CHILDREN'S PLAN PERFORMANCE REPORT

Government of the District of Columbia

Department of Behavioral Health

Fiscal Years 2009 – 2013

64 New York Avenue, NE • 2nd Floor • Washington, DC • 20002

Acknowledgements

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Barbara Bazron, Ph.D.
Interim Director

Denise Dunbar
Director of Child and Youth Services

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EXECUTIVE SUMMARY

The *Children's Plan* was developed in 2009 as a blueprint for change in the mental health system of care for children. After five years of concentrated improvement, the District's children's mental health system has been transformed, and significant progress made to meet the goals set forth in the *Children's Plan*. Guided by system of care values and principles, the Department of Behavioral Health is serving more children and youth in the community with proven evidence-based practices and is intervening at an earlier age when it can make a lifetime difference. Further, more clinicians are trained to offer a wider variety of specialized services, and families are more involved in directing the appropriate care.

System highlights include but are not limited to the following:

* Expansion of available evidence-based practices from one in 2009, to 12 in 2013;
* Utilization of the Community Services Review process to monitor and ensure the quality of children's mental health services;
* Co-location of mental health clinical and enrollment staff at CFSA to provide and link children and families with needed services and supports on-site;
* Development and expansion of early childhood identification and intervention mental health services;
* Utilization of wraparound and community-based services, resulting in a decrease in the number of youth served in psychiatric residential treatment facilities and reduction in their lengths of stay;
* Improved efforts to engage youth and families as partners at all levels; and,
* Enhanced cross-systems collaboration through periodic data matches, resulting in improved care coordination for youth and families, and more strategic resource allocation and planning.

This report reviews the accomplishments towards each goals and work still to be done.

INTRODUCTION

The Children's Plan Summary of Recommendations

Between 2009 and 2013, the District of Columbia's public mental health system served an average of nearly 6,000 children, youth, and transition-age young adults with severe emotional disturbance annually, totaling 14,327 unduplicated consumers. Mental health treatment services are primarily delivered through a network of community based providers as well as through the government operated outpatient services for youth eight and under and their families/guardians. In addition, DBH provides direct school-based services, court-ordered assessments, and oversight of youth placed in Psychiatric Residential Treatment Facilities (PRTF) within its authority.

The *Children's Plan* presented 21 recommendations condensed into seven broader goals. This progress report addresses each of the seven goals. The system performance data represented in this report is claims-based, pulled from DBH's eCura billing and claims system on May 14, 2014, with the exception of psychiatric hospital discharge follow-up services data. The Child/Youth Hospital Discharge Report was run on September 24, 2014. Please note, only Medicaid Fee for Service claims are represented in this report. Children, youth and young adults insured by Medicaid Managed Care Organizations, or private insurers are not included.

1. Expand the range of available mental health services

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

Performance Indicators

a. Expansion of evidence-based services proven to improve functioning in the home, school, and community.
b. Increased number of freestanding mental health clinics able to provide psychotherapy.

c. Expansion of treatment options for youth with co-occurring mental health and substance use disorders.
d. Establish rates for psychotherapy for fee-for-service children and youth that are comparable to surrounding jurisdictions.

2. Ensure the quality of mental health services

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

Performance Indicators

a. Develop and implement outcome measures for all services to ensure that quality services are delivered.
b. Ensure that all children receive services through a specified practice model, emphasizing a coordinated and integrated process that reflects team formation and team functioning.
c. Ensure that all child mental health providers are using appropriate, standardized tools to ensure the right level of care and measure functional outcomes of the children they are serving.
d. Improve the number of children receiving appropriate services within seven days of enrollment
e. Ensure that all children receive appropriate follow up services within seven days of discharge from a psychiatric hospitalization.

3. Improve access for children and families

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

Performance Indicators

a. Increase the capacity and competencies of community mental health providers that serve children and youth.
b. Require Managed Care Organizations (MCOs) to build system capacity to serve more children and youth.
c. Reduce fragmentation and complication of the children's mental health system by "carving out" mental health services from MCOs.
d. Produce a comprehensive, mental health services access (resource) guide.
e. Develop and implement a social marketing and public awareness campaign stressing prevention and early intervention.
f. Provide technical assistance and coaching to agencies experiencing challenges engaging families in the treatment planning and delivery process.

4. Create a strong early identification and prevention system

According to the New Freedom Commission on Mental Health, one in five children from birth to age 18 years have a diagnosable mental disorder. One in 10 youth has a serious mental health problem that is severe enough to impair how they function at home, school, or in the community[1]. Without early screening and treatment, childhood conditions may persist and lead to a cycle of school failure, poor employment opportunities, and poverty.

Performance Indicators

a. Reduce stigma regarding mental health needs, increase awareness of the importance of social and emotional health of children, and encourage access to mental health services.
b. Adopt early screening as a standard practice with children and youth among child-serving agencies.
c. Ensure children are screened for mental health in primary care settings, develop a psychiatric referral protocol for children and youth from primary care providers to mental health providers, and ensure coordination of care.

[1] New Freedom Commission on Mental Health. 2003. Achieving the Promise: Transforming Mental Health Care in America. Final Report (DHHS Pub. No. SMA-03- 3832) Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

d. Promote easily accessible, high-quality school-based mental health services for all children in need.
e. Expand and ensure coordinated, robust mental health services for children five years and younger.

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

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

Performance Indicators

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

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

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

Performance Indicators

a. Engage family and youth as partners at all levels of the children's mental system to develop and implement the District's System of Care.
b. Facilitate the development of a Family Organization Coalition in the District.
c. Ensure that family members are primary decision makers on the child/youth/family's treatment team.

7. Enhance cross-systems collaboration and data sharing

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

Performance Indicators

a. Implement a coordinated, team-based approach to service delivery at all levels of service, from mental health promotion to early intervention, to intensive intervention, as a framework for best practice.
b. Enhance the exchange of health-related data across systems to ensure appropriate care coordination, and increase provider capacity to collect and report data to inform policy, training, and planning decision making.
c. Implement shared data systems based on common elements of information across all child-serving agencies that provide real-time data.
d. Create an interagency accountability office to support cross-systems implementation of best practices.
e. Provide ongoing, cross-systems training and technical assistance to agencies to illustrate methods of System Integration and Accountability design and implementation.

CHILDREN'S PLAN PERFORMANCE REVIEW

System Goal 1: Expand the range of available mental health services

Performance Indicators

a. Expansion of evidence-based services proven to improve functioning in the home, school and community

Since Fiscal Year 2009, CYSD has added 11 evidence-based practices (EBPs) to the array of mental health services offered to eligible children/youth in the District. Table 1 shows expansion of this service array. The term "evidence-based services" refers to treatment and/or a series of services that have been studied and repeatedly proven effective. These services demonstrate outcomes in symptom reduction and improved functioning, which may include any combination of improved school attendance and performance, improved family and peer relationships, decreased involvement with law enforcement and the juvenile justice system, and reduction in self-harm and suicide-related behaviors. Moreover, DBH strategically has implemented EBPs to prevent and reduce deep-end service utilization, for example, hospital admissions, psychiatric residential treatment facility placement, and other out-of-home placements. These efforts have expanded the mental health services array available to children and families in the District. The service expansion timeline in Table 1 also shows the targeted age groups.

Table 1. Service Expansion Timeline

Fiscal Year	Evidence-based and Promising Practices Added	Impacted Age Range
Before 2009	In-home and Community-based Intervention Services (CBI)	10 – 17
	School Mental Health Program (SMHP)	5 – 21
2009	Multi-systemic Therapy (MST)	10 – 17
	High Intensity Wraparound Services	10 – 21
2010	Primary Project	5 – 8
	Early Childhood Mental Health Consultations (Healthy Futures)	0 – 5
	Functional Family Therapy (FFT)	10 – 17
2011	Parent-Child Interaction Therapy (PCIT)	2 – 6
2012	Multi-systemic Therapy for Youth with Problem Sexual Behavior (MST-PSB)	10 – 17
	Trauma-focused Cognitive Behavioral Therapy (TF-CBT)	4 – 18
	Juvenile Behavioral Diversion Program (JBDP)	9 – 21
	Child-Parent Psychotherapy for Family Violence (CPP-FV)	0 – 8
2013	Transition-age Youth Supported Employment (TAYSE)	17 – 25

b. Increased number of freestanding mental health clinics able to provide psychotherapy

From 2009 and 2013, the number of freestanding mental health clinics in the District of Columbia increased significantly from 23 ~~in 2009,~~ to 37 ~~in 2013~~, an improvement of 61% during the period. The Department has created a new

Child Choice Provider (CPP) certification status, created to provide the highest quality services to youth involved in the child welfare system. In order to meet the certification criteria, the service provider must also become certified as a Free Standing Mental Health Clinic (FSMHC). In addition, the provider must be approved by DBH to provide at least one of the following EBPs, which can be provided in the FSMHC setting: Child-Parent Psychotherapy for Family Violence (CPP-FV), Functional Family Therapy (FFT), Parent-Child Interaction Therapy (PCIT), Trauma Systems Therapy (TST) or Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). This will strategically build the children's mental health system's capacity to offer EBPs as alternatives to traditional treatment modalities and bolster the number of freestanding mental health clinics in the District.

c. Expansion of treatment options for youth with co-occurring mental health and substance use disorders

In accordance with the "Department of Behavioral Health Establishment Emergency Act of 2013", effective July 30, 2013 (D.C. Act 20-130; 60 DCR 11384), the District's Department of Mental Health and the Addictions, Prevention, and Recovery Administration merged October 1, 2013 to become the Department of Behavioral Health[2] to make it easier to treat individuals with both mental and substance use disorders.. As a result of this merger, there is an increased focus on treatment options for youth with co-occurring mental health and substance use disorders. Screening to identify youth with co-occurring disorders using the GAIN-SS began in 2013. Of the 3,693 youth and young adults between the ages of 14 and 24 who received MHRS services during 2013, 221 (6%) received both mental health and substance use treatment. These 221 youth represent 35% of the 640 youth and young adults between the ages of 14 and 24 years who received substance use treatment services in 2013 (see Table 2).

[2] Effective 10/1/2013, the DC Department of Mental Health and the Addiction Prevention and Recovery Administration under the Department of Health were integrated into one District department, the Department of Behavioral Health.

Table 2. DBH Youth with Co-occurring Disorders (Fiscal Year 2013)

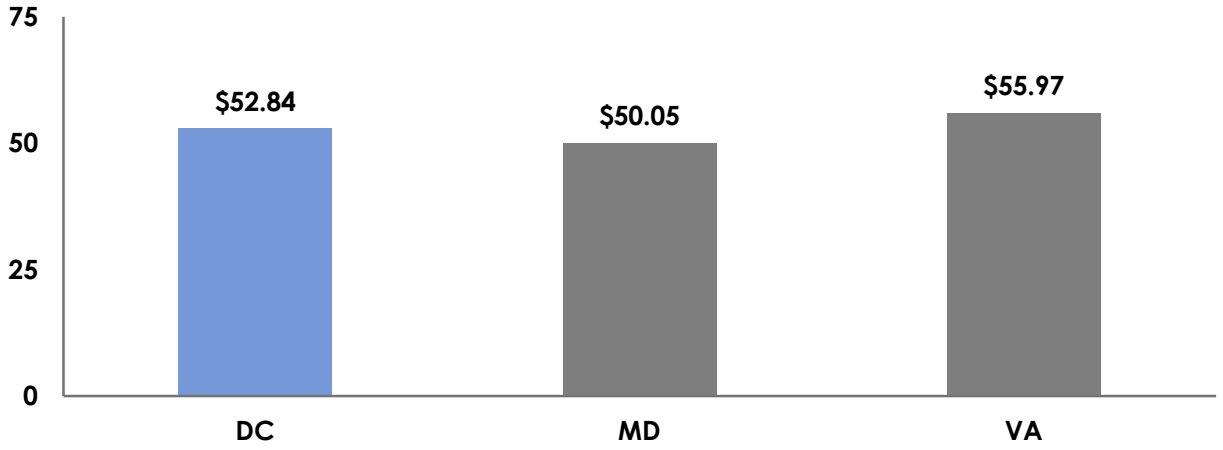
Youth/Emerging Adults Served (14-24) - MHRS	**3693**
Youth/Emerging Adults Served (14-24) - ~~APRA~~ SUD	**640**
Youth/Emerging Adults Matched	***221***
Percentage of MHRS Population Matched	6%
Percentage of SUD Population Matched	35%

Recognizing the need to orient all relevant stakeholders in the behavioral health system to best practices in providing services to individuals with both mental health and substance use disorders DBH began delivering training specific to consumers with co-occurring disorders. There are three distinct training paths: an in-depth, 18-module clinical series; a basic, 6-module training, and, a variety of subject-related, one-day workshops and seminars that are open to the general public. By the end of 2013, there were 69 clinicians who attended the clinical series; 68 clinicians received the basic training; and there were 78 who participated in the one-day trainings.

d. Establish rates for psychotherapy for fee-for-service children and youth that are comparable to surrounding jurisdictions.

