WORKING
PAPER

Guide to the Behavioral Health Care System in the District of Columbia

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HEALTH

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GLOSSARY

Access to Recovery (ATR) - a discretionary grant program funded by the Substance Abuse and Mental Health Administration aimed at expanding capacity, supporting client choice, and increasing the array of faith-based and community based providers for clinical treatment and recovery support services

Addiction Prevention and Recovery Administration (APRA) – an agency housed in the Department of Health; responsible for substance abuse prevention, treatment and recovery

Addiction Severity Index (ASI) – tool used to assess appropriate substance abuse treatment

Adolescent Substance Abuse Treatment Expansion Program (ASTEP) – allows adolescents access to a network of substance abuse treatment providers; overseen by the Addiction Prevention and Recovery Administration (APRA)

Alcohol, Tobacco, and Other Drug (ATOD) – term describing use of these substances

Alliance – the DC Healthcare Alliance is a public program providing free health care for eligible District residents

American Society for Addiction Medicine Patient Placement Criteria (ASAM PPC) – criteria used by the Addiction Prevention and Recovery Administration (APRA) to help determine the appropriate level of care for all clients

Assertive Community Treatment (ACT) - intensive, community based mobile clinical services for adults who have been non-compliant with traditional outpatient services; overseen by the Department of Mental Health

Avatar - database used to process transactions, including claims and authorizations; used by the Department of Mental Health (DMH)

Centers for Medicare and Medicaid Services (CMS) – federal agency responsible for health care coverage of its beneficiaries

Central Detention Facility (CDF) – a facility that houses male inmates; overseen by the DC Department of Corrections

Child and Family Services Agency (CFSA) – District agency responsible for the protection of at-risk children and child victims; services include foster care

Children and Adolescents Mobile Psychiatric Program (ChAMPS) – 24/7 emergency intervention program for youth, overseen by the Department of Mental Health and operated by Catholic Charities

Children's National Medical Center (CNMC) – a pediatric hospital in the District

Choosing Options for Recovery and Empowerment Program (CORE) – the Access to Recovery program in the District of Columbia to provide culturally sensitive substance abuse treatment and recovery support services

Community Based Intervention (CBI) - intensive services for children and youth, designed to keep the child in home; overseen by the Department of Mental Health

Comprehensive Psychiatric Emergency Program (CPEP) – a program administered by the Department of Mental Health that provides 24/7 emergency psychiatric services for adults, including mobile crisis services and observation beds

Community Residential Facilities (CRF) - group homes in which people receive 24-hour a day/ 7 days per week supervision

Community Supervision Program (CSP) – the Court Services and Supervision Agency's (CSOSA) probation and parole system for adults in the District of Columbia

Co-Occurring State Incentive Grants (COSIG) - grants provided to states to develop their capacity to treat persons with co-occurring substance abuse and mental disorders

Core Services Agency (CSA) – provider that contracts with the Department of Mental Health to provide mental health rehabilitation services

Correctional Treatment Facility (CTF) – medium security facility used to house female inmates; overseen by the DC Department of Corrections

Court Services and Supervision Agency (CSOSA) – federal agency that performs offender supervision in coordination with the Superior Court of the District of Columbia and the U.S. Parole Commission

Court Urgent Care Center (CUCC) – a program for individuals in the criminal justice system, overseen by the Department of Mental Health

District's Automated Treatment Accounting system (DATA) - a performance monitoring system in development by the Addiction Prevention and Recovery Administration (APRA) based on the Web Infrastructure for Treatment Services (WITS)

DC Community Services Agency (DC CSA) – a public agency that previously provided mental health rehabilitation services; the direct provision of most services by the DC CSA has been discontinued

DC Housing Authority (DCHA) – a public agency that provides affordable housing to eligible District residents

Department of Corrections (DOC) – District agency responsible for the operation of the DC jail and other correctional facilities

Department of Disability Services (DDS) – District agency that provides services for people with disabilities

Department of Health Care Finance (DHCF) – the District's state Medicaid agency; administers Medicaid fee for service, Medicaid managed care organizations (MCOs) and the Alliance program

Department of Housing and Community Development (DHCD) – District agency responsible for affordable housing

Department of Human Services (DHS) – District agency that provides services for residents facing economic and social challenges

Department of Mental Health (DMH) – District agency responsible for the financing and delivery of publicly funded inpatient and outpatient services for individuals with severe mental illness

Department of Health (DOH) – District agency responsible for the promotion and protection of health

Department of Youth Rehabilitation Services (DYRS) – District agency responsible for youth in the juvenile justice system

Diagnostic and Statistical Manual of Mental Disorders, IV (DSM-IV) – manual containing standard classification of mental disorders; contains diagnoses categorized into different levels, including Axis I and Axis II disorders

Disproportionate share (DSH) payments – payments made to compensate hospitals that treat a large share of Medicare and low-income patients

Drug Treatment Choice Program (DTCP) – the District's adult substance abuse treatment program, administered through vouchers provided by the Addiction Prevention and Recovery Administration (APRA)

eCura – database used to process transactions, including claims and authorizations; used by the Department of Mental Health

Free standing mental health center (FSMHC) - offers behavioral health treatment under the supervision of a psychiatrist on a fee schedule. Services may be used by the general public, including the uninsured and people enrolled in Medicaid and the Alliance

Global Assessment of Individual Needs (GAIN) – a series of standardized measures to assess problems and service utilization related to adolescent substance use; utilized in the Addiction Prevention and Recovery Administration's (APRA) Adolescent Substance Abuse Treatment Program (ASTEP)

HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration (HAHSTA) – District agency housed under the Department of Health, responsible for the prevention of HIV/AIDS, hepatitis, STDs, and tuberculosis and providing services to persons with the diseases

Homeless Management Information Systems (HMIS) – software designed to collect data on the needs of the homeless

Health Services for Children with Special Needs (HSCSN) - a special managed care plan for Supplemental Security Income (SSI)-eligible children

Department of Housing and Urban Development (HUD) – federal agency responsible for affordable housing

Institution for Mental Disease (IMD) – an institution with more than 16 beds that provides care to persons with mental illness

Managed care organization (MCO) – a health care delivery system that provides care through a network of providers for a predetermined monthly fee

Mental Health Rehabilitation Services (MHRS) – mental health services provided by the Department of Mental Health via the core services agencies (CSAs)

Pretrial Services Agency (PSA) - the subdivision of the Court Services and Supervision Agency (CSOSA) that is responsible for clients during the stage between lock up and arraignment and sentencing. PSA provides a number of services for clients with mental health and substance abuse issues

Psychiatric Institute of Washington (PIW) – a psychiatric hospital in the District

Residential Substance Abuse Treatment Program (RSAT) - a national program providing residential substance abuse treatment for inmates, funded through Bureau of Justice Assistance, a department within the US Department of Justice

School Mental Health Program (SMHP) – Department of Mental Health program that provides mental health services to youth in some District public and charter schools

Substance Abuse and Mental Health Services Administration (SAMHSA) – federal agency responsible for decreasing the impact of substance abuse and mental disorders

Substance Abuse Treatment Branch (SATB) – a branch in the Community Supervision Program (CSP) of the Court Services and Supervision Agency (CSOSA); supervises offenders with mental health and substance abuse issues after release

Severe emotional disturbance (SED) - term used to describe children experiencing emotional, behavioral, or mental disorders; defined by the Department of Mental Health as having a primary diagnosis on either AXIS I or AXIS II of the DSM-IV Manual or equivalent ICD-9 codes, excluding substance abuse or developmental disorders unless co-occurring

Severe mental illness (SMI) – term used to describe adults experiencing mental disorders; defined by the Department of Mental Health as having a primary diagnosis on either AXIS I or AXIS II of the DSM-IV Manual or equivalent ICD-9 codes, excluding substance abuse or developmental disorders unless co-occurring

So Others Might Eat (SOME) – a community-based organization providing services to the poor and homeless residents of DC

Specialized Supervision Unit (SSU) – unit of the Court Services and Supervision Agency (CSOSA) responsible for supervising adults with mental illness, and developmental delay who have been arrested

Strategic Prevention Framework State Incentive Grant (SPF-SIG) – grants designed specifically to help states design and implement prevention models

Supplemental security income (SSI) – a federally funded program providing benefits to persons with disabilities

United Medical Center (UMC) – a hospital in the District

Web Infrastructure for Treatment Services (WITS) – a performance monitoring system developed by the Substance Abuse and Mental Health Services Administration (SAMHSA)

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1. Introduction

As a result of the tobacco litigation settlement reached in 1998, more than $200 million was made available to the District of Columbia to invest in the health of the city's residents. In 2007, the District contracted with the RAND Corporation to study health and the health care delivery system in the District and provide an informed assessment of policy options for improving the health care delivery system, including through the investment of the tobacco settlement funds. The findings from this work are summarized in two RAND reports.[1] RAND conducted a subsequent study for Children's National Medical Center, which focused on health and health care delivery among District of Columbia youth.[2]

Mental health and substance abuse problems and access to behavioral health care services were resounding issues in community and provider focus groups conducted as part of both RAND evaluations. Primary care physicians in the District, for example, reported significant challenges finding specialty care for patients enrolled in Medicaid, including notably limited options for Medicaid patients with mental health problems. District residents pointed to substantial gaps in the availability of outpatient specialty care, and District parents reported that getting behavioral health care for their children was a daunting problem.

These findings, and others, pointed clearly to the need for more intensive study focused on behavioral health and health care in the District. To address this need, the District of Columbia's Department of Mental Health asked RAND to conduct an evaluation of behavioral health and health care in the District. As we began that evaluation, it became clear to us that the public behavioral health care system was enormously complex and not well understood, and that the first necessary task, before an evaluative effort could proceed, was to document the many pieces and nuances of DC's behavioral health care system. This working paper is intended to meet that need. It provides a detailed handbook for understanding the behavioral health care system. A companion report, presents an analysis of existing data sources and discusses policy recommendations. (Gresenz et al, 2010).

Three District agencies constitute the core of the public behavioral health care system: the Department of Mental Health (DMH), the Department of Health Care Finance (DHCF), and the Addiction Prevention and Recovery Administration (APRA). These agencies provide services, funding, and policy leadership for adults, children, and special populations (e.g., homeless, individual involved with the criminal or juvenile justice system) that access the behavioral care system. The remainder of this working paper is organized around descriptions of these agencies. Chapter 2 describes DMH in terms of its programs, services, and funding; Chapter 3 describes DHCF; and Chapter 4 describes APRA. Because the criminal justice system is separate from the behavioral health system, we have dedicated a chapter (Chapter 5) to describe the special programs for those with behavioral health needs in the D.C. criminal justice system. Chapter 6 summarizes our main findings and presents conclusions.

[1] http://www.rand.org/pubs/working_papers/WR534/ and http://www.rand.org/pubs/working_papers/WR579/
[2] http://www.rand.org/pubs/technical_reports/TR751/

2. Department of Mental Health

In the District, financing and delivery of public mental health services are provided by the Department of Mental Health (DMH), a cabinet-level agency operating separately from the Department of Health (and therefore separate from the APRA substance abuse services) and from DHCF.

The services DMH provides can be broadly classified into outpatient, inpatient, emergency, and "other" services, which includes school-based services. For many of these services, DMH works closely with, and in some cases subcontracts with, community-based providers. An overview of these services appears in Table 2.1.

Table 2.1. Types of Services Offered by the Department of Mental Health

Type of Service	Description
Outpatient	DMH provides outpatient services through the Mental Health Rehabilitation Services program for adults with severe mental illness or children with severe emotional distress.
Inpatient	DMH is responsible for St. Elizabeth's, the sole public psychiatric hospital in the District, and for involuntary civil inpatient commitments to St. Elizabeth's as well as 3 other contracted hospitals: Psychiatric Institute of Washington (beds as needed), Providence (up to 14 beds) and United Medical Center (up to 30 beds).
Emergency	DMH oversees the Comprehensive Psychiatric Emergency Program for adults, the Children and Adolescents Mobile Psychiatric Service, and the Court Urgent Care Center for individuals in the criminal justice system. DMH also contracts with Children's National Medical Center to provide emergency psychiatric evaluations for children.
Other	DMH offers a school-based mental health program, homeless outreach, and services for the individuals in the criminal justice system.[3]

The subsequent sections describe inpatient, outpatient, emergency, and school-based public mental health services. Other services are described in Chapter 5, which focuses on special populations with a high prevalence of mental illness, specifically the homeless and those involved with the criminal justice system.

2.1 OUTPATIENT MENTAL HEALTH SERVICES

DMH primarily provides outpatient services for individuals with severe mental illness through the Mental Health Rehabilitation Services (MHRS) program. Until 2009, DMH was both a funder and direct provider of outpatient mental health services. Its main role now is to fund these services, relying on community-based providers for delivery of care.

[3] The District of Columbia Public Schools also offer counseling and social work services, which will not be discussed in this report.

MHRS provides services for persons with severe mental illness that is amenable to rehabilitative care. In fiscal year 2009, there were a total of 16,977 individuals in MHRS. The majority of these (11,921) were covered by Medicaid Fee For Service (FFS) followed by persons without insurance (3,779) and those in DC HealthCare Alliance (referred to as Alliance in the rest of the document)[4] (2,731).

Eligibility. To be eligible for outpatient services through the MHRS program, individuals must be District residents and meet DMH-established criteria for severe mental illness (SMI, for adults) or severe emotional disturbance (SED, for children). For adults over age 22, the DMH criteria for a severe mental illness are that the condition:

- Has a primary diagnosis on either Axis I or Axis II of Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) or equivalent ICD-9 diagnoses, excluding V codes.[5]
- Is not a substance abuse or developmental disorder unless co-occurring; and,
- Results or is likely to result in a functional impairment that substantially interferes with major life activities. (District of Columbia Register, 2002; The Mental Health Service Delivery Reform Act, 2001)

These criteria also apply to the definition of serious emotional disturbance (SED) for children and youth less than 22 years old.

The MHRS eligibility criteria do not include an income threshold. Although we do not have information on the range of income of persons who currently participate in MHRS, the majority of participants are covered by Medicaid and therefore meet the income requirements of this program. For persons who qualify for Medicaid based on disability, which is the primary means in which coverage for mental health services is obtained, the income requirement in the District is up to 100% of the federal poverty level.[6] (District of Columbia Department of Health Care Finance, 2010). Although there is no time limit for which eligibility expires, it is expected that patients should have a treatment plan that shows that rehabilitative services are needed and that an active plan is in place. A patient is evaluated by providers to determine and update this treatment plan upon entry into the system as well as every 180 days during continuous care and when a higher or different level of care is needed (Department of Mental Health, 2009).[7] Providers receive periodic audits to ensure that clients in their care have an appropriate treatment plan justifying MHRS care.

For many individuals the primary access point for MHRS services is the DMH Access HelpLine. The Access HelpLine is a 24-hour service staffed by a team of mental health clinicians (licensed

[4] The DC HealthCare Alliance is a public program funded by the District local government to provide free health care services to uninsured individuals and families.

[5] Although District Code states that individuals must have DSM IV diagnoses or ICD-9 equivalent diagnoses. However, per communication with DMH staff (December, 2009), in most cases these refer to Axis I and Axis II diagnoses.

[6] The income requirement for children enrolled in Medicaid is up to 300% of poverty for ages 0-18 and up to 200% of poverty for ages 19-21.

[7] The initial and periodic assessments are completed using the Level of Care Utilization System evaluation tool for adults or for children (generally between the ages of 6-18) a Child and Adolescent Level of Care Utilization System.

social workers and nurses), which serves as a referral point for linking clients with mental health services. It can be accessed by anyone, including potential MHRS clients and health care providers. HelpLine staff perform a brief screening assessment, can determine provisional MHRS eligibility and, as appropriate, direct individuals to contracting providers (known as Core Service Agencies or CSAs). Staff typically work with a client to identify their individual needs, such as language requests, provider preference, location, age and population characteristics, to match them to an appropriate provider. The Access HelpLine can authorize a number of services, including: outpatient services, admission to St. Elizabeth Hospital, crisis bed continuing stays (greater than 48 hours), and involuntary admissions for the uninsured. It does *not* authorize children's hospitalizations, community hospital voluntary hospitalizations, ambulance transports or housing. Although authorizations can occur at the time of the call, more specialized services, such as Assertive Community Treatment or Community Based Intervention may take 48-72 hours for approval.

Consumers may also directly enroll in MHRS on-site at a CSA. In addition, individuals may be referred to MHRS by hospital staff, through crisis services such as the Comprehensive Psychiatric Emergency Program, after a discharge from the DC Jail, or through pretrial services.

At the CSA, providers perform a more detailed intake assessment of clients (than that done by the Access HelpLine) to determine eligibility for services. This assessment is forwarded to DMH for approval. For individuals not enrolled in Medicaid, the CSA may also help initiate an application for Supplemental Security Income benefits.[8]

Services. Individuals in the MHRS program are eligible to receive a variety of services designed to both treat and rehabilitate adults with severe mental illness or children with severe emotional disturbance. The services provided for MHRS clients are shown in Table 2.2. There are four "core" services: 1) medication and somatic treatment, 2) counseling and psychotherapy, 3) community support, and 4) diagnostic and assessment services. Other non-core services are provided as needed. (Department of Mental Health MHRS Services)

[8] Supplemental Security Income is a federal program for low income, disabled individuals that provides cash assistance as well as Medicaid benefits.

