as “irrational,” “bizarre,” “unpredictable,” or “weird.” These outward observable symptoms could be the result of suicidal intent, mental illness, or medical complications.
3. Mental Illness – Disorder in thought or mood so substantial that it impairs judgment, behavior, perception of reality, or the ability to cope with the ordinary demands of life.
4. Professional Resources – Resources available to the MPD such as mental health professionals, emergency medical facilities, psychiatric institutes and detoxification centers.
5. Voluntary and Involuntary Detentions– Provisions within the D.C. Official Code (Title 21, Chapter 5) which the MPD shall use for detaining persons requiring professional psychological intervention.

IV. REGULATIONS

- A. Members shall analyze the circumstances of incidents involving individuals with diminished mental capacity.

NOTE: Persons of diminished capacity may display conduct that is irrational, unpredictable, or threatening. They may not receive or comprehend commands or other forms of communication in the manner that members may expect. They often do not respond to authoritative persons or the display of force.

- B. The first member on the scene involving an individual with diminished mental capacity shall establish control, determine the facts and circumstances surrounding the need for assistance, and request a Crisis Intervention Officer.

1. Should a Crisis Intervention Officer be available, he/she shall respond and assume responsibility for the assignment, ensuring all avenues of remedy are explored and executed and complete all applicable reports, including but not limited to the PD Form 251-C (Crisis Intervention Tracking Form.)
 2. If a Crisis Intervention Officer is not available, the members on the scene shall handle the incident in accordance with this order and applicable MPD policies and procedures.
- C. In determining whether a physical arrest is warranted for a person of diminished mental capacity, the member shall use reasonable judgment and take into account:
1. The nature of the crime;
 2. The nature of any injuries;
 3. The nature of the illness; and
 4. Any other mitigating factors (e.g., the capability to formulate criminal intent).
- D. Detention, either voluntary or involuntary, in lieu of a physical arrest **must** be approved by a supervisor with the concurrence of the Watch Commander.
- E. Members trained as Crisis Intervention Officers may be dispatched as first responders for hostage and barricade situations prior to the arrival of members of the Homeland Security Bureau, Special Operations Division, Emergency Response Team and shall be incorporated into the Incident Command System structure organized for the incident.

V. PROCEDURES

- A. Utilization of Crisis Intervention Officers
1. Crisis Intervention Officers shall go in service at the beginning of each tour of duty with the Office of Unified Communications (OUC) dispatcher, and i-Mobile if applicable, and provide the fact that they are Crisis Intervention Officer trained.
 2. OUC dispatchers may refer to the list of trained members for dispatch or may request a Crisis Intervention Officer over the radio for assignment.
 3. Crisis Intervention Officers shall respond to all calls or incidents involving a confirmed or suspected mentally ill person in crisis if

available. Crisis Intervention Officers may handle calls for service outside their assigned Patrol District with the approval of the District Watch Commander and/or the Night Supervisor.

4. Crisis Intervention Officers, when not on an assignment, shall periodically visit residences or locations where individuals with diminished mental capacity are known to frequent.

B. Responsibilities of On Scene Members

1. The first Crisis Intervention Officer on the scene shall be responsible for the entire call or incident including, but not limited to:
 - a. Conducting a dialogue with the person of diminished capacity;
 - b. Determining the appropriate action to be taken;
 - c. Completing all necessary paper work; and
 - d. Maintaining responsibility for the call or incident unless otherwise directed by a supervisor.
2. Other members on the scene shall provide necessary backup and support as needed.
3. When a Crisis Intervention Officer is reassigned during the incident, the supervisor shall ensure the scene is handled appropriately and all required reports are prepared.
4. In all cases, the Crisis Intervention Officer shall complete the PD Form 251-C for all instances when they encounter a mental health consumer in crisis and submit the form with copies of any supporting paperwork to the Crisis Intervention Officer Coordinator at the end of the tour of duty.

NOTE: The Crisis Intervention Tracking Form shall only be completed by members trained in Crisis Intervention as outlined in Part V.H of this order.

C. Detention Procedures

One of the primary purposes for police response to an incident involving a person of diminished capacity is to control the situation and ensure that the person receives the most appropriate form of care and access to appropriate professional resources.

1. In determining the most appropriate form of professional resource and referral, members shall:

- a. Consider the information provided by professional resource persons, family members, friends and/or the reporting person;
- b. Determine what, if any, on-going threat potential the subject poses to him/herself, or others; and

NOTE: This threat potential may necessitate an involuntary detention procedure rather than allowing the subject to go with the family or friends for voluntary treatment.

- c. Consider the use of professional/medical crisis intervention personnel, if available, when making a detention decision.
2. Any member with reasonable grounds to believe that an **adult** individual is mentally ill and poses a danger or threat of danger to him/herself or others shall transport the individual without delay to the Comprehensive Psychiatric Emergency Program (CPEP) located in Building 14 on the grounds of the former DC General Hospital.
 - a. When the adult voluntarily agrees to go to CPEP, the member shall inform the staff of the circumstances for the transport and execute a PD Form 251 with the classification "Sick Person to the Hospital".
 - b. When the adult will **not** submit voluntarily, the member shall execute a PD Form 251 "Sick Person to the Hospital" **and** complete the Form FD 12 (Application for Emergency Hospitalization by a Physician, Officer or Agent of the D.C. Department of Human Services or an Officer Authorized to Make Arrests) outlining the circumstances for the detention and provide this form to the staff of the facility.
 3. Members shall transport juvenile subjects in accordance with Special Order 10-08 (Juvenile Mental Health Services).

D. Use of Restraints

1. Members shall determine the appropriate use of restraints to ensure the safety of both the subject and transporting members.

NOTE: The use of restraints when dealing with persons of diminished capacity may present members with conflicting considerations in determining the best means for restraint and transportation. In some cases, restraints must be utilized and/or an ambulance may be required.
2. Members shall accompany subjects who are restrained and transported by ambulance to the treatment facility.

E. Duties of Crisis Intervention Coordinators

1. Commanding Officials of each patrol district and the School Security Division shall designate an official the rank of Captain as the unit's Crisis Intervention Coordinator. The Crisis Intervention Coordinator shall be tasked with leading, managing and supervising day-to-day administrative and operational aspects concerning the Crisis Intervention Officer Initiative. The Crisis Intervention Coordinator shall be responsible for:
 - a. Supervising Crisis Intervention Officers and providing managerial oversight for the Crisis Intervention Officer Initiative;
 - b. Establishing and maintaining an effective liaison with other law enforcement departments and agencies, which interact with or impact MPD operations;
 - c. Preparing the monthly status/activity report which is to include:
 - (1) Calls for service with date, time and location,
 - (2) Self-initiated calls with date, time and location,
 - (3) Any injuries with date, time and location, and
 - (4) Brief summary of any significant cases;
2. Attending the monthly Crisis Intervention Coordinator meeting;
3. Preparing required administrative reports, operations plans, staff studies, and responses to emergency situations that could impact the community;
4. Participating in basic and advanced Crisis Intervention Officer training sessions as required; and
5. Ensuring that Crisis Intervention Officer trained personnel are accountable and responsible for follow-up investigations of all complaints assigned which entail further interviews of suspects, victims, witnesses, completion of thorough supplementary reports and a final disposition at the United States Attorney's Office.

F. Duties of Patrol District Watch Commanders

1. Patrol District Watch Commander shall notify the Command Information Center (CIC) after roll call and supply the names, CAD numbers and assignments of each Crisis Intervention Officer for every

tour of duty and shall include this information on the daily deployment schedules.

2. Ensure copies of the PD Form 251-C are forwarded to the Crisis Intervention Coordinator prior to the end of the tour of duty.

G. Crisis Intervention Officer Criteria

1. Patrol members who wish to volunteer and be considered for training shall contact their Patrol District Administrative Captain or Training Coordinator.
2. The following traits are essential in providing services to persons of diminished capacity to resolve the encounter in the safest possible manner, and members should possess:
 - a. Strong communication skills;
 - b. Active listening skills;
 - c. Ability to work well under pressure;
 - d. Ability to maintain a positive attitude under stressful conditions;
 - e. Ability to absorb verbal abuse without negative responses;
 - f. Ability in exercising good judgment and decision-making skills;
 - g. Ability to work in close harmony with peers, officials, command officials, mental health and medical practitioners and the general public; and
 - h. Ability to maintain self-control during all types of crisis.
2. Members who volunteer to be trained as a Crisis Intervention Officer shall not receive additional compensation.

H. Crisis Intervention Training

1. Members selected to serve as Crisis Intervention Officers shall attend and successfully complete a forty (40) hour Crisis Intervention training course of instruction and attend continuing educational courses as required.

NOTE: The training focuses on recognizing mental illnesses and personality disorders and applying appropriate crisis intervention techniques. Training also addresses officer awareness, safety, and tactics. The training emphasizes that while good evaluation, empathy, and communication skills are necessary for the Crisis Intervention

Officer, officer safety remains paramount.

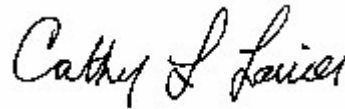
2. The Commanding Official/Director, Metropolitan Police Academy, shall maintain an updated list of members who have successfully received certification and shall ensure the list is provided to the Command Information Center (CIC) whenever it is updated.
3. The Commanding Official/Director, CIC, shall maintain a current list of those members certified as Crisis Intervention Officers and shall ensure the list is easily accessible to assist in the deployment of Crisis Intervention Officers in Patrol Districts.

VI. CROSS REFERENCES

1. GO-308.04 (Processing of Persons Who May Suffer from Mental Illness)
2. D.C. Official Code, Title 21, Chapter 5 (Hospitalization of the Mentally Ill)

VII. ATTACHMENT

- A. PD Form 251-C (Crisis Intervention Tracking Form)



Cathy L. Lanier
Chief of Police

CLL:PH:MOC:CC

D.C. Metropolitan Police Department
 D.C. Department of Mental Health
 Crisis Intervention Officer (CIO) Tracking Form

Dispatched Date ___/___/___ CCN# _____
 On-scene Engage Time _____ Disengage Time _____

Subjects Name (*Last, First*) _____ Date of Birth (MM/DD/YY) ___/___/___

Event Address _____

Reporting Officer _____ District _____ CAD# _____

Nature of Incident (*Check all that apply*)

- Disorderly/disruptive behavior
- Neglect of Self Care
- Nuisance (loitering, trespassing)
- Threats or violence to others
- Public Intoxication
- Drug related offenses
- Suicide threat or attempt
- Inappropriately dressed or undressed
- No Information
- Other (*Specify*) _____

Did the subject use/brandish any weapons? Yes No Don't Know
 If Yes, specify type of weapon _____

Incident Injuries

Did subject injure or attempt to injure self? Yes No
 Did subject injure or attempt to injure others? Yes No
 If so, whom? Self Officer Animal Other (i.e., person)

Prior Contacts

Known Person? Yes No
 If Yes, Specify: _____

Drug Alcohol Involvement

Evidence of drugs/alcohol? Yes No
 If yes, Alcohol
 Other Drug/specify _____
 Don't Know

Medication Compliant? Yes No Don't Know

Behaviors Observed During Incident (*check all that apply*)

- Disoriented or confused
- Hearing voices/Seeing things
- Hostile or uncooperative
- Intoxication
- Incoherent speech
- Frightened/Anxious
- Developmental concern
- Depressed
- Hyperactive
- Nothing

Disposition (*check all that apply*)

- No action/resolved on scene
- On-Scene crisis intervention
- Transported to detox
- Ervin Act/FD-12-826
- Transported for evaluation to: _____
- Mental health referral made (i.e. called Access Helpline)
- Outpatient/case management referral
- Police notified case manager or mental health center
- Other-specify _____

Before CIO training, would you have responded differently? Yes No
 What would the charges have been? _____

Summary (Nature of Event and Outcome/Action Taken):

**Please attach copy of PD-251*

Resource Information

Department of Mental Health (DMH) 24 Hour Access Help-Line

Phone: 1 (888) 793-4357 TDD Access Helpline: 202-561-7000

Children & Adolescent Mobile Psychiatric Services (CHAMPS)

Direct: (202) 481-1450 OR DMH Access Help-Line (Above)

Adult Mobile Crisis Services

Direct: (202) 673-9300 OR DMH Access Help-Line (Above)

Comprehensive Psychiatric Emergency Program (CPEP)

Direct: (202) 673-9319
 DC General Hospital Compound • 1905 E St. SE, Building #14

DMH Homeless Outreach Program

Direct: 202-671-0388
 64 New York Avenue, NE

Common Psychiatric Medications:

Psychotic Disorders

Geodon
 Haldol
 Mellaril
 Prolixin
 Risperadol
 Serenil
 Seroquel
 Thorazine
 Zyprexa
 Xanax
 Clozaril