In 2009, the District's Department of Health Care Finance (DHCF) fee-for-service reimbursement rate for a 30-minute individual psychotherapy session was $33.41. In 2013 the rate was $52.84, a 58% increase and closely aligned with rates for Maryland and Virginia. The DC reimbursement rate is about 5% more than the Maryland rate of $50.05; however, the District's rate is nearly 6% less than the Virginia rate of $55.97 and is virtually equal to the average of the two surrounding jurisdictional rates ($53.01) (See Figure 1.)

Figure 1. 30-Minute Individual Psychotherapy Session - Current FFS Reimbursement Rates (FY 2013)



System Goal 2: Ensure the quality of mental health services

Performance Indicators

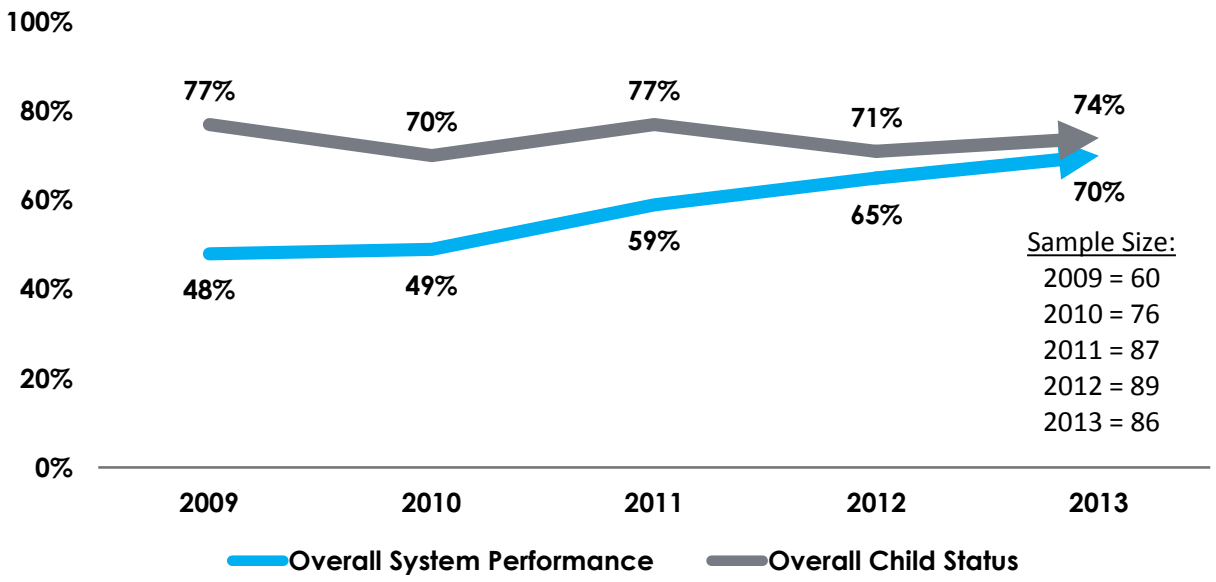
a. Develop and implement outcome measures for all services to ensure that quality services are delivered.

DBH utilizes the Consumer Service Review (CSRs) process to measure service performance at the system, provider, and individual consumer levels. The reviews are conducted by independent teams. Annual data collection on individuals includes consumer and family interviews, record reviews, staff interviews, caregiver interviews, and analysis of data. The teams cover key areas of review for each consumer. For children and youth, these key areas include home and school activities, life skills, health and development, treatment planning, treatment, family supports, specialized services, coordination of care, and emergent/urgent response to needs.

Figure 2 illustrates Overall System Performance, relative to Overall Child Status. The overall performance of the DC Children's Public Mental Health System has shown a 22% improvement in Overall System Performance, with 48% of cases reviewed in 2009 rated Acceptable, compared to 70% of cases reviewed in

2013. Upon reaching 70% in Overall System Performance, DBH satisfied one of the remaining Dixon requirements.

Figure 2. Community Services Review (CSR) Results - Children

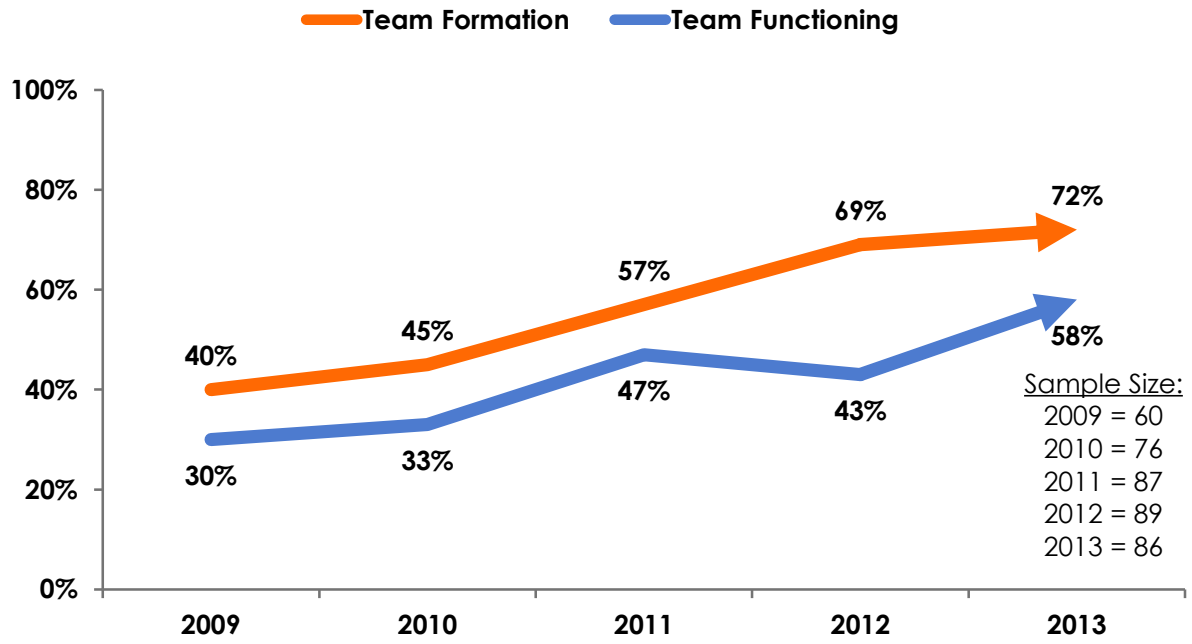


b. Ensure that all children receive services through a specified practice model, emphasizing a coordinated and integrated process that reflects team formation and team functioning.

The 2009 Community Service Review showed the system performing in the area of team formation at a 40 per cent acceptable rate, and 30 per cent for team functioning. Based on these findings, DBH provided professional development and technical assistance. In 2011, DBH released "*Expectations for High Quality Practice and Achieving Results with Consumers and Families within the District of Columbia's Public Mental Health System.*" The document defines key expectations for the delivery of high-quality services within the District's public behavioral health system. This report was developed to guide the service systems' performance and incorporate the critical components of team formation and team functioning, and forward planning which has been identified through the Community Service Reviews. Acceptable team formation ensures that all necessary personnel involved with the youth and family participate on the team through regular communication and planning.

While team functioning is an ongoing process, rather than a discrete event, strong team processes include a flow of communication and information among members in a timely manner and a respectful and reciprocal relationship with the child and parents. Teams should be cohesive and non-hierarchical, and able to discern which aspects of teaming to execute at particular times, such as when to meet face-to-face and how to use resources or team members strategically. As a result, from 2009 to 2013, the team formation score jumped to 72 per cent—a 32 per cent increase—and the team functioning score rose to 58%--a 28 per cent increase.

Figure 3. CSR Team Formation and Functioning



c. Ensure that all child mental health providers are using appropriate, standardized tools to ensure the right level of care and measure functional outcomes of the children they are serving.

In 2009, DBH implemented the web-based Child and Adolescent Level of Care Utilization System (CALOCUS) to ensure all children and youth receive appropriate services and as an outcome measure. The CALOCUS is intended to measure impairment in functioning among children and adolescents, emphasizing the level-of-care (LOC) needs of the child/family. DBH has used the

CALOCUS to quantify the clinical severity and the service needs of children/youth with psychiatric disorders. The CALOCUS assesses a consumer's status across six subscales or dimensions: Risk of Harm; Functional Status; Recovery Environment (Environmental Stressors, Environmental Supports); Co-morbidity; Resiliency and Treatment History; and, Acceptance and Engagement (Child/adolescent, Parent/caregiver).

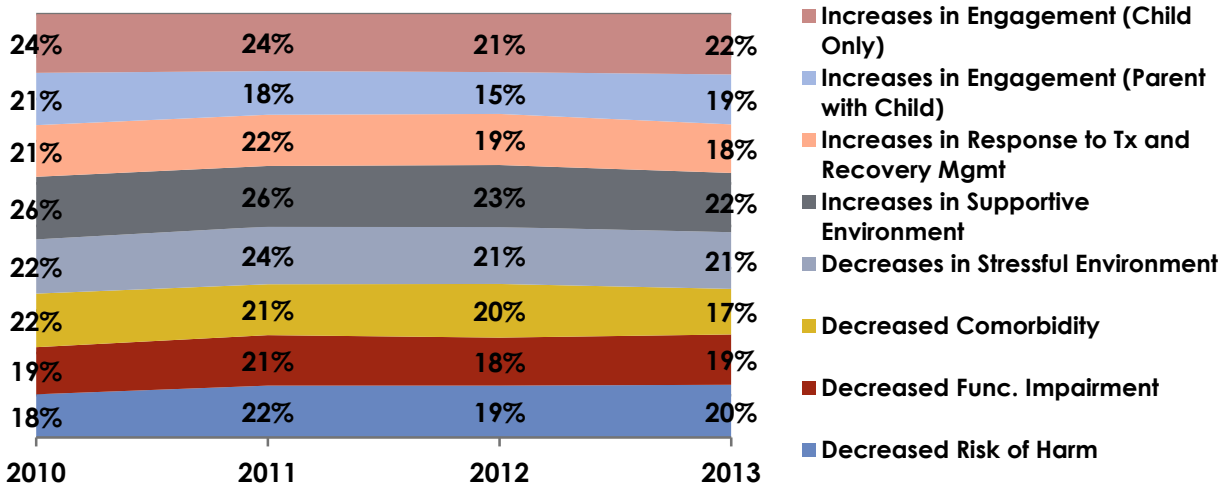
Table 3 provides a crosswalk of the composite score ranges with their corresponding LOC and description:

Table 3. Level of Care Scores

Level	Description	Composite Score
0	Basic Services for Prevention and Maintenance	7-9
1	Recovery Maintenance and Health Management	10-13
2	Outpatient Services	14-16
3	Intensive Outpatient Services	17-19
4	Intensive Integrated Services Without 24-Hour Psychiatric Monitoring	20-22
5	Non Secure, 24-Hour Psychiatric Monitoring	23-27
6	Secure, 24-Hour Psychiatric Monitoring	28+

A DBH Core Service Agency (CSA) generally administers the CALOCUS every 180 days. On average from FY09 to FY13, nearly half (47%) of the consumers meeting the criteria for inclusion remained at the same level of care from their first CALOCUS that year to their second. On average, 24% were assessed a higher level of care, while on average 30% of assessed children/youth had a reduced level of care. Nine percent of the children had a CALOCUS level of two or below one their first assessment of the year, meaning there was not a lower level of services into which they could step down. Figure 4 shows the percentage of children/youth who improved across the individual domains.

Figure 4. CALOCUS: Children/Youth with Improved Dimension Scores



d. Improve the number of children receiving appropriate services within seven days of enrollment.