Table 2.2. Mental Health Rehabilitation Services

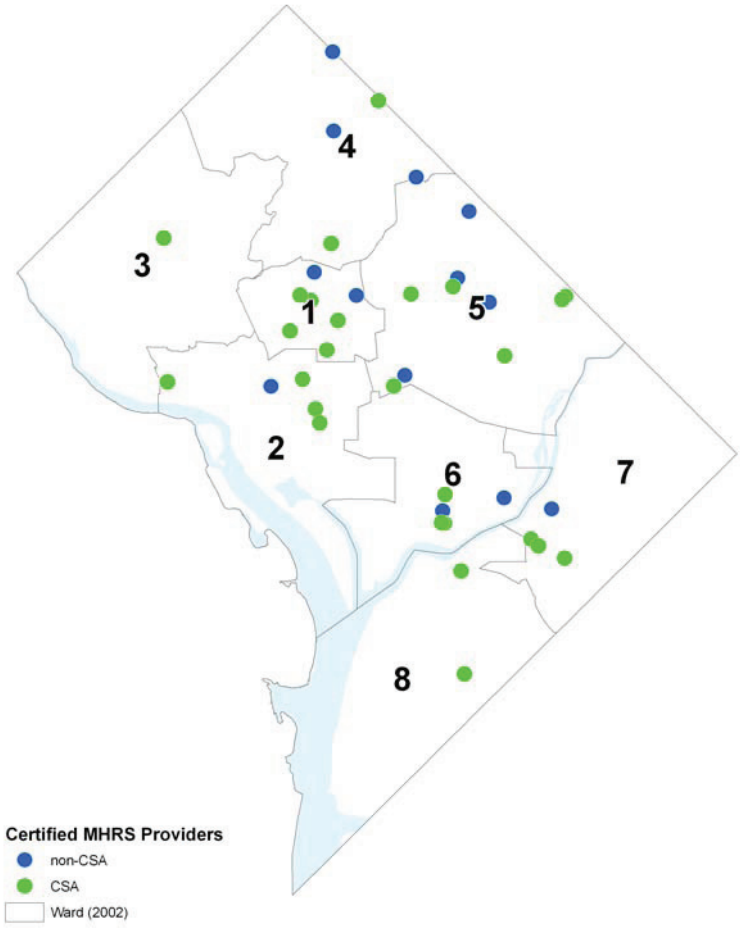
Service Type	Description of Services
Medication/Somatic Treatment*	Medical interventions including the prescription, supervision and/or administration of mental health-related medications.
Counseling and Psychotherapy*	Individual, group or family face-to-face services for symptom and behavioral management; increasing adaptive behaviors, and enhancing daily living skills
Community Support*	Services which help agencies build and maintain a therapeutic relationship with the consumer. These include supportive employment and housing assistance.
Diagnostic/ Assessment*	Intensive clinical and functional evaluation of a consumer's mental health with recommendation for service delivery.
Day Rehabilitative Services	Structured clinical programs, available for adults and children, that are not offered in a home or residential facility.
Intensive Day Treatment	Facility-based structured intensive treatment 7 days a week for acute cases, serving primarily as an alternative to inpatient care or as a step down from inpatient care.
Crisis and Emergency Services	Immediate response to an emergency situation involving a consumer with mental illness or emotional disturbance.
Community Based Intervention	Intensive services for children and youth, designed to maintain the child in-home.
Assertive Community Treatment	Intensive, community based mobile clinical services for adults with a history of non-compliance with traditional outpatient services.
Supportive Services	Referral to housing services and supported employment.

*Core Services

Service Delivery. DMH contracts with a number of agencies to deliver MHRS services.[9] Providers who offer the four core services are classified as CSAs; those providers who offer only a subset of these core services can be certified as a sub-provider. (DMH, 2009) The CSAs are located in a number of locations throughout the city. Figure 2.1 shows the locations of MHRS providers in the District; some of the providers are also CSAs, some are not.

[9] Some of the same agencies that are certified CSAs also accept Medicaid FFS, participate in one ore more Medicaid managed care networks, or are free standing mental health centers and thus may serve both MHRS and non-MHRS populations. But, their non-MHRS service provision is independent of any relationship with DMH.

Figure 2.1 Locations of Mental Health Rehabilitation Services Providers



After a patient has been assessed and deemed eligible by DMH for MHRS, the CSA establishes a treatment plan and submits an electronic authorization for services. Although the four core services do not require pre-authorization, other services require authorization DMH.

DMH certifies CSAs, offers technical support and training (such as on diagnostic tools and assessment software) and provides intermediary billing services (i.e., bills DHCF for Medicaid eligible services provided at CSAs). DMH also oversees the quality of care provided by CSAs through a number of mechanisms: 1) audits of provider claims and charts to determine overpayments as well as review the quality and appropriateness of a randomly selected subset of individual treatment plans, 2) an annual survey to assess consumer satisfaction, 3) development of a provider 'scorecard' that when complete will provide the public with details regarding the provider's quality (e.g. organization's staff levels of training and audit infrastructure), and 4) risk management and investigations of potential fraud and abuse among MHRS providers.

There are 27 CSAs under contract with DMH to provide MHRS services. (DMH website; DC CSA News Transition Brief). Between 2005 and 2010 DMH stopped certifying new CSA providers to ensure that there was adequate patient volume at the existing CSAs. Over that time

period, DMH lost an average of 2-3 CSAs per year. CSAs vary tremendously in terms of the number and types of MHRS clients served, with some CSAs serving as few as 5 clients and others as many as 4,000 clients. Eighteen of the 27 CSAs provide services for children and youth. (DMH website; CSA Consumer Transition Information)

In March 2009, DMH began transitioning away from direct service provision for persons within MHRS in order to focus on its role as a primary funder of services.[10] The DMH Mental Health Services and Support Division (MHSD) has retained some responsibility for direct service provision to particular populations, most notably consumers dually diagnosed with SMI and developmental disabilities as well as those with SMI who have hearing impairments. MHSD also provides cultural and language services, some pharmacy services, services aimed at competency restoration for persons presenting to the court who are incompetent to stand trial, a psycho-education program, and a program that deploys psychiatrists to fill gaps where CSAs have a need.

Outpatient Services for Children. Through their MHRS program DMH provides mental health services to approximately 3,500-4,000 children. About 2,000 of these children are in the Child and Family Services Agency (CFSA). Children also receive DMH services through other mechanisms including via DMH's emergency services (see Section 2.3) as well as through the School Mental Health Program (see Section 2.4).

CFSA is responsible for child protective services, supportive family services, and foster care. When a child enters the CFSA system, he or she is disenrolled from his or her Medicaid MCO and then receives coverage via Medicaid FFS. Mental health services, if needed, are provided through DMH's MHRS program. There is an intake clinic onsite at CFSA that does initial screening for children to assess mental health needs. As of September 2009, there were five CSAs responsible for providing care for all CFSA children who require mental health care. These CSAs comprise the DMH "Choice" service providers, which serve as the integrated behavioral health home for children with the foster care system.[11] The Choice providers offer a number of wraparound services including intensive community based services. These Choice providers are also paneled with the Medicaid MCOs so that when a child leaves MHRS (Medicaid fee for service) and returns to a Medicaid MCO, he or she can have continuity of care.

Children generally receive outpatient care through their Medicaid MCOs or through CSAs. Children's National Medical Center has outpatient services including a number of programs for children with special mental health needs (e.g., special programs for attention deficit and hyperactivity disorder, mood disorders, anxiety, autism, neurobehavioral problems) and physical health co-morbidities (e.g., programs for HIV, hematology/oncology, obesity and diabetes). These programs are not part of MHRS; they are reimbursed separately through the child's insurance.

[10] Services were also provided directly by DMH through its DC Community Service Agency. The transition is described in more detail in Appendix B.

[11] The five Choice CSAs are Community Connections, Universal Healthcare, Family Matters, Progressive Life, and First Home Care (as of August, 2009).

DMH's MHRS program includes intensive in-home treatment that is not otherwise covered by the three of the Medicaid MCOs (Unison, Chartered and HealthRight). The fourth Medicaid MCO, Health Care for Children with Special Needs, has some intensive therapy for its children as part of its coverage, which is provided directly rather than through DMH. As of September, 2009, there were no residential treatment facilities in the District. Children currently enrolled in residential programs are located in a number of states throughout the country. DMH is working to repatriate many of these children back into the District.

Free-Standing Mental Health Centers. Free-standing mental health centers (FSMHCs) are one source of outpatient care for persons who are not enrolled in MHRS. FSMHCs offer behavioral health treatment under the supervision of a psychiatrist on a fee schedule. Services may be used by the general public, including the uninsured and people enrolled in Medicaid and Alliance. Services provided to Medicaid enrollees are directly reimbursed by Medicaid and are not routed through DMH. These reimbursable services include individual psychotherapy, prescription visits, family therapy, family conferences, complete psychological testing and group therapy. (Office of the Secretary, District of Columbia)

As of December, 2009, DMH did not provide oversight to FSMHCs that were not CSAs; however, DMH plans to improve integration of care provided by the FSMHCs with DMH-provided services. As of March, 2010, there were 28 freestanding mental health centers, 7 of which were also CSAs.[12] In the past, FSMHCs have had a different Medicaid reimbursement fee schedule which had been substantially lower than the MHRS rates. The difference in fee schedules led to the reduction in the number of FSMHCs. (Baskerville, 2007) In 2009, the reimbursement rate for all Medicaid provider services, including psychiatric services provided by FSMHCs, was increased to narrow the gap with MHRS rates. (DC Behavioral Health Association, 2008)

Mental Health Service Delivery for Individuals with Co-Occurring Disorders. A significant number of persons with severe mental illness also have co-occurring substance abuse disorders. In 2009, the self reported rate of substance abuse among MHRS clients was about 34% (or 5,831 of 16,977 persons in the MHRS). In 2005, the District of Columbia was awarded a Co-Occurring Disorders State Incentive Grant (COSIG) from SAMHSA. DMH administered the grant and collaborated with APRA to implement grant-related activities. The purpose of the grant was to improve integration and collaboration across agencies that treat individuals with co-occurring mental health and substance abuse disorders, and develop common assessment tools and a shared data infrastructure to facilitate the treatment of this population. As a result of the COSIG grant, providers at St. Elizabeth's Hospital received training on how to screen and treat individuals with co-occurring disorders. Through the COSIG, DC also identified three community providers that had trained staff and could treat individuals with co-occurring disorders: Anchor, Green Door, and Community Connections. The COSIG grant expired in 2008.

[12] List of current CSAs and FSMHCs provided from the Department of Mental Health.

2.2 INPATIENT MENTAL HEALTH SERVICES

Inpatient hospitalizations for mental health can be categorized along several dimensions, including:

- civil vs. forensic hospitalizations
- voluntary vs. involuntary hospitalizations
- short (14 days or less) vs. long-term hospitalizations

Civil vs. Forensic Hospitalizations. Forensic hospitalizations involve the criminal justice system and can include hospitalizations for evaluations of competence to stand trial, restoration of competence to stand trial, and for treatment of inmates who need more help than can be provided through a correctional setting. (Fisher, 2002) Civil hospitalizations involve individuals who are not in the criminal justice system and can be involuntary or voluntary.

Voluntary vs. Involuntary Hospitalizations. Voluntary hospitalizations can be the hospitalization of a competent adult with the individual's consent or a hospitalization made voluntarily on behalf of an incompetent adult or minor by a guardian or health care durable power of attorney. (DC Code DC ST § 7-1231.07; DC ST § 21-511) An involuntary hospitalization, or "commitment", is made by an authorized agent, and occurs when an individual is deemed to be a danger to himself/herself or others due to mental illness if not hospitalized.[13]

Short vs. Long Term Hospitalizations. A short-term hospitalization is when an individual is hospitalized due to mental illness for 14 days or less; contrastingly, a long-term hospitalization lasts for more than 14 days.

DMH has two key roles with regard to inpatient services. First, it is responsible for staffing, operating and overseeing the sole public psychiatric hospital in the District—St. Elizabeth's Hospital. Second, DMH is responsible for involuntary hospitalizations of District residents.

St. Elizabeth's Hospital. St. Elizabeth's receives both civil and forensic patients. All of the District's forensic hospitalizations occur at St. Elizabeth's.

Other than forensic patients, most persons admitted civilly (either involuntarily or voluntarily) do not go immediately to St. Elizabeth's when an acute inpatient stay is needed. These patients are only transferred to St. Elizabeth's after a 14 day inpatient mental health stay at another District

[13] An involuntary commitment occurs after paperwork is filed by an authorized agent (i.e. Metropolitan Police Department, authorized agent accredited by DMH, practicing psychologist or practicing physician) who determines that emergency hospitalization is needed. Within 48 hours, an individual who is committed must receive an evaluation by a psychiatrist or psychologist and a petition must be filed with the court; emergency detention can extend for 7 days, and can later be extended to 14 days. A court can order extended commitment periods, though this must occur in the least restrictive environment. Commitment will end when the court orders the person to be discharged or when the hospital or department determines that the person no longer requires inpatient treatment. (DC Code DC ST § 21-526) Anyone who is involuntarily hospitalized has the right to consult with counsel or be assigned a court appointed counsel to petition their commitment.

hospital. In generally, persons who are transferred from a District hospital to St. Elizabeth's after a 14 day inpatient have Medicaid or Alliance coverage or lack insurance.[14]

Occasionally, patients may have an involuntary civil commitment to St. Elizabeth's before they have had a 14 day stay elsewhere. Such commitments may occur for individuals known to have a history of prolonged inpatient stays or persons who are "committed" outpatients (i.e., a patient who has been court-ordered to receive outpatient care for a year or more).

Involuntarily Committed Patients. DMH negotiates contracts with hospitals to care for involuntarily committed patients. In the District, involuntarily committed patients are sent to one of four hospitals: St. Elizabeth's, Psychiatric Institute of Washington, Providence Hospital and United Medical Center. [15] DMH (through the Access HelpLine) helps to place all involuntarily committed patients.

DMH pays for involuntarily committed uninsured and Alliance patients (as well as anyone without a mental health benefit). When a patient has private insurance or Medicaid, the insurance pays for their hospitalization. Medicaid FFS will not pay for individuals aged 22 to 64 that are hospitalized inpatient at Institutions for Mental Diseases (IMDs), defined as inpatient facilities of more than 16 beds whose patient roster is more than half people with severe mental illness. In the District, St. Elizabeth's and the Psychiatric Institute of Washington are IMDs. Medicaid FFS enrollees who are involuntarily committed are typically sent to either Providence or United Medical Center, which may be reimbursed by Medicaid FFS for an inpatient admission. When a Medicaid FFS enrollee does go to one of the IMDs, DMH has to cover the costs solely out of local dollars. The IMD exclusion does not apply to Medicaid MCO enrollees.

DMH also pays for hospitalizations that last longer than 7 days for patients with Medicaid FFS.[16] Patients with Medicaid FFS, Alliance or who are uninsured and require prolonged hospitalization (greater than 14 days) are typically transferred to St. Elizabeth's, where the cost is paid by DMH.

Voluntary Admissions. DMH's role is different for voluntary inpatient admissions. DMH is *not* financially responsible for Alliance and uninsured individuals who have a voluntary inpatient mental health hospitalization. Hospitals who accept these patients may receive some compensation through federal Disproportionate Share Hospital, or DSH, payments, although at general hospitals DSH payments are not specifically earmarked for mental health services and therefore it is not possible to calculate the specific amount of DSH payments allotted towards mental health services. Medicaid enrollees who have a short-term voluntary inpatient mental health hospitalization are also *not* under DMH's purview; rather, these individuals may be hospitalized in an inpatient mental health unit at any of the hospitals that accept FFS Medicaid insurance or contract with one of the Medicaid managed care organizations. As noted, Medicaid FFS does not reimburse care provided at IMDs. Further, for patients who are transferred to St.

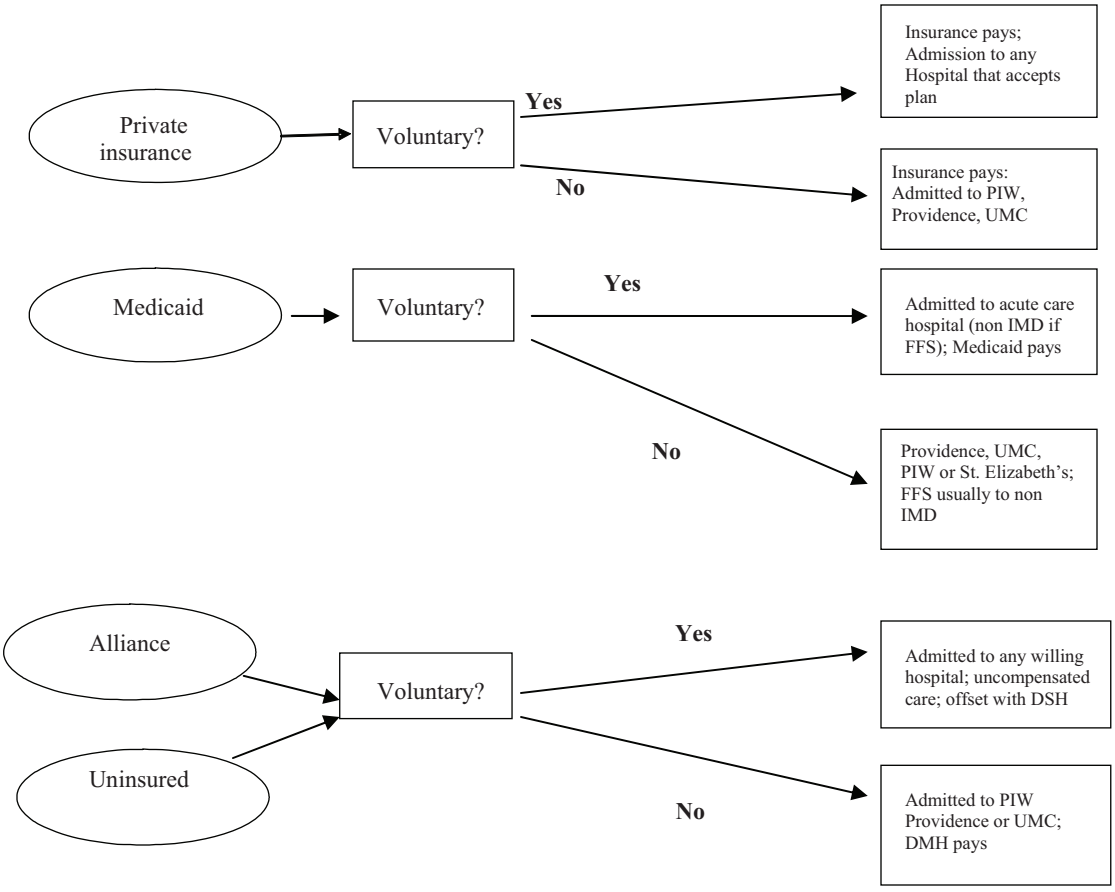
[14] Most privately insured patients, if their benefits provide coverage, stay at the original admitting facility.
[15] DMH is contracted with United Medical Center (UMC) for up to 30 involuntary beds, Providence for up to 14 involuntary beds, and PIW as needed (since it is an IMD). Personal communication DMH May 10,2010.
[16] This coverage after day 7 at acute care hospitals allows for hospitals to be paid the full cost of care. Since acute care hospitals operate using diagnostic related groups (DRGs), Medicaid will cover only 7 days of care. DMH will cover care beyond 7 days.