Mood Disorders

Depakote
 Effexor
 Neurontin
 Paxil
 Prozac
 Tegretol
 Topamax
 Wellbutrin
 Zoloft
 Anafranil

Anxiety Disorders

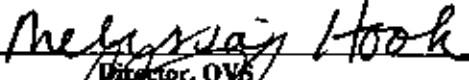

Buspar
 Centrax
 Inderal
 Klonopin
 Serax
 Tranxen
 Valium
 Ativan

SO-10-07 (Crisis Intervention Officer Initiative)
 Attachment A



GOVERNMENT
OF THE
DISTRICT OF
COLUMBIA

GRANT AWARD

DISTRICT OF COLUMBIA OFFICE OF VICTIM SERVICES 1350 PENNSYLVANIA AVENUE, NW SUITE 407 WASHINGTON, DC 20004 TEL: (202) 727-3934 FAX: (202) 727-6332		DESCRIPTION OF GRANT GRANT NO: 11-VAF-03 SOAR #: FED 11 TITLE: Victim Assistance Fund DATE OF AWARD: 10/1/2010 GRANT PERIOD: 10/1/2010-9/30/2011	
GRANT STATUS: NEW (X) CONTINUATION ()		FISCAL YEAR: 2011	
PROJECT TITLE: Homicide Survivor Response Project			
AGENCY: DC Department of Mental Health			
ADDRESS: 1905 E St, SE, Bldg #14, Washington, DC 20003			
TEL: 202/ 673-9302 FAX: 202/ 673-9411		TEL: 202/ 671-3211 FAX: 202/671-2981	
PROJECT DIRECTOR:		FINANCIAL OFFICER:	
NAME: Luis Vasquez		NAME: Joyce Jeter	
TITLE: Director, Mobile Crisis Services		TITLE: Agency Fiscal Officer	
EMAIL: luis.vasquez@dc.gov		EMAIL: joyce.jeter@dc.gov	
BUDGET DETAILS	DISTRICT	MATCH N/A	GRANT AWARD CONDITIONS
Personnel Services	150,919.00		SEE: TERMS AND CONDITIONS OF THE GRANT AGREEMENT
Fringe	0.00		
Travel	0.00		
Contractual	0.00		
Supplies	0.00		
Equipment	0.00		
Operating Expenses	0.00		
Training	0.00		
SUBTOTAL	150,919.00		
TOTAL PROJECT AMOUNT: \$150,919.00			
Signature	 Director, OVS		Date 8/24/2010
Signature	 Authorized Official from Grantee Agency		Date 10/12/10
Signature	President of Board of Directors from Grantee Agency		Date



**MEMORANDUM OF UNDERSTANDING
FOR
INTRA-DISTRICT FUNDING**

This Memorandum of Understanding ("MOU" or Agreement) is between the DC Office of Victim Services (the "Buyer") and the DC Department of Mental Health (the "Seller" or "grantee").

A fully executed copy of this MOU along with copies of the attached Grant Award and Grant Agreement may be used by the Seller/ grantee to establish budget and spending authority with its Chief Financial Officer.

This is a hundred percent (100%) cost reimbursement MOU.

INTRODUCTION

Grant funds awarded to the DC Department of Mental Health are to be used to provide an array of services to surviving family members of homicide victims.

GENERAL PROVISIONS

All the terms and conditions of the attached Grant Award and Grant Agreement are specifically incorporated into this MOU.

ROLES AND RESPONSIBILITIES

In accordance with this MOU the Buyer/grantor agrees to perform the following:

1. The Buyer/grantor agency will make sure that the revenues for this project are reflected in SOAR on the Intra-district line (screen 61) along with its appropriated accumulators.
2. The Buyer/grantor will establish an agency internal service fund with a corresponding index that ties to the fund and agency organizational structure.
3. The Buyer/grantor will not authorize payment or allow direct charging of any cost reimbursements under this MOU received after September 30, 2011.
4. The Buyer/ grantor agrees to transfer funds to DMH in the amount of \$150,919.00 via Intra-District transfer.

4. See the attached Grant Award and Grant Agreement No: **11-VAF-03** for specific details.

In accordance with this MOU the Seller/sub-grantee agrees to perform the following:

1. The Seller/ Grantee must budget for all services requested in this MOU.
2. The Seller/ Grantee must meet the goals, objectives, performance measures, and reporting requirements as identified in the Grant Award and Grant Agreement.
3. The Seller/ Grantee will submit a signed Intra-District Standard Request Form (ISRF) that identifies the Seller/Grantee's funding attributes. The ISRF should be returned with a signed copy of this MOU. Subsequent ISRF should accompany each cost reimbursement (Grantee Request for Funds) request along with the associated supportive documentation.
4. The Seller/ Grantee must submit the final Grantee Request for Funds, Project Expenditure Report and ISRF no later than **October 15, 2011**.
5. The Seller/ Grantee will not attempt to direct charge the Buyer's/grantor's "record of business" for any ISRF's submitted after **October 15, 2011**.
6. See the Grant Award and Grant Agreement No: **11-VAF-03** for General Conditions and Special Conditions of the award.

FUNDING SOURCE

The funding allocation of this MOU shall be **\$150,919** under the Victim Assistance Fund.

PERIOD OF PERFORMANCE

The term of this MOU is from **10/01/2010** through **09/30/2011**. This MOU may be terminated upon a (30) thirty-day written notice provided by either party. The parties to this MOU may extend the term of this MOU with a fully executed Grant Adjustment Notice (GAN) signed by an authorized signatory from the Buyer/Grantor agency. The parties to the MOU shall provide written notice of intent to renew the MOU (60) sixty days prior to the expiration of the agreement.

AMENDMENTS AND OR MODIFICATIONS

The **DC Department of Mental Health** reserves the right to request modifications and or renegotiation of this MOU at any time, in writing to the Office of Victim Services and with the agreement of the parties. Modification to this MOU shall be incorporated in the form of an amendment dated and signed by authorized signatories of both the Seller and

Buyer agencies. However, minor modifications may be made by memorandum to the signatories.


MONITORING AND EVALUATION

Pursuant to the attached signed Grant Agreement and the Financial Review Process (FRP) mandated by the Office of the Chief Financial Officer of the District of Columbia, all services provided by the MOU shall be reported at a minimum quarterly to the Buyer/grantor.

The Buyer/grantor will monitor the Seller/Grantee periodically to ensure compliance with the MOU. All parties agree to review the activities under this MOU at a mutually agreed to time and to undertake any corrective action(s) required to remedy deficiencies existing in the MOU. All parties agree to share information and follow procedures timely to ensure release of all reports required by the Seller/grantor.

IN WITNESS WHEREOF, The parties hereto have executed this Memorandum of Understanding and do certify that the information provided is true and correct, and that the parties do, hereby agree to and will abide by all of the terms set forth herein. Each party understands that the provisions of this MOU are subject to the laws and regulations of the District of Columbia Government.

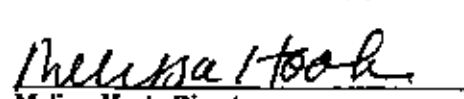
For the DC Department of Mental Health:



Stephen T. Barron, Director

10/12/10
(Date)

For the Office of Victim Services:



Melissa Hook, Director

Sept 24, 2010
(Date)



DISTRICT OF COLUMBIA
Office of Victim Services
1350 Pennsylvania Avenue, NW, Suite 407
Washington D.C. 20004

GRANT AGREEMENT

GRANT NUMBER: 11-VAF-03
CFDA #: N/A
SOAR #: FED 11
PROJECT TITLE: Homicide Survivor Response Project

WHEREAS, a grant has been awarded by the Victim Assistance Fund to be administered by the District of Columbia, Office of Victim Services (OVS), the Office charged with and empowered to carry out the responsibilities imposed by the aforesaid law; and

NOW, THEREFORE, It is hereby agreed by and between the District of Columbia, Office of Victim Services (OVS) and the *DC Department of Mental Health* that:

A. SERVICES TO BE PROVIDED BY DC Department of Mental Health:

Funds awarded pursuant to this grant agreement shall be used to support the following:

Personnel

Marshall Cain Mental Health Counselor	\$3,073
Isha Edwards Mental Health Counselor	\$3,073
Veronica Fabani Mental Health Specialist	\$4,053
Teresa Gibbs Mental Health Specialist	\$4,432
Nicholle Hill Addiction Treatment Specialist	\$4,305
Mary Miller Social Worker	\$5,161
Areliis Perez Mental Health Specialist	\$4,053
Gordon Person Mental Health Counselor	\$2,792
Stanley Peters Mental Health Specialist	\$5,063
Rosetta Price	

Peer Counselor	\$2,792
Sheryl Rutledge Addiction Treatment Specialist	\$3,927
Jim Vambrech Social Worker	\$5,009
Gary Yingling Peer Counselor	\$3,284
TBH Mental Health Counselor	\$49,951
TBH Mental Health Counselor	\$49,951
Sub Total	\$150,919
Total	\$150,919

Project Activities:

- Respond to 100% of locations, where homicide survivors are present, when a response is requested by the DC Metropolitan Police Department.
- Offer mental health and other supportive services to homicide survivors at 100% of locations where a response has been requested by the DC Metropolitan Police Department.
- Provide follow-up attempts including telephone calls and home visits with 100% of homicide survivors, referred by the DC Metropolitan Police Department, that have expressed willingness to receive mental health and/or other supportive services.

B. FUNDS AND MATCH REQUIREMENT

1. The funds in this grant shall be derived from the following sources:

Amount of grant funds	\$ 150,919
Amount of cash match contribution	\$ 0
Amount of in-kind contribution	\$ 0
Total project funds	\$ 150,919

Source of cash match: (N/A).

2. Matching contribution in the amount of \$ 0 (cash or in-kind), is required; the match must be derived from non-federal and non-District sources. All funds designated as match must be expended within the grant period, are restricted to the same uses as the grant funds, and must submitted quarterly with requests for reimbursement to OVS with the proper documentation.

GRANT TERMS AND CONDITIONS PAGE 2

3. For the purpose of this program, in-kind match may include donations of expendable equipment, office supplies, workshop or classroom materials, work space, or the monetary value of time contributed by professionals and technical personnel and other skilled and unskilled labor, if the services they provide are an integral and necessary part of the funded project. The value placed on donated services must be consistent with the rate of compensation paid for similar work in the sub-grantee's organization. If the required skills are not found in the sub-grantee's organization, the rate of compensation must be consistent with the labor market. In either case, fringe benefits may be included in the valuation. The value placed on loaned or donated equipment may not exceed the fair rental value. The value of donated space may not exceed the fair rental value of comparable space and facilities as established by an independent appraisal of comparable space and facilities in privately-owned buildings in the same locality.
4. Grantee or Sub-grantee must maintain a record that clearly identifies the match allocation. The basis for determining the value of personnel services, materials, equipment, and space must be documented.
5. Volunteer services must be documented and the extent feasible and supported by the same methods used by the sub-grantee for its own paid employees.
6. Indirect costs are not allowed under any circumstances.

C. EXPENDITURE AND PAYMENT PROVISIONS

1. In the Budget Support Act of 2008, Congress encourages OVS to coordinate our activities with the Superior Court Crime Victim Compensation Program to become more cost effective. Beginning October 1, 2008, all grantees and sub-grantees who receive local and/or federal funds are required to bill the Crime Victim Compensation Program for all eligible client services and report expenses paid by the Crime Victim Compensation Program as part of the quarterly reimbursement process with OVS. (Please refer to Crime Victim Compensation Program Guidelines for payable/allowable client services at the following web site: <http://www.dccourts.gov/dccourts/superior/cvcp.jsp>)).

More specifically, the process will be in effect as follows:

- All grantees and sub-grantees will be required to bill the Crime Victim Compensation Program for allowable costs/expenses.
- All grantees and sub-grantees will be required to document all compensation expenses paid by the Crime Victim Compensation Program and report to OVS on a quarterly basis.

Please note: All services to crime victims must be free of charge with the

exception of eligible victim services that can be directly billed to the Crime Victims Compensation Program. Crime victims cannot be billed directly for services.

OVS will evaluate payments made to grantees and sub-grantees for services to eligible victims by the Crime Victim Compensation Program and will use its discretion in reducing grant amounts when deemed appropriate.