The percentage of children and youth ages 0 – 17 who were seen within seven days of enrollment decreased by 8%, from 26% in 2009 to 18% in 2013. Over the five year period, the average percentage of children and youth seen within seven days was 21%. DBH continues to work with CSAs to improve and ensure timely access and service delivery. Table 4 displays the total number of new system enrollments and the elapsed time between enrollment and the first service received.

Table 4. Elapsed Time Between Enrollment and Services Received (0 – 17)

FY	Total	0-7 Days	8-14 Days	15-30 Days	30+ Days	Never Seen
2009	1723	26%	7%	11%	32%	24%
2010	2876	15%	5%	7%	28%	45%
2011	1779	27%	8%	13%	27%	25%
2012	1720	20%	7%	11%	27%	34%
2013	1747	18%	7%	11%	21%	43%

e. Ensure that all children receive appropriate follow-up services within seven days of discharge from a psychiatric hospitalization.

DBH partners with the National Children's Medical Center (NCMC) and the Psychiatric Institute of Washington (PIW) to ensure children hospitalized for psychiatric concerns are linked appropriately to providers and receive prompt community-based follow-up services after discharge. Table 10 shows the number and percentage of discharged youth (under 18 years old) who were seen within seven and 30 days of discharge. DBH's goal for timely access to services is for youth to be seen within seven days of discharge. Table 5 divides the child and youth psychiatric discharges into two groups: youth who were linked to a DBH CSA prior to release from the hospital; and the overall number of children and youth discharged, which includes a smaller number of youth who were linked after they were discharged and received follow-up mental health services. For those children and youth who were linked before discharge, the number seen by a mental health provider within seven days has increased from 43% to 63% from 2009 to 2013, respectively. Follow-up services for all discharges showed a similar increase of 21% for youth seen within seven days from 39% in 2009 to 60% in 2013.

Table 5. Total Youth (0-17) Discharged from Psychiatric Hospitals Linked and Served

FY	Total Discharges	Linked Before Discharge				Linked Before or After Discharge			
		Seen in 0-7 Days		*Seen in 8-30 Days*		*Seen in 0-7 Days*		*Seen in 8-30 Days*	
		Number	%	Number	%	Number	%	Number	%
2009	**452**	173	43%	57	14%	174	39%	60	13%
2010	**622**	235	43%	87	16%	238	38%	95	15%
2011	**485**	220	49%	74	17%	222	47%	79	17%
2012	**729**	358	54%	101	15%	361	50%	110	15%
2013	**692**	401	63%	109	17%	409	60%	120	18%

System Goal 3: Improve access for children and families

Performance Indicators

a. Increase the capacity and competencies of community mental health providers who serve children and youth.

As the total number of children, youth and emerging adults (age 18-24) served has increased by 28% from 2009 to 2013 from 4,871 to 6,236, DBH has continued to expand the array of available services, specifically EBPs and promising practices; and simultaneously focusing on developing, supporting, and sustaining broad-based provider expertise.

In addition, DBH and System of Care (SOC) partners developed and piloted a Universal Intake Form and associated training curriculum in 2013. The form was created to facilitate improved access and linkage to a mental health provider when a family seeks help through a non-mental health organization. The completed form is included in the referral package and should reduce the amount of information needed at intake for mental health services.

b. Require Managed Care Organizations (MCOs) to build system capacity to serve more children and youth.

In 2013 DBH began working with the Department of Health Care Financing (DHCF) to make additions to the contracts between DHCF and the four Medicaid Managed Care Organizations (MCOs). As of July 1, 2013, MCOs must provide data regarding access to behavioral health services, penetration rates, and the adequacy of the available provider network, including psychiatric coverage. Integration of primary care and behavioral health screening is supported by the new MCO contract, which requires social/emotional screening for children as a part of the annual well child checkup. In addition, monthly meetings with MCO have been established to facilitate improvements in capacity and in the overall MCO behavioral health service delivery system for children, youth and young adults.

c. Reduce fragmentation and complication of the children's mental health system by "carving out" mental health services from MCOs.

In the District of Columbia, most Medicaid recipients are in an MCO. In the MCO contract, MCOs are responsible for office-based mental health services but not

community or home-based services. These are provided through DBH and are designated for children/youth with Serious Emotional Disturbance (SED). Discussion has focused on improving communication between the MCOs and DBH providers to support more timely access and ease of access to mental health services. It is anticipated that earlier access to community and home-based services to stabilize a youth's functioning in the community will lead to decreased emergency room mental health visits and acute psychiatric hospitalization. Emergency room visits and acute hospitalization are services covered by the MCOs. Discussions among DBH, the Department of Healthcare Finance (DHCF), and the MCOs are resulted in the development of strategies to improve sharing of data.

d. Produce a comprehensive mental health services access (resource) guide.

Progress toward this performance indicator was not achieved during the reporting period.

e. Develop and implement a social marketing and public awareness campaign stressing prevention and early intervention.

A social marketing plan was developed as a component of DC Gateway Project SOC planning grant activities. This plan is centered on increasing community awareness regarding mental health resources and reducing the stigma associated with having identified mental health concerns. This effort supports the development of a mental health awareness framework that encourages maintenance of mental wellness, with the same fidelity given to the maintenance of physical well-being.

A critical component of increasing public awareness focused on prevention and early intervention is the implementation and provision of Youth Mental Health First Aid training, which began in 2013. This initiative is a public education program that introduces participants to the unique risk factors and warning signs of mental health problems in adolescents. It builds understanding of the importance of early identification and intervention; and most importantly, provides specific strategies to assist and support youth and families experiencing a mental health or substance use crisis. Mental Health First Aid uses role playing

and simulations to demonstrate how to assess a mental health crisis; select interventions and provide initial help; and connect young people to professional, peer, social, and self-help care.

Participants in the training leave with the ability to:

- Assess for risk of suicide or self-harm,
- Listen non-judgmentally,
- Give reassurance and information,
- Encourage appropriate professional help, and
- Encourage self-help and other support strategies.

DBH has reached out to a diverse group of community partners and other DC agencies, and has trained nearly all of the Department of Recreation's recreational and aquatic specialists who work with youth in a number of different extracurricular and enrichment programs around the city. DBH also has facilitated several trainings for the a number of providers, community and family organizations, and members of the general public who interact with youth, resulting in 1285 people trained.

An essential element of the five-year SOC grant has been the recognition and celebration of National Children's Mental Health Awareness Day. National Children's Mental Health Awareness Day is a key strategy of the Caring for Every Child's Mental Health Campaign, which is a part of SAMHSA's Public Awareness and Support Strategic Initiative. The efforts, including poster contests at Friendship and private meetings with the Mayor, seek to raise awareness about the importance of children's mental health and that positive mental health is essential to a child's healthy development from birth.

In 2013, DBH hosted school-based activities to reach youth in elementary, middle, and high school. DBH also partnered with several child-serving agencies, community providers, family organizations, and schools for outreach.

f. Provide technical assistance and coaching to agencies experiencing challenges in engaging families in the treatment planning and delivery process.

In 2013, CYSD developed and implemented a strategy utilizing Technical Assistance Coordinators who work in partnership with CSAs and other stakeholders to address administrative and clinical practices that require improvements to better meet the needs of children and families served. The goal is to enhance and sustain the highest quality services consistent with the values and guiding principles of the System of Care for children and families in the District.

System Goal 4: Create a strong early identification and prevention system

Performance Indicators

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

DBH's efforts to reduce stigma and increase mental health awareness are shown through the previously mentioned social marketing activities and public awareness campaign efforts, which highlight the importance of social and emotional health of children while promoting access to mental health services. Moreover, programs based in educational settings, like Healthy Futures, the Primary Project and the School Mental Health Program engage early learning center and school staff regarding the importance of social and emotional well-being, while providing screenings, referrals, and mental health support and treatment services.

b. Adopt early mental health screening as a standard practice with children and youth among child-serving agencies.

DBH has co-located mental health clinicians at CFSA since 2009. These clinicians conduct mental health screenings for children and youth removed from their homes and placed in foster care. Clinicians also provide clinical consultative support services to social workers and participate in Review, Evaluate, Direct

(RED) team and family team meetings.

Table 6 highlights the number of students screened in schools and at child development centers, the number of students identified as eligible for the Primary Project, and the number of students identified as needing mental health services. Prior to School Year (SY) 2010/2011, the Primary Project was implemented in public and public charter schools and only children in Kindergarten and 1st grade were screened. As the program continued to expand, the program was offered to children in Pre-K4 classrooms at child development centers and to children in grades Pre-K4 through 3rd grade at public and public charter schools. While an in-depth analysis has not been conducted, the increases in the number of mental health referrals may be related to the expansion of screening to children through the third grade.

Table 6. Number of Students Screened by School Year (SY)

Indicators	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
# of students screened	**1435**	**835**	**1445**	**2664**	**3031**
# of students screened positive for Primary Project	522	323	497	579	567
# of students participating in Primary Project	329	206	269	328	247
# of students screened positive for SMHP/HF services	99	105	354	785	868

c. Ensure children are screened for mental health in primary care settings, develop a psychiatric referral protocol for children and youth from primary care providers to mental health providers, and ensure coordination of care.

Beginning in 2013, extensive planning and coordination between DBH, the Children's Law Center, the Children's National Medical Center (CNMC), and the Departments of Health and Health Care Finance for the implementation of DC Mental Health Access in Pediatrics (DC MAP) began. DC MAP has the following goals:

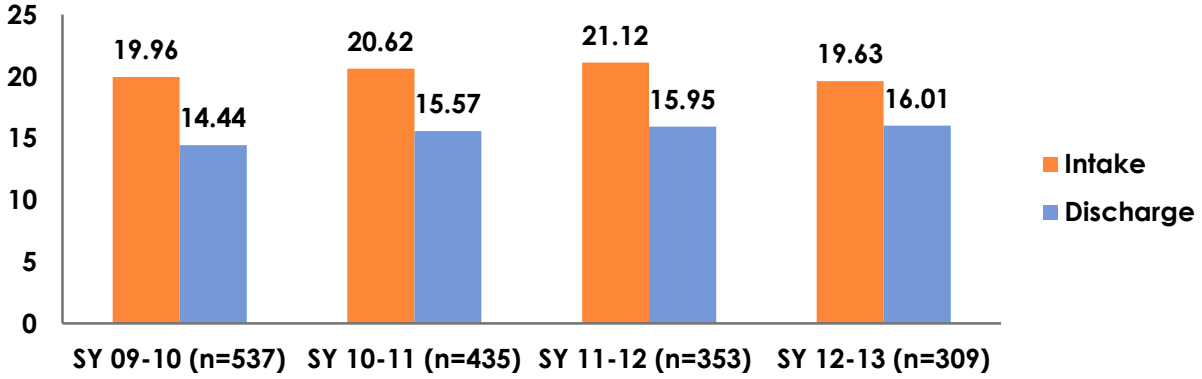
1. Increase collaboration between PCPs and MH providers.
2. Promote mental health within primary care.
3. Improve identification, evaluation, and treatment

4. Promote the rational utilization of scarce specialty mental health resources for the most complex and high-risk children.

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

The Department's School Mental Health Program (SMHP) is based on a strong partnership with DC Public Schools and public charter schools. The program, located in 52 of schools, provides screening, behavioral and emotional assessments, school-wide or classroom-based interventions, psycho-educational groups, consultation with parents and teachers, crisis intervention, and individual, family and group treatment. The program uses the Ohio Youth Problems, Functioning and Satisfaction Scales to evaluate the effectiveness of its services. Over the past five years, data have consistently shown improvement, such as decreases in problems and increases in functioning over the course of treatment. SMHP clinicians use Ohio Scales as brief measures to assess the outcome of mental health services for youth who are 5 to 18 years of age.[3] Figures 5 and 6 show Ohio Scales scores trends from School Years 2009/2010 through 2012/2013 specific to reductions in behavioral problem severity and increased youth functioning.