Elizabeth's (typically after 14 days), DMH pays for care for patients with Alliance, Medicaid FFS and the uninsured. Table 2.3 describes inpatient services by insurance and admission category. Figure 2.2 shows the flow of patients by these same categories.

Table 2.3. Inpatient Services and the Department of Mental Health

Insurance Type	Initial Voluntary (Civil) Admission	Initial Involuntary Civil Commitment	Individuals Requiring Prolonged Care (>14 Days)
Medicaid	Medicaid FFS pays for admissions to acute care hospitals; no Medicaid FFS payments are made for admission to an IMD. Medicaid MCOs can pay for both acute care and IMD hospitalizations.	Medicaid FFS pays for admissions to acute care hospitals; no Medicaid FFS payment for admission to an IMD. DMH pays after day 7 of hospitalization for Medicaid FFS admissions. Medicaid MCO pays for Medicaid MCO patients at both acute care and IMDs.	DMH pays for patients admitted to St. Elizabeth's.
Alliance Or Uninsured	No DMH role; admissions may be compensated through federal Disproportionate Share Hospital (DSH) payments.	DMH responsible; contracts with local hospitals for inpatient bed and pays for services	DMH pays for patients admitted to St. Elizabeth's
Privately Insured	No DMH role; admissions covered through private insurance.	Admissions covered through private insurance.	Privately insured patients will usually stay at initial hospital as long as insurance covers care.

Figure 2.2. Flow Diagram for (Initial) non-Forensic Inpatient Mental Health Care Services*



**Applies to non-criminal cases; forensic (criminal) cases are admitted to St. Elizabeth's and paid for by DMH. (PIW: Psychiatric Institute of Washington; UMC: United Medical Center)*

Inpatient Services for Children. Children can receive inpatient mental health services at only two sites in the District: Children's National Medical Center (CNMC) or at the Psychiatric Institute of Washington (PIW). CNMC has two inpatient psychiatry units. The first is a 12-bed unit for children ages 13 and under. The second is a 14-bed adolescent unit for ages 13 to 18 years. CNMC also has a consultation service for children hospitalized with physical health complaints who also need inpatient mental health services. When psychiatry beds are not available at CNMC, children must be transferred to other facilities. The only other facility available for children with Medicaid is PIW. Children with private insurance can be transferred to Maryland or Virginia facilities.

PIW has 3 inpatient units for children with services generally covered by Medicaid. There are two acute care units, which provide inpatient care for children in crisis needing emergent

services and a subacute unit, which provides longer term care provided in the interim between crisis and recovery. One acute care unit has 12 beds and is targeted for children aged 5-12 (up to 12 beds). The second acute care unit has 30 beds and is for adolescents. The sub-acute unit is designed to help reintegrate children in the juvenile justice system into the community. This unit was initially started in partnership with the Division of Youth Rehabilitative Services but has been expanded to include referrals from other sources, including the DC Public Schools, as well as the courts and Medicaid MCOs. It is designed for children who need closer monitoring (i.e. in a 24 hour setting) but who are not actively homicidal or suicidal. More discussion about children in the juvenile justice system (served by the Division of Youth Rehabilitative Services) appears in chapter 6.

2.3 CRISIS AND EMERGENCY SERVICES

DMH is also responsible for mental health crisis and emergency safety net services for DC. Key components of these services include the:

- Comprehensive psychiatric emergency program (CPEP), which offers adult crisis services and operates a mobile crisis van;
- Children and Adolescent Mobile Psychiatric Service (ChAMPS).
- Court Urgent Care Center (CUCC), which provides crisis services through the DC judicial systems.

CPEP is located on the grounds of the former DC General Hospital and provides twenty-four hour/seven day a week emergency psychiatric services, mobile crisis services and extended observation beds (up to 72 hours) for individuals 18 years of age and older. CPEP services can be accessed by telephone or in person; and people are frequently brought in by the Metropolitan Police Department and the mobile crisis service team. CPEP's main goal is to stabilize clients and move them into appropriate treatment services, if needed. Clients are assessed for mental health and substance abuse disorders, screened for drugs and medical conditions, and offered brief mental health and substance abuse counseling and pharmacotherapy. From CPEP, individuals can be discharged to home, admitted to an inpatient facility (both voluntarily and involuntarily) or sent to a crisis bed. DMH subcontracts with Jordan House and Crossing Place to provide crisis beds for persons who are discharged from CPEP and need more prolonged intensive therapy after discharge from CPEP (but not inpatient hospitalization). Jordan House and Crossing Place are operated by So Others Might Eat and Woodley House, Inc., respectively, and provide intensive 24-hour mental health services in a community-based setting.

The mobile crisis van, established in November 2008 and operated by CPEP, responds to the needs of adults throughout the District who are experiencing a psychiatric crisis at home or on the street and who are unable or unwilling to travel to receive mental health services. It provides daily services from 9am to 1am. More detail on the flow of patients through the CPEP system is provided in Appendix C.

For children, emergency services are provided primarily through two DMH funded programs. The first is the ChAMPS program, which began in October 2008, and is run by Catholic

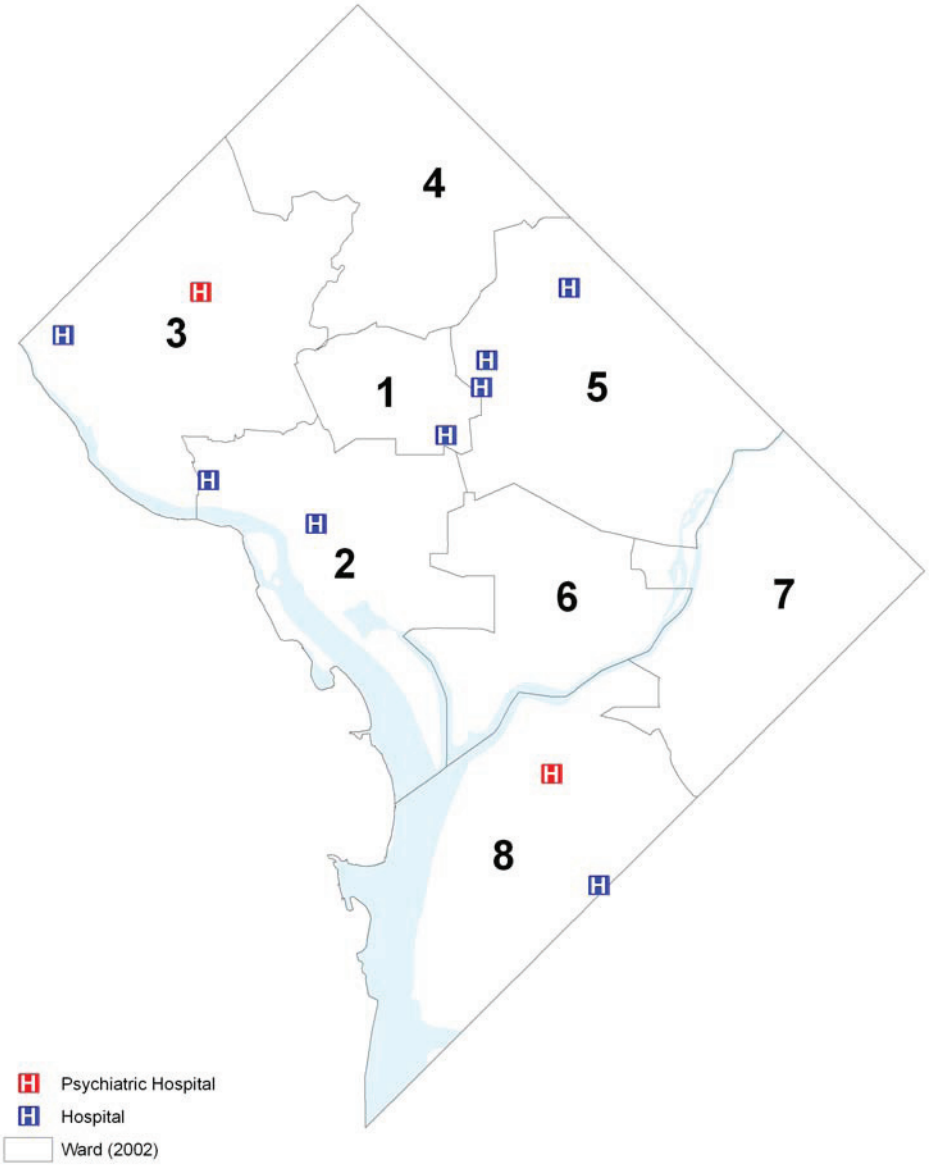
Charities. This program provides crisis intervention to children, youth and families. It provides rapid response for stabilization, including the operation of a mobile crisis unit; provision of crisis/respite beds at Catholic Charities, St. Ann's Infant and Maternity Home and Sasha Bruce Youthwork; and follow-up visits and/or connection to family support services. Second, the Crisis/Emergency Service at CNMC provides psychiatric evaluation for children and youth in psychiatric crisis (through a subcontract with DMH). This program funds social workers who are available to provide emergency psychiatric evaluations at CNMC Monday through Friday 24 hours a day. On average, about 130-150 children per month are evaluated through this program.[17]

The CUCC, which opened in June 2008, provides urgent crisis care to persons in the court system. DMH oversees and funds the program, which is operated by PIW. Clients are screened during a pre-trial assessment (between the time of lock-up and arraignment), and those persons identified as having urgent symptoms are sent to CUCC for further evaluation. CUCC and other services provided for adults and youth in the criminal justice system are described in greater detail in chapter 5.

Emergency services can be obtained at local acute care emergency departments. There are eight acute care hospitals in the District. Voluntary acute care admissions from emergency departments can be made directly to the hospital of presentation if beds are available. Any involuntary admissions that result from the emergency visit must go to one of the four sites that contract with DMH. Children can also get emergency services through PIW if they are referred from DYRS or brought in directly by the Metropolitan Police Department, although PIW does not have a formal emergency department. Although emergency departments at acute care hospitals can bill an individual's insurance directly for an emergency visit, at PIW emergency evaluations cannot be billed as a separate service. DMH is not responsible for coverage of emergency services at acute care hospitals for persons who are not insured. Figure 2.3 shows a map of the eight acute care hospitals in the city along with PIW and St. Elizabeth's.

[17] These evaluations are supervised by psychiatry attending staff at CNMC. DMH funds 4.2 full time equivalent (FTE) social worker staff (out of a total of 6.0 FTE which staff the CNMC during the week). CNMC funds the other 1.8 FTEs of the social work staff, as well as attending supervisory staff and weekend coverage by psychiatry fellows. Currently insurance is not billed for the psychiatry services. Children who do present to the emergency department do receive medical clearance for which insurance is billed.

Figure 2.3 Locations of Acute Care Hospitals



2.4 SCHOOL MENTAL HEALTH PROGRAM

DMH funds and oversees a School Mental Health Program (SMHP). The program was started through a grant from the Departments of Education, Health and Human Services and Juvenile Justice (Safe Schools/Healthy Students Initiative). DMH maintained the program after the end of the grant and recently has begun to bill Medicaid for covered services provided through the SMHP.[18]

As of FY 2008, the program had grown to include 58 schools, served by 48 DMH funded mental health professionals and involving collaboration with the school system, the Office of the State Superintendent for Education and the Child and Family Services Agency. The SMHP is available in participating schools at two levels of intensity. "Tier 1" schools have a part-time clinician who provides a subset of services (typically counseling). "Tier 2" schools have a dedicated, full-time clinician who provides a broader range of services. (Price, 2008) Figure 2.4 shows a map of school mental health programs in the city.

[18] The initial grant was $1 million/year and ran from October 1999 through September 2002. Under this initial grant, the program was directed towards 17 DC chartered schools that contracted with DMH to implement the program.

Figure 2.4 Locations of School Mental Health Programs

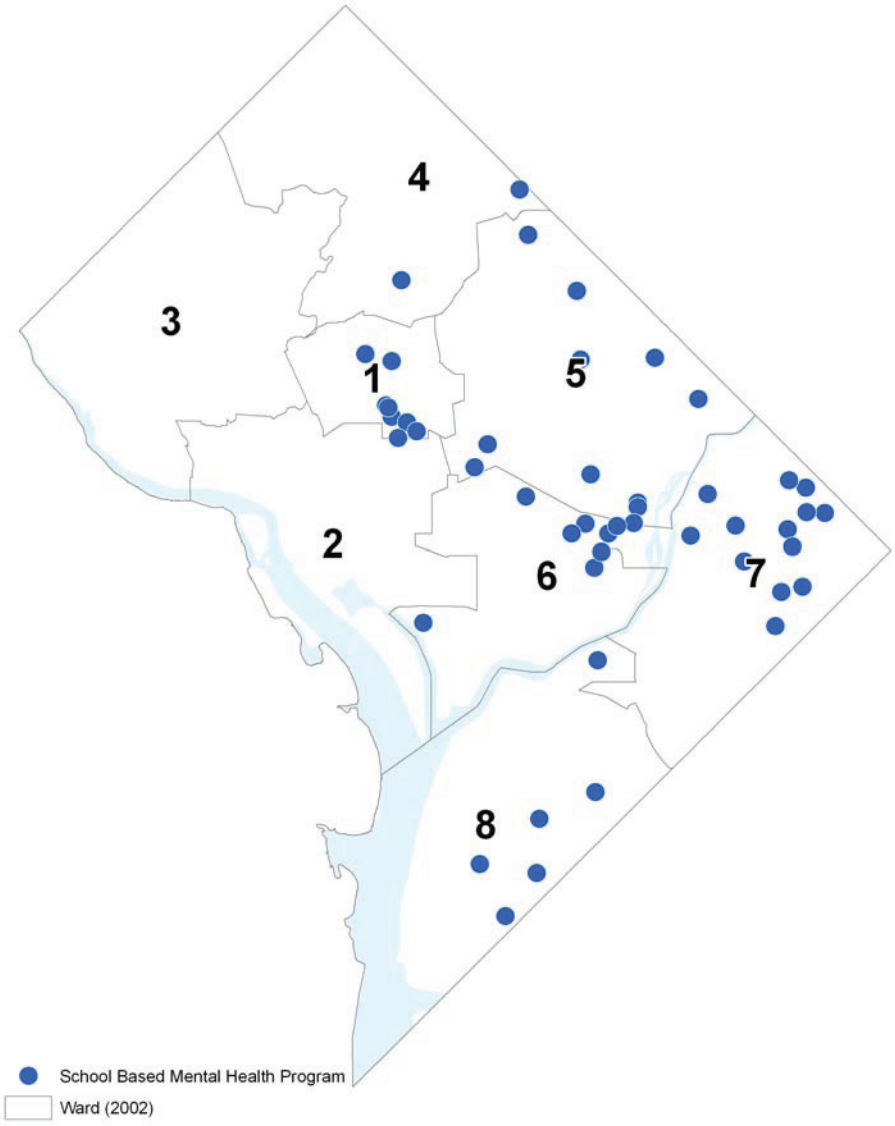


Table 2.4 describes the services provided through the SMHP. As shown, interventions include individual treatment sessions, group sessions, and family contacts.

Table 2.4. School Mental Health Program (SMHP) Services

Service Type	Brief Description of Service
Primary Prevention	Interventions targeted to all students to prevent mental and behavioral health issues, such as substance abuse prevention activities, violence and sexual abuse prevention and anger management and prevention.
Early intervention	These services are provided for the first occurrence of behavioral health issues. These include psychological and educational sessions, social skills, anger management and support groups.
Treatment services	These services involve treatment of students with identified mental health problems and may include individual, family and group counseling
Crisis services	Urgent situations and needs may be addressed with crisis debriefing, grief counseling and psychiatric referrals.
Parent and family support	Educational and treatment services are provided for families.

Source: Scott, 2008; Price, 2008.

Children, regardless of their insurance coverage, are referred to the program by teachers, administrators, families, self-referral, and other sources. The largest portion of referrals comes from teachers for disruptive behavior in the classroom.