2. The enclosed *Budget Notice* is made part of the final grant proposal and Grant Award. Where this notice modifies the project budget submitted in the original grant application by this Award, it represents final approved expenses for the project and governs expenditures accordingly. *Grant funds may not be expended for items not part of the budget approved by OVS.*
3. All funds awarded to the grantee or sub-grantee pursuant to this Grant Award will be expended for the purpose(s) and activities set out in the grantee or sub-grantee's proposal/application submitted to OVS on 9/16/10 as amended and approved by OVS, which is hereby made a part of this grant agreement.
4. Grant funds shall be expended in accordance with the cost principles delineated in the Office of Management and Budget Circular A-21, Cost Principles for Educational Institutions", A-122, Cost Principles for Non-Profit Organizations", A-87, and Cost Principles for State, local and Indian Tribal Governments", Circular A-133 (Audits of States, Local Governments and Non-Profit Organization), and the U.S. Department of Justice's Financial Guide and the Grant Program Guide. An electronic copy can be found at: <http://www.ojp.usdoj.gov/financialguide/>
5. The grantee or sub-grantee should, at a minimum, request a cost-reimbursement using the "Request for Funds" form on a quarterly basis. Each request must be accompanied by a Financial Report and its associated documentation. After the first quarter, reimbursement requests will not be honored unless the required quarterly Financial and Programmatic Reports are on file. If more frequent reimbursements are needed the grantee should contact their OVS Program Manager.
6. The District of Columbia shall make payment(s) on paid invoiced amounts in accordance with the approved grant budget and as cited in Section C.5 above after all supporting documentation has been validated by the OVS Program Manager.
7. The grantee or sub-grantee, in order to receive payment, shall submit a signed "Request for Funds" form and supporting documentation of actual expenditures as described in Section D.I.

D. FINANCIAL MANAGEMENT AND AUDIT

GRANT TERMS AND CONDITIONS PAGE 4

1. The project expenditures shall be based on actual costs incurred by the grantee or sub-grantee and shall be supported by detailed documentation (i.e., vouchers, receipts, paid invoices, paid checks, and payroll registers, etc.). This applies to petty cash, miscellaneous office expenditures and all other expenditures.
2. This documentation is to be submitted to the Grant Administrator, Office of Victim Services, 1350 Pennsylvania Avenue, NW, Suite 407, Washington D.C. 20004.
3. All personnel funded in whole or in part under this Grant must be identified by name. Using an OVS Grant Adjustment Request Form (GAR), the Authorized Official or Project Director must give written notification within 15 days of any changes in project personnel. In addition, accurate time and attendance records must be kept for all personnel hired/employed under this project.
4. All unallowable or unsupported costs, as determined by either an on-site visit or desk audit performed by OVS or an official audit, shall be refunded to OVS within 90 days of notification by OVS.
5. The fiscal administration of the grant shall conform to the generally accepted accounting principles recognized by the Financial Accounting Standards Board, set forth in the most current edition of the Department of Justice, Office of Justice Programs, Office of the Comptroller Financial Guide: An electronic copy can be found at : <http://www.ojp.usdoj.gov/financialguide/>
6. The grantee or sub-grantee must obtain prior written approval from OVS for all requests for changes or modifications to any portion of the Grant Award. Requests must be submitted within 30 days of the change or occurrence and require the written approval of the Office of Victim Services (OVS) to become effective. In addition, all requests must be submitted on the approved OVS *Grant Adjustment Request Form (GAR)*. After the start of the fiscal year's fourth (4th) quarter (July 1st), requests for reprogramming of funds and changes to the project's goals and objectives will not be considered.
7. It is the responsibility of the grantee or sub-grantee to close out the grant accounting records at the end of the project, and submit a grant closeout report, using the format for quarterly programmatic reports. Failure to complete required documentation may result in suspension of funds or may make the program ineligible for future funds.
8. The Director of OVS, the D.C. Inspector General and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for purposes of audit and examination of any books, documents, papers, and records of the grantee or sub-grantee related to this grant project at any time.
9. Grant funds may not be obligated prior to the effective date or subsequent to the

GRANT TERMS AND CONDITIONS PAGE 5

termination date of the grant period without advance written approval by OVS.

10. All contracts relating to or deriving from the grant must be procured using an established agency approved process. Records must be maintained of the procedure used, a minimum of 3 bids received (if competed), and rationale for final decisions.
11. If the grantee or sub-grantee expends \$500,000 or more in federal or District funds, the grantee or sub-grantee is required to conduct a single audit in accordance with the provisions of OMB Circular A-133 (Audits of States, Local Governments and Non-Profit Organization), dated June 24, 1977. A copy shall be maintained current on file with the Office of Victim Services.
12. Compensation for individual consultant services is to be reasonable and consistent with that paid for similar services in the market place. In addition, when the rate exceeds \$450 (excluding travel and subsistence costs) for an eight-hour day, a written PRIOR APPROVAL is required from OVS. Prior approval requests require additional justification. An eight-hour day may include preparation, evaluation, and travel time in addition to the time required for actual performance. This does not mean that the rate can or should be \$450 for all consultants. Rates should be developed and reviewed on a case-by-case basis and must be reasonable and allowable in accordance with OMB cost principles. Approval of consultant rates in excess of \$450 a day that are part of the original application with appropriate justification and supporting data will be reviewed on a case-by-case basis.
13. If the grant or sub-grant award amount is \$25,000 or more, the grantee or sub-grantee is required to register in the Central Contractor Registry (CCR), which also requires the sub-grantee to have a Data Universal Numbering System (DUNS) number. The sub-grantee is required to maintain a current registration in the CCR and DUNS number during the grant period.

E. REPORTING SCHEDULE FOR PROGRAMMATIC REPORTS

1. The grantee or sub-grantee must furnish a quarterly programmatic and financial progress report to OVS due fifteen (15) days after the end of each quarter as described below. The reports will reflect the progress and implementation of the project for which the funds have been granted and the funds expended to date if significant changes are indicated in the work plan, spending plan (by budget line item and by project objectives) and staffing plan which comprised the grant's implementation plan. Programmatic progress reports must be submitted in the format required by the OVS.

Reporting Schedule for Programmatic and Financial Reports

Reporting Period

Report Due

1st Quarter:	October 1 – December 31	January 15 th
2 nd Quarter:	January 1 – March 31	April 15 th
3 rd Quarter:	April 1 – June 30	July 15 th
4 th Quarter:	July 1 – September 30	October 15 th

2. The grantee or sub-grantee must submit quarterly financial and programmatic reports to the Grant Administrator. The financial reports will be itemized according to the approved budget and cost categories for the grant. If match funds are required, a separate expenditure report must accompany each quarterly financial report.
3. The grantee or sub-grantee agrees to comply with any other reasonable reporting requirements that may be placed on the project.
4. The grantee or sub-grantee must periodically provide criminal justice and demographic related information to OVS from the project file to assist OVS in fulfilling its Federal and District requirements for information on justice events and activities in the District of Columbia. The schedule for the grantee or sub-grantee to submit information will be determined by request from OVS. OVS will make these requests in writing, stating the reason for the data. OVS will make its requests for information in a manner, which is as timely and considerate of the grantee or sub-grantee's work schedule.
5. The grantee or sub-grantee must maintain all data applicable to the Grant Award and Grant Agreement for a period not less than 3 years from date of the grant's closing.
6. Reimbursements will not be released if reports are delinquent.

F. COMPLIANCE AND ASSURANCES

1. In accordance with the applicable federal statutes listed below, as well as, District non-discrimination requirements, the grantee or sub grantee agrees not to discriminate against any protected populations, in hiring or the provision of services. In addition the grantee or sub grantee agrees to notify OVS within 48 hours of any and all employee or beneficiary formal complaints of discrimination against any and all employee units within their organization, and to more generally comply with all civil rights hiring and beneficiary service policies and procedures as identified in the below listed applicable statutes. Applicable statutes may include the Omnibus Crime Control and Safe Streets Act of 1968, as amended, and 42 USC 3789(d); the Victims of Crime Act (42 USC 10604(e)); Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; Title II of the Americans with Disabilities Act (ADA) of 1990; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; 28 CFR Part 38 – Equal Treatment for Faith-Based Organizations; the Department of Justice Nondiscrimination

Regulations 28 CFR Part 42, Subparts C,D,E, and G; and Department of Justice regulations on disability discrimination, 28 CFR Part 35 and Part 39.

2. In the event a Federal or District court or administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin or sex against the grantee or sub-grantee, the grantee or sub-grantee must forward a copy of the finding to the 1) DC Office of Victim Services, 1350 Pennsylvania Ave NW, Suite 407, Washington ,DC 20004, 2) DC Office of Human Rights, 441 4th St NW, Suite 570N, Washington ,DC 20001 and the 3) US Office on Civil Rights, 810 7th Street, NW, Washington, DC 20531.
3. The grantee or sub-grantee is required to complete the DC Office of Human Rights web-based Equal Employment Opportunity, Diversity & Language Access E-Learning Program available at <http://ohr.dc.gov/ohr/cwp/view,A,3,Q,635337.asp>. Additionally, the grantee or sub grantee agrees to post and display the *District of Columbia Equal Employment Opportunity* poster in a conspicuous area accessible to employees.
4. In accordance 28 CFR Part 69, grantee or sub-grantee will not expend any federal or District funds to pay a person for influencing or attempting to influence an officer or employee of any agency, member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following Federal actions: a) the awarding of any Federal contract; b) the making of any Federal award; c) the entering into of any cooperative agreement; d) and the extension, continuation, renewal, amendment, or modification of any Federal contract, award, or cooperative agreement.
5. In accordance with 28 CFR Part 38, grantee or sub-grantee will not engage in inherently religious activities, such as worship, religious instruction, or proselytization, as part of the funded program or services. If a grantee or sub-grantee conducts such activities, the activities must be offered separately, in time or location, from the funded program or services and participation must be voluntary for beneficiaries of the funded programs or services.
6. The grantee or sub-grantee will have on file, a current Equal Employment Opportunity Program (EEOP) plan in accordance with 28 CFR 42.301 *et. seq.*
7. The grantee or sub-grantee agrees to complete and keep on file, as appropriate, Immigration and Naturalization Service Employment Eligibility Verification Form (I-9).
8. All grantee or sub-grantee will comply with Title V of the Anti-Drug Abuse Act of 1988 and regulations promulgated by the Federal Government to maintain a drug-free workplace.
9. The grantee or sub-grantee certifies, that neither it nor its principals or its

GRANT TERMS AND CONDITIONS PAGE 8

contractors are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any District department.

10. The grantee or sub-grantee assures that grant funds will not be used to supplant District funds, but will be used to increase the amounts of such funds that would be made available for the purposed criminal justice projects.
11. The grantee or sub-grantee must comply with all applicable confidentiality regulations.
12. Pursuant to the requirement of the Freedom of Information Act, all information, documents, correspondence, and other materials relating to the project, not to include client or employee specific information, shall be available for public information.
13. The grantee agrees to indemnify, defend and hold harmless the Government of the District of Columbia and its authorized officers, employees, agents and volunteers from any and all claims, actions, losses, damages, and/or liability arising out of this grant or sub grant from any cause whatsoever, including the acts, errors or omissions of any person and for any costs or expenses incurred by the District on account of any claim therefore, except where such indemnification is prohibited by law.
14. The grantee or sub-grantee shall comply with all applicable District and Federal statutes and regulations as may be amended from time to time including, but not necessarily limited to the following: The Americans with Disabilities Act of 1990, Pub. L. 101-336, July 26, 1990, 104 Stat. 327 (42 U.S.C. 12101 et seq.); Rehabilitation Act of 1973, Pub. L. 93-112, Sept. 26, 1973, 87 Stat. 355 (29 U.S.C. 701 et seq.); The Hatch Act, Chap. 314, 24 Stat. 440 (7 U.S.C. 361a et seq.); The Fair Labor Standards Act, Chap. 676, 52 Stat. 1060 (29 U.S.C. 201 et seq.); The Clean Air Act (Sub-grants over \$100,000) Pub. L. 108-201, February 24, 2004, 42 USC cha. 85et.seq.; The Occupational Safety and Health Act of 1970, Pub. L. 91-596, Dec. 29, 1970, 84 Stat. 1590 (26 U.S.C. 651 et seq.); The Hobbs Act (Anti-Corruption), Chap 537, 60 Stat. 420 (see 18 U.S.C. § 1951); Equal Pay Act of 1963, Pub. L. 88-38, June 10, 1963, 77 Stat.56 (29 U.S.C. 201); Age Discrimination Act of 1975, Pub. L. 94-135, Nov. 28, 1975, 89 Stat. 728 (42 U.S.C. 6101 et. seq.); Age Discrimination in Employment Act, Pub. L. 90-202, Dec. 15, 1967, 81 Stat. 602 (29 U.S.C. 621 et. seq.); Title IX of the Education Amendments of 1972, Pub. L. 92-318, June 23, 1972, 86 Stat. 235. (20 U.S.C. 1001); Immigration Reform and Control Act of 1986, Pub. L. 99-603, Nov 6, 1986, 100 Stat. 3359, (8 U.S.C. 1101); Executive Order 12459 (Debarment, Suspension and Exclusion); Medical Leave Act of 1993, Pub. L. 103-3, Feb. 5, 1993, 107 Stat. 6 (5 U.S.C. 6381 et seq.); Lobbying Disclosure Act, Pub. L. 104-65, Dec. 19, 1995, 109 Stat. 693 (31 U.S.C. 1352); Drug Free Workplace Act of 1988, Pub. L. 100-690, 102 Stat. 4304 (41 U.S.C. 701 et seq.); Assurance of Nondiscrimination and Equal Opportunity as found in 29 CFR 34.20; Title VI of

the Civil Rights Act of 1964; 28 CFR Part 38 – Equal Treatment for Faith Based Organizations; District of Columbia Human Rights Act of 1977, D.C. Official Code § 2-1401.01; District of Columbia Language Access Act of 2004, DC Law 15 – 414, D.C. Official Code § 2-1931 et seq.); *City-Wide Grants Manual and Sourcebook* available at <http://www.opgs.dc.gov>.