Figure 5. Ohio Scales Problem Severity Score from Intake to Discharge as Reported by Clinician



[3] Ogles, Ben. https://sites.google.com/site/ohioscales

Figure 6. Ohio Scales Functioning Score from Intake to Discharge as Reported by Clinician

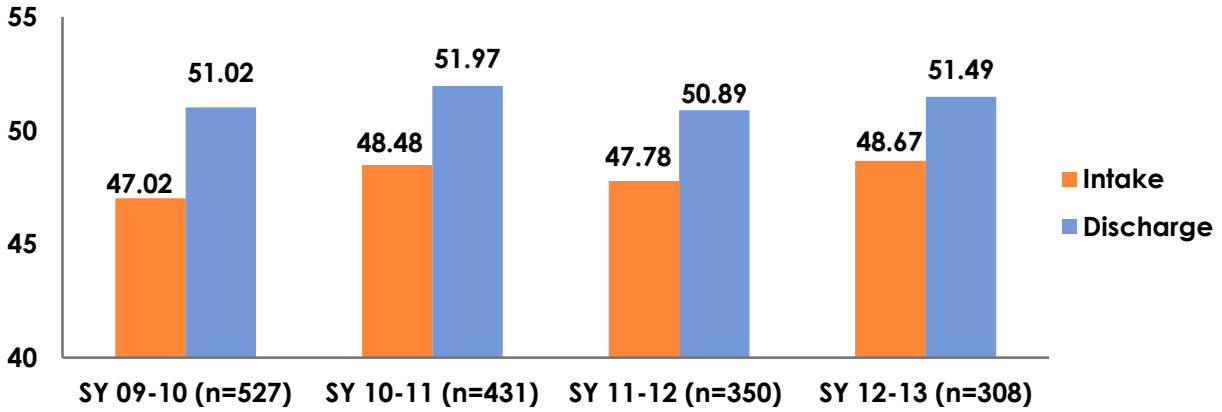


Table 7 describes SMHP utilization. During School Year (SY) 2012-2013, more than 1,600 students were referred to the SMHP, and 1,222 students met with a clinician and directed to the appropriate level of care. More than one third of the SMHP referrals (37%) came from the Primary Project. The remaining referrals were made by a variety of other individuals including teachers (17%), administrators (12%), families (10%), school counselors and/or social workers (10%). A smaller number of youth were referred by other individuals (e.g., nurse, friends) or were identified through other means (e.g., Signs of Suicide (SOS) screening). The four most prevalent diagnostic categories at the beginning of treatment were: Mood Disorders, Adjustment Disorders, Attention Deficit Disorders, and Behavior Disorders.

Table 7. SMHP Utilization

SMHP Utilization	SY 09-10	SY 10-11	SY11-12	SY 12-13	SY 13-14 (as of July 14)
# of students referred to SMHP clinician	1715	1538	1453	1659	1618
# of students referred and seen by SMHP clinician	1255	1179	1088	1222	1007
# of students on caseload	737	665	609	629	638
# of students referred to outside services (e.g., housing, food, etc.)	406	236	156	275	184
# of students referred to outside mental health services	152	131	132	202	162

Some individuals needed short-terms supports whereas others required more long-term services. Linkages were made for students and families needing additional supports. Specifically, 275 students and families were referred for outside services (e.g., housing, food) and 202 students and families were referred for additional mental health services. Clinicians assisted with the linkages and provided follow up as needed.

e. Expand and ensure coordinated, robust mental health services for children five years and younger.

DBH continues its effort to increase the system's capacity to provide well-coordinated, evidence-based mental health services for young children. The Parent, Infant, and Early Childhood Enhancement (PIECE) program is operated by DBH and is an outpatient, freestanding, mental health clinic that provides community-based mental health to infants, toddlers, preschool, and school-age children (ages 6 and under), and their families and caregivers. The PIECE program includes two components that focus on early childhood intervention

and treatment. The early intervention and treatment component serves children from ages three to seven years old who have been identified as having social, emotional, and behavioral challenges that negatively impact home, daycare, school, and community. The second component is the Healthy Start Project, which serves women of childbearing age during and after pregnancy who have been identified as having mental health challenges and depression.

The PIECE Program provides an array of services and utilizes two EBPs—Parent Child Interaction Therapy and Child Parent Psychotherapy (Trauma-Focused). Utilization of the Early Intervention and Healthy Start program components is shown in Figures 7 and 8. A steady increase in utilization was seen for Early Intervention services from 2009 to 2013, while utilization of Healthy Start services increased by 32% from 2010 to 2013. Healthy Start program data from 2009 were not available because the program was administered through the Department of Health.

Figure 7. PIECE Early Intervention and Treatment - Unduplicated Consumers

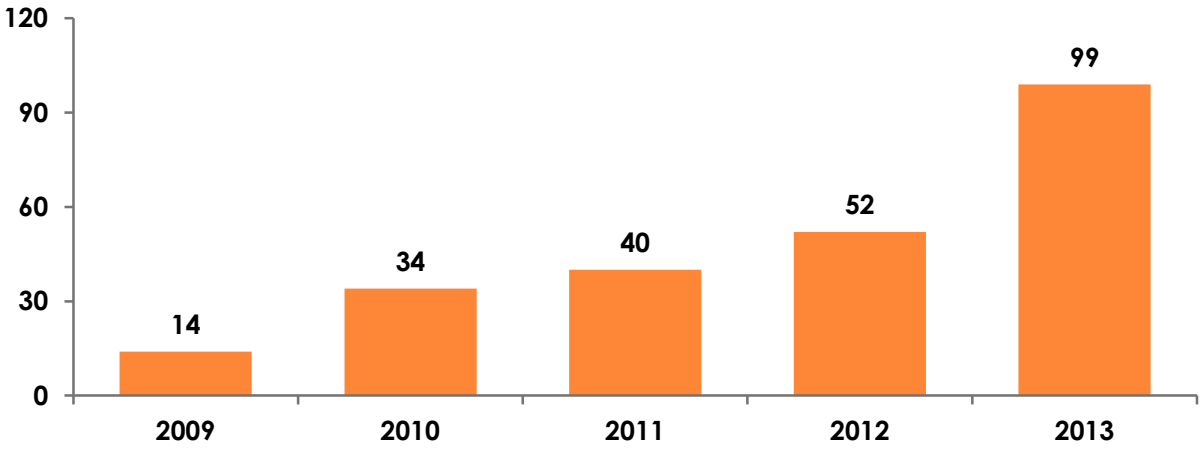
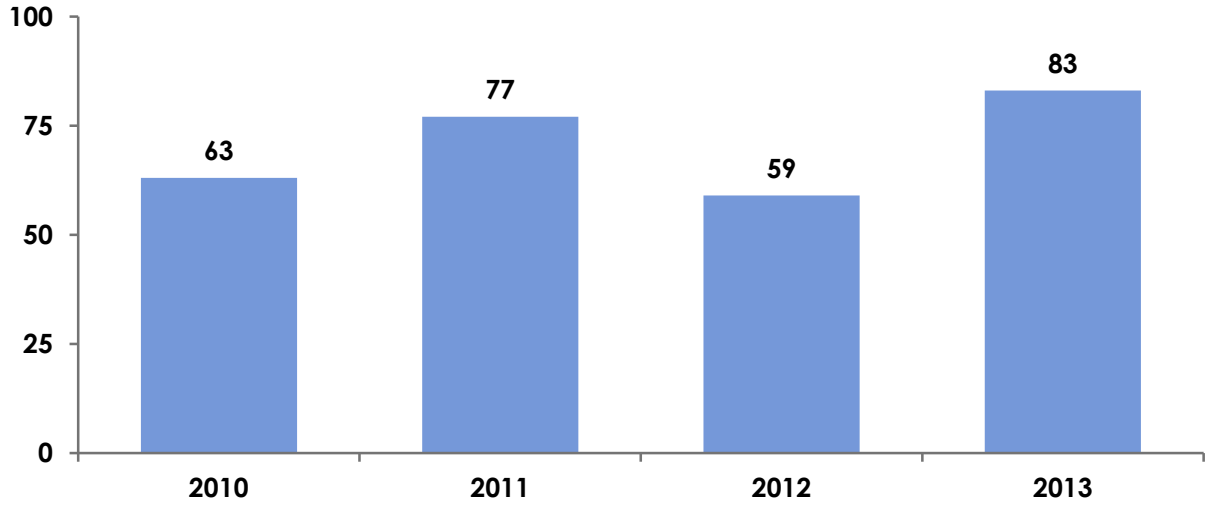
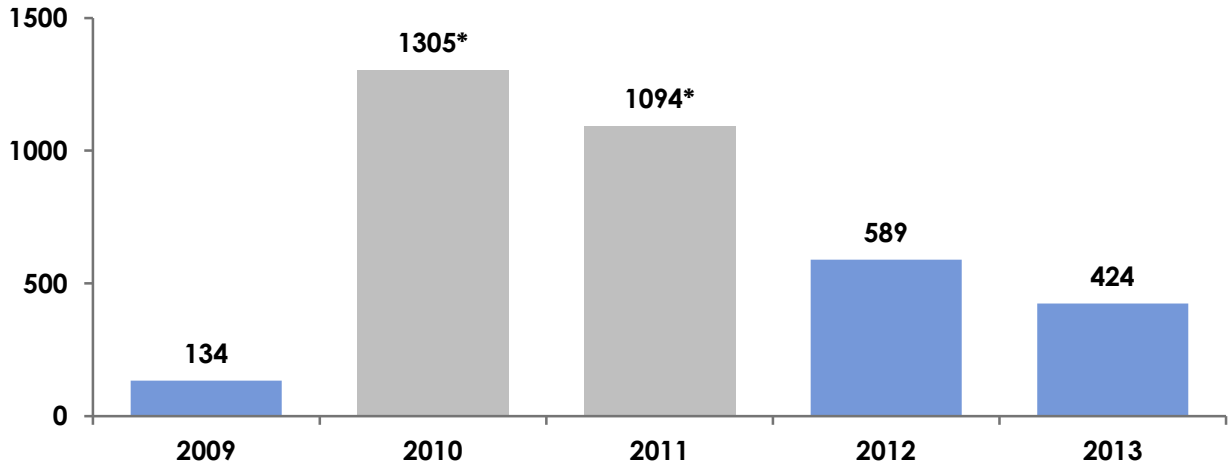


Figure 8. DC Healthy Start - Families Served



Functioning as an urgent care option for the public mental health system, the Physicians' Practice Group (PPG) provides psychiatric evaluations, medication assessments, education, and medication monitoring for children and adolescents ranging in age from 4 to 21. The PPG is intended to operate as a sub-provider when system capacity is reached. Figure 9 shows utilization of the PPG. It should be noted that the low number of youth served in Fiscal Year 2009 reflects the first full year of PPG operations.

Figure 9. Physician's Practice Group Utilization



Moreover, there was a large number of consumers who were enrolled in the government operated DC CSA (District of Columbia Community Service Agency) at the time of its closure in 2010. Many were not transferred to other CSAs in the District, but were reassigned to the PPG to ensure continuity of mental health services. The large increase in PPG enrollment and service utilization in 2010 and 2011 is reflective of the DC CSA closure. By the start of Fiscal Year 2012, a majority of those consumers found more permanent clinical homes.

System Goal 5: Strengthen community-based services to reduce psychiatric residential facility placement and length of stay

Performance Indicators

a. Make use of the interagency Sub-Committee on Residential Placements to monitor/streamline the placement based on a level of care determination.

Placement of a child or youth in a Psychiatric Residential Treatment Facility (PRTF) requires a determination of medical necessity. Pursuant to D.C. Municipal Regulation 29 DCMR § 948, DBH has the authority and responsibility to determine medical necessity for all PRTF placements for Medicaid eligible children and youth of the District.

To ensure an efficient and transparent process, DBH has developed referral procedures for admission to PRTFs that requires: (a) participation by an inter-agency PRTF Review Committee; (b) exploration of all community-based alternatives to residential placement before a PRTF placement recommendation is made; and (c) documentation of teaming efforts to stabilize the child/youth, which includes an explanation of why lower levels of community services have not been successful, and compelling reasons why placement in a PRTF is necessary. DBH has also developed a uniform referral process for continued stay in a PRTF and criteria that must be met in order for the child/youth to remain in a PRTF beyond the original medical necessity certification.