2.5 SERVICES FOR HOMELESS INDIVIDUALS WITH BEHAVIORAL HEALTH NEEDS

The Homeless Outreach Program provides outreach to homeless individuals, families, and children living in shelters and on the streets with the goal of connecting people to CSAs, Assertive Community Treatment, and other social services. In addition to performing outreach to homeless individuals, DMH oversees the operation of a sobering station for intoxicated men and women during hypothermia season which, in 2008, served 185 men and women. (DMH Comprehensive Strategy Mental Health Services to the Homeless, 2009) DMH also contracts with Catholic Charities to run the Hermano Pedro Day Program for homeless individuals, which is designed to provide referrals for homeless individuals to receive medical care and social services. Interagency monthly meetings are conducted to discuss plans to assist homeless adults and for families and children/youth. The Office of Homeless Services also assists with reviewing applications for individuals with mental health problems who are seeking housing and coordinates with DMH's Housing Division (described below).

Referral and Intake. Homeless individuals may be connected to the Office of Homeless Services through multiple different mechanisms:

- Shelter staff, family members, and the DC Metropolitan Police Department may refer individuals to the Office of Homeless Services.

- Staff from the Office of Homeless Services visit shelters to identify individuals in need of services.
- Individuals may self-refer.
- Referrals from the above or other mechanisms may occur through the Access HelpLine. An Office of Homeless Services staff member takes calls on the helpline to link callers to services.

Coordination of Homeless Services with Other DMH Services and City Agencies. DMH's efforts to assist homeless individuals with mental illness are part of broader city-wide efforts to reduce homelessness through the development of permanent supportive housing. DMH participates on the Interagency Council on Homelessness, which includes the Department of Health, the Department of Human Services and The Community Partnership for the Prevention of Homeless. (Interagency Council on Homelessness, 2010) The Community Partnership is an independent, non-profit agency that manages DC's continuum of care for the homeless, acting as an intermediary between District and federal funders and providers of homeless services. Additionally, the Criminal Justice Coordinating Council's Substance Abuse Treatment and Mental Health Service Integration Taskforce serves as a forum for communication among agencies and addresses issues of homelessness. (Substance Abuse and Treatment and Mental Health Services Integration Task Force, 2010)

DMH coordinates service provision with the Department of Human Services (DHS). DHS oversees housing initiatives for homeless individuals in the District and runs a hypothermia van that transports homeless individuals at risk of hypothermia to support services. In addition DMH operates the DC SSI/SSDI Outreach, Access and Recovery Services (DC SOARS) project which helps chronically homeless individuals access Social Security Administration benefits.

The Homeless Management Information System (HMIS) is run by The Community Partnership for the Prevention of Homelessness and allows the city to analyze trends in homelessness and service provision. (The Community Partnership for the Prevention of Homelessness, 2010) The use of this system is paid for by a federal technical assistance grant and its use is required by the Department of Housing and Urban Development. Currently, there is no linkage between the HMIS and DMH-specific data systems (e.g. eCura, Avatar).

2.6 HOUSING PROGRAMS FOR PEOPLE WITH MENTAL ILLNESS

DMH is involved in a range of programs and services to help people with mental illness either avoid losing their home and/or obtain affordable housing. These programs generally fit into five categories, which sometimes overlap:

- Rental subsidies/voucher programs
- Supported living programs that provides people with support services to help them live independently
- Community residential facilities that provide 24 hour support,
- Other transitional and housing programs
- The development of affordable housing units (DMH Comprehensive Strategy Mental Health Services to the Homeless, 2009).

These programs primarily fall under the leadership of DMH's Housing Program, which supports over 2000 consumers in a variety of housing programs. The Program works closely with the Homeless Services Division within DMH and with the CSAs. Each CSA has a housing liaison. There is no formal relationship with APRA, even though many people in its housing programs are dually diagnosed. Many persons with housing needs also have co-occurring mental health and developmental disabilities. People who are in need of emergency housing funds are typically referred to the Department of Human Services. A brief description of each of these programs is provided in Table 5.1 and each type of program is discussed in more detail below.

Table 2.5 Housing Programs and Services for the Homeless

Program	Description
Rental subsidized/voucher programs	Rental assistance programs provide subsidies for people with severe mental illness include: • *Home First*. A 'housing first' model of care[19] in which clients are linked with a CSA and receive a housing voucher. DMH works in conjunction with the DC Housing Authority (DCHA) and serves approximately 750 consumers through this program. • *Housing Choice Voucher Program.* DMH has partnered with DC Housing Authority (DCHA) to provide tenant-based and project-based housing programs. There are approximately 50 vouchers set aside for people with severe mental illness. • *Mainstream Housing Opportunities for Persons With Disabilities.* Administered by the Department of Housing and Urban Development (HUD) in coordination with the DC Housing Authority (DCHA), the program sets aside approximately 40 federal vouchers for people with mental illness.[20] • *Shelter Plus Care.* The Community Partnership for the Prevention of Homelessness administers the funding for this program, acting as an intermediary between the federal and District government and direct service providers. The program serves approximately 300 clients.
Supported independent living programs	Individuals live in their own homes and receive supportive services, typically for a few hours a day or week. These individuals may need frequent contact with community support workers, but not the 24-hour supervision provided by Community Residential Facilities. Approximately 460 people are served.
Community Residential Facilities (CRFs)	People receive 24-hour a day/ 7 days per week supervision. Though all facilities are licensed and regulated by DMH, facilities are either under contract with DMH or independent. Approximately 650 people are served.
Other Transitional Housing Programs	Falling under DMH's Jail Diversion Program, DMH provides funds to the Recovery House at N Street Village for dually-diagnosed homeless individuals.
Development of housing units	In 2008, DMH provided $14 million to the Department of Housing and Community Development (DHCD) to develop 300 affordable housing units by 2010 for chronically homeless individuals with mental illness as part of the Capital Fund Program (DC Government Website, 2008).

Rental subsidies/voucher programs. Although persons with severe mental illness can participate in some programs that also apply to the general population, such as the Housing Choice Voucher Program and the DC Local Rent Supplement Program, DMH has additional rental assistance programs that, in collaboration with other agencies, target individuals with severe mental illness. Below, we describe housing voucher and subsidy programs available for clients with mental illness.

[19] In the housing first model, clients are offered housing without requirements to participate in mental health or substance abuse treatment.(Pearson, 2007)

[20] In addition, there are also 75 vouchers for a Housing First ACT Initiative for clients in need of both housing vouchers and assertive community treatment and 78 vouchers for the Partnership Program for Affordable Housing which supports properties whose construction and/or renovation was funded by DMH. (Makenta and Haynes, 2009)

Home First. Home First provides housing subsidies to approximately 750 consumers (as of September 2009). Eligibility is determined by mental illness, income criteria, and demonstrable need for housing. Potential consumers are linked with a CSA which assists with the application process, and they are followed by a community support worker. In applying for the Home First program, consumers must also apply for a voucher from DC Housing Authority (DCHA). Though the Home First subsidy is intended to be a temporary solution until a consumer receives a voucher from DCHA, in practice many clients do not transition out of the program.

Home First is considering a "housing first" model of care. In the housing first model, clients are offered housing without requirements to participate in mental health or substance abuse treatment. (Pearson, 2007) With the Home First subsidy, consumers pay 30% of their income to live in apartments where rents are 80% of the fair market rate. Housing units must meet minimum quality standards. DMH has developed a partnership with a group of approximately 200 landlords who accept the potentially lower rental rates that the vouchers cover in return for the reliable payment source and the support system that DMH's consumers have in place. Although the Home First program is primarily administered by DMH, it is in close partnership with DCHA. In particular, DCHA inspects the housing, pays landlords, and assesses consumer income and household composition annually.

As of September 2009, there is a waitlist of approximately 600 people for this program, including individuals and families, many of who are homeless or living in unstable or unaffordable housing. People may be placed on the waitlist through a variety of sources including the homeless outreach team, CSAs or through direct contact with DMH. Vacancies are generally low and the time on the wait list is reported to be long.

The Home First program's budget is approximately $6 million, of which $380,000 is from the federal mental health block grant; approximately $57,000 is from the PATH grant for homeless services; and the rest is local dollars.

Housing Choice Voucher Program. DMH has partnered with DCHA to provide tenant-based and project-based housing programs. In tenant-based programs, the vouchers are portable and follow the client. In project-based vouchers, the vouchers reside with a specific housing unit. As of December, 2009, there are 50 vouchers set aside for consumers of mental health services (Makenta and Haynes, 2009).

Mainstream Housing Opportunities for Persons With Disabilities. The Mainstream Program, administered by the Department of Housing and Urban Development (HUD) in coordination with the DCHA, provides federal vouchers for people with disabilities. Mental health consumers have been eligible to participate in this program since 1999; as of 2010 there are 40 vouchers dedicated to mental health consumers. There are also 75 vouchers for a Housing First ACT Initiative for clients in need of both housing vouchers and assertive community treatment and 78 vouchers for the Partnership Program for Affordable Housing which supports properties whose construction and/or renovation was funded by DMH (Makenta and Haynes, 2009).

Shelter Plus Care. The Shelter Plus Care is a permanent housing program subsidized by the federal government through HUD. The Community Partnership for the Prevention of Homelessness administers the funding for this program, acting as an intermediary between the federal and District government and direct service providers. To be eligible, consumers must be chronically homeless and be linked with supportive services for at least one of the following conditions (a) serious mental illness, (b) substance abuse, and (c) HIV/AIDS. In the Shelter Plus Care program, people receive rental vouchers which enable them to live in housing units that meet specific rent and quality criteria. As of November 2009, there were 318 clients (individuals and families) being served through the program and a waitlist of 54 consumers, which was closed to new applicants. DMH's Homeless Outreach Program works closely with The Community Partnership to review applications and determine which meet eligibility criteria. Once clients with severe mental illness are enrolled in Shelter Plus Care, DMH works with CSAs to ensure the delivery of supportive services.

Supported independent living programs. Of the approximately 2000 consumers served by the Housing Division of DMH, 461 participate in Supported Independent Living. In these programs, individuals live in their own homes and receive supportive services, typically for a few hours a day or week. These individuals may need frequent contact with community support workers, but not the 24-hour supervision provided by Community Residential Facilities (see discussion below). Programs competitively bid for contracts to serve fixed numbers of clients under this program. Providers are paid a daily rate to ensure that the consumers in this program get needed follow-up (e.g. weekly visits, help with learning about activities of daily living). The funding for this daily rate currently comes from local funds. In the future, DMH plans to have providers bill Medicaid for the support services. In addition to the direct services, individuals in Supported Independent Living may receive rent support (e.g. from the voucher programs described above).

Community Residential Facilities (CRFs). For clients in need of greater community support, CRFs are group homes in which people receive 24-hour a day/ 7 days per week supervision. All CRFs are licensed and regulated by DMH though they may either be under contract with DMH (as of September 2009, approximately 225 beds) or independent (approximately 436 beds). CRFs are paid for by funds from SSI (including the Optional State Supplementation payments). Contract CRFs are typically run by CSAs and may receive additional payment from DMH. In contrast, independent CRFs are ineligible to receive additional DMH funding and are frequently run by small businesses.

Other Transitional Housing. In addition to the above vouchers and supported housing, DMH provides some funding to the Recovery House (for dually diagnosed homeless individuals) at N Street Village (although DMH is not the only source of funding for this program).

Development of housing units. In 2008, DMH provided $14 million to the Department of Housing and Community Development (DHCD) to develop 300 affordable housing units by 2010 for chronically homeless individuals with mental illness as part of the Capital Fund Program (DC Government Website, 2008). These units, which are owned by private developers, include new constructions and renovations. While the funding assists with the construction and/or renovation, developers are encouraged to apply for federal vouchers and local subsidies to help clients with mental illness afford to rent these units.

2.7 FINANCING

The DMH operating budget in FY 2009 was $231.7 million, of which $212.4 million was provided through directly appropriated District local dollars. Intra-district funds (funding from other District agencies, such as Child and Family Services Agency [CFSA]) provided smaller amounts of funding, totaling $11.3 million. Federal funds totaled just under $8 million. Private funds and donations to DMH made up $44,000 in FY 2009.

Within DMH, funds are allocated by six operations. These cut across the four service categories presented above.

- Mental Health Authority
- Mental Health Services and Supports
- Mental Health Financing/Fee For Service.
- St. Elizabeth's Hospital
- Agency Management
- Financial Management

Starting in FY2011, budget line items will be based on these six operations (prior to FY2011, there was overlap of the Mental Health Authority and Mental Health Services and Supports divisions' budgets). Spending by DMH division for FY2009 is shown in Table 2.5.

Table 2.6. Department of Mental Health Spending in FY 2009

Services and Activities	Amount (in millions, rounded)
Mental Health Authority/Mental Health Services and Supports	$40.4
Mental Health Financing/Fee for Service	$38.8*
St. Elizabeth's Hospital	$102.1
Agency Management	$16.5
Financial Management	$1.6
TOTAL DMH FY2009 Budget	**$231.7**

*Includes both local and federal dollars.

Funding for Outpatient Services. Most of the outpatient programs in MHSD are financed with DMH funds through budget line items. However some programs receive support from federal grants, in-kind contributions or are funded through claims payments submitted to Medicaid and third party payers. For example, federal funding supports close to half of the homeless services program budget via the Projects for Transition in Assistance from Homelessness.[21] (This program is described in more detail in Chapter 5). The psychiatric physician's practice services

[21] The Projects for Transition in Assistance from Homelessness grant is administered by the Center for Mental Health Services under the Substance Abuse and Mental Health Services Administration and provides funding for people with serious mental illness who are homeless or at risk of becoming homeless.

(i.e. psychiatrists staffed by DMH to provide care at CSAs) are paid through claims submitted via eCura along with other CSA charges—i.e., these claims are submitted to DMH, after which DMH sends appropriate claims onto Medicaid for payment.[22] The school mental health program has recently begun to submit claims for some services to Medicaid. In addition, the DC Public Schools contributes resources such as phones and computer equipment to the school mental health program.

The Mental Health Authority of the District of Columbia is in charge of overall mental health planning and funds services provided by MHRS that are not covered by Medicaid FFS (discussed below). In FY2009 and FY2010, this division's budget included many of the services under the Mental Health Services and Supports division. The combined budget for these divisions was $40.4 million in FY2009 and $69.1 million in FY2010, most of which went to Mental Health Services and Supports.

The Mental Health Financing/Fee For Service division includes MHRS services that are covered by Medicaid fee-for-service plans. These services typically are covered through a combination of Medicaid dollars (local and federal) and DMH local dollars. DMH pays out of its budget the local share of Medicaid dollars that together with federal contributions (from DHCF) pay for Medicaid-covered MHRS services to Medicaid enrollees. DMH is also financially responsible for all MHRS services provided to uninsured and Alliance enrollees, as well as for the costs of MHRS services not covered by Medicaid which are provided to Medicaid enrollees.[23] The FY2009 budget for this division was $38.8 million, of which $7.8 million were locally matched dollars.

CSAs receive payments for Medicaid covered MHRS services from DHCF after submitting its claims through DMH for cleaning and initial overview. CSAs also submit claims directly to DMH for payment (through local dollars) of MHRS services not funded through Medicaid. We describe the process for funding of Medicaid reimbursable services as well as those services covered by DMH directly through local dollars in the sections that follow.

Funding for Services Covered by Medicaid. Medicaid reimbursable claims are processed through several steps:

- *Step 1*: CSAs or office-based providers first send Medicaid reimbursable claims to DMH for review for completeness.
- *Step 2*: DMH then processes the claims and submits them to DHCF for reimbursement. If DMH finds incomplete claims, it returns them to the CSA for correction/clarification.
- *Step 3*: DHCF will make payments directly to CSAs for approved claims. Claims that are rejected by DHCF do not go back to DMH but instead directly to the providers for resubmission to DHCF (bypassing DMH). CSAs have 90 days after the end of the any fiscal year (December) to submit all claims, including those denied initially.

[22] This is a DMH run practice in which staff psychiatrists see patients at other CSAs and act as 'loaner' staff, allowing DMH to help supplement the need for psychiatrists at CSAs.

[23] In terms of the billing process, CSAs bill MCOs for managed care enrollees for Medicaid covered services and bill DMH for non Medicaid covered services. CSAs also bill DMH for both covered and non covered services for FFS enrollees.

In FY2009, 83% of claims that were submitted from DMH to DHCF were paid.

Funding for Non-Medicaid Reimbursable Services. DMH determines the amount budgeted for non-Medicaid reimbursable services including services administered to the uninsured and Alliance MHRS enrollees. The total amount that DMH spends on MHRS services is capped at a level set each year as part of the annual DMH budgeting process. DMH in turn allocates in advance a set amount of funding each year to each Core Services Agency (CSA) to pay for care provided. The amount each CSA receives for non-Medicaid reimbursable services (their "purchase order") is determined based on the average amount of funding paid to the CSA for these services over the previous three years.

The budgeted funds are not paid up front in a lump payment to providers, instead CSAs submit claims for services to receive payment from their budgeted purchase order funds. Prior to September 30th (the end of any fiscal year) providers can request an increase in total allotted funds if they anticipate needing funds to pay for additional non-Medicaid services or consumers.

At the end of the year, if claims submitted do not reach the total purchase order amount, remaining funds can be shifted to other CSAs who have exceeded their purchase order amount. If no additional money is available to a CSA that has exceeded their purchase order, the CSA may consequently limit the services it provides to clients. For example, a CSA might reduce a patient's sessions from 3 to 1 per week to limit the overage on the purchase order. $16.9 million was budgeted for MHRS services in FY2009.

Funding for St. Elizabeth's Hospital. DMH dollars contribute to patient care and administration at St. Elizabeth's hospital, as well as capital improvements. St. Elizabeth's funding makes up the largest percentage of the DMH annual budget. Of total FY 2009 budget, $102.1 million was allocated to St. Elizabeth's. St. Elizabeth's is mainly funded by DMH; however, it receives some money from the DHCF via Disproportionate Share Hospital Payments as well as from the U.S. Marshall's Office and the U.S. Virgin Islands (for caring for forensic patients and U.S. Virgin Island residents).