G. RIGHTS IN DATA

- 1. Where activities supported by this grant produce original computer programs, writings, sound recordings, pictorial reproductions, drawings or other graphical representation, and works of any similar nature (the term computer programs includes executable computer programs and supporting data in any form), OVS has the right to use, duplicate, and disclose, in whole or in part in any matter for any purpose whatsoever and have others, do so. If the material is copyrightable, the grantee or sub-grantee may copyright such, but OVS reserves a royalty-free non-exclusive and irreversible license to reproduce, publish, and use such materials, in whole or in part and to authorize others to do. The grantee or sub-grantee shall include provisions appropriate to effectuate the purpose of this condition in all contracts under the grant.**
- 2. The grantee or sub-grantee may publish or announce the results of grant activity provided that there is prior review and approval by OVS and provided that any publication (written, visual, or sound) contains an acknowledgment of OVS and the applicable Federal agency. Copies of any such publication must be furnished to OVS not less than twenty (20) days prior to public release, except otherwise requested or approved by OVS.**
- 3. If the grant program produces patentable items, patent rights, processes, or inventions in the course of the work sponsored by grant funds, such facts must be promptly and fully reported to OVS. Unless there is a prior agreement between the grantee or sub-grantee and OVS on the disposition of such items, OVS will determine whether protection on the invention or discovery will be sought. OVS will also determine how its rights in the invention or discovery (including rights under any patents issued thereon) shall be allocated and administered in order to protect the public interest consistent with Government Patent Policy (President's Memorandum for Heads of Executive Departments and Agencies, dated August 23, 1971, and statement of Government Patent Policy, as printed in 36 FR 16839).**
- 4. The grantee or sub-grantee agrees that when issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with grant money, the sub-grantee shall clearly state: (1) the percentage of the total cost of the program or project that will be financed with grant money, (2) the dollar amount of grant funds for the project of program, and (3) an acknowledgment of OVS grant support.**

H. RECORDS

1. Appropriate grant records and accounts will be maintained and made available for audit as prescribed by Federal and District regulations.
2. All grant records shall be maintained for at least three (3) years after the completion of a project or until an audit is completed and/or any litigation is resolved and all questions rising there from are resolved, whichever is later. These records and supporting documentation must be sufficient for the D.C. Inspector General's auditors or a certified independent auditor (one who is not an employee of the sub-grantee or a member of the sub-grantees board of directors) to audit the project records and determine whether the costs incurred and billed are reasonable, allowable and necessary under the terms of the grant.

I. MONITORING

1. The Grant Administrator, or designee, will monitor the financial and programmatic management systems used by the grantee or sub-grantee in the execution of the terms and conditions of the grant agreement.
2. The Grant Administrator, or designee, may make at least one on-site visit to the service facilities of the grantee or sub-grantee. The failure of the grantee or sub-grantee to maintain a financial and programmatic management system that will assure the terms of the grant are met may result in suspension of payment, or termination of the grant and debarment of future funds.

J. GRANT PERIOD

The period of this Grant Agreement shall be from 10/1/10 to 9/30/11.

K. GRANT START UP AND TERMINATION

1. Within 30 days after receipt of the grant award, steps should be taken to ensure that the grantee or sub-grantee's funds are not commingled with funds from other District or Federal agencies. Each award must be accounted for separately.
2. The grantee or sub-grantee is responsible for notifying OVS in writing, that either all the grant funds will not be utilized per the grant award and grant agreement or the project will be terminated at an earlier date than indicated on the grant award and grant agreement. *The Notification of Project Commencement Form* must be signed by the Project Director and returned to OVS within two weeks after project commencement, or within 30 days of receipt of the award. Note: If the project has not commenced within 60 days of the starting date or if Project Personnel has not been hired within 30 days of the project start date, explanation of the steps taken to initiate the project, the reason for delay, and the expected commencement date must be indicated on the Notification of Project Commencement/Delay in Project Commencement Form.

3. If after 90 days adequate project funds have not been expended, OVS reserves the right to terminate the award. At this point, OVS staff will determine whether the delays are excessive or unwarranted. If appropriate, OVS may terminate the grant agreement and reallocate funds to other projects.
4. The grant may be terminated in whole or in part by the OVS at anytime that the OVS finds a substantial failure to comply with the provisions of regulations promulgated there under by the Department of Justice, or the District of Columbia, and /or the OVS, including grant award and grant agreement conditions, work plan and outlined goals and objectives or other activities projected in the grantee or sub-grantee's grant proposal /application.
5. A project which is prematurely terminated will be subject to the same requirements regarding audit, recordkeeping, and submission of reports as a project which runs for the duration of the project period.

L. GRANT ADMINISTRATOR

The Grant Administrator for this grant agreement will be **Bryan Criswell, 202-727-5047 / bryan.criswell@dc.gov**, Office of Victim Services, 1350 Pennsylvania Avenue, NW, Suite 407, Washington D.C. 20004.

M. AUTHORIZATION OF TERMS AND CONDITIONS OF GRANT

I understand and agree to all of the terms and conditions stated above.

Melissa Hook 9/24/2010
Director, Office of Victim Services Date

[Signature] 10/12/2010
Signature of Authorized Official Date

Printed Name and Title of Authorized Official from Grantee Organization

Signature of President of Board of Directors Date

Printed Name of President of Board of Directors from Grantee Organization

**MEMORANDUM OF UNDERSTANDING
BETWEEN
DEPARTMENT OF MENTAL HEALTH
AND
OFFICE OF VICTIM SERVICES**

I. INTRODUCTION

This Memorandum of Understanding ("MOU") is entered into between the District of Columbia Department of Mental Health, the buyer agency ("DMH") and Office of Victim Services, the seller agency ("OVS"), collectively referred to herein as the "Parties," on the date this agreement is executed by the Parties.

DMH has requested the services of OVS to provide training, coaching and consultation in Trauma-Focused Cognitive Behavioral Therapy.

II. PROGRAM GOALS AND OBJECTIVES

DMH has as its goal to use evidence-based practices that address the issues of the children and youth in the District of Columbia. One of those evidence-based practices is Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). The training and coaching model that the DMH would like to employ will involve:

- A.** Introductory and Advanced training in the TF-CBT Model;
- B.** Ongoing coaching and consultation to the trained clinicians and agencies for implementation and fidelity to the model;
- C.** A community-based learning collaborative; and
- D.** Access to a web-based learning site for TF-CBT.

III. SCOPE OF SERVICES

Pursuant to the applicable authorities and in the furtherance of the shared goals of the Parties to carry out the purposes of this MOU expeditiously and economically, the Parties do hereby agree:

A. RESPONSIBILITIES OF OVS

- 1. Provide for thirty-five (35) to forty (40) participants the activities identified in Attachment A, incorporated herein by reference, which shall include:
 - a. Introductory and advanced training in the TF-CBT model;

- b. Ongoing coaching and consultation to the trained clinicians and agencies for implementation and fidelity to the model;
- c. A community-based learning collaborative; and
- d. Access to a web-based learning site for TF-CBT.

B. RESPONSIBILITIES OF DMH

- 1. Identify individuals for participation in the TF-CBT model; and
- 2. Provide financial support to OVS to help bolster the training and coaching/consultation model.

IV. DURATION OF MOU

- A. The period of this MOU shall be from the date this MOU is executed by both Parties, through March 31, 2013, unless terminated in writing by the Parties prior to the expiration.
- B. The Parties may extend the term of this MOU by exercising a maximum of one (1) one-year option period. Option periods may consist of a year, a fraction thereof, or multiple successive fractions of a year. DMH shall provide notice of its intent to renew an option period prior to the expiration of the MOU.
- C. The exercise of an option period is subject to the availability of funds at the time of the exercise of the option.

V. AUTHORITY FOR MOU

D.C. Official Code § 1-301.01(k) and D.C. Official Code § 7-1131.04.

VI. FUNDING PROVISIONS

A. COST OF SERVICES

- 1. Total cost for services under this MOU shall not exceed one hundred and fifty thousand dollars (\$150,000.00). Funding for the services shall not exceed the actual cost of the goods or services. (Sec Attachment A).
- 2. The estimated cost of this MOU is based on the cost of providing training, consultation and coaching to thirty-five to forty participants from the DMH as outlined in Attachment A during the term of this MOU.

3. In the event of termination of the MOU, payment to OVS shall be held in abeyance until all required fiscal reconciliation, but not longer than September 30th of the current fiscal year.

B. PAYMENT

1. Upon execution of this MOU, DMH (buyer agency) agrees to transfer funds to OVS (seller agency) in the amount of \$150,000.00 via Intra-District transfer in payment for goods and services provided for in this MOU.
2. OVS shall submit quarterly reconciliations which shall explain the amounts billed for that period. The reconciliations shall include: (1) List of materials and their costs; (2) Labor costs including hourly rates for all laborers; and (3) reasonable overhead.
3. Advances to OVS for the services to be performed/goods to be provided shall not exceed the amount of this MOU.
4. OVS will receive the advance and bill DMH through the Intra-District process only for those goods or services actually provided pursuant to the terms of this MOU. OVS will return any excess advance to DMH by September 30 of the current fiscal year, unless the Parties agree to an extension of the advance through Fiscal Year 2012. If extended through 2012, the Parties may further extend the advance as necessary into Fiscal Year 2013.
5. The Parties' Directors or their designees shall resolve all adjustments and disputes arising from services performed under this MOU. In the event that the Parties are unable to resolve a financial issue, the matter shall be referred to the D.C. Office of Financial Operations and Systems.

C. ANTI-DEFICIENCY CONSIDERATIONS

The Parties acknowledge and agree that their respective obligations to fulfill financial obligations of any kind pursuant to any and all provisions of this MOU, or any subsequent agreement entered into by the parties pursuant to this MOU, are and shall remain subject to the provisions of (i) the federal Anti-Deficiency Act, 31 U.S.C. §§1341, 1342, 1349, 1351, (ii) the District of Columbia Anti-Deficiency Act, D.C. Official Code §§ 47-355.01-355.08 (2001), (iii) D.C. Official Code § 47-105 (2001), and (iv) D.C. Official Code § 1-204.46 (2006 Supp.), as the foregoing statutes may be amended from time to time, regardless of whether a particular obligation has been expressly so conditioned.

VII. COMPLIANCE AND MONITORING

As this MOU is funded by District of Columbia funds, the seller agency will be subject to scheduled and unscheduled monitoring reviews to ensure compliance with all applicable requirements.

VIII. RECORDS AND REPORTS

OVS shall maintain records and receipts for the expenditure of all funds provided for a period of no less than three years from the date of expiration or termination of the MOU and, upon request by DMH shall make these documents available for inspection by duly authorized representatives of DMH and other officials as may be specified by the District of Columbia at its sole discretion.

IX. CONFIDENTIAL INFORMATION

The Parties to this MOU will use, restrict, safeguard and dispose of all information related to services provided by this MOU, in accordance with all relevant federal and local statutes, regulations, policies. Information received by either Party in the performance of responsibilities associated with the performance of this MOU shall remain the property of the buyer agency.

X. TERMINATION

Either Party may terminate this MOU in whole or in part by giving thirty (30) calendar days advance written notice to the other Party.

XI. NOTICE

The following individuals are the contact points for each Party under this MOU:

Marie Morilus-Black
Director of Child and Youth Services Division
Office of Programs and Policies
DC Department of Mental Health
64 New York Avenue NE
Washington, DC 20002
Phone 202-673-4443
Fax 202- 673-2192

Melissa Hook
Director of Victims Services
John A. Wilson Building
1350 Pennsylvania Ave, NW, Ste 407
Washington, DC 20004
Phone 202-724-7216
Fax 202- 727-6332

XII. MODIFICATIONS

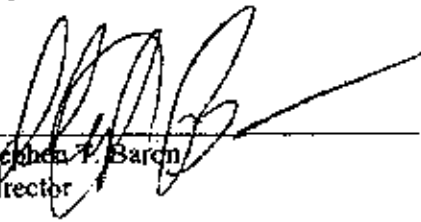
The terms and conditions of this MOU may be modified only upon prior written agreement by the Parties.