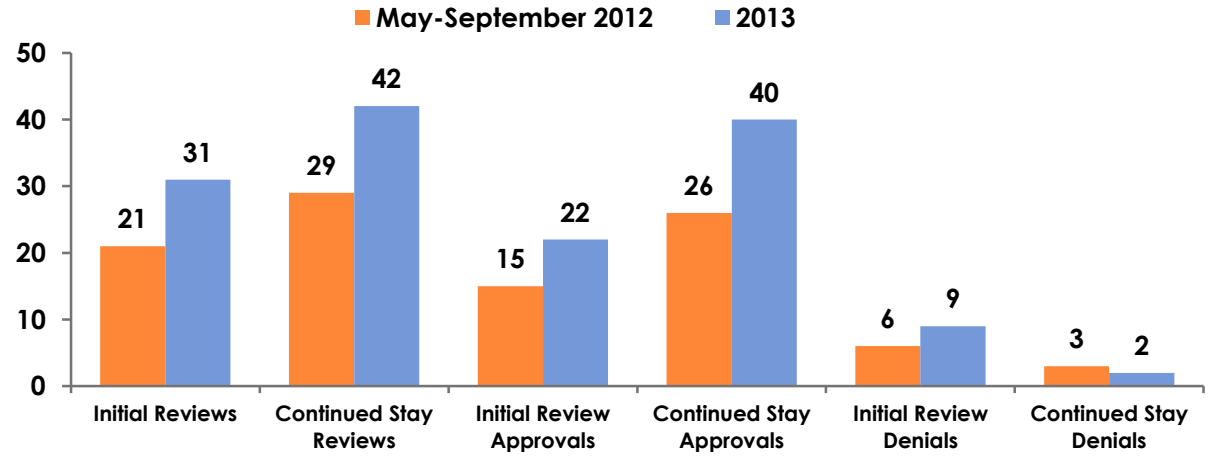
In order to issue a medical necessity determination for placement of a child or youth in a PRTF, the following PRTF medical necessity criteria must be met:

a) Community-based services available in the District do not meet the treatment needs of the child or youth;
b) Proper treatment of the child or youth's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
c) Services in a PRTF can reasonably be expected to improve the child or youth's condition or prevent further regression so that PRTF services will no longer be needed.

If the Committee determines that the child or youth does not meet medical necessity for placement in a PRTF and can be served best in the community, the Committee will deny the referral and provide a list of recommended services and actions necessary to properly serve the child or youth's needs in the community.

DBH began capturing PRTF Review data in May 2012. The Fiscal Year 2012 review data are only representative of five months of the fiscal year. From May 2012 through September 2012, a total of 50 reviews were conducted, 42% of which were initial reviews, with the remaining 58% being continued stay reviews. Compared to the number of reviews completed from May – September 2012, reviews in 2013 increased by 46% to 73 reviews completed. As in the previous period, 42% were initial reviews versus 58% continued-stay reviews. During the 2012 reporting period, 71% of initial reviews resulted in approvals, while 90% of continued stay reviews resulted in approvals. In 2013, 71% of initial reviews resulted in approvals, compared to 95% approval of continued stay reviews. For both initial and continued stay reviews during 2012, 82% were approved, with a slight increase in 2013 at 85%. PRTF Review Committee outcomes are shown in Figure 10.

Figure 10. PRTF Review Committee Outcomes



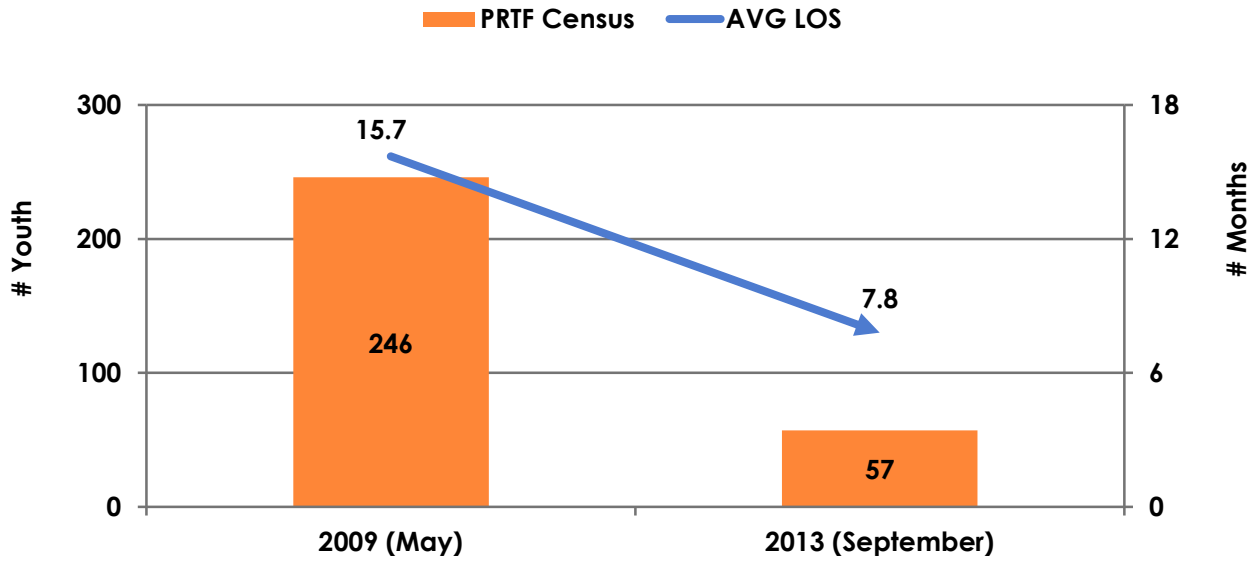
b. Ensure that there are appropriate community-based programs and services to support youth diverted to or returning from residential placements in the community.

DBH has expanded both community and school-based wraparound services with the goal of maintaining children/youth with significant mental health concerns and/or multi-system involvement, successfully and productively in the community. This service is supported through the blending of funds from DBH, CFSA, the Department of Youth Rehabilitation Services (DYRS), OSSE, and the Department's System of Care SAMHSA grant. Wraparound services target youth at risk of placement outside of their home and community (psychiatric residential treatment facilities, residential treatment centers, and nonpublic schools) and for children returning from residential and nonpublic school placements.

In May 2009, a total of 246 District youth (point-in-time census) were located in various PRTFs across the country. Since that time, DBH and its partners have employed a two-pronged approach focused keenly on reducing the total number of youth in PRTFs, while simultaneously working to reduce the amount of time youth spend in treatment at PRTFs. The monthly PRTF census at the end of Fiscal Year 2013) was reduced to 57 youth, a substantial reduction of 77%, compared to the baseline set in May 2009. The average length of stay in PRTFs was 15.7 months in 2009. As shown in Figure 11, by the end of 2013 the average

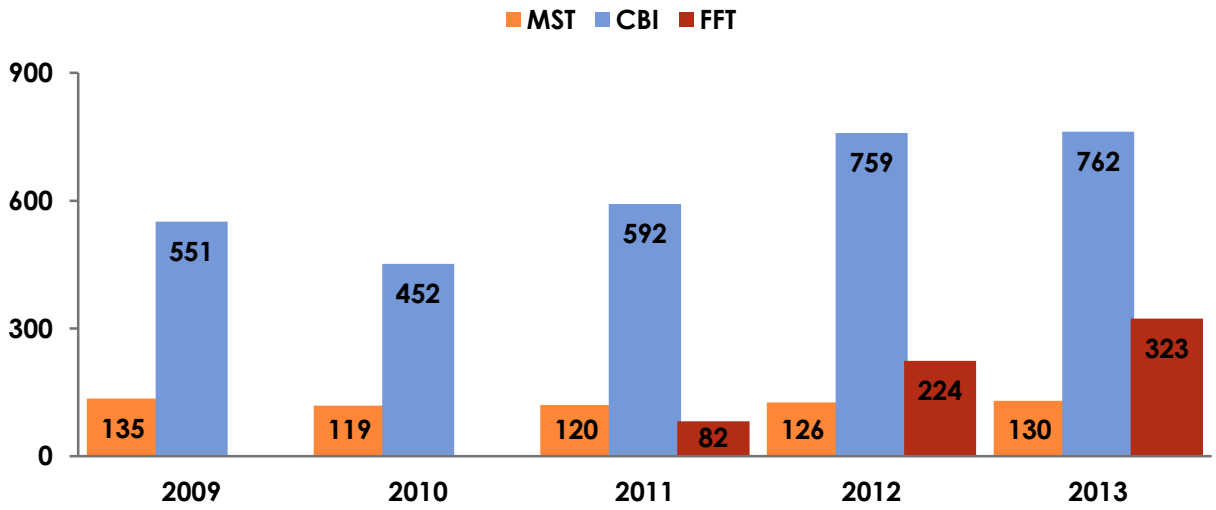
length of stay of youth in PRTFs was reduced to 7.8 months, a decrease of 50%. Because of the decrease in both average census and length of stay between 2009 and 2013 the District was able to reduce spending on PRTF services by approximately $35 million, a savings of $24.5 million in Medicaid funding and $10.5 million in District local dollars. This figure is based on the average cost per day for a PRTF, the average number of youth in PRTFs, and the average length of stay.

Figure 11. Reduction in PRTF Utilization



A concerted effort has been made to increase the overall capacity of the District's CSAs to provide evidence-based intensive therapy and treatment to children, youth, and families within the District of Columbia. The increased availability of intensive services locally means fewer youth are in need of the PRTF level of care, and admitted youth can be stepped-down and discharged from PRTFs sooner. Youth served in the community benefit from living with their family and utilizing natural supports. This expanded availability and increased access to intensive community based services is a critical component in the strategy to reduce PRTF utilization. System-wide growth in utilization of these evidence-based and promising practices is shown above in Figure 12.

Figure 12. Children/Youth Served Locally via Intensive Community-based Interventions



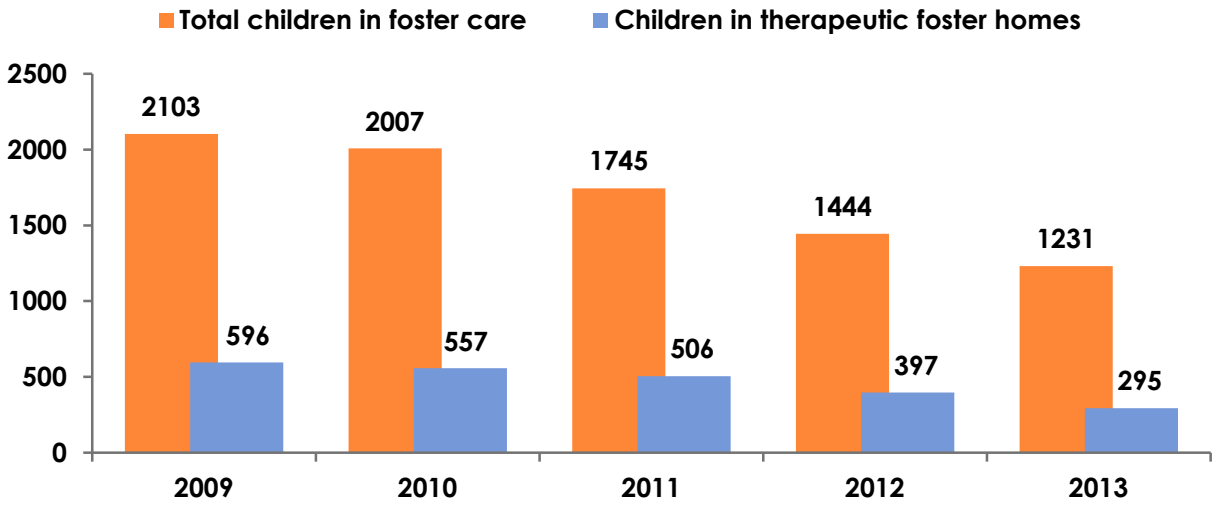
The number of children and youth receiving In-home and Community-based Services (CBI) increased by 38% from 551 in 2009, to 762 in 2013. The greatest growth has been in the utilization of Family Functional Therapy (FFT), which was implemented in 2011. In its first year, 82 children/families received FFT, compared to 323 in 2013, a nearly 300% increase.

c. Expand the therapeutic foster care network and improve the quality of current services.

From 2009 to 2013, the average number of District children in foster care through the Child and Family Services Administration (CFSA) decreased by 41% from 2,103 to 1,231 and the number in therapeutic foster homes, also decreased from 596 to 295 youth, a 51% reduction. (See Figure 13)

Between 2009 and 2013, there was a focus on performance-based contracting with private agencies. Five therapeutic foster care contracts with CFSA were ended for performance reasons over this five-year period, thereby increasing the overall quality of the therapeutic foster care network.