DMH dollars support:

- Voluntary inpatient stays for Medicaid fee for service patients between the ages of 21 and 64 (due to the Institute for Mental Disease exclusion, described above)
- Uninsured and Alliance patients
- Involuntary patient stays
- Forensic services
- Staff, including nursing and ancillary services
- Administrative activities

In general voluntary inpatient stays for Medicaid, uninsured and Alliance patients are transferred from other local District hospitals for admissions lasting longer than 14 days.

Local dollars support most inpatient stays by Medicaid FFS enrollees between the ages of 21 and 64 at St. Elizabeth's because the hospital is an IMD.[24] DMH funds also support Medicaid MCO patient stays after day 7.

To help reduce the heavy reliance on local financing, St. Elizabeth's is in discussion with the Center for Medicare and Medicaid Services to allow reaching of the 'lifetime days' coverage limit during a *single* hospital stay if needed. Usually, this limit cannot be reached within a single hospitalization and hospitals can only bill Medicaid or Medicare for fewer days than the lifetime days' coverage limit. However, many St. Elizabeth patients require prolonged hospitalization and therefore may risk exceeding their days of coverage.

Funding for DMH Agency Management In FY 2009, agency management totaled $16.5 million of the total DMH budget; financial management made up $1.6 million of the budget. (OCFO, FY2011 Budget) Agency management activities include the personnel, employee development, information technology and other agency administrative activities. Agency management also includes funds spent by DMH on the *Dixon Case.* Approximately, $750,000 is used annually to finance activities related to court monitor reporting. Financial management is a standard operating line for all District agencies and includes budget and accounting operations.

[24] Starting October 1, 2009, a claims-based payment system has been implemented at St. Elizabeth's hospital to better track the financing of specific services delivered to patients.

3. Department of Health Care Finance

The District of Columbia's Department of Health Care Finance (DHCF) is a cabinet-level agency which administers Medicaid and the Alliance programs in the District.[25] In this role, it determines what behavioral healthcare services are covered by programs and sets reimbursement rates for services. In what follows, we describe behavioral health care services that fall under the authority of DHCF. We begin with Medicaid and then discuss the Alliance.

3.1 MEDICAID

Medicaid enrollees may be in a managed care plan (MCO) or in a fee-for-service plan (FFS). Low-income, disabled adults are generally enrolled in Medicaid FFS; low-income disabled children are primarily enrolled in Health Services for Children with Special Needs (HSCSN), a special managed care plan for this population; and non-disabled Medicaid enrollees are usually enrolled in managed care, currently in one of three plans—Chartered, HealthRight, and Unison. As of May 1, 2010, HealthRight discontinued its participation in the Medicaid or Alliance Programs.

The majority of persons with severe mental illness are covered by Medicaid FFS (or 11,921 out of a total of 16,977 persons in MHRS in fiscal year 2009). Medicaid covers a range of mental health services, although more intensive services, such as community-based intervention, multi-systemic therapy, intensive day services, assertive community treatment, and certain rehabilitation services, are covered by Medicaid FFS through DMH rather than directly through the Medicaid MCO. Some prescription medications for mental health conditions are covered under Medicaid. DHCF has a preferred drug formulary; prior authorization is required for use non-formulary drugs. For a list of MCO formularies, please see Appendix D.

Medicaid coverage of substance abuse services is optional and negotiated on a state-by-state basis. In the District, substance abuse services are not covered, with the exception of medically necessary detoxification and outpatient services provided by APRA to children and youth. These services became eligible for Medicaid payment in 2009 as part of the Adolescent Substance Treatment Expansion Program.

Some Medicaid beneficiaries are enrolled in DMH's MHRS program, which increases the scope of mental health services they can receive without paying out of pocket. DMH pays for mental health services for Medicaid enrollees who are part of MHRS but not covered by Medicaid.

Other aspects of access to behavioral health care services vary, depending on the type of Medicaid plan the enrollee has. We describe these services below.

Medicaid Managed Care. In this section we describe managed care services for Chartered, HealthRight and Unison. We note several features of the contracts between the MCOs and

[25] In the District, the State Children's Health Insurance Program is an expansion of Medicaid.

DHCF. Each of the Medicaid MCOs has a contract with DHCF that governs certain aspects of the delivery of care to their enrollees. DHCF pays each MCO a per-member per-month fee for enrollees they serve.[26] In return, MCOs are required to cover a set of benefits that include mental health services (such as inpatient, emergency, prescription drug, and outpatient) and medically-necessary substance abuse hospitalizations.

There are five such requirements as follows:

- MCOs must provide up to 10 sessions of behavioral health services for an enrollee without pre-authorization. The total number of behavioral health sessions each Medicaid enrollee receives is based upon medical necessity as determined by a physician.
- Medicaid MCOs are financially at risk for inpatient behavioral health admissions for Medicaid enrollees, which means that the MCOs are financially responsible for the costs of any inpatient behavioral health admission by one of their enrollees.
- The contract states that there be no "day" limits on coverage; this means there are no yearly or lifetime limits on the amount of outpatient or inpatient care that can be received.
- MCOs are required to perform care coordination, both between primary and specialty care providers as well as with APRA, for enrollees who need substance abuse treatment.[27]
- Assertive Community Treatment, community based intervention, multisystem therapy and other rehabilitative services to Medicaid enrollees are excluded, or "carved out," of the MCO contracts. Consequently, DMH pays the costs of these services for Medicaid managed care enrollees who receive them as part of MHRS.

Two of the MCOs operating in the District—HealthRight and Chartered—subcontract behavioral health services to a managed behavioral health care organization, Beacon Health Strategies, LLC. Beacon has managed behavioral health services for Chartered since May 2008 and for HealthRight since December 2008. Beacon is paid a per member, per month rate directly by these MCOs, but is not financially responsible for the costs of psychotropic drugs or inpatient mental health hospitalizations. A third MCO, Unison, provides behavioral health care through its own provider network. Both Beacon and Unison contract with mental health providers in the community, such as those in local community health centers, private office-based providers, clinicians in free standing mental health centers, and providers in DMH-certified CSAs.[28]

Table 3.1 compares key features of behavioral health care service delivery for enrollees in Unison and Beacon Health (which contracted behavioral health services for Chartered and HealthRight).

[26] Though MCOs are paid on a capitated basis, they are not at full financial risk beyond a pre-determined "risk corridor."
[27] Taken from DC Chartered contract with DC DHCF.
[28] As the result of a memorandum of understanding (MOU) between DMH and the DHCF in 2007, MCOs are required to include DMH Core Service Agencies, although not exclusively, in the MCO network

Table 3.1. Behavioral Health Care Service Delivery for Enrollees in Medicaid Managed Care

	Medicaid Enrollees in Chartered and Health Right	Medicaid Enrollees in Unison
Subcontract	• Full risk subcontract to Beacon for behavioral health care services.	• No subcontract to a behavioral health management organization.
Preauthorization	• The first 10 individual outpatient individual sessions per lifetime do not require a pre-authorization. After the first 10 visits, approval must be requested before or within 48 hours of an individual outpatient session. • Group therapy and medication management sessions (including methadone for opioid treatment) never require authorization and have no limits. • Preauthorization for psychological testing, partial hospitalization, electroconvulsive therapy, and inpatient admissions is required.	• In network outpatient services do not require authorization for services such as individual and group therapy and medication management, and there is no limit on the number of allowable visits. • Preauthorization for psychological testing, partial hospitalization, electroconvulsive therapy, and inpatient admissions is required.
Care Coordination and Quality Assurance	• Beacon provides an intensive case management program for eligible members with eligibility based on diagnosis, health care costs, and/or health care utilization; coordination and referral around substance abuse tends to be more fragmented. • Beacon offers programs in which they perform outreach in concert with medical management including post-partum depression screening, a childhood obesity initiative, high risk pharmacy reviews, and depression screening using the Patient Health Questionnaire-2. • Beacon provides two care coordination programs for enrollees with mental health disorders and chronic disease.	• Unison conducts utilization management and provides care-coordination with case managers for court-ordered enrollees, inpatient admissions, and high-users of health care. • InterQual measures are used in determining the appropriateness of mental health or detoxification admissions.
Contracts with CSA Providers	• Beacon contracts with approximately half of the CSAs in the District, and two crisis centers (ChAMPS and CPEP).	• Unison contracts with CSA providers as well as others in the District to provide behavioral health services.

Funding for Health Care Services for Children with Special Needs (HSCSN). HSCSN is a managed care organization targeted to children with disabilities. To be eligible for HSCSN, a child must be under the age of 24, a District of Columbia resident, and be receiving Supplemental Security Income (SSI) disability benefits or have an SSI-related disability, as

defined by District DHCF. Enrollment in HSCSN is voluntary; SSI children having the option to remain in fee-for-service Medicaid. In 2009, there were approximately 3,429 children enrolled in HSCSN and over 2,000 providers participated in the HSCSN network (HSCSN, 2009) [29] HSCSN serves a population with high mental health needs.

A substantial fraction of children in HSCSN are eligible for SSI because of a behavioral health-related disability (as opposed to a physical disability) with approximately 40% of the qualifying diagnoses for HSCSN are mental health related diagnoses. (Chandra, 2009)

HSCSN receives a capitated rate (per member per month fee) from DHCF, Children and Family Services Administration, and Department of Youth Rehabilitation Services. Children are referred to HSCSN by the DHCF, which sends a list of eligible children to HSCSN's Outreach Department on a monthly basis. Children involved in the juvenile justice system can also be referred to HSCSN through a sub-acute treatment program.

HSCSN provides eligible children and their families with individualized care management, access to 24-hour care coordination, outreach services, respite care, medically necessary home modifications and wraparound mental, behavioral, and developmental services. Individualized care management and coordination is provided through a care manager who is assigned to each enrollee based on their specific needs. There are approximately 45 care managers that work on eight teams; two of the teams are dedicated to behavioral health issues. Children typically stay with the same care manager unless their needs change, necessitating a transition to a care manager for a higher or lower level of care.

The functions of the care manager include:

- Linking enrollees to appropriate service providers
- Preparing a care coordination plan in conjunction with enrollees' providers. The plan is updated bi-annually
- Scheduling primary care, behavioral health, and specialty appointments and arranging transportation to health care services
- Facilitating health information exchange between primary care physicians and other providers
- Educating families about management of their child's medical conditions
- Transition planning prior to the child reaching 24 years of age (i.e., age-out of the program), to connect the client to community services and programs offered by the DC Rehabilitation Services Administration and the DC Department on Disability Services.

A description of the wraparound mental health and substance abuse services is provided in Table 3.2.

[29] Enrollment number from personal communication, Department of Health Care Finance, June, 2009.

Table 3.2. Behavioral Health Services Offered by Health Care for Children with Special Needs

Type of Service	Specific Services
Mental health services	- Diagnostic and Assessment services - Individual, group and family psychotherapy - Crisis services - Partial hospitalization - Inpatient hospitalization and emergency department crisis services - Intensive outpatient hospital services - Case management services - Inpatient psychiatric facility services for - Members through age 21
Substance abuse services	- Inpatient drug and alcohol detoxification - Inpatient and residential day treatment - Outpatient drug and alcohol rehabilitation day treatment

Source: Healthcare for Children with Special Needs, Inc. Enrollee Handbook

After children in HSCSN with developmental disabilities reach age 24 (and children with Medicaid FFS with developmental disabilities turn 18), services are coordinated by the Developmental Disabilities Administration of the Department of Disability Services. The Developmental Disabilities Administration serves persons with impairments in intellectual function and problems with adaptive behavior (such as problems with social skills, conceptual skills and practical skills). Developmental disabilities covered include intellectual disability, cerebral palsy, Down syndrome, autism, or brain impairment of childhood.[30] In order to receive developmental disability services, the disability has to originate before age 18. (Department on Disability Services website) The Service Planning and Coordination Division of the Developmental Disabilities Administration provides individualized assistance to eligible clients through the development of Individual Support Plans. (DDS, "Service Planning and Coordination Division") Based on these Individual Support Plans, service coordinators link clients to appropriate services, including services that provide residential support (such as residential habilitation, supported living, and in-home support), professional services (such as physical therapy, occupational therapy, and skilled nursing), vocational assistance, and behavior support. The Intake and Eligibility Determination Unit of the Developmental Disabilities Administration works in transitioning eligible youth from schools to adult services. (DDS, "Operations Division") The Rehabilitation Services Administration of Department of Disability Services houses the Office of Youth and Transition Services, which has programs to aid eligible youth, both in and out of school, in finding appropriate vocational and educational opportunities. (DDS, "Youth Programs") Staff members of HSCSN often refer clients who are aging out of their system to Developmental Disability Administration and the Rehabilitation Services Administration.

Fee for Service Medicaid. The majority of adults in MHRS are covered by FFS Medicaid through the SSI program. SSI income eligibility is determined by the Social Security

[30] As of March, 2010, there is pending legislation to expand the role of the Developmental Disability Administration to cover all persons with developmental disabilities.

Administration and based on mental or physical disability, residency requirements, and income and wealth thresholds Low-income individuals over age 65 may also qualify for supplemental security income without a mental or physical disability.

In order for an adult to quality for supplemental security income on the basis of a mental health disability, the individual must be low income and have one of 9 general categories of diagnoses, expected to persist for at least 12 months.[31] These 9 categories are: 1) organic mental disorders, 2) schizophrenic, paranoid and other psychotic disorders, 3) affective disorders, 4) mental retardation, 5) anxiety-related disorders,6) somatoform disorders, 7) personality disorders, 8) substance addiction disorders, and 9) autistic disorder and other pervasive developmental disorders. The individual cannot reasonably perform any gainful activity. In addition, persons with substance abuse disorders must have behavioral or physical changes that have resulted from regular substance abuse use. The Social Security Administration requires documented medical evidence that the mental illness not only impairs activity but also to what extent the ability to perform the activity is impaired. (Social Security Administration, 2008)

Children can also get SSI benefits through mental health criteria. The diagnostic categories for children are similar to those among adults with additional categories and specifications for disorders that are only present in childhood. There are a total of 11 diagnostic categories: 1) organic mental disorders, 2) schizophrenic, delusional (paranoid), schizoaffective, and other psychotic disorders, 3) mood disorders, 4) mental retardation, 5) anxiety disorders, 6) somatoform, eating, and tic disorders, 7) personality disorders, 8) psychoactive substance dependence disorders, 9) autistic disorder and other pervasive developmental disorders, 10) attention deficit hyperactivity disorder, and 11) developmental and emotional disorders of newborn and younger infants. Children are eligible until age 18 but can then be evaluated for SSI eligibility as adults. (Social Security Administration, 2008)

In the District and most states, most persons with SSI eligibility are automatically eligible for Medicaid FFS. Children who are not covered by HSCSN but are SSI eligible receive services through the Medicaid FFS program and may receive services through MHRS. Approximately 13,000 children are covered by Medicaid FFS, a number of whom have HSCSN qualifying diagnoses. According to a 2009 analysis by RAND, about 14 % of children with Medicaid SSI had mental health or developmental disabilities. (Chandra, 2009)

There is a large degree of overlap between the SSI and the MHRS population. Although most persons in MHRS have Medicaid SSI, individuals may also qualify for SSI due to non-mental health related reasons (i.e. due to physical disability, age thresholds, and/or being blind). Individuals in MHRS but not in SSI may be uninsured, in the Alliance, enrolled in a Medicaid managed care plan, or be in the process of applying for SSI benefits; or they may have been determined to be ineligible for SSI.

[31] In the District, the income threshold is $759 per month and resources may be worth no more than $2,000 for an individual or $3,000 for a couple.

3.2 ALLIANCE

The Alliance program provides access to health care services for low-income individuals who are ineligible for Medicaid. All Alliance enrollees are enrolled in managed care. The Alliance does not provide access to behavioral health care. As of April 2009, only Zoloft, an antidepressant, is part of the Alliance formulary and can be prescribed by Alliance providers. The Alliance program does cover life-threatening detoxification that is medically managed in an acute care hospital. Many Alliance beneficiaries get charity care from local clinics or receive treatment for mental health conditions from their primary care providers.[32]

Some Alliance enrollees are enrolled in DMH's MHRS program. Alliance enrollees in MHRS have access to the full range of MHRS services, including access to the MHRS drug formulary (see Appendix E), funded through DMH.

3.3 FINANCING

In FY2009, DHCF made over $1.7 billion in provider payments for Medicaid and Alliance, which accounted for the bulk of its budget. In addition, DHCF also has budgeted funds for other services that support Medicaid and Alliance operations including management and quality/accountability services.

DHCF reimburses CSAs for the federal match for Medicaid eligible MHRS services. 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 MCOs serving Medicaid enrollees. A fraction of these payments are used to cover the range of mental health care services, including psychotropic medications, which MCOs are required to cover for their enrollees.

In addition DHCF serves as the pass-through agency for the federal share of Medicaid dollars for inpatient stays at St. Elizabeth's that are eligible for Medicaid reimbursement; namely, inpatient stays for Medicaid enrollees who are less than age 21 or greater than age 64.

Financing for the Alliance also comes through DHCF. Though the program currently has no mental health benefit, it does include psychotropic medications in the formulary. DHCF is able to cover medications for Alliance enrollees at a reduced rate (the same rate available to the Department of Defense). DHCF budgets almost $4 million annually to purchase all medications for the approximately 55,000 Alliance beneficiaries; however as of April 2009, Alliance has just one psychotropic medication, Zoloft, on its formulary.

[32] If Alliance patients receive a prescription for a non-formulary psychiatric medication from a psychiatrist employed by Unity, these prescriptions can typically be filled by the DMH pharmacy.