XIII. MISCELLANEOUS

The Parties shall comply with all applicable laws, rules and regulations whether now in force or hereafter enacted or promulgated.

IN WITNESS WHEREOF, the Parties hereto have executed this MOU as follows:

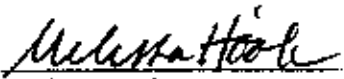
Department of Mental Health



Stephen T. Baren
Director

Date: 4/5/11

Executive Office of the Mayor



Melissa Hook
Director

Date: 4/11/2011

**Memorandum of Understanding
Between
The District of Columbia Public Schools
And
The District of Columbia Department of Mental Health**

1. **Introduction.**

This Memorandum of Understanding (“MOU”) is between the District of Columbia Department of Mental Health (DMH) and the District of Columbia Public Schools (DCPS). The purpose of this MOU is to provide for prevention, assessment and treatment services for DCPS students through a collaborative effort by both parties.

The shared vision of DMH and DCPS is to provide a supportive school environment in which all children are emotionally and socially prepared, ready to learn, and able to progress toward their next educational experience.

The shared mission of DMH and DCPS is to create a child and family-centered school mental health program which includes prevention, early intervention and treatment in collaboration with community-based child and family serving organizations.

The DMH provides mental health services and supports on behalf of DCPS to DCPS students. Currently, the DMH operates in 48 DCPS schools. DMH clinicians are located on-site to provide consultation, treatment and linkages to additional services. In order to ensure thorough consultations and referrals, DMH clinicians and school-based mental health professionals often need to exchange information about students to ensure appropriate services are provided.

2. **Overview, Program Goals and Objectives.**

DCPS collaborates with DMH in the implementation of a comprehensive system of mental health care for DCPS students and their families.

The DCPS goal is to provide a continuum of integrated, high quality, and effective services and programs delivered by educators, school-based and community mental health professionals that include evidence-based practices and data-driven decision making.

DCPS’ collaboration with DMH will:

- Create a safe and engaging learning environment for DCPS students;
- Provide social, emotional, and behavioral support for students;

- Provide mental health services to DCPS students that remove barriers to learning;
- Enhance student learning; and
- Engage students and families at all levels of service delivery.

DMH provides a broad spectrum of mental health services inclusive of primary prevention, early intervention, assessment and treatment services to enhance the behavioral, emotional and social skills of children and adolescents. The DMH goal is to provide a broad spectrum of mental health services that are community-based, child-centered and family-focused, and culturally and linguistically competent.

DMH guiding principles and goals specify that services should be:

- Comprehensive, incorporating a broad array of services and supports;
- Individualized;
- Provided in the least restrictive, appropriate setting;
- Coordinated both at the system and service delivery levels;
- Involve families and children as full partners; and
- Emphasize early identification and intervention.

3. Services

DMH and DCPS have an overall goal of improving student learning through the collaboration of the student, parent, educators and mental health professionals.

The Parties agree to work collaboratively to:

- Provide a safe, nurturing, student-centered, family friendly environment and a comprehensive multi-dimensional educational program;
- To provide intensive therapeutic treatment in an academic and home environment in order to help students develop new skills that allow them to achieve success in the school environment;
- To offer students an opportunity to achieve their full potential to successfully manage their life experiences and to be productive members of society;
- Utilize Evidence-Based Interventions; and
- Integrate care through a team-based approach to service/support planning and delivery that includes a partnership with the youth and family, all child-serving systems, and the family's natural support network.

4. Obligations and Responsibilities of DMH

- a. Ensure (and include a provision in its agreement with contract agencies ensuring) that all clinicians placed in DCPS schools submit to all background checks required by DCPS, including a criminal background check as required by the Criminal Background Checks for the Protection

of Children Act of 2004 (D.C. Code § 4-1501.01, et seq. (2009)) and rules promulgated thereunder. Such background check may be conducted by DMH, provided DMH provide DCPS with the results of any background check it conducts pursuant to this MOU. DMH shall also ensure that any clinicians who have not submitted to a background check be restricted from serving in positions affording such individuals access to DCPS students participating in this program. DMH must also submit to DCPS annual verification of a negative tuberculosis screening for each clinician.

- b. DMH will place one clinician at each participating school to assist in the school mental health program implementation.
 - i. The clinician will provide prevention, early intervention, and treatment and/or assessment services to children and adolescents enrolled in the school as appropriate.
 - ii. The clinician will also provide consultation, training, and support to teachers, administrators, and other school staff
 - iii. The clinician will also provide outreach to parents through the provision of parent workshops, family therapy and home visits as needed.
- c. DMH will work in accordance with the DMH Team Formation and Team Functioning Practice Guidelines Protocol for Children and Youth in order to ensure that all children/youth enrolled in the public mental health system receive coordinated services/supports that reflect the family's engagement and participation of all parties involved in the youth/family's life.
- d. DMH shall immediately notify the school principal and the DCPS Office of Youth Engagement whenever there are any allegations of misconduct made against DCPS staff and provide supporting documentation as soon as it is available.
- e. DMH shall provide comprehensive mental health services to students and their families enrolled in participating DCPS schools. DMH will seek reimbursement from applicable health insurance providers for treatment services provided to those students with diagnosable mental health disorders.
- f. Students within Full Service Schools (FSS) who have behavioral support services as part of an IEP will have the option to be served by DMH clinicians, pending caseload capacity and case review by DMH and DCPS program managers.
- g. Students attending participating schools and receiving special education services that do not include behavioral support services may receive individual or group counseling services by the DMH clinician assigned to their school.

- h. DMH will provide the curriculum, supplies and training necessary to implement the prevention, early intervention and treatment services needed to meet the individual mental health needs of the students served in each of the participating schools. Clinical supervision will be provided to DMH clinicians.
- i. Although not a school employee, the DMH clinician is expected to work closely with the school staff to share non-confidential and confidential information only as permitted by the Mental Health Information Act, D.C. Code Section 7-1201.01. DMH will maintain separate clinical records for each student served by the DMH clinician. Compliance with a request to share any other information related to a student's treatment will require an appropriate release by the student's legal guardian or by the student if the student is 18 or older. DMH agrees to share information with DCPS to the extent permitted by law, subject to the requirements and limitations set forth in section 7 below.
- j. DMH will provide monthly summary reports of aggregate mental health data to each participating school's principal indicating students in receipt of mental health referrals, names of students receiving services to the extent permitted by law, types of therapeutic group counseling and a total number of clients served. In FSS, caseload information for students served by the mental health clinicians, including DMH clinicians, must be kept and shared in the DCPS FSS Quickbase Services Tracker. Information will include student name, number of individual student contacts, and number of parent contacts made with the student. This information sharing will be subject to the requirements and limitations set forth in section 7 below.
- k. DMH clinicians may visit students' homes as necessary and without obtaining permission from the school. DMH clinicians assigned to a particular school may be deployed to another school for several days to provide school-based crisis services.
- l. Although functioning in a school setting, the clinician is governed by the DMH policies and procedures. DMH clinicians will be compensated and supervised by DMH, but under the direct control of DCPS regarding direct access to personally identifiable information in education records.

5. **Obligations and Responsibilities of DCPS**

- a. Upon request and subject to the limitations/requirements set forth in Section 7 of this MOU, DCPS will provide DMH clinicians the following personally identifiable information from the education records of a student who has consulted with the DMH clinician: (a) Student ID, (b) attendance records, (c) student behavior tracker data, and (d) grades.
- b. Subject to obtaining any use agreements which may be required by the Office of Public Education Facilities Modernization, DCPS will provide DMH clinicians with private locked office spaces with resources available in existing DCPS inventory, including desks, chairs, locking file cabinets to maintain confidential records, computers and access to printers,

internet access, and dedicated phone lines prior to, or immediately after, placement of a clinician in a school.

- c. DCPS shall immediately notify DMH whenever there are any allegations of misconduct made against DMH clinicians and provide supporting documentation as soon as it is available.
- d. All participating schools are expected to hold ongoing Student Support Team (SST) meetings. School mental health program (SMHP) clinicians are to be included as members of the SST and full participants of these meetings wherever possible, subject to the requirements and limitations set forth in section 7 below. SMHP staff will assist in the design and implementation of appropriate interventions developed by the SST. In FSS, DMH clinicians will operate as part of the FSS Leadership Team.
- e. DCPS will provide a contact person to work with DMH who is responsible for assisting with problem-solving and communication in order to facilitate effective implementation of the SMHP at DCPS sites. This person will be identified by DCPS Central Office and the person's name and contact information will be provided to DMH and DCPS school staff.
- f. DCPS will communicate to DMH's designee the roles of and expectations for DMH clinicians, DCPS social workers and psychologists, DCPS teachers, DCPS school counselors, and DCPS school administrators in the service of effective collaboration that utilizes the scope and the expertise of each professional.

6. Mutual Obligations of DMH and DCPS.

- a. DCPS and DMH will jointly review and identify schools annually for the SMHP based upon utilization patterns from the previous school year, current need, availability of existing mental health resources and readiness for the program.
- b. DMH and DCPS will collaborate to serve and support youth/families from a team-based approach
- c. DMH and DCPS agree to work collaboratively and continually to design and develop a comprehensive program that will reflect a strong therapeutic and educational program designed to address the needs of all students at participating schools. Both parties will work collaboratively to promote growth in the emotional, behavioral and academic areas.
- d. DCPS and DMH will identify and implement standard quality indicators and benchmarks for measuring student progress and overall program progress in achieving the goals set forth in this MOU.

7. **Data Sharing and Confidentiality**

- a. DCPS and DMH agree to maintain confidential all personally identifiable information contained in student educational records (as defined in 34 C.F.R. § 99.3), and all personally identifiable student mental health information (“Confidential Information”).
- b. In instances where a student is receiving services under the Minor Consent Law (DCMR 600.7), DMH must have the student’s written consent to receive those services. However, parental consent must still be sought when sharing personally identifiable information from student records if such student is under 18 years of age.
- c. Confidential information will be shared only with DCPS or DMH personnel who need access to the information to fulfill their professional responsibilities, and only with consent, as follows:
 - i. DCPS will seek consent annually from the parent/guardian, or student if 18 years or older, to share personally identifiable information from student education records (including student health records maintained by the school nurse) with DMH clinicians. Consent will be in a form conforming to the requirements of 34 C.F.R. § 99.30(b).
 - ii. DCPS will obtain parental consent (for a student less than 18 years old) before sharing student mental health data (maintained by DCPS school mental health providers) with DMH clinicians, Head Start Family Service workers, or other personnel not employed by DCPS who need access to student mental health data to do their jobs. Consent will be in a form conforming to the requirements of 34 C.F.R. § 99.30(b).
 - iii. DMH will obtain parental consent (for a student less than 18 years old if parents consented to treatment) and student consent (for a student 14 years or older) before sharing student mental health data with School Officials, DCPS staff, Head Start Family Service workers, or other personnel who need access to student mental health data to fulfill their professional responsibilities. Consent will be in a form conforming to the requirements of DC Code § 7-1202.02.
- d. The consents described in c(i-iii) of this section shall specifically provide for sharing of the following student information:
 - i. DCPS will request authorization to share (a) student name, (b) student ID number, (c) attendance records, (d) student behavior tracker data, and (e) grades from the educational records of a student that has consulted with DMH.
 - ii. DMH will request authorization to share (a) student name, (b) type of treatment, and (c) progress in treatment.
- e. The use of personally identifiable student information shall be limited as follows:

- i. DCPS and its agents and employees agree to use student mental health information provided by DMH employees exclusively for the purposes specified in this MOU, and in accordance with all applicable District and Federal laws and regulations, and as specifically consented to by a parent/guardian (if the student is under 18) and student (if 14 years or older).
 - ii. DMH and its agents and employees agree to use educational record information received from DCPS exclusively for the purposes specified in this MOU, and in accordance with all applicable District and Federal laws and regulations, and as specifically consented to by a parent/guardian or student if 18 years or older.
 - iii. DCPS, DMH, and their respective agents and employees will obtain written consent from a parent/guardian (and student if 14 years or older for mental health information) or student if 18 years or older before disclosing information specified in i-ii of this section to a third party, even in furtherance of a previously consented to purpose, except as permitted by law.
 - iv. Agents and employees of DCPS and DMH shall have access to and may use Confidential Information only to the extent necessary to do their jobs.
- f. Any student mental health data obtained from DMH will be kept confidential per the DC Mental Health Information Act of 2001, and will not be released to any third parties, except as required by law or with the written consent of the student's custodial parent or guardian if such parent or guardian gave informed consent for treatment and the student if 14 years or older.
- g. All parties will ensure secure data transfers in accordance with applicable law when sharing data.
- h. DCPS and DMH will comply with the students' mental health and personally identifiable information (PII) confidentiality requirements of the Family Educational Rights and Privacy Act (FERPA) approved 20 U.S.C. § 1232g, and the regulations promulgated under FERPA, including 34 CFR Part 99; the Health Insurance Portability and Accountability Act (HIPAA) approved 42 U.S.C. § 1320d *et seq.*, and the regulations promulgated under HIPAA, including 45 CFR Part 164; and the District of Columbia Mental Health Information Act of 1978, effective March 3, 1979 (D.C. Law 2-136; D.C. Official Code § 7-1201.01 *et seq.*).