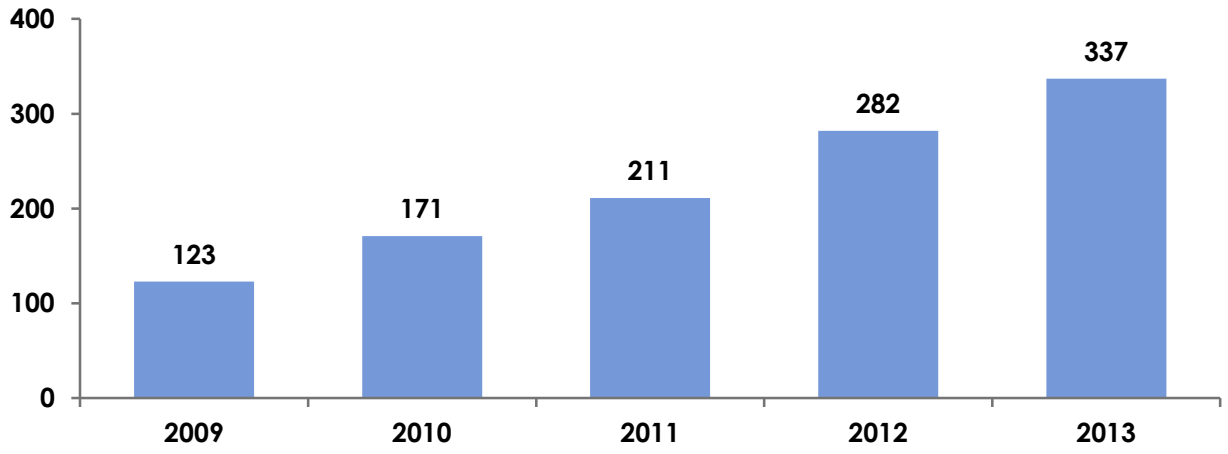
Figure 13. Therapeutic Foster Care



d. Expand the capacity of the community-based services, such as the Wraparound Program.

Concerted effort has been made to expand the capacity of the provider network to offer high-quality community-based services and EBPs and promising practices including Wraparound. Wraparound is a promising practice that works to ensure youth and their families can access individualized care and remain in the most appropriate community setting. Utilization of wraparound services in the District has increased since 2009 when 123 youth and families were served, to 337 in 2013 (Figure 14). During this time, additional providers were added: DC Choices, and the Georgia Avenue and Far Southeast Family Strengthening Collaboratives.

Figure 14. System-wide Wraparound Services Utilization



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

Performance Indicators

a. Engage family and youth as partners at all levels of the children's mental health system, to develop and implement the District's System of Care

To support the strengthening of families and youth as partners in the system of care implementation, DBH selected Total Family Care Coalition (TFCC) to serve as the lead family organization TFCC conducts outreach activities to increase mental health awareness and engages family members and youth in ongoing system of care activities. TFCC has collaborated with DBH, Court Social Services, DYRS, CFSA, DC Public Schools, and other community organizations to support families with a child, or children currently or previously placed in a psychiatric residential treatment facility (PRTF).

b. Facilitate the development of a Family Organization Coalition in the District

In June of 2012, six family organizations indicated interest in developing a federation of family-run organizations. The DC Family Alliance was established

with the goal of strengthening the voice of family organizations to work collaboratively on issues of importance across the system.

c. Ensure that family members are primary decision makers regarding the child/youth/family's treatment

Significant planning occurred during the period to develop a Family Support Specialist training and certification process. Building upon DBH's existing adult peer support program, the program is designed to certify peers who in some cases work for providers and deliver MHRS services. Basic responsibilities of peer specialists include:

- Providing peer-to-peer support
- Supporting families in their efforts to get needs met
- Identifying child and family Team members to include natural and community supports
- Working with families to organize and prepare for meetings so their voices can be heard
- Attending meetings with families
- Partnering with the Care Coordinator

The Family Peer Support Specialist will be a member of the wraparound team whose role is to serve the family by helping them engage and actively participate on the team, facilitating informed decisions that drive the process. Family Peer Support Specialists have a strong connection to the community and are knowledgeable about resources, services, and supports for families, in addition to having an array of personal experiences. These experiences are critical to earning the respect of families and establishing a trusting relationship that the family values.

System Goal 7: Enhance cross-systems collaboration and data sharing

Performance Indicators

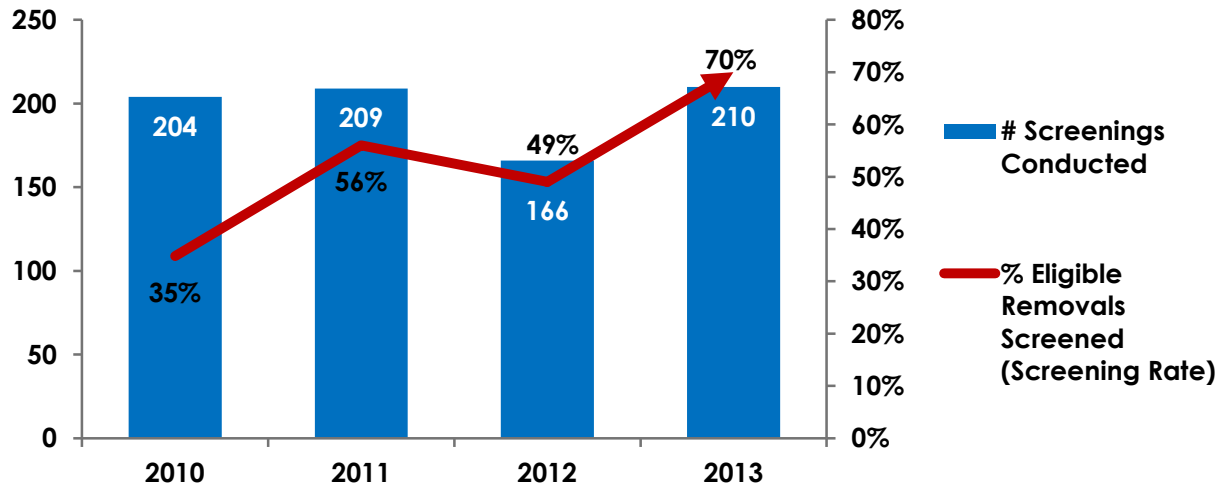
a. Implement a coordinated, team-based approach to service delivery at all levels of service, from mental health promotion to early intervention, to intensive intervention, as a framework for best practice.

Prior to 2009, there was a lack of awareness of shared consumers among DBH and other primary child-serving sister agencies. Since that time, DBH has developed relationships with community partners and sister agencies to provide a coordinated, team-based approach to service delivery. DBH, CFSA, and DYRS now exchange information electronically for case planning and treatment, and program monitoring and evaluation. This exchange of information not only facilitates the identification of children/youth affiliated with more than one human service agency, but also facilitates the inclusion of relevant stakeholders within the District's SOC as participants in treatment planning and family team meetings. Collaboration between District agencies and other critical stakeholders in the children's SOC has brought about the identification and pending implementation of a universal functional assessment, providing real-time client-, agency- and system-level data that is shared between the HIPAA-covered entities involved. DBH participated in regular conversations with the CFSA, the DC Courts and Court Social Services (CSS), and the Department of Youth Rehabilitative Services (DYRS), and internally between DBH's mental health and substance use treatment departments.

Child Welfare:

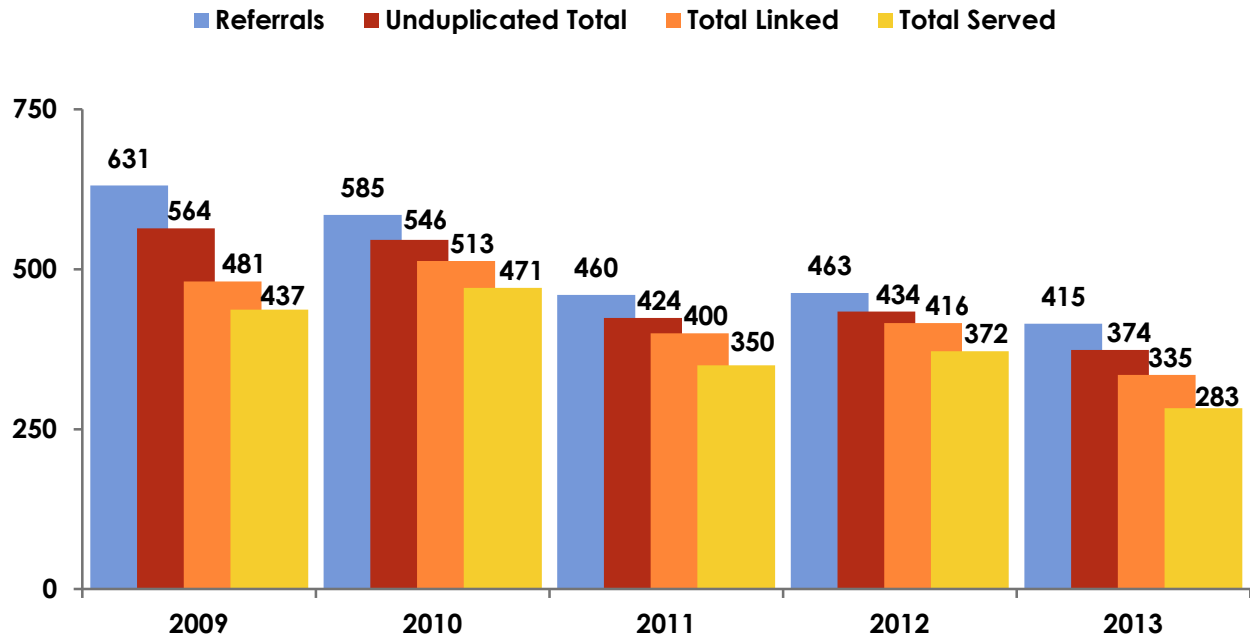
An example of a coordinated approach between District agencies is the co-location of DBH mental health clinicians at CFSA. DBH clinicians screen all youth over the age of two removed from their homes for both initial removals and foster care re-entries. Since its inception in 2009, the program shifted from a referral-based service delivery model to one that ensures that screening takes place for an eligible child within 30 days of the initial removal. Co-located DBH clinical staff doubled the screening rate of foster care removals from 35% in its first full year of operation to 70% in 2013 (Figure 15).

Figure 15. CFSA Screenings and Screening Rate



DBH also located staff on-site at CFSA to promptly process referrals, link children to DBH providers, and notify the prospective provider of the linkage. Figure 16 shows the total number of CFSA referrals for mental health services, the unduplicated total number of referrals, total linked to a DBH CSA, and the total number of those youth who received a mental health service during the fiscal year. CFSA has focused strategically on "narrowing the front door," resulting in a steady decline in the number of children entering foster care. As a result, there was a 34% decrease in referrals, a 30% decrease in the number of youth linked to a CSA, and a 35% decrease in the number of youth served from 2009 to 2013.

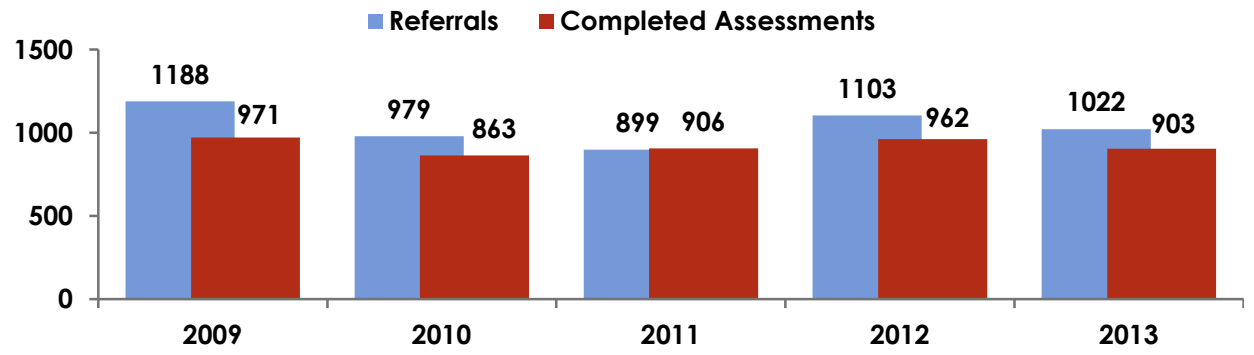
Figure 16. CFSA On-Site Mental Health Services Enrollments



Juvenile Justice:

The Department during the 2009-2013 reporting period has continued its focus on youth involved in the juvenile justice system. The DBH Assessment Center, which is co-located within the DC Superior Court, is an example of interagency coordination and collaboration between Courts and DBH. Court-mandated mental health assessments and psychiatric evaluations are conducted on site. Data from the Assessment Center are shown in Figure 17.