4. Addiction Prevention and Recovery Administration

This chapter focuses on APRA, which is responsible for substance abuse treatment and prevention. APRA is an agency operating within the District's Department of Health (and therefore separate from DMH), with primary responsibility for substance abuse treatment and prevention. The subsequent sections describe the treatment, recovery, and detoxification services supported by APRA, prevention efforts, the role that APRA plays in provider credentialing and quality assurance, and funding for additional services and management activities.

APRA provides the following services:

- Adult and adolescent treatment (including assessment, referral, detoxification and residential treatment)
- Recovery support services
- Substance abuse prevention

4.1 TREATMENT AND RECOVERY SUPPORT SERVICES

APRA funds substance abuse treatment through two programs, the Drug Treatment Choice Program and the Adolescent Substance Abuse Treatment Expansion Program. The Choosing Options for Recovery and Empowerment Program is the primary vehicle through which recovery services are provided. Individuals may be referred to APRA from their primary care or mental health care provider, CPEP, DMH's homeless outreach program, other DMH programs or through the court system; or they may simply walk in for services.

We describe each of the treatment and recovery programs in turn.

The Drug Treatment Choice Program. Prior to 2000, APRA contracted for a fixed number of treatment "slots" (e.g., inpatient beds) with local providers. Following national trends toward the treatment of alcohol and other drug disorders in community settings, APRA ceased contracting for "bricks and mortar" treatment capacity in 2000 and began to issue vouchers that clients could use to pay for care from community-based treatment providers. This system is known as the Drug Treatment Choice Program (DTCP). Central to the design of the program was the idea of allowing consumers to choose among a set of providers certified by APRA, thereby encouraging competition among providers.

To be eligible for DTCP services, individuals must:

- be a resident of DC during the entire time they are receiving treatment,
- be uninsured, publicly insured, or be privately insured with medical insurance that does not cover substance abuse treatment services, and
- have an Axis I diagnosis of a substance use disorder.

Assessment and referral services are provided at APRA's headquarters in northeast Washington. A satellite assessment and referral center also exists at the DC Superior Court. Clients must present in person in order to receive assessment and referral, and are assessed using the Addiction Severity Index, and their level of need for services is identified using the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-IIR).[33] [34] [35] Clients then receive information about different providers at their level of service, select a provider within their level of care, and receive a voucher for services. Treatment providers receive a written evaluation of their client's psychosocial, medical, addiction treatment, and behavioral health from APRA staff within 24 hours of their referral to treatment.

DCTP offers the following types of services for adults:

- Level I outpatient substance abuse treatment services
- Level I outpatient narcotic/opioid substance abuse treatment services
- Level II intensive outpatient substance abuse treatment services
- Level III residential sub-acute non-hospital medically monitored detoxification substance abuse treatment services
- Level III non-hospital residential substance abuse treatment services
- Level III day/partial hospitalization substance abuse treatment services
- Narcotic/opioid substance abuse treatment services (jail-based program)

In August 2009 there were approximately 40 providers certified to participate in the program. In addition to certifying providers, APRA has implemented an ongoing training program for providers to facilitate implementation of evidence-based practices.

Adolescents receive substance abuse services through the Adolescent Substance Abuse Treatment Expansion Project.

Adolescent Substance Abuse Treatment Expansion Project (ASTEP). Adolescents may be referred for substance abuse treatment services in a variety of ways, such as through their school, the SMHP, their parents or a primary care doctor. They may also self-refer for services, without the consent of a parent or guardian. To be eligible for ASTEP, adolescents (up to 21 years) must

[33] The Addiction Severity Index is a standard substance abuse assessment tool used to assess a client on the six dimensions of the ASAM PPC IIR: acute intoxication or withdrawal potential; biomedical conditions and complications; emotional, behavioral or cognitive conditions and complications; readiness to change; relapse, continued use, or continued problem potential; and recovery environment.

[34] The American Society for Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders (2nd edition) (ASAM PPC IIR) is a widely used, standardized guideline for placement, continued stay, transfer among levels of care, and discharge of patients with alcohol and other drug problems; ASAM PPC IIR utilizes six dimensions, measured by the Addiction Severity Index, to determine a comprehensive snapshot of the patient.

[35] The use of the ASAM criteria has helped to make referrals consistent and clinically appropriate. Before its implementation, referrals for services were based on the discretion of the caseworker.

meet the same criteria as for DTCP. (The program also serves individuals up to 22 years old if they have been determined to be disabled by the Social Security Administration). ASTEP is jointly funded by APRA and Medicaid; DHCF reimburses for services to Medicaid enrollees and APRA pays for services for other ASTEP participants.

Adolescents can get both intake (assessment and referral) and treatment services at one of the five certified ASTEP providers in the city (Federal City Recovery Services, Hillcrest Children's Center, Latin American Youth Center, Riverside Treatment Center, and Second Genesis); they do not need to visit APRA's single assessment center. Youth are assessed using the Global Assessment of Individual Needs (GAIN) – a series of standardized measures to assess problems and service utilization related to substance use – and then referred to an appropriate level of care using the Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders (2nd edition) (ASAM PPC IIR).[36] Youth are also assigned a care coordinator to ensure that they follow through on referral.

Although each of the three sites offers substance abuse services, some offer specialized services targeted to particular groups of youth. For example, Federal City offers a special program for HIV positive individuals, and the Latin American Youth center offers services for individuals with co-occurring mental health and substance abuse disorders. (APRA, 2009)

Choosing Options for Recovery and Empowerment (CORE). In September, 2007, District was awarded approximately $10.6 million by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) under the Access to Recovery program. The Access to Recovery program is an initiative aimed at expanding capacity, supporting client choice, and increasing the array of faith-based and community-based providers for clinical treatment and recovery support services. The funds support DC's Choosing Options for Recovery and Empowerment Program (CORE). CORE is funded by SAMHSA through FY 2010; APRA has applied for additional grant funding from SAMHSA to continue the program.[37]

CORE program goals are to provide culturally sensitive substance abuse treatment and recovery support services over the three-year federal grant period. The key target populations for the program are the estimated 20,000 substance abusers who annually exit jail or prison and return to the District's streets; single women; women with dependent children; and methamphetamine users. As with treatment services, individuals may be referred to APRA for recovery services from a variety of places (DMH programs, court system) or they may self-refer. The primary location for assessment is APRA's headquarters in northeast DC. Caseworkers meet with clients to discuss needs and determine appropriate recovery support services; no standardized screening process is used to determine client needs and appropriate services. The caseworker and the client jointly identify the types of services that the client may need to work toward recovery.

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[36] The American Society for Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders (2nd edition) (ASAM PPC IIR) is a widely used, standardized guideline for placement, continued stay, transfer among levels of care, and discharge of patients with alcohol and other drug problems; ASAM PPC IIR utilizes six dimensions, measured by the Addiction Severity Index, to determine a comprehensive snapshot of the patient.

[37] As of May 2010, APRA is still awaiting a decision from SAMHSA for its grant application for $4 million a year for up to 4 years.

In August 2009, the CORE program had approximately 30 active participating providers, offering the recovery services outlined in Table 4.1.

Detoxification. In December 2009, the Detoxification and Stabilization Center operated by APRA on the campus of DC General was closed. APRA had released an RFP to contract out the services, but did not award an RFP for a new service provider. Instead, APRA continued an existing contractual relationship with PIW, who is now providing the majority of detoxification services for APRA clients. PIW has a total capacity for both mental health and substance abuse services for adults of 40 beds. The beds can be used for clients with mental health disorders, substance abuse disorders, or dual diagnoses. The initial authorization for detoxification services is 3 days (shortened from 7 days at the former DC General campus), but can be extended if medically necessary. Detoxification services primarily focus on individuals detoxifying from alcohol, narcotics, and benzodiazepines. Detoxification services for youth are also available at the Psychiatric Institute of Washington. APRA also maintains a contract for detoxification services with the Seton House, but Seton House in not currently listed in APRA's DTCP provider directory (Updated last in January 2010).

Individuals may walk in for detoxification and stabilization services, be transported from the Assessment and Referral Center at APRA's headquarters, be dropped off by law enforcement, or be taken in by outreach or community group workers. Medicaid covers inpatient detoxification services (when deemed medically necessary) for its enrollees. Individuals without insurance or whose insurance does not cover detoxification can get a voucher for services from APRA, if they are eligible according to the DCTP criteria. Individuals who come to detoxification from APRA often come with a voucher for residential treatment; however, persons entering detoxification without a voucher (such as through referral for a mental health diagnosis) must be referred back to APRA's central site to get a voucher for residential treatment to continue after initial detoxification is complete. Residential treatment is provided at an APRA certified provider (i.e., Community Action Group, Federal City, Gospel Rescue Ministries, House of Help City of Hope, Regional Addiction Prevention Inc., Safe Haven, Salvation Army Harbor Light Center, Second Genesis, and So Others May Eat[38]).

[38] This list represents APRA certified residential treatment providers as of January, 2010.

Table 4.1. Recovery Services Offered by the Addiction Prevention and Recovery Administration

Service Type	Brief Description of Service
Recovery support evaluation	Evaluation and documentation of client's individual recovery support service needs
Case management	Facilitating access to service network and other available community resources to sustain recovery
Spiritual support groups	Universal, non-denominational, spiritually-based recovery support in a group setting
Recovery mentoring or coaching	Assist clients in assessing their current situation, defining goals, targeting areas to strengthen or improve, creating an effective life-action plan, understanding and overcoming barriers that may inhibit progress, and; holding the individual accountable for implementing the changes and reaching the goals they desire
Education services	Provide individualized or group instruction to stabilize or expand client's reading and other skills
Life skills	Teach clients employment skills, work preparation, daily living skills and nutrition support to equip them to succeed in recovery
Parenting services	Assist parents with child development skills and provide parenting information in an individual or group setting
Family and marital services	Teach and enhance communication, personal and family management skills to reduce marriage/family conflict
HIV/AIDS education	Educate client of the risks, statistics, transmission, legal, and financial aspects of the disease; as well as educate them about local, low-cost and free resources for HIV testing, treatment and supportive services
Child care	Services provided only while client is participating in clinical treatment and/or recovery support services for up to three children under the age of 13 years
Transportation	Mileage incurred or Metro system (bus and subway) access for the purpose of accessing treatment and/or recovery services, job interviews, medical appointments, 12 step or other support groups, school, work, childcare providers, or any other approved activity that supports a client's recovery. Must be associated with another billable service
Methamphetamine treatment	Non-hospital or hospital-based methamphetamine addiction treatment services using the Matrix Model IOP for Methamphetamine Treatment, as well as group recovery social activities for Methamphetamine treatment using the Community Reinforcement Approach (CRA) for Lesbian, Gay Bi-sexual, Transgender, and Questioning (LGBTQ) Communities.

4.2 SUBSTANCE ABUSE PREVENTION

APRA received two grants dedicated to substance abuse prevention, the SAMHSA Substance Abuse Prevention and Treatment Block Grant and the SAMHSA Strategic Prevention Framework State Incentive Grant.

SAMHSA Substance Abuse Prevention and Treatment Block Grant. In 2009, APRA awarded grants (with financing from the SAMHSA Substance Abuse Prevention and Treatment Block Grant) to help establish four Substance Abuse Prevention Centers in the District. The goal of the prevention centers is to strengthen community capacity, address needed community and system changes, reduce substance abuse risk factors, and achieve target outcomes for District children and youth across all eight wards and 120 neighborhoods. Communities will individually select target outcomes for change such as reducing the number of alcohol and tobacco outlets in a neighborhood or increasing the number and type of messages that youth receive about the harmfulness of drug use. Each center targets their activities in two Wards, and the centers are envisioned as hubs that engage, support, and help connect the many community elements that are needed for promoting healthy children, youth, and families as well as a drug-free city.

The grants are intended to be up to three years, with the first year focused on developing an overarching strategy, including the vision, goals, community target outcomes, and potential action steps. The second and third years are devoted to developing a formal prevention plan for each Ward based on the following steps:

- *Community Assessment*: analyze and summarize Ward level baseline information to establish substance abuse prevention need, risk and protective factors, and resource and readiness gaps.
- *Community Strategy*: develop a vision, goals, community target outcomes, and action steps to address community and system changes for substance abuse prevention, priority risk factors, and outcomes.
- *Community Implementation*: monitor and/or provide technical assistance support for the implementation of the community strategy.
- *Community Changes*: document community changes in policies, programs, and practices related to the community strategy and disseminate results within the designated geographic area and to other Prevention Centers, APRA, and community stakeholders.

Prevention Center grantees are required to report SAMHSA's Substance Abuse Prevention and Treatment National Outcome Measures to APRA on a quarterly basis. APRA will use this information to fulfill reporting requirements to SAMHSA and to monitor individual grantee progress, as well as District wide data on the following three outcomes: (1) Increase in attitudes opposed to children and youth alcohol, tobacco and other drug (ATOD) use; (2) Delay of first use (onset) and progression of risk and ATOD use among children and youth; and (3) Families, youth, and citizens are part of their community's planning, decision-making and evaluation for substance abuse prevention.

SAMHSA Strategic Prevention Framework State Incentive Grant. APRA is also in the process of implementing a substantial expansion of its substance abuse prevention activities. The agency received a Strategic Prevention Framework State Incentive Grant (SPF-SIG) from SAMHSA to develop a data driven planning process at the Ward level and District wide. A minimum of 85% of the funds are to build community capacity for implementing a five step data-driven planning process and to implement and evaluate evidence-based practices, strategies, and programs.

4.3 SUBSTANCE ABUSE SERVICES FOR THE HOMELESS

APRA's Choice Vouchers serve all District residents, including those who are homeless. It tends to have fewer programs directed specifically at the homeless population and, as part of the 2000 Choice in Drug Treatment Act, APRA is only permitted to fund treatment providers rather than housing in isolation.

Referral and Outreach. As described in chapter 3, APRA uses ASAM's Patient Placement Criteria (ASAM-PPC-2R) to help determine the appropriate level of care for all clients. The criteria include a dimension called the "Recovery Environment," indicating whether the environment is safe. In this regard, housing is one dimension among many in determining the appropriate level of drug treatment and placement for patients.

APRA helps fund Project Orion, a mobile van run by Andromeda Transcultural Health that provides substance abuse counseling as well as intake for medical detoxification programs. While not exclusively targeted to homeless individuals, the van helps engage many homeless clients. It further includes primary medical care, testing and counseling for infectious diseases, and housing/shelter referrals.

Other APRA Services for Homeless Individuals. From federal block grant funds, APRA provides loans to Oxford House, a non-profit, drug-free home. Under this arrangement, loans are provided to help acquire and renovate buildings.[39] There are currently 32 houses in the District, serving approximately 194 people. Tenants need to be sober for 28 days prior to moving in and must pay rent/utilities.

Other Residential Treatment Programs for Homeless Individuals. The District is home to other transitional housing programs for homeless individuals with substance abuse issues that are not directly sponsored by APRA. As an example, So Others Might Eat (SOME) operates drug treatment programs for homeless men and women. These programs include temporary placement (Kirwan House), 90 day treatment programs (Exodus House and Maya Angelou House), transitional housing programs (Harvest House and Leland Place), and employment training (Ralph Kueher House). SOME also offers continuing substance abuse services for those persons who graduate from their transitional housing programs (SOME website). SOME is licensed as a Level I and II provider by APRA and therefore may receive funding for outpatient and intensive outpatient treatment provided to clients who have received vouchers.

[39] Once the loan is paid back, it may be lent again to acquire additional properties.

4.4 PROVIDER CREDENTIALING AND QUALITY ASSURANCE AT THE ADDICTION PREVENTION AND RECOVERY ADMINISTRATION

Two of APRA's key functions include certification of providers and quality assurance. The Certification and Regulation Section of APRA certifies substance abuse treatment facilities and programs to ensure compliance with District and federal laws and regulations. In addition, DTCP and ASTEP providers need to have a Human Care Agreement, which is a contract between the provider and APRA that lays out the specific terms of work, required documentation, reimbursement rates, and contract conditions.

With regard to quality assurance, APRA conducts surveys of and works with substance abuse treatment providers. APRA also relies on the effectiveness of client decisions to assure quality. This is based on the idea that clients will choose treatment programs that deliver high quality services and that low quality providers will be motivated to improve quality in order to increase revenue under the voucher system. A competitive consumer driven market is created by giving client the option to choose a treatment provider. It is assumed that these consumer drive markets will reward high quality treatment programs with more clients.

Quality assurance efforts also include tracking and analyzing performance data. DTCP providers must collect, analyze and submit performance data each quarter. Access to Recovery providers must collect and report the Substance Abuse Prevention and Treatment National Outcomes Measures data such as the total number of people served and the number of people receiving methamphetamine-related services; the total number of vouchers issued and the number of vouchers issued for methamphetamine-related services. Further, APRA is in the process of implementing an internet-based performance monitoring system called District's Automated Treatment Accounting system (DATA), based on the SAMHSA-developed Web Infrastructure for Treatment Services.[40] DATA will start collecting the basic data required for APRA to comply with SAMHSA's requirements.

4.5 FINANCING

In FY 2009, the total APRA budget was approximately $46.3 million. Approximately 70 percent of APRA's budget derives from District of Columbia general revenue funds (SAMHSA State Summaries). APRA also receives a number of grants for prevention and treatment from the Substance Abuse and Mental Health Services Administration (SAMHSA). In addition, APRA has some resources from intra-district transfers from other agencies. For example, APRA has an inter-district arrangement with the Child and Family Services Agency (CFSA) to provide a residential treatment program for mothers with substance use disorder who have an open child welfare case. CFSA provides approximately $750,000 in funding to APRA annually via intra-district funds. Finally, APRA also receives some of the proceeds from assets seized by District law enforcement related to narcotic trafficking and seizures.