8. **Privacy Compliance.**

DMH and DCPS shall, at various times during the term of this MOU, each act as a "covered entity" and as each other's "business associate," as those terms are defined in 45 CFR 160.103.

9. **Termination.**

Either Party may terminate this MOU by providing the other party 30 days notice.

10. **Notices.**

Any notice required pursuant to this MOU shall be in writing and shall be deemed to have been delivered and given for all purposes (a) on the delivery date if delivered by confirmed facsimile or delivered personally to the Party to whom the notice is addressed; (b) one (1) business day after deposit with a commercial overnight carrier with written verification of receipt; or (c) five (5) business days after the mailing date, whether or not actually received, if sent by US Mail, return receipt requested, postage and charges prepaid or any other means of rapid mail delivery for which a receipt is available.

The following individuals are the contact points for each Party under this MOU:

Barbara Parks
Clinical Program Administrator, Prevention & Early Intervention Programs
Department of Mental Health
202-698-1871

Diana Bruce
Director of Health and Wellness
District of Columbia Public Schools
202-442-5103

11. **Term.**

This agreement shall be for a period of five years beginning upon execution and ending September 30, 2015, unless terminated in writing by the Parties prior to the expiration.

12. **Entire Agreement.**

This MOU contains the entire understanding of the Parties with respect to the matters contained herein, and supersedes any and all other agreements between the parties relating to the matters contained herein. No oral or written statements not specifically incorporated or referenced herein shall be of any force or effect.

13. **Modifications.**

This MOU may only be amended by a written instrument signed by both Parties.

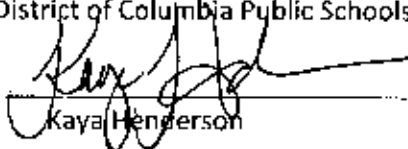
14. **Headings; Counterparts.**

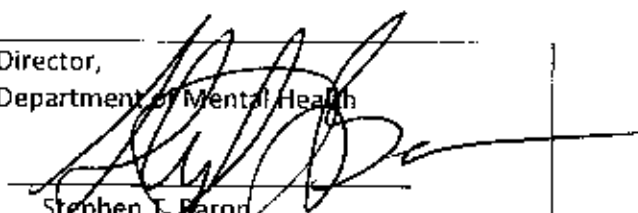
The headings in this MOU are for purposes of reference only and shall not limit or define the meaning of any provision hereof. This MOU may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same document.

15. **Authority of the Parties.**

By executing this MOU, each Party represents to the other party that it is authorized to enter into this MOU, that the person signing on its behalf is duly authorized to execute this MOU and that no other signatures are necessary.

IN WITNESS WHEREOF, the undersigned hereby execute this MOU on behalf of their respective organizations as of the Effective Date.

Chancellor, District of Columbia Public Schools  Kaya Henderson Date: 12/22/10

Director, Department of Mental Health  Stephen T. Baron Date: 12/22/10
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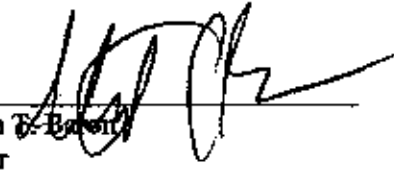
**EXTENSION NUMBER ONE EXERCISING FIRST OPTION TO RENEW
MEMORANDUM OF UNDERSTANDING
FOR INTRA-DISTRICT FUNDING
BETWEEN
THE OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
AND
THE DEPARTMENT OF MENTAL HEALTH**

The Parties hereto hereby exercise the first option to renew the Memorandum of Understanding executed October 19, 2009 for intra-District funding between the District of Columbia Office of the State Superintendent of Education ("OSSE") and District of Columbia Department of Mental Health ("DMH"), to fund the Full Service Schools wrap pilot project through a care management entity, as follows:

1. The MOU is hereby renewed for a period of one year from October 1, 2010 through September 30, 2011.
2. OSSE shall transfer the amount of \$1,375,284 (one million three hundred seventy-five thousand two hundred eighty-four dollars), the same amount as transferred in FY2010 under the original MOU, to DMH in one intra-District advance as of October 1, 2010.
3. The funding levels, the scope of services, the number of schools to be served, the number of wrap-around slots, reporting requirements, the respective responsibilities of the parties, and all other terms and conditions of the MOU entered on October 19, 2009 shall remain in full force and effect.

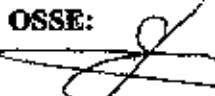
IN WITNESS WHEREOF, the undersigned hereby execute this Extension Number One to the MOU between DMH and OSSE on behalf of their respective organizations, effective as of the date this agreement is signed by all parties:

DMH:


Stephen E. Barton
Director

Date: 8/20/10

OSSE:


Kerri Briggs Bath H. Collyer
State Superintendent for Education

Date 9/24/10

in facsim

**MEMORANDUM OF UNDERSTANDING
FOR INTRA-DISTRICT FUNDING
BETWEEN THE DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION
AND
DEPARTMENT OF MENTAL HEALTH
FOR FISCAL YEAR 2010**

I. INTRODUCTION

This Memorandum of Understanding ("MOU") is entered into between the Office of the State Superintendent for Education ("OSSE"), the Buyer agency, and the Department of Mental Health ("DMH"), the Seller agency, collectively referred to herein as the "Parties".

PROGRAM GOALS AND OBJECTIVES

The purpose of this MOU is to fund a pilot project that provides wraparound services for 110 students attending the Full Service Schools ("FSS") pilot project through a care management entity ("CME") with which DMH has entered into a contract ("Contractor").

The funding for the FSS pilot project includes staff salaries, training, flex funds and other program-related costs. The FSS pilot is one of a series of initiatives to be implemented in response to an agreement reached through the Blackman/Jones Alternative Dispute Process.

This MOU establishes funding for the total expected costs for contracting with the CME for the period of October 1, 2009 through September 30, 2010. CME performance oversight shall be regarded as an agency shared responsibility. This shared responsibility shall be accomplished through the Wraparound Implementation Work Group, which consists of designated liaisons of DMH, OSSE, and District of Columbia Public Schools ("DCPS"), as well as designees of other D.C. child serving agencies.

II. SCOPE OF SERVICES

Pursuant to the applicable authorities and in furtherance of the shared goals of the Parties to carry out the purposes of this MOU expeditiously and economically, the Parties do hereby agree:

A. RESPONSIBILITIES OF THE OSSE

1. The OSSE shall:

- a. Transfer funding in the amount of \$1,375,284 (one million three hundred seventy five thousand two hundred eighty four dollars) to DMH to cover services related to the FSS pilot initiative in one (1) Intra-District advance, in the following manner:
 - i. Transfer funding in the amount of \$1,375,284 (one million three hundred seventy five thousand two hundred eighty four dollars) to DMH as of October 1, 2009.
- b. Name a senior manager to serve as the agency designee to the Wraparound Implementation Work Group, which shall:
 - i. Engage in the oversight and management of the contract (which includes regular attendance at work groups, participation in planning sessions, responding to data requests, preparation of reports and evaluation of and comments on materials); and
 - ii. Develop a funding strategy for full-scale implementation of the Wraparound process;
- c. Assign the State Superintendent or her designee to participate in the Wraparound Steering Committee, which is responsible for oversight and management of the contract, policy and resource-related decisions.
- d. Support DMH in facilitating implementation of the services related to the FSS pilot.

B. RESPONSIBILITIES OF DMH

1. DMH shall:
 - a. Ensure that the Contractor hires and trains staff as outlined in the FSS-pilot budget.
 - b. Ensure that the FSS Wrap-Care Coordinators are hired and trained.
 - c. Ensure that one FSS Wrap-Care Coordinator is placed in each of the eleven (11) DCPS middle schools participating in the pilot.
 - d. Ensure that the Contractor fulfills reporting obligations set forth in this MOU.

- e. Support and ensure that the students selected for the Wrap-Care Coordinators case-loads are determined at the local school level by the school administrators and staff consistent with the high fidelity Wraparound model which will be implemented in eleven (11) DCPS middle schools.
- f. Allocate 110 wrap-slots and associated Flex Funds of one hundred sixty five thousand dollars (\$165,000.00) for students who attend the 11 middle schools participating in the FSS pilot.
- g. Serve as the lead agency for the contract with the Contractor and shall exercise full responsibility for managing the procurement with the Blackman/Jones procurement exemption¹ and shall serve as the lead agency with respect to contract management;
- h. Ensure that the MOU funds are used for the expenses incurred under the CME contract, as it may be renewed, modified or extended.
- i. Ensure that the vendor will participate in monthly meetings, provide reports on progress of the Care Coordinators; and participate in an independent evaluation of the FSS pilot project.
- j. Facilitate and coordinate activities of the Wraparound Implementation Work Group. The Work Group, shall:
 - i. Engage in the oversight and management of the Contract (which includes regular attendance at work groups, participation in planning sessions, responding to data requests, preparation of reports and evaluation of and comments on materials); and
 - ii. Extend an invitation to DCPS to join the Wraparound Implementation Work Group; and
 - iii. Develop a funding strategy for full-scale implementation of the wraparound process.

III. DURATION OF MOU

¹ Pursuant to the requirements of a consent decree entered August 24, 2006, in *Blackman, et al., v. District of Columbia, et al.*, Civil Action No. 97-1629 (PLF), consolidated with *Jones, et al. v. District of Columbia*, Civil Action No. 97-2402 (PLF) (D.D.C.) "Consent Decree". Paragraph 139 of the Consent Decree provides that: "Under this Consent Decree, the Defendants are not bound by the D.C. Procurement Practices Act, D.C. Code §2-301.01 et seq., and other District or federal law relating to procurement, and any regulations there under."

- A. The period of this MOU shall be as of October 1, 2009 through September 30, 2010, unless terminated in writing by the Parties prior to the expiration.
- B. The OSSE may extend the term of this MOU by exercising a maximum of three (3) one-year option periods. Option periods may consist of a year, a fraction thereof, or multiple successive fractions of a year. The OSSE shall provide notice of its intent to renew an option period prior to the expiration of the MOU.
- C. The exercise of an option period is subject to the availability of funds at the time of the exercise of the option.

IV. AUTHORITY FOR MOU

- A. The authority for this MOU is D.C. Official Code § 1-301.01 [(k)] and any other authority under the Parties' programs.
- B. DMH is the agency within the Government of the District of Columbia responsible for developing a system of care for persons with mental illness, including children, youth and their families. DMH operates in accordance with the requirements of the Mental Health Establishment Amendment Act of 2001, D.C. Official Code § 7-1131, (the "Act") which is required to be construed in a manner consistent with all outstanding orders of the United States District Court in *Dixon, et al. v. Fenty, et al.*, including the Final Plan adopted by the District Court in its April 2, 2001 order (the "Dixon Plan"). DMH is authorized to enter into this MOA pursuant to D.C. Official Code §§ 1-301.01(k), and 7-1131.04.
- C. The OSSE is the agency within the Government of the District of Columbia responsible for all state-level functions of the District's public education system. The OSSE sets academic standards, provides resources, and holds local education agencies accountable for providing all students with a free appropriate public education.
- D. The OSSE was established and operates in accordance with the requirements of the *Public Education Reform Amendment Act of 2007* (D.C. Law 17-9) D.C. Official Code § 38-2602 et seq., which consolidated state-level education functions into one agency, the Office of the State Superintendent of Education (OSSE).
- E. Under this legislation, the OSSE also assumed responsibility for compliance with all outstanding orders and judicial decrees as they pertain to state-level educational functions, including the Blackman/Jones Consent Decree. Additional responsibilities ensued when the District reached a non-binding agreement with the Blackman/Jones class counsel on December 10, 2007. This agreement is referred to as the "Alternative Dispute Resolution Agreement of the Parties to Blackman/Jones case" ("ADR Agreement").

V. FUNDING PROVISIONS

A. COST OF SERVICES

1. Total cost for services under this MOU shall not exceed \$1,375,284 (one million three hundred seventy five thousand two hundred eighty four dollars) for Fiscal Year 2010 activities.
2. This amount will fund the costs of the services described in the FSS CME Wraparound Services Contract between DMH and D.C. Choices, Inc. (RM-09-SAS-052-BY)-VM) through February 24, 2010, which DMH plans to modify to serve 110 students through the FSS pilot, and any subsequent contract or contracts entered into between DMH and a CME for the FSS pilot wraparound services described in this MOU.
3. In the event of termination of the MOU, payment to DMH shall be held in abeyance until all required fiscal reconciliation has been completed, but not longer than September 30, 2010.