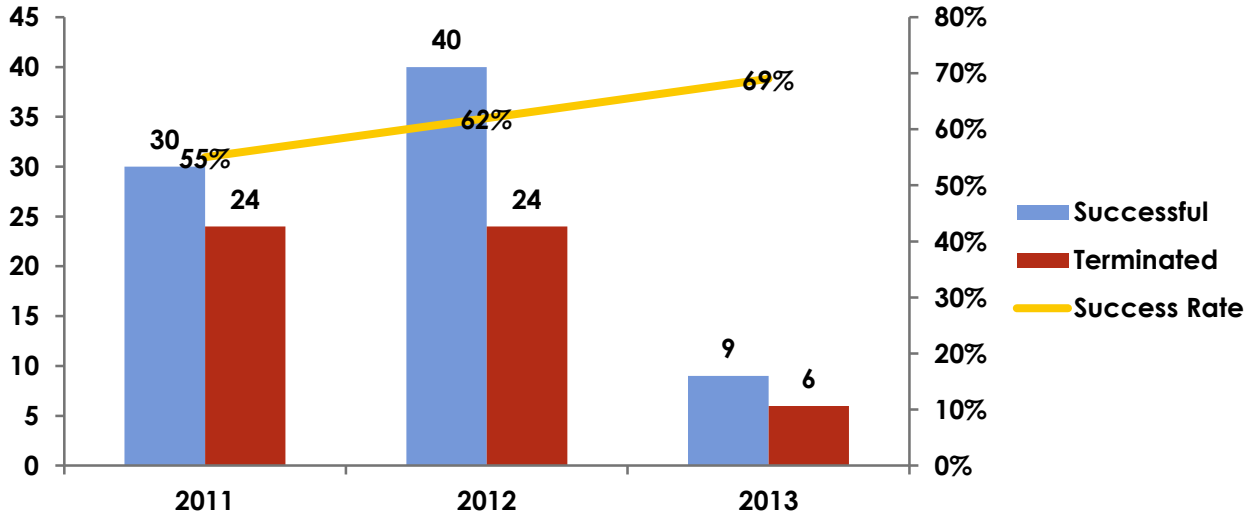
Figure 17. Assessement Center Referrals and Completed Assessments



In 2011, there were slightly more assessments completed than referrals made because a small number of referrals were made at the end of 2010 and completed in 2011.

In 2011, DBH, Court Social Services (CSS), the Office of the Attorney General, the Public Defender Service developed the Juvenile Behavioral Diversion Program (JBDP). The JBDP provides eligible youth charged with certain misdemeanor offenses, the option of voluntarily participating in mental health treatment rather than jail. In most cases, program completion results in the youth's criminal record being expunged. As part of its implementation CSS's research component reviewed and analyzed data generated by JBDP participants, evaluating the program's effectiveness for youth enrolled in the program during the 2011 calendar year. The participants in this cohort were followed for one year post program completion. Results for this 2011 JBDP class showed a significant decrease in the re-arrest rate. Compared to the control group, youth involved in JBDP had a re-arrest rate of 7% while the control group rate was much higher at 43%. Results from the 2012 JBDP cohort showed an increase in re-arrests from 2011to nearly 19%, still significantly lower than the re-arrest rate for the control group (43%). The outcomes and success rates that are shown in Figure 18 indicate the number of youth who met the conditions for JBDP.

Figure 18. JBDP Enrollment Outcomes



Department of Youth Rehabilitative Services (DYRS):

Between 2009 and 2013, there were 1,078 unduplicated youth committed to DYRS who at some point also had involvement with the public mental health system. DYRS and DBH coordinate care for the youth who receive services from both agencies so as to improve continuity of care. Table 8 shows the diagnosis distribution of youth who have been involved with both DYRS and DBH.

Table 8. Primary Diagnosis Distribution for DYRS Youth (2009-2013)

Diagnosis Category	# Youth
Adjustment Disorders	44
Attention Deficit Disorders	112
Bipolar Disorders	79
Conduct Disorders	210
Manic, Depressive, and Other Episodic Mood Disorders	494
Other Disorders	40
Post-traumatic Stress Disorder	34
Schizophrenic Disorders	61
Substance Use Disorders	4
Total	**1078**

b. Enhance the exchange of health-related data across systems to ensure appropriate care coordination, and increase provider capacity to collect and report data to inform policy, training, planning, and decision making.

DBH partners regularly with CFSA and DYRS to routinely produce regular, collaborative, cross-agency reports (described below in Table 9).

Table 9. DBH Collaborative Cross-Agency Data Reports

Agency	Population Description	Report Produced and Exchanged	Frequency
CFSA	Foster care and in-home census	CFSA Comprehensive Mental Health Services Report	Monthly/ Annually
CFSA	Initial removals and re-entries to foster care	CFSA Mental Health Screenings Report	Quarterly/ Annually
CFSA	CFSA youth referred for mental health services	CFSA Access to Mental Health Services Report	Quarterly/ Annually
DYRS	Committed youth census	DYRS Mental Health Services Report	Quarterly/ Annually

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

Although full implementation did not occur during this reporting period, extensive planning for the District-wide adoption of the Child and Adolescent Functional Assessment System (CAFAS) for children ages six and older, and the Primary and Early Childhood Functional Assessment System (PECFAS) for children ages three through five, were determined to best meet the needs of all youth in the District. The CAFAS/PECFAS was selected as the city-wide, uniform, functional assessment for children and youth regardless of the agency. This set of instruments is designed to measure day-to-day functioning among children and adolescents with mental health impairment. The CAFAS/PECFAS is used in the following manner:

- To determine the intensity of services needed (replacing CALOCUS);
- As an outcome measure (pre-/post);
- As an aid to actively manage cases during the course of treatment;
- To assess strengths and weaknesses when setting treatment goals; and
- To inform agency and system-level quality improvement efforts

The CAFAS assesses functioning in the following domains:

- School/work role performance
- Home role performance
- Community role performances
- Behavior toward others
- Moods/emotions
- Self-harmful behavior
- Substance use, and
- Thinking

d. Create an interagency accountability office to support cross-systems implementation of best practices.

Although there is no official interagency accountability office, the SOC Expansion Implementation Executive Team, which is co-chaired by the Deputy

Mayor for Health and Human Services, and the Director of Behavioral Health, serves in a similar capacity. Members include the Directors of all DC child-serving agencies including mental health, health, schools (public and public charter), child welfare, juvenile justice, human services, developmental disabilities, and parks and recreation. In addition, there is representation from the DC Superior Court (Family Court) and families. The team meets bi-monthly and provides oversight of the SOC Expansion Implementation grant and the trauma grant awarded to the CFSA from the Administration of Children Youth and Families.

e. Provide ongoing, cross-systems training and technical assistance to agencies to illustrate methods of System Integration and Accountability design and implementation.

Significant progress has been made toward building an enhanced system of care infrastructure to increase capacity for the provision of effective, family-driven, youth-guided, mental health services. A diverse group of family members, community organizations, providers, and DC agencies have worked collaboratively to design and implement initiatives related to improved access, parent and youth peer support, CAFAS utilization, behavioral health and primary care integration, and reinvestment strategies.

Regarding improved access, a pilot project is currently underway to provide training on screening and linkage to services for mental health related concerns for intake workers at community organizations and to finalize a universal intake form that will support effective linkage and communication. This universal intake form will be implemented across agencies. It will provide a common set of information that documents a family's identified needs and supporting cross-agency communication and care coordination. As mentioned earlier, DC child-serving agencies have agreed to implement the CAFAS for youth receiving services for behavioral and or emotional concerns. This assessment will be used for children involved with the juvenile justice and child welfare systems, as well as those receiving mental health and substance use treatment services. The implementation of the CAFAS has the potential to increase the understanding of both strengths and concerns for an individual child across agency lines, and better inform treatment and practice at both agency and citywide levels.

CONCLUSION

In the last five years, DBH has worked with its partners and stakeholders to achieve the goals presented in the Children's Plan from 2009. As a result of the District's system of care partnership:

- more clinicians offered a wider variety of specialized services proven to improve outcomes for children and youth;
- more children and youth were served in the community, rather than in institutions, and
- the system made measurable progress on teaming among families, District agencies, and community partners.

DBH set as a priority the cultivation of diversity in the type and intensity of available services. This led to increased capacity and types of evidence-based providers, which resulted in the reduction in the number of youth in PRTF placements and the length of time spent in those placements. DBH prioritized early intervention, leading to positive outcomes for young children in their pre-schools and homes. The system has increased teaming and family involvement, thereby, supporting collaboration and more effective practice.

ADDITIONAL SERVICE UTILIZATION INFORMATION

Children's System Demographics and Service Utilization

Figures 19 and 20, and Table 10 provide breakdowns of MHRS utilization by age, race, and gender. Service utilization among children, youth and emerging adults zero to 24 years old increased by 28%, from 4,871 in 2009 compared to 6,236 by the end of 2013. Between 2009 and 2013, DBH served a total of 14,327 unduplicated children, youth and emerging adults.

Figure 19. MHRS Utilization by Age (0-24 years)

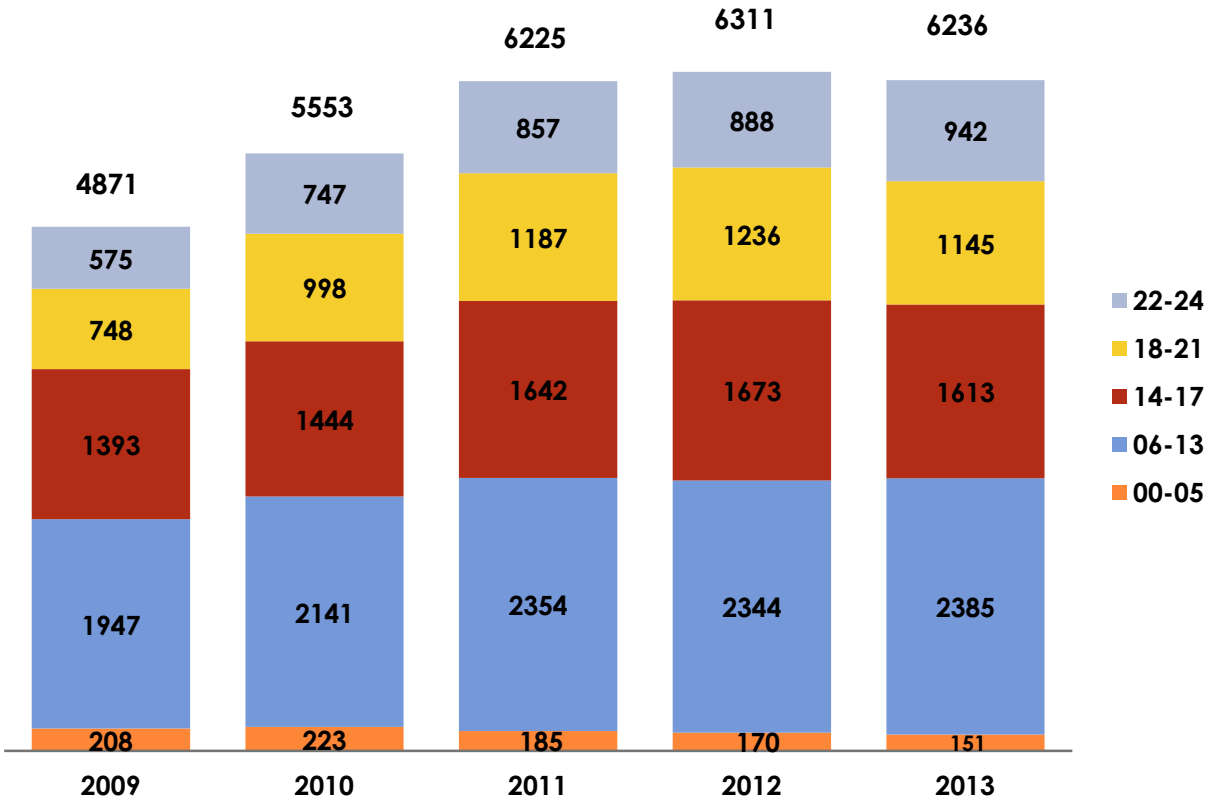
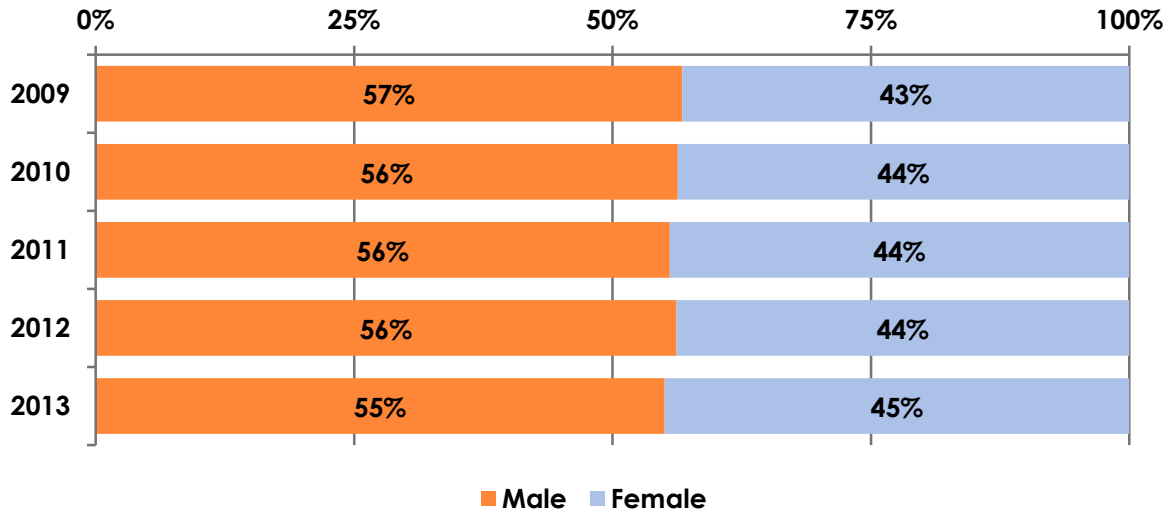