[40] Web Infrastructure for Treatment Services (WITS) is a web based application sponsored by SAMHSA that allows collection and tracking of client treatment data. (Source: SAMHSA)

Treatment and recovery services for adults represent the largest amount of funding ($27.4) million), followed by prevention activities and the ASTEP program ($7.7 million) and Detoxification and residential services ($7.0 million). Budgets for these services are described in the sections below.[41]

Table 4.2. APRA spending in FY 2009

Services and Activities	Amount (in millions, rounded)
Detoxification, Residential Services	$7.0
Adult Treatment and Recovery Services	$27.4
Prevention and Youth Treatment Services	$7.7
Assessment and Referral	$1,9
Management and Oversight	$2.4
TOTAL APRA FY2009 Budget	**$46.3**

Source: OCFO, FY2011 budget.

Funding for Adult Treatment and Recovery Services. Over half of APRA's FY 2009 budget, $27.4 million out of $46.3 million, was dedicated to adult treatment and recovery services. Approximately, $12.2 million was used to pay for the Drug Treatment Choice Program (DTCP) services. In order to receive substance abuse treatment, after intake a client is issued a voucher for services. This voucher is then submitted to a certified substance abuse treatment provider who later submits invoices to APRA for the payment for the delivery of these services. APRA makes payments to these providers within 30 days.[42] Providers are paid on a fee-for-service basis for services administered but not initially outlined in the voucher.

Adult treatment and recovery services budget also supports programs geared towards special populations and women's services as we well as APRA support services, including wraparound services such as mentoring, education skills and job training. (OCFO, FY2011 Budget).

APRA has a 3 year $10.6 million grant from the Access to Recovery (ATR) program funded by SAMHSA , which provides vouchers to clients for coverage for substance abuse treatment and recovery. Money from this program is used to target special populations including recently released jail inmates, women (and women with dependent children and methamphetamine users).

Medicaid covers certain services provided through the Adolescent Substance Abuse Expansion Program. APRA is responsible for the local matching funds for Medicaid covered ASTEP

[41] The budget breakdown is based on the FY2009 budget breakdown, for FY2011, APRA's budget breakdown is different, with line items based on 7 offices: Deputy Director for Operations, Deputy Director for Administration, Prevention Services Performance management, Deputy Director for Treatment, Implementation of Drug Treatment Choice. Source: DOH Budget, OCFO, FY2011

[42] Because this system has not functioned as a true claims process, APRA has not had the capacity to monitor the services delivered to patients or determine whether patients routinely use fewer or all of the prescribed voucher services.

services for Medicaid enrollees. APRA is also responsible for the costs of ASTEP treatment services not covered by Medicaid, including adolescent residential treatment services or case management services, and for ASTEP services to adolescents not enrolled in Medicaid.

Funding for Detoxification and Residential Services. In FY2009, APRA budgeted $5.3 million to detoxification and residential services. This also includes acute detoxification services. As of December, 2009, APRA began contracting out its detoxification and residential services to the Psychiatric Institute of Washington. APRA pays a negotiated payment for detoxification services, which is about 30-40% less than Blue Cross and Medicare rates.

Substance Abuse Prevention Funding. The Substance Abuse Prevention and Treatment (SAPT) block grant is a grant program awarded by SAMHSA in which at least 20% of funds must go to primary prevention activities. SAPT grant allocation to DC for FY2010 is just under $6.7 million with about $333,000 designated to early intervention activities specifically focused on HIV. (SAMHSA) APRA reports implementing a substantial expansion of its substance abuse prevention activities and has received additional federal funding to support local prevention activities. (Public Oversight Testimony, 2009) SAMHSA's Strategic Prevention Framework-State Incentive Grant, designed specifically to help states design and implement prevention models, awarded APRA $10.6 million over 5 years in July 2009 to support its prevention activities.

Funding for Referral and Intake Services. Approximately $1.9 million of APRA's budget is for referral and intake services occurring at its assessment and referral center. This is the central site from which clients can receive vouchers for services at one of the certified community based treatment agencies.

Funding for the Management and Oversight of the Addiction Prevention and Recovery Administration. In FY 2009, $2.4 million were devoted to management and oversight activities, with $1.5 million allotted towards quality improvement and $0.9 million towards certification and regulation services. (OCFO, FY2011 budget) Management and oversight activities include reporting, managing federal grants, certification and training of community provider agencies, implementation and monitoring of the WITS data system, evaluation of agency performance, and quality assurance. APRA has increased FTE staff for quality assurance, creating Quality Assessment Specialists, Policy Advisors for Youth and Adult Treatment, and Risk Manager/Privacy Officer positions. (Public Oversight Testimony, 2009)[43]

[43] Public oversight roundtable on the Addiction Prevention and Recovery Administration. Oct 15, 2009. Testimony of T. Fernandez-Whitney.

5. Behavioral Health Services for Individuals Involved with the Criminal Justice System

The criminal justice population has a higher rate of behavioral health issues than the general population, emphasizing the importance of behavioral health services for this population. This chapter describes public mental health services that the District provides to this population. Information from this chapter is taken from stakeholder interviews and a number of published reports, including reports prepared by the Urban Institute for the Criminal Justice Coordinating Council in 2004, as well as, the 2008 Annual Report of the Criminal Justice Coordinating Council. (Zweig, 2004; Criminal Justice Coordinating Council, 2008)

In the District, along with DMH and APRA as well as a number of community-based agencies, three other agencies that play a role in care for persons in the criminal justice system with mental health or substance abuse disorders:

- The Metropolitan Police Department (MPD) helps identify of persons who may need mental health services at the time of arrest
- Court Services and Supervision Agency for the District of Columbia (CSOSA) performs offender supervision in coordination with the Superior Court of the District of Columbia and the U.S. Parole Commission and includes the following units that are further devoted to mental health and substance abuse services:
    - Pre-Trial Services Agency (PSA) is the subdivision of CSOSA that is responsible for clients during the stage between lock up and arraignment and sentencing. PSA provides a number of services for clients with mental health and substance abuse issues. The Specialized Supervision Unit (SSU) responsible for supervising adults with mental illness, and developmental delay who have been arrested.
    - Substance Abuse Treatment Branch (SATB) in the Community Supervision Program (CSP) of CSOSA supervises offenders with mental health and substance abuse issues after release
- Department of Corrections provides mental health services for people who are at the DC Jail awaiting trial or transfer to the federal prison system

In addition, the District of Columbia Department of Youth and Rehabilitative Services plays a major role for provision of care for youth in the juvenile justice system. This is discussed in more detail in section 5.6.

This chapter describes the role of these agencies in providing referral and care for persons in the criminal justice system. We describe these services using the 5 level model used by DMH to identify key points in the criminal justice process where individuals should be connected to the behavioral health system for evaluation and treatment(Criminal Justice Coordinating Council, 2008):

- *Level 1*: During police/law enforcement's initial response to crime or incident (including responses by the Metropolitan Police Department (MPD), Capitol Police, Metro Transit Police, Park Police, and Secret Service Uniformed Division)

- *Level 2*: After an individual has been arrested, detained, and participated in initial hearings and is managed by the Pre-Trial Services Agency
- *Level 3*: Once an individual has moved from detention to jail or prison and is in the court system, including during forensic evaluations and commitments from the Department of Corrections
- *Level 4*: Once an individual is released from jail, state prison or forensic hospitalization to begin their re-entry into their community with support from Court Services and Offender Supervision Agency (CSOSA), DMH and APRA
- *Level 5*: Maintenance mental health management through community corrections and community support, including parole and supervision from CSOSA.

We provide more detail about services and referrals at each level in the sections that follow.

5.1 SERVICES AVAILABLE AT LEVEL 1: POLICE/LAW ENFORCEMENT

The Metropolitan Police Department, DC's primary law enforcement agency is often the initial responder to individuals with acute psychiatric or substance abuse conditions. When responding to an incident involving an adult who is intoxicated or mentally ill, MPD may:

- provide assistance to individuals who request mental health or other medical services by transporting them to Comprehensive Psychiatric Emergency Program (CPEP), or an acute care hospital
- intervene with individuals that are a danger to themselves or others, by escorting them (voluntarily or involuntarily) to the Detoxification Center at the Psychiatric Institute of Washington or CPEP. The MPD can involuntarily commit an individual through the court mediated process described in chapter 2 (forced detainment "FD-12").
- arrest individuals, send them to initial lockup where there are arraigned and next sent to Pre-Trial Services to be processed accordingly (see services at Levels 2 to 5).

In 2009, the Department of Mental Health's Crisis Intervention Training program began training the MPD to help divert mentally ill individuals to treatment. The Metropolitan Police Department provides training (16 hours initial and 16 hours of in-service work) for all new recruits to help them address persons in psychiatric crisis (District of Columbia Government, 2008). It also provides a more intensive 5 day Crisis Intervention Officer (CIO) training course for selected MPD officers to help them work with persons in acute mental health emergencies. In fiscal year 2009, 108 officers had been training in the CIO program (DC Council, 2010).

Four other law enforcement agencies also have arrest powers — the Metro Transit Police, the Capitol Police, the Park Police and the Secret Service Uniformed Division. These four agencies have discretion about how they handle issues related to intoxication and mental illness. DMH has begun the process of partnering with these other law enforcement agencies for CIO training.

5.2 SERVICES AT LEVEL 2: PRE-TRIAL SERVICES

The Pre-Trial Services Agency (PSA) is a subdivision of the Court Services and Supervision Agency for the District of Columbia (CSOSA). CSOSA is a federal, executive branch agency, created by Congress in 1997 to perform the offender supervision function for DC in coordination with the Superior Court of the District of Columbia and the U.S. Parole Commission (CSOSA, 2009). CSOSA's other component is the Community Supervision Program, described later in the chapter.

PSA serves clients from the period between lock-up through arraignment and prior to trial or sentencing by the DC Superior Court or the U.S. District Court. In 2008, PSA served a total of 1729 defendants who were placed in substance abuse treatment programs, 2970 defendants in mental health services, and 1639 defendants under supervision of PSA's Specialized Supervision Unit (SSU, described below).

Flow of Clients within the Pre-Trial Services Agency. Between lock-up and arraignment there is a brief screening/interview with the PSA's diagnostic unit staff to assess criminal risk and determine if a patient needs mental health or substance abuse services. In addition, during the intake interview clients have the option to take a voluntary drug test. The majority of clients elect to undergo drug screening. PSA does not provide medications prior to arraignment—individuals receive medications at the DC Jail and PSA staff inform the judge to issue a medical alert when transferring patients in need of medications to the DC Jail.

The screening interview can identify persons with substance abuse and treatment needs and refer them to a number of resources:

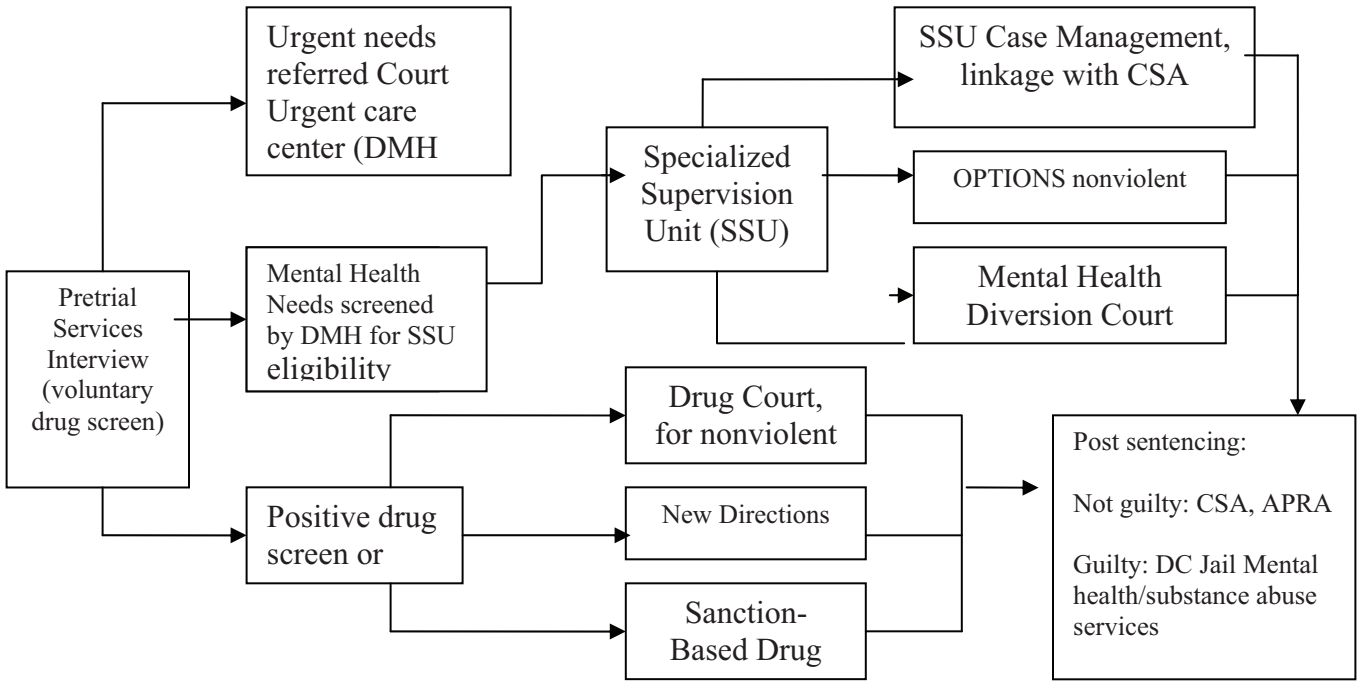
- If an initial screen identifies mental health issues (or persons are found to be already linked with DMH), the client is referred to the DMH mental health liaison, who then performs a mental health assessment to determine whether the person is eligible for services through the Specialized Supervision Unit
- People who are flagged as having a substance abuse risk or who have a positive drug test receive substance abuse screening with the Addiction Severity Index (ASI). If a client had screening recently within 90 days, PSA staff will not necessarily repeat the screening, but they will assess for current symptoms as well as suicidal or homicidal ideation. A number of sanctions related treatment programs, some with the option of early release, are available through PSA
- Persons who are identified to have urgent symptoms are sent to Court Urgent Care, which is run by the Psychiatric Institute of Washington.

Figure 5.1 shows the flow of persons through the pre trial services agency. After sentencing, an individual will go on to receive services through the community if released or placed on parole or proceed to receive services through the DC Jail (if sentenced or if detained prior to

sentencing).

This section describes components of PSA substance abuse and mental health treatment programs in more detail.

Figure 5.1: Flow of Persons with Mental Health and Substance Abuse Needs Through Pre-Trial Services Agency[a]



[a]*Flow chart information sources: Pretrial.org, 2008; Zweig, 2004.*

Mental Health Services Provided by the Pre-Trial Services Agency. The PSA Specialized Supervision Unit (SSU) is a dedicated mental health unit within the PSA for persons who have been arrested. It serves persons with serious and persistent mental illness, mild mental retardation, personality disorder and co-occurring substance abuse disorder and mental illness who are assigned a case manager upon entry. Persons who are identified with mental health issues on their initial assessment are referred to the SSU, regardless of whether their crime is violent or non-violent. Typically, clients who have been previously under the SSU (during prior arrests) are immediately placed back into the SSU. However there are no strict criteria for prior arrest or level of crime that require people to get referrals to the SSU. If someone has situational depression, they do not qualify for SSU and are referred to community services. Services provided by the SSU include psychiatric services, medication management, housing,

hospitalization, psychosocial rehabilitation, employment services, and connection to permanent mental health services. As of October, 2009, their staff included 18 supervision officers and 12 case managers.

The DC Superior court has a Forensic DMH staff member at the SSU. This staff member provides assessment of patients in the courts, and contacts the CSA if a patient was previously seen in the system. Once in the SSU, the client will be referred to one of three programs/sources of care:

- *CSAs.* The PSA prefers to use community services to ensure patients and providers can continue together after their involvement with pre-trial service ends.
- *Mental Health Court.* This court is designed for individuals that are under supervision by the SSU and who have a misdemeanor case. Individuals get a deferred prosecution if they agree to comply with mental health treatment.
- *Options*. Clients who were not previously linked with a CSA and/or for those seen by Mental Health Courts can be referred to the Options program. Options is a CSA funded by DMH that focuses on clients in the pre-trial system. Its focus is to identify people in the pre-trial period in need of transitional housing and connect them to psychiatric services. The program provides services for between 30 and 35 people at any one time, with 16 slots for housing, and serves approximately 110 persons per year. Participation in the program is voluntary. To be eligible to participate in the Options program individuals must have 1) no current or pending dangerous, violent, or weapons offense; 2) no conviction or supervision in the past five years for dangerous, violent, or weapons offenses; and 3) no primary substance abuse disorder. (Howell, 2004)

Case managers work closely with the DMH liaison, and meet monthly to discuss cases. DMH often relies on SSU to get patients into substance abuse treatment.