B. PAYMENT

1. Payment for all of the goods and services shall be made through one Intra-District advance by the OSSE to DMH based on the total amount of this MOU. The one Intra-District advance shall be made in the following amount: \$1,375,284.00 (one million three hundred seventy-five thousand two hundred eighty four dollars) for Fiscal Year 2010.
2. Pursuant to the Financial Review process ("FRP") mandated by the Office of the Chief Financial Officer of the District of Columbia, all services provided through Intra-District funding shall be reported in the Buyer Agency's FRP submission to the Office of Budget and Planning.
3. Advances to DMH for the services to be performed/goods to be provided shall not exceed the amount of this MOU.
4. DMH will use funds transferred through the Intra-District advance only for those goods or services actually provided pursuant to the terms of this MOU. DMH will return any excess or unspent funds to the OSSE by September 30 of each fiscal year this Agreement is in effect.

5. The Parties' Directors or their designees shall resolve all adjustments and disputes arising from services performed under this MOU. In the event that the Parties are unable to resolve a financial issue, the matter shall be referred to the D.C. Office of Financial Operations and Systems.

VI. ANTI-DEFICIENCY CONSIDERATIONS

The Parties acknowledge and agree that their respective obligations to fulfill financial obligations of any kind pursuant to any and all provisions of this MOU, or any subsequent agreement entered into by the parties pursuant to this MOU, are and shall remain subject to the provisions of (i) the federal Anti-Deficiency Act, 31 U.S.C. §§1341, 1342, 1349, 1351, (ii) the District of Columbia Anti-Deficiency Act, D.C. Official Code §§ 47-355.01-355.08 (2001), (iii) D.C. Official Code § 47-105 (2001), and (iv) D.C. Official Code § 1-204.46 (2006 Supp.), as the foregoing statutes may be amended from time to time, regardless of whether a particular obligation has been expressly so conditioned.

VII. COMPLIANCE AND MONITORING

As this MOU is funded by District of Columbia funds, the seller agency will be subject to scheduled and unscheduled monitoring reviews to ensure compliance with all applicable requirements.

VIII. RECORDS AND REPORTS

A. DMH shall submit to the OSSE a copy of the monthly payments made by DMH to Choices, which will identify the number of children receiving services from the CME at the cost identified in the contract between DMH and D.C. Choices, Inc. as described in Section VI(1)(2) above. In addition, DMH shall require the Contractor to submit a monthly report to the OSSE, explicitly, that contains the following information:

1. Operational details, including: number of service providers hired, number of students served and caseloads, progress towards goals, number of face-to-face contacts with families, number of Due Process complaints filed by families on service provider caseloads and number of Hearing Officer Decisions issued in respect of students on service provider caseloads.
2. Strengths and weaknesses observed within the District's school system, particularly within the special education system. Non-exhaustive examples of topics for such reports include: rates of, and reasons for, placement in nonpublic schools; barriers to implementation of SST, IEPs and HODs/SAs; along with vulnerabilities in the network of related services.

3. Use of flex funds (refers to funds associated with the DMH MOU) used within the reporting period, including an accounting of all monies disbursed.
 4. Number of students referred and connected to community-based services.
 5. Services sought for Medicaid reimbursement and subsequent collection.
 6. Any other aspects of the program deemed pertinent by the parties.
- B. The Seller agency shall maintain records and receipts for the expenditure of all funds provided for a period of no less than three years from the date of expiration or termination of the MOU and, upon the District of Columbia's request, make these documents available for inspection by duly authorized representatives of the buyer agency and other officials as may be specified by the District of Columbia at its sole discretion.
- C. The Seller shall report monthly in writing about the status of the program objectives, progress against goals and outcomes. The Seller shall also report verbally when requested and continuously inform the coordinating committee established by the Seller to provide communication, coordination and recommendations for this program.

IX. CONFIDENTIAL INFORMATION

The Parties to this MOU will use, restrict, safeguard and dispose of all information related to the services provided by this MOU, in accordance with all relevant federal and local statutes, regulations and policies including HIPAA and the D.C. Mental Health Information Act.

X. TERMINATION

Either Party may terminate this MOU in whole or in part by giving ninety (90) calendar days advance written notice to the other Party.

XI. NOTICE

The following individuals are the contact points for each Party under this MOU:

Contact person for DMH:

Barbara J. Bazron, Ph.D.
Deputy Director, Office of Programs & Policy
Department of Mental Health
ATTN: Laurie Ellington
64 New York Avenue, NE, 4th Floor

Washington, DC 20001
Phone 202-673-4443
Fax 202- 671-3191

e-mail address: Barbara.Bazron@dc.gov and Laurie.Ellington@dc.gov

Contact person for the OSSE:

Tamera Lewis
Acting Assistant Superintendent of Special Education
Office of the State Superintendent for Education
ATTN: Charity Hallman
51 N Street, 7th Floor, NE
Washington, DC 20002
Phone 202-741-0478

e-mail addresses: tamera.lewis@dc.gov and charity.hallman@dc.gov

XII. MODIFICATIONS

The terms and conditions of this MOU may be modified only upon prior written agreement by the Parties.

XIII. MISCELLANEOUS

The Parties shall comply with all applicable laws, rules and regulations whether now in force or hereafter enacted or promulgated.

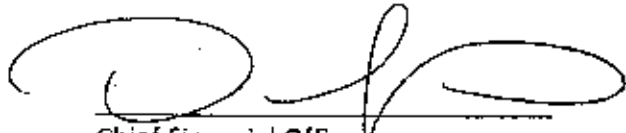
A. APPLICABLE LAWS

The Parties shall comply with all applicable laws, rules and regulations whether now in force or hereafter enacted or promulgated.

B. NO RIGHTS CREATED

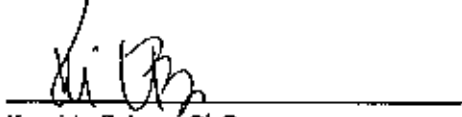
This MOU shall not be construed to create any rights, substantive or procedural, enforceable at law by any person in any matter, administrative, civil or criminal.

IN WITNESS WHEREOF, the Parties hereto have executed this MOU as follows:



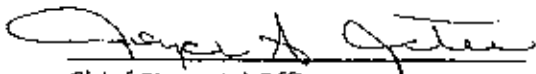
Chief Financial Officer
Office of the State Superintendent of Education

Date: 15 October 2009



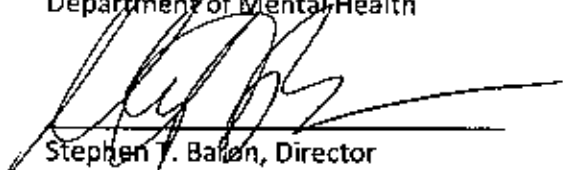
Kerri L. Briggs, PhD.
State Superintendent,
Office of the State Superintendent of Education

Date: 10/13/09



Chief Financial Officer
Department of Mental Health

Date: 10/15/09



Stephen T. Balon, Director
Department of Mental Health

Date: 10/19/09

IV: Narrative Plan

O. State Behavioral Health Advisory Council

Page 49 of the Application Guidance

Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

DMH in consultation with the District Office of Boards and Commissions has revised the 1988 Mayoral Order establishing the planning council. The process of revising the Mayoral Order began in 2010, prior to the change in administration and the issuance of the instructions from SAMHSA regarding establishing a behavioral health advisory council. DMH elected to proceed with updating the Mayoral Order establishing the State Mental Health Planning Council, rather than stopping the process, because the existing order is very old and needed to be updated to reflect the current organizational structure in the District and for use in membership recruiting. As DMH begins to engage in more extensive planning with APRA about behavioral health, we will explore the expanding the State Mental Health Planning Council to include substance abuse and substance use disorders.

The revised order is currently pending signature by the Mayor. After the revised order is issued, DMH will work with the Mayor's Office of Board and Commissions to recruit new members so that all vacancies are filled.

A copy of a letter from the State Mental Health Planning Council chairman commenting on the District's FY 2012 Mental Health Block Grant application is attached and marked as Attachment O-1.

**DISTRICT OF COLUMBIA
STATE MENTAL HEALTH PLANNING COUNCIL**



August 30, 2011

Virginia Simmons
Grants Management Officer
Division of Grants Management
OFR/SAMHSA
1 Choke Cherry Road-Rm. 7-1109
Rockville, MD 20857

Dear Ms. Simmons:

I am submitting this letter on behalf of the District of Columbia State Mental Health Planning Council (D.C.SMHPC) to convey our views about the District of Columbia FY 2012-2013 Mental Health Services Block Grant Application.

D.C. SMHPC View of Department of Mental Health Initiatives, Programs, and Services

Our Council's fundamental belief about the Department of Mental Health (DMH) initiatives, programs and services in general, and those specifically funded by the Mental Health Block Grant, is that they should: 1) directly benefit children and youth with serious emotional disturbances (SED) and their families, and adults with serious mental illness (SMI); 2) are innovative including use of evidence-based, best and/or promising practices; 3) identify measurable results; 4) describe consumer outcomes; and 5) are monitored and evaluated. It is this belief that guides our Council's deliberations and activities, participation in DMH and other planning initiatives, and our review and critique of the District's Mental Health Plan.

Status of Concerns in the FY 2011 Mental Health Block Grant

The Council pointed out several issues related to the FY 2011 Mental Health Block Grant.

- **Transition Age Youth:** DMH received FY 2011 Mental Health Block Grant funds for continued implementation of the development phase of this initiative that was also funded in FY 2010. It remains unclear how this initiative will become fully integrated into the service delivery system. Since the FY 2012- FY 2013 Block Grant Application is silent on this issue, our Council recommends that it should be addressed during FY 2012.
- **Older Adults:** There appears to have been no activities during FY 2011 that would move DMH closer to articulating a service strategy for older adults. Our Council would like to

reiterate the questions that were raised over the past two (2) years that might be helpful to this process: What is currently known about older adults? How many are in the system? Where are they in the system? What unique service needs do they represent? What services do they receive? What is the relationship between the services they need and those they receive? What public and private community resources are available to assist DMH to address their service needs? What partnerships can DMH form related to available resources for these populations? How do other states address the service needs of this population? What resources will be identified to implement any planned service strategies for this population?

A small amount of funds were set-aside in the FY 2011 Mental Health Block Grant to begin the process of developing an Older Adult Initiative. Our Council expressed an interest in helping DMH to move this process forward; however neither party took the initiative during FY 2011. Since the FY 2012- FY 2013 Block Grant Application is silent on this issue, our Council recommends that it should be addressed during FY 2012.

System Re-Design: In our Council's letter regarding the FY 2011 Mental Health Block, we recommended that: 1) transition age youth and older adults be identified among priority populations that are addressed in the System Redesign Plan, and 2) that a public review and comment period be built into the process before the System Redesign Plan is finalized. With regard to the first issue, as previously noted during FY2012 the Planning Council would like to know the specific plans, services, and outcomes related to these populations. With regard to the second issue, our Council would like to know the results of this planning process including what initiatives have been and/or are being implemented.

Comments About the FY 2012 – FY2013 Mental Health Block Grant

Description of Substance Abuse and Mental Health Services Administration (SAMHSA) Mandatory Reporting Requirements Using the Eight (8) Strategic Initiatives

The D.C. SMHPC believes that the DMH description of Criterion 1, Comprehensive Community-Based Mental Health Service Systems, using the SAMHSA Eight (8) Strategic Initiatives was both interesting and informative. It provided a national context by which our Council could see how the District' mental health system's initiatives, programs, and services address these issues. We are pleased by the large array of different services that DMH is able to offer to the public.

Our Council believes that expanding services to our criminal justice system, as well as court service agencies is a very aggressive approach to reducing crime and preventing inappropriate placement of mental health consumers in jails and correctional facilities. Also, the expansion of mental health services to our schools to help reduce the risk of emotional and traumatic experiences through early screening and diagnostic assessments; and counseling to parents, teachers, children and youth is exceptional and outstanding.

There are a number of other noteworthy DMH sponsored and/or supported initiatives that address the child and adult systems of care. These include but are not limited to the following: 1) the early identification and intervention projects (Healthy Start, Parent Infant Early Childhood Enhancement Program, Early Childhood Mental Health Consultation Project-Healthy Futures, and Primary Project); 2) the Juvenile Behavioral Diversion Project; 3) the Youth Suicide Prevention Project (Citywide Approach to Reduce Risk for and Eliminate Youth Suicide-Capital CARES); and 4) the Mobile Crisis Services Homicide Survivor Response Project in collaboration with the Office of Victim Services and the D.C. Metropolitan Police Department.