Table 10. MHRS Utilization by Race (ages 0 – 24 years)

Race	2009	2013	% Change
American Indian/Alaskan Native	1	3	200%
Asian	7	11	57%
Black/African American	4494	5961	33%
Hispanic	207	138	-33%
More than one race	4	2	-50%
Native Hawaiian/Pacific Islander	1	0	-100%
Unknown/Other	87	64	-26%
White	70	57	-19%

Figure 20. MHRS Utilization by Gender Distribution (ages 0-24 years)



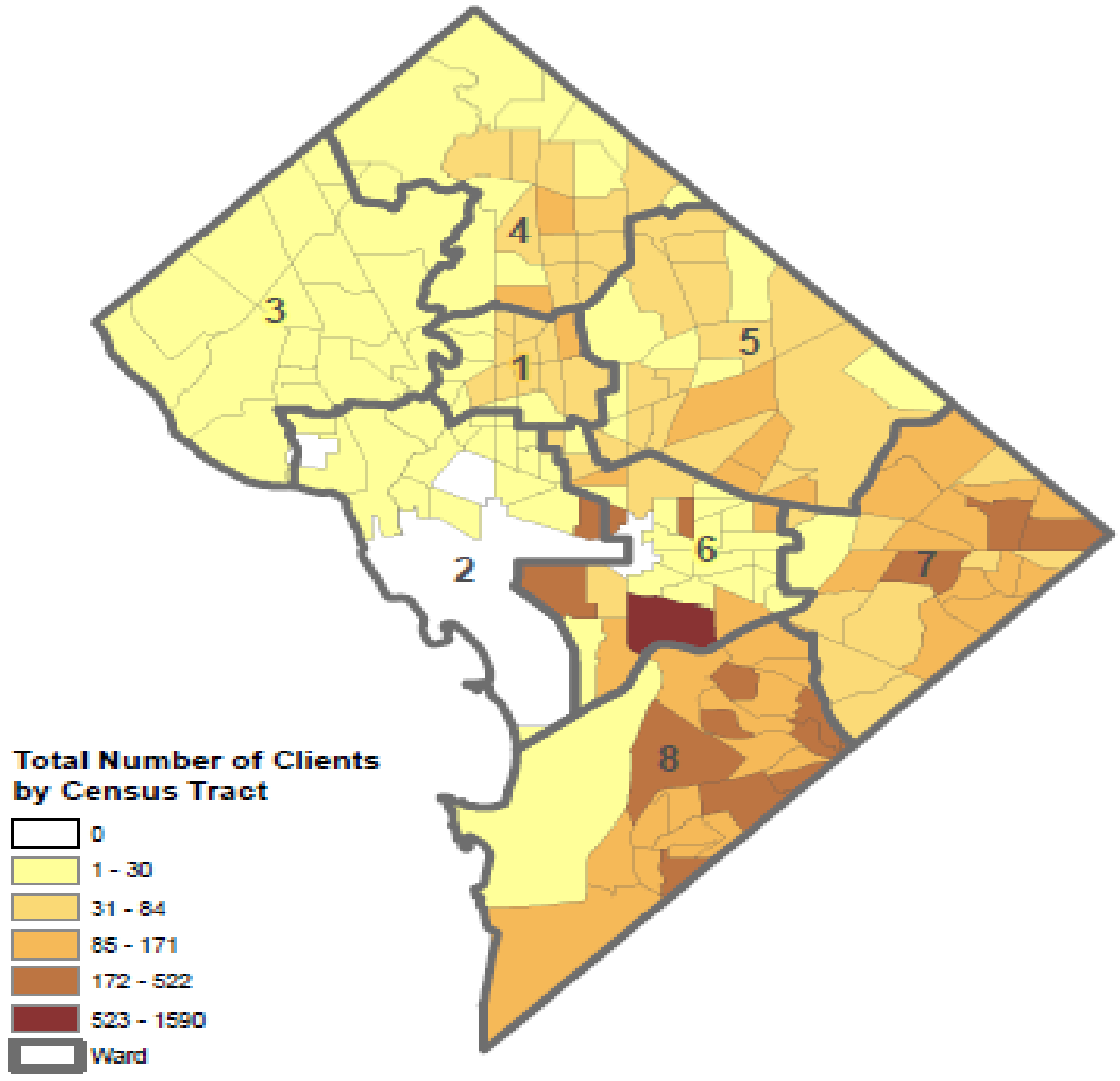
Among children ages 0 – 17, the most common diagnoses were manic depressive illness, and other episodic mood disorders, followed by attention deficit disorders (Table 11). The total number of children and youth receiving MHRS services in this age group rose 17% from 3,545 in 2009 to 4,152 in 2013.

Table 11. MHRS Utilization by Primary Diagnoses Type (ages 0 – 17 years)

Diagnosis Category	2009	2010	2011	2012	2013
Adjustment Disorders	545	666	710	565	482
Attention Deficit Disorders	917	1023	1131	1154	1314
Bipolar Disorders	92	97	96	78	54
Manic, Depressive, and Other Episodic Mood Disorders	1018	1114	1239	1440	1507
Other Diagnoses	733	682	796	762	625
Post-Traumatic Stress Disorder	104	139	144	110	91
Psychoses	126	75	57	66	68
Schizophrenic Disorders	13	12	9	12	11
Total Served	**3548**	**3808**	**4182**	**4187**	**4152**

Utilization by Geography

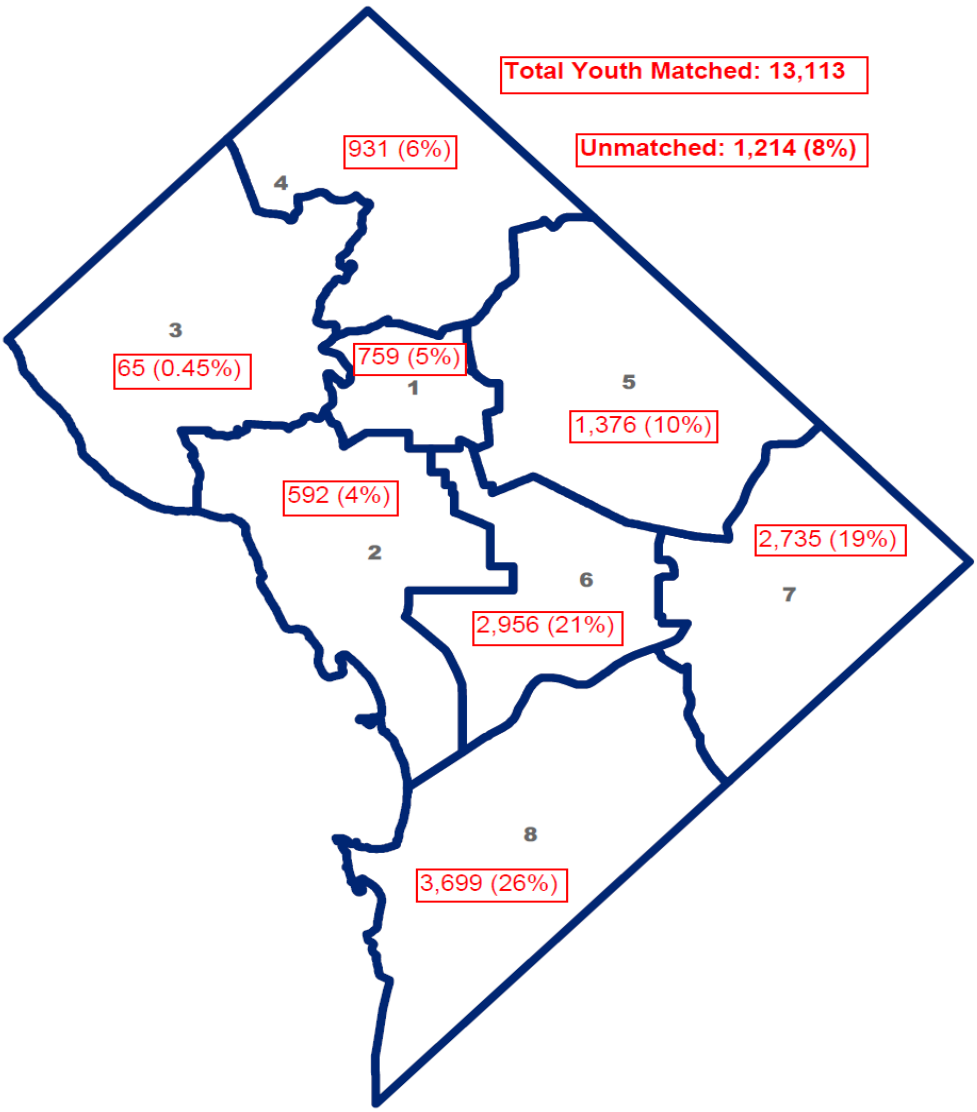
Figure 21. Children, Youth and Emerging Adults Served (2009-2013)



There were 14,327 unduplicated children, youth and emerging adults served between 2009 and 2013. Of those, 13,113 are represented in Figure 21 above, and following in Figure 22. Unmapped addresses for the remaining 1,214 youth were either outside of the District of Columbia or the address could not be found. Figure 21 shows mental health services penetration by District Ward and census tract. Please note the census tract within Ward 6 representing the highest consumer count, includes 1,765 youth in foster care with CFSA

addresses, 1,559 with the current CFSA address, 200 I Street, SE and 205 with the former CFSA address, 400 Sixth Street, SW. More than half of children and young adults served reside in District Wards 8 (26%), 7 (19%) and 5 (10%) as shown in Figure 22.

Figure 22. Consumer Count by Ward (2009-2013)



Child and Youth Mental Health Services Spending

Overall spending on child and youth services (ages 0 – 17) increased by 49% from 2009 ($15.2 million) compared to 2013 (nearly $22.6 million). More specifically, Medicaid spending rose by 71% from 2009 ($12.8 million) to 2013 ($21.9 million). Conversely, spending of local dollars on mental health services for eligible non-Medicaid insured children/youth (usually immigrant/non-citizen) decreased by 72%, from nearly $2.4 million in 2009, to less than $700,000 in 2013. This is in large part due to the shift to bill Medicaid for evidence-based practices. Figure 23 shows the distribution of children's mental health funding streams in the District.

Figure 23. Child & Youth MHRS Spending (ages 0 - 17 years)