The Planning Council also commends DMH and the Office of Consumer and Family Affairs for supporting consumer initiatives. These include: 1) funding consumer-run organizations to provide advocacy, obtain consumer feedback, provide training and outreach to consumers, and to operate a self-help center; 2) employing Peer Transition Specialists who assist persons leaving the hospital with community reintegration; 3) implementing the Peer Specialist Certification Training program; and 4) convening the annual Olmstead Conference held in collaboration with the D.C. Office of Disability Rights (second and third annual conferences focused on social inclusion).

There were some areas where our Council would like more clarity about the approach and/or practices that are being implemented. For example, with regard to the section on reduction in hospital utilization a number of initiatives/activities are cited. It is not clear what underlying philosophy and/or best practice is being implemented to achieve a specific outcome (e.g., care transition model).

Another issue was being able to discern specifically what DMH and/or other agencies are doing related to a specific issue. For example, with regard to Health Information Technology DHCF and DMH need to move to adopt an affordable and good governance electronic health record (EHR) that will allow the District to better control costs and effectively deliver a higher quality of service. This would facilitate moving to a health information exchange (HIE) process that allows monitoring, the exchange of patient information, and better coordination of care for behavior health and primary health consumers.

Also, our Planning Council views the recommendations that resulted from the evaluation of the D.C. Regional Health Information Organization (RHIO), D.C. Primary Care Association (DCPCA), as important and critical to developing and sustaining this entity. The Planning Council believes they should be implemented.

Description of Behavioral Health Assessment and Plan

Behavioral Health Planning, Training and Service Initiatives- Our Council is pleased to see that there are a number of DMH behavioral health related initiatives including some collaboration with the Addiction Prevention Recovery Administration (APRA). This includes: 1) the acknowledgment of the D.C. SMHPC collaboration with APRA regarding the review of substance use disorder proposals in response to our Council's 2012 Block Grant Request for Projects process; 2) continuation of the 72-hour Co-Occurring Clinical Competency Curriculum Certificate Program through the DMH Training Institute; 3) expansion of services at the Court

Urgent Care Clinic to include substance use disorder assessment and referral; 4) Mental Health Rehabilitation Standards requirement that DMH programs and the provider network assess, document, and provide care coordination related to substance use disorder; 5) some DMH certified MHRS providers are also APRA certified treatment programs and facilities; and 6) DMH substance use disorder treatment and/or support services are provided through the Mental Health Services Division, Comprehensive Psychiatric Emergency Program components, and Saint Elizabeths Hospital.

The Planning Council is less clear how substance use disorder services are provided for children and youth. Our Council would like to know more about the services for this population provided by DMH and APRA.

Behavioral Health and Primary Health Initiatives- The Chronic Care Initiative (CCI) in Mental Health and the Integration of Mental Health Services into Primary Care Settings were briefly described from a process perspective. Our Council would like more information about the CCI outcomes and the specific recommendations for integrating mental health and primary care.

Study of District of Columbia Behavioral Health Care System- The RAND Corporation findings identify five (5) priority areas: 1) reduce unmet need for public mental health care; 2) track and coordinate care for individuals in the public system with mental health diagnoses; 3) improve the availability and accessibility of substance abuse treatment services; 4) increase the coordination of care for individuals with co-morbid mental health and substance abuse conditions; and 5) fundamentally upgrade the data infrastructure of the public behavioral health care system to allow for improved monitoring of service utilization, quality of care, and consumer outcomes.

Our Council is pleased that DMH has begun addressing some of the findings. This includes: 1) the Service Utilization Task Force work to develop a format for regular reporting and analysis of MHRS service utilization patterns and gaps; and 2) the Co-occurring Certification Project that DMH and APRA has begun in an effort to coordinate care for individuals with mental health and substance abuse disorders.

The Planning Council believes that the other proposed priority planning initiatives are also very important. These include: 1) integration of key performance and outcome measures into standard reporting processes; 2) evaluating the Juvenile Behavioral Diversion Program; and 3) the development of performance indicators and data bases for two (2) of the early childhood identification and intervention programs (Healthy Start and Parent Infant Early Childhood Enhancement).

D.C. SMHPC Activities

There are three (3) activities that the Planning Council would like to highlight. They include: 1) D.C. Mental Health First Aid Program, 2) Request for Projects, and 3) Regional Health Summit.

D.C. Mental Health First Aid Program- The Planning Council established a Public Education Forum Committee to obtain information and develop a proposal to launch the Judge Aubrey E.

Robinson, Jr. Memorial Lecture Series during FY 2011. The agreed upon proposal was to create a District of Columbia Mental Health First Aid (D.C. MHFA) Program. In previous years, the Planning Council has convened and reported in the Block Grant outcomes associated with the Annual Judge E. Robinson, Jr. Memorial Annual Mental Health Conference.

The design for the D.C. MHFA Program introduced this important public education program to a diverse audience including: consumers, family members, advocates, providers (mental health, substance use disorder, health, and others), government and other public agencies, community-based and other private agencies, faith-based community, academia, and the general public. The Council partnered with DMH in implementing this initiative.

The D.C. MHFA Program used two (2) primary communication methods: 1) a 4-hour kick-off event, and 2) four (4) community orientation sessions. Also, a 12-hour certificate course was planned. The program was so well received there were several unanticipated outcomes: 1) one of the community orientation sessions included a presentation at the Department of Human Services conference on TANF issues at their request; 2) another community orientation session was convened specifically for D.C. Public Libraries staff (also at their request); 3) DMH will sponsor a 12-hour Certificate Course in addition to the course the Planning Council will sponsor in September 2011; and 4) a proposal from DMH to expand the D.C. MHFA Program focusing on additional certificate courses and an instructor's course will receive Homeland Security funding in FY 2012.

Request for Projects- The D.C. SMHPC Council incorporated the new SAMHSA focus on behavioral health, as well as the SAMHSA Eight (8) Strategic Initiatives into our Request for Projects process for funding consideration under the FY 2012 Mental Health Block Grant. The applicants were required to review and identify the strategic initiative and the specific goal their project addressed. As previously mentioned, our Council received input from APRA about project proposals that addressed substance use disorder issues. The Planning Council wanted to be sure that these projects were consistent with APRA initiatives and services and whether there were available funds to help support them. While there were no available funds for FY 2012, DMH and the Council should continue to collaborate with APRA on joint projects and funding opportunities.

Regional Health Summit- The Planning Council Interim Chair informed and invited the Council to participate in this event, which he attended. The Summit was convened on May 12, 2011, which was the second time this event was held. The inaugural summit in 2010 focused on bringing together community stakeholders interested in improving health outcomes of vulnerable populations in Prince George's County. A key outcome noted was the lack of primary care resources in the target area. As a result, many residents were seeking care in the District of Columbia because of the lack of primary care resources in Prince George's County. It was also determined that a regional approach was needed to address the problem.

The May 12, 2011 Summit was a regional response and addressed "Greater Seat Pleasant Public Health and Health Equity: Target Service Area Inner Beltway in Prince George's County and Ward 7 and Ward 8 in the District of Columbia." An added feature was the Townhall meeting to solicit community input.

The 24th and 25th legislative district in Prince George's County and Wards 7 and 8 in the District of Columbia have many of the worst health outcomes in the region. The health outcomes of the residents in both areas are abysmally low. In addition, the burden of the uninsured are threatening the sustainability of the two (2) safety net hospitals serving this population— Prince George's Hospital Center and United Medical Center (formally Greater Southeast Medical Center). The purpose of the Health Summit was to present a model for action to immediately address health disparities in the 24th and 25th legislative district in Prince George's County and Wards 7 and 8 in the District of Columbia. The goal is that collective efforts will meet the objectives of the health reform legislation to improve health outcomes and lower costs.

Our Council looks forward to continuing to work with DMH programs in order to improve the delivery of mental health services for District residents.

Sincerely,



Burton E. Wheeler, Jr.
Interim Chair D.C. State Mental Health Planning Council

IV: Narrative Plan

Table 11 List of Advisory Council Members

Pages 51 and 52 of the Application Guidance

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Lorry Bonds	State Employees	Housing	1133 North Capitol Street, N.E., , Suite 242 Washington, DC 20002 PH: 202-535-2737 FAX: 202-535-1102	lbonds@dchousing.org
Merita Carter	State Employees	Education	825 N. Capitol Street, NE, Suite 8116 Washington, DC 20002 PH: 202-442-5640 FAX: 202-442-5602	
Ricardo Galbis	Providers	Andromeda Transcultural Mental Health Center	1843 S Street, NW Washington, DC 20009 PH: 202-291-4707 FAX: 202-723-4560	
Maude Holt	State Employees	Medicaid	825 North Capitol Street, NE, Room 4330 Washington, DC 20002 PH: 202-724-7491 FAX: 202-478-1397	maude.holt@dc.gov
Henry Lesansky	State Employees	Criminal Justice	1923 Vermont Avenue, NW, Suite N121 Washington, DC 20001 PH: 202-671-2066	henry.lesansky@dc.gov

64 New York Avenue, NE,

Peggy Massey	State Employees	Social Services	6th Floor Washington, DC 20002 PH: 202-671-4346 FAX: 202-279-8742	peggy.massey@dc.gov
Edmund Neboh	State Employees	Vocational Rehabilitation	810 First Street, NE, 10th Floor Washington, DC 20002 PH: 202-442-8633 FAX: 202-442-8742	edmund.neboh@dc.gov
Juanita Reaves	State Employees	Mental Health	64 New York Avenue, NE, 5th Floor Washington, DC 20002 PH: 202-671-4080 FAX: 202-673-4386	juanita.reaves@dc.gov
Senora Simpson	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		323 Quackenbos Street, NE Washington, DC 20011 PH: 202-529-2134	ssimps2100@aol.com
Effie Smith	Individuals in Recovery (from Mental Illness and Addictions)		461 H Street, NW , Suite 919 Washington, DC 20001 PH: 202-408-1817	esmith@can-dc.org
Lynne Smith	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		921 French Street, NW Washington, DC 20001 PH: 202-412-3999	lynne.smith@dc.gov
Burton Wheeler	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		3800 25th Street, NE Washington, DC 20018 PH: 202-468-5607 FAX: 202-392-1014	burton.globalbiz@gmail.com
Samuel Awosika	Individuals in Recovery (from Mental Illness and Addictions)		4201 Fort Dupont Terrace, SE Washington, DC 20020 PH: 202-299-5157 FAX: 202-561-6974	samuel.awosika@dc.gov
Bertha Holliday	Others (Not State employees or providers)		1719 First Street, NW Washington, DC 20001 PH: 202-265-8308	bhollidaypsy@gmail.com

Sharon
White

State Employees

District of Columbia
Department of Mental
Health

64 New York Avenue, NE,
4th Floor
Washington, DC 20002

sharon.white@dc.gov

Footnotes:

There are currently three (3) vacancies on the State Mental Health Planning Council. DMH in consultation with the District Office of Boards and Commissions has revised the Mayoral Order establishing the planning council, which was originally issued in 1988. The revised order is currently pending signature by the Mayor. After the revised order is issued, DMH will work with the Mayor's Office of Board and Commissions to recruit new members so that all vacancies are filled.

IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

Pages 52 and 52 of the Application Guidance

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	18	
Individuals in Recovery (from Mental Illness and Addictions)	2	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	3	
Vacancies (Individuals and Family Members)	<input type="text" value="3"/>	
Others (Not State employees or providers)	1	
Total Individuals in Recovery, Family Members & Others	9	50%
State Employees	8	
Providers	1	
Leading State Experts	0	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	9	50%

Footnotes:

There are currently three (3) vacancies on the State Mental Health Planning Council. DMH in consultation with the District Office of Boards and Commissions has revised the Mayoral Order establishing the planning council, which was originally issued in 1988. The revised order is currently pending signature by the Mayor. After the revised order is issued, DMH will work with the Mayor's Office of Board and Commissions to recruit new members so that all vacancies are filled.

IV: Narrative Plan

P. Comment On The State Plan

Page 50 of the Application Guidance

Narrative Question:

SAMHSA statute requires 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 should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

The District of Columbia FY 2012- FY 2013 Mental Health Services Block Grant Application will be published on the Department of Mental Health (DMH) website and comments solicited from the public (inclusive of Federal, District and other public and private agencies). Also, DMH will compile a list of specific community-based organizations that will be asked to review and comment on the Plan. The comments will be integrated at the various stages of the planning process (development, implementation, and submission), as appropriate.

The D.C. State Mental Health Planning Council served as the first level of review and comments are included in their letter in this Application. DMH and the Planning Council have received input from the Addiction Prevention and Recovery Administration (APRA) related to areas of mutual interests and projects for funding consideration. APRA will be asked to review and provide input on the Plan as their review of this document did not occur prior to the September 1, 2011 due date.

Since the District's FY 2012 -FY 2013 Block Grant Application will be submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA) before the comment period is completed, for any changes deemed warranted by the Planning Council and DMH a Plan Amendment will be developed. Any amendment will be forwarded to SAMHSA upon completion.