The court also has an urgent care center that DMH staffs via contract with the Psychiatric Institute of Washington (staffed with a psychiatrist, social worker, and psychologist Monday to Friday between 9 a.m. and 5 p.m.). Persons with acute psychiatric issues can receive evaluation at the Urgent Care Center,

Pre-Trial Services Agency Substance Abuse Programs. In fiscal year 2008, PSA conducted 3,571 Addiction Severity Index (ASI) assessments. Ninety nine percent of the ASIs revealed a need for further treatment. Once a PSA client has been identified as having substance abuse treatment needs, there are three sanctions linked options for him/her in pre-trial services:

- *Superior Court Drug Intervention Program (Drug Court)* - In order to be eligible for this program, a client must have a non-violent misdemeanor or felony charge, and not previously been convicted of a violent crime. Clients with certain misdemeanors use Drug Court as a diversion program, while other misdemeanor-charged and felony-charged defendants use Drug Court as a pretrial or post-trial pre-sentencing release option. Participation is court-ordered and noncompliance (i.e., positive drug test, failure to submit a sample for drug-testing) could result in additional sanctions for the client (i.e., program is sanction-based). There are 4 phases of this program, each of which involves

court hearings and treatment. Participants appear before one judge and upon graduation from this program, participants may have their sentence reduced to probation. As of 2003, the capacity for this program was 300 at any time. (Urban Institute, 2004)

- *New Directions Program* - This treatment program is run in house by PSA staff and provides intensive outpatient and residential treatment to persons with misdemeanors or felony charges, without restriction to type of conviction (i.e., can include violent and non-violent crimes); however, individuals on methadone or pending sentence are ineligible for this program. As of 2003, the capacity for this program was also 300 individuals at any given time. (Urban Institute, 2004).
- *Sanction-Based Treatment Program*: This program is for both violent and non-violent offenders who do not qualify for either the Drug Court or the New Directions Program. The program mandates regular drug testing and contracts with providers for a variety of substance abuse treatment options. It has established a transition process for defendants placed on probation to continue contracted treatment. Diversion is not available through this program. (Urban Institute, 2004)

Since February 2009, New Directions and drug court and been run by the PSA Support, Treatment, and Addiction Recovery Services (STARS), both staffed by PSA case managers. The majority of clients are treated internally, receiving up to 12 hours per week of intensive outpatient substance abuse treatment. (Pretrial Services Agency, 2009) STARS clients who need residential substance abuse treatment are treated by providers who contract directly with PSA. Clients receiving methadone get continued treatment from their regular community based DC provider (via APRA). None of PSA substance abuse treatment programs are tied to medication-assisted (e.g., Buprenorphine or Methadone) treatment. PSA also contracts with community based providers for treatment under the Sanctions-Based Treatment Program. (Urban Institute, 2004)

PSA uses a $7 million direct congressional allotment to finance the substance abuse treatment services described above (Makenta and Haynes, 2009) PSA also dedicates a small amount of money to send patients to detoxification services at the Psychiatric Institute of Washington ($500K).

PSA relies on APRA for detoxification and methadone treatment, and will send lower-risk defendants to APRA if they do not have capacity within the PSA system. PSA and APRA have a memorandum of understanding that guarantees PSA low-risk defendants priority treatment and assessment.

There is no formal linkage between APRA and PSA to ensure that when an individual leaves the substance abuse treatment programs supported by pre-trial services, they are provided a voucher, referred to, and seen by a treatment provider.

Care Provided by the Pre-Trial Services Agency for Individuals with Co-occurring Mental Health and Substance Abuse Disorders. PSA dedicates money from its own budget to provide some services for dually-diagnosed persons ($500K), through programs such as SafeHaven. If a

client does not need residential care, then the client can use a CSA for mental health and receive treatment through one of PSA's substance abuse treatment programs.

Other DMH Court Programs. DMH also supports three court programs for individuals incompetent to stand trial, civilly committed, or found not guilty by reason of insanity:

- *Outpatient competency restoration program* - Individuals who are incompetent to stand trial are referred to DMH via this program, started in 2005, for psychoeducation and treatment. As of August, 2009, approximately, 41% of program participants had eventually been found competent via this program.
- *Committed consumers program* - Individuals that have been civilly committed because they are a danger to themselves or others are also followed by DMH forensic staff. In August 2009, the program had approximately 180 people, the majority of whom are seen in the community as outpatients.
- *Services to the legally insane* - The DMH forensic office tracks defendants found 'not guilty by reason of insanity' to notify their CSA if they have been hospitalized. The social worker responsible for these consumers will contact the Access Helpline to access a CSA, if the patient was not formerly a CSA client.

Funding for Pretrial Services. PSA financing for outpatient and residential substance abuse treatment services is almost entirely through congressionally-appropriated funds. A direct congressional allotment ($2.8 million) and funds from the agency's budget ($0.5 million) enables PSA to finance substance abuse treatment services for clients. CSP finances outpatient and residential SA treatment services also via a congressional funding source.

CSOSA's PSA and CSP program funds flow primarily to finance FTE staff and community-based substance abuse treatment services. Both PSA and CSP contract directly with community-based substance abuse treatment providers that offer a range of services. Both agencies use existing APRA services in the community to deliver substance abuse treatment to low-risk offenders. For mental health services, PSA finances FTE staff and uses existing DMH community mental health services to serve clients. PSA staff perform a coordination and case management role linking former DMH community service agency and MHRS patients to their prior sites of care.

CSOSA's CSP also finances FTE staff that provide case management services to offenders upon release for referral to DMH core service agency providers to receive mental health services. CSOSA operates a Special Supervision Services branch, which serves released domestic violence, mental health, and sex offenders. Contracted domestic violence counselors are paid on a sliding fee schedule by CSOSA. Other supervised offenders in need of mental health services have care financed via DMH contracted providers.

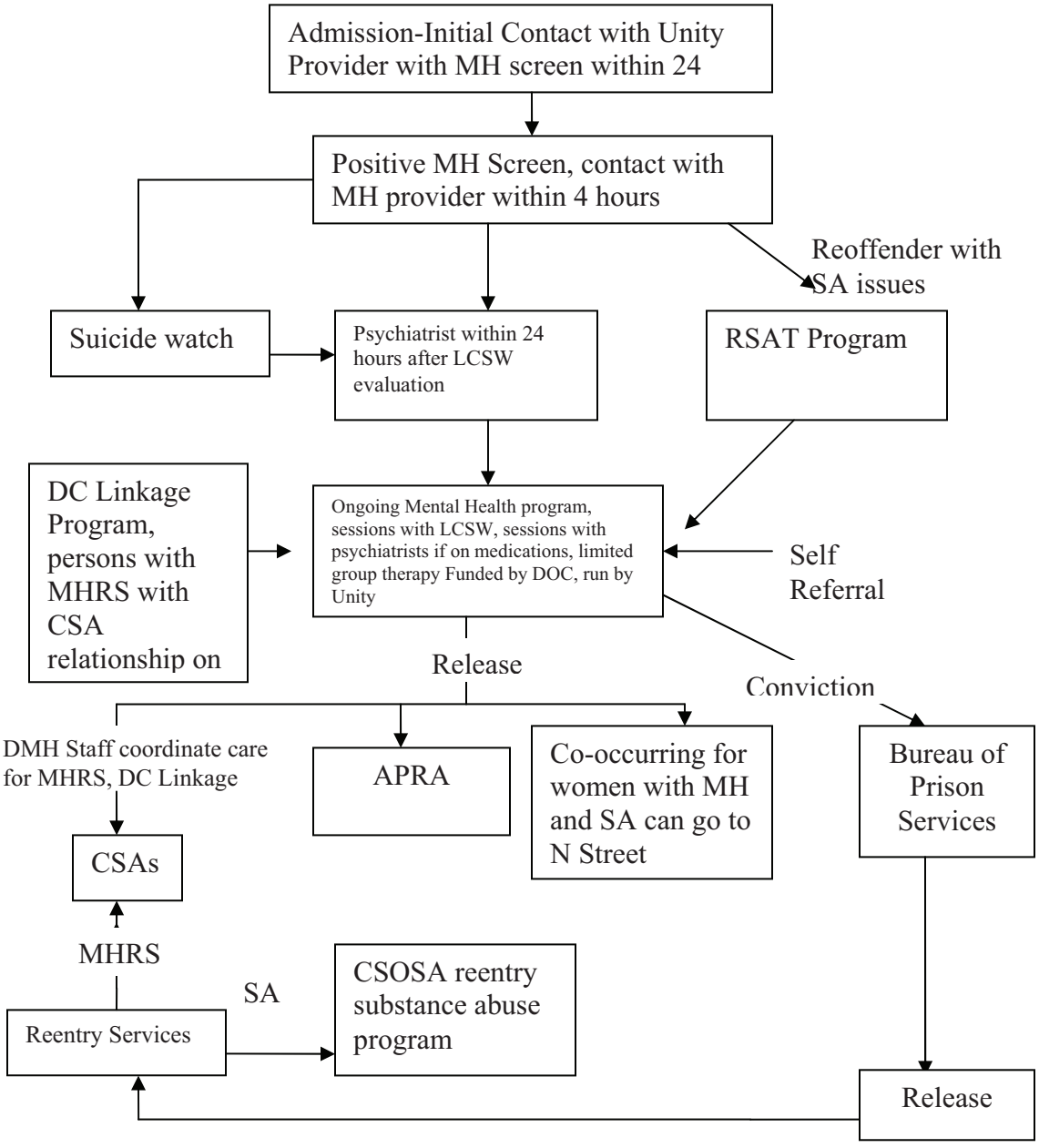
5.3 SERVICES AT LEVEL 3: THE D.C. DEPARTMENT OF CORRECTIONS

The District of Columbia Department of Corrections (DOC) provides mental health services, as well as other medical care, food and housing, for the following populations (DC Department of Corrections, 2008):

- Pretrial or presentenced felons or misdemeanants ordered to be held by the DC Superior Court
- Sentenced felons who await placement by the Bureau of Prisons (BOP)
- Parole or Supervised Release Violators who are detained awaiting final hearing from the Superior Court and decision from the U.S. Parole Commission.
- Individuals with cases that cross more than one jurisdiction, when taken into custody in DC, while awaiting final decision in DC Superior Court.
- Individuals whose paroles have been revoked
- Other persons for whom the DC Superior Court is responsible, such as persons in contempt of court or who are material witnesses
- Juvenile Offenders prosecuted as adults until sentencing and/or transfer to a BOP facility.

***Flow of Patients within DC Jail*.** Upon admission, each jail inmate receives a mental health screening performed by a physician or nurse practitioner. As part of the mental health screening, questions are asked about substance abuse; at the Jail, there is no formal screening process such as the use of the Addiction Severity Index (ASI). If an inmate needs further immediate evaluation at this point, he or she is seen within 4 hours by a mental health clinician. If psychiatric care is needed, a psychiatrist sees an inmate within 24 hours. Acutely psychotic or suicidal inmates are sent to a special unit or placed on suicidal watch.

Figure 5.2: Flow of Persons with Mental Health and Substance Abuse Needs Within the DC Jail[a]



DC Jail Mental Health Services. Approximately 33-36% of DC Jail inmates have been diagnosed with Axis I and II mental health disorders. The most frequent diagnoses are major depressive disorder, bipolar, and schizophrenia. Unity manages health care and mental health services for the DC Jail and the Correctional Treatment Facility through a contract with DOC.

The jail has a mental health unit that has 78 beds, which are reserved for individuals with acute symptoms.

A DMH staff person located at the jail will coordinate with outside providers regarding prior treatment plans if an inmate has received prior care in the community. Because the majority of inmates housed at DOC facilities are in custody fewer than three months, services are focused on stabilization and transition to care outside of DOC.

Inmates can self-refer for mental health services and be seen within 5 days. The correctional officers can also refer inmates to the mental health clinicians. All mental health plans are individualized, so therapy can be offered once per month, once per week, or once every several days.

Inmates are generally referred directly to psychiatrists if they are taking psychotropic medications or having acute psychiatric symptoms; those inmates taking psychotropic medications are seen once per month by a psychiatrist and a mental health clinician. If there is an emergency (e.g., suicide attempt) inmates can get care at one of the acute care hospitals or be admitted to the Locked Ward at United Medical Center. Otherwise, the attending psychiatrist would need to petition the court system for an inmate to receive hospital treatment.

Mental health staffing is provided 24-hours per day. As of August, 2009, there were 5 master's level clinicians, 7 full time psychiatrists, and 2 psychiatric nurse practitioners. Two clinicians work at Correctional Treatment Facility along with two psychiatrists, and a Spanish-speaking clinician who supervises all the Spanish-speaking inmates. One clinician supervises a caseload of about 250-300 inmates at the Central Detention Facility and the mental health services director supervises inmates and handles all administrative responsibilities.

DC Jail Substance Abuse Treatment Service. Approximately 20% of DOC inmates have been diagnosed with substance abuse disorder. The most frequently abused substance is marijuana, followed by multiple drug abuse, cocaine, and opioid use. Although there is not a formal screen for substance abuse during intake, inmates are queried about use during their initial physician visit.

The DC Jail offers the Residential Substance Abuse Treatment Program (RSAT). RSAT is a national program funded through Bureau of Justice Assistance, a department within the US Department of Justice (DOJ). The grant program is available to all 50 states as well as the District of Columbia. Although individual state programs may vary, in general, according to the DOJ website, RSAT guidelines require individual and group treatment activities and must:

- Have a duration between 6 to 12 months.
- Be administered in a residential treatment facility that is distinct within the correctional facility (separate from the rest of the population).
- Have a focus on the substance abuse problem of the inmate that includes developing associated life skills (including job training skills)

RSAT has 64 beds at the Central Detention Facility and an additional 20 beds on CTF for females (84 total). There are an additional 8 beds for mentors and for persons in pre-RSAT

orientation. To be eligible for the RSAT program, inmates have to be sentenced for at least 30 days and voluntarily agree to participate. Participation is based on self-referrals as well as referrals from other inmates, courts, the Bureau of Prisons (for persons with a prior history), Unity health's medical or mental health staff or from other family members.

There are 4 phases of the program:

- *Phase I Assessment*: Each inmate receives an assessment to determine length of in-house participation based on an individual interview and the Addiction Severity Index.
- *Phase II Receipt of group and individual counseling*: The program covers a number of life skills including anger management, domestic violence, mental health, HIV, behavior modification, and employment. Inmates are also oriented to community based resources for substance abuse. Inmates can stay for a minimum of 30 days and a maximum of 90 days at the in house DOC program; they can stay in the unit for an additional 30 days as a mentor (maximum of 120 days in unit).
- *Phase III Aftercare planning*: An inmate has to have an aftercare plan in order to be released from the DOC's in-house RSAT program. DOC facilitates the relationship between inmates and community based providers through a discharge planner. The discharge planner has to have a case conference with the inmate to discuss aftercare within 21 days prior to discharge from the program. Aftercare is paid for by CCOSA and APRA and is done in coordination with Unity to also insure that the inmate has a medical follow-up plan and outpatient appointment (see below).
- *Phase IV Aftercare*: Inmates receive continued care with the assistance of CCSOA from local community providers, including Safe Haven (6 months for female inmates), Community Action Group, Second Genesis, RAP Inc, Fulton House and City of Hope. CSOSA also has individual aftercare programs described elsewhere in this chapter.

Methadone treatment is provided to inmates for maintenance purposes only, no new users are incorporated. There are no buprenorphrine certified providers in the jail, but buprenorphrine is available to inmates through the DOC's medical program, run by Unity. This is funded by the Department of Corrections. In facility rates of use for methadone and buprenorphrine are five times higher than in the community. DOC is currently exploring the reason for this discrepancy.

***DC Jail Discharge Planning*.** Discharge planners in the jail provide inmates with information regarding insurance (including, for those without insurance, how to apply for it) and develop a discharge plan for each inmate that describes inmates' medicines and initial diagnoses. DMH forensic staff performs assessments to determine outpatient mental health care needs and provide referrals to appropriate CSAs; however, this staff does not assess inmates for substance abuse disorders or provide referrals for related services. CSAs are responsible for connecting with discharged inmates within 7 days of their release and for assessing inmates for substance abuse disorders and/or coordinating substance abuse services with APRA. As of August, 2009, there was no formal system to track whether this follow up occurs for inmates (except for inmates enrolled in the Linkage Plus Program, see below) Upon discharge, inmates are typically given a seven day supply of their medications.

Adults with MHRS are eligible to participate in the DC Linkage Plus Program at the Central Detention Facility. The Linkage jail liaison (a DMH employee) identifies MHRS clients who have been admitted to the jail (using a list of clients from the eCura system and recent CPEP visits) and works with CSAs to provide pre-release services and coordination. The Forensic Office at DMH tracks whether these clients (with MHRS and enrolled in the DC Linkage Plus Program) are seen in the CSAs within 7 days of release from prison. In order to promote continuity of care, CSA staff has clearance from DMH and DOC to meet with inmates prior to release. In FY 2008, 455 persons were served in this program and four core service agencies currently participate (DC Community Service Agency (DC CSA), Anchor Mental Health, Green Door, Family Preservation, and Washington Hospital Center). (DC Council FY2008 Budget Oversight, 2009).

DMH staff (in the forensic services department) also works with the Bureau of Prisons prior to release of prisoners. DMH conducts a video-conferencing with mental health providers and inmates at RIVERS (a Bureau of Prison site in North Carolina that houses many convicted District residents) to conduct discharge planning.

5.4 LEVELS 4 AND 5: COMMUNITY REENTRY SERVICES AND PAROLE

Each year, approximately, 2000 to 2500 persons re-enter the DC community from Department of Corrections. It is estimated that up to 60,000 DC residents are felons (1 in 10 residents) with about 15,000 residents under court supervision. Approximately a third of the newly released prisoners become homeless. About 70% have a substance abuse history (Pierre, 2007).

In DC, the federal government is directly responsible for supervising released prisoners through CSOSA's Community Supervision Program (CSP). (CSOSA Website). CSOSA's Substance Abuse Treatment Branch (SATB) is the unit within CSP directly responsible for supervising offenders with mental health and substance abuse issues. CSOSA works with DMH and APRA in the provision of mental health and substance abuse services to inmates re-entering the community.

Mental Health Services at Reentry. A CSOSA representative works with inmates before release to help connect them with community mental health services. Released inmates can also seek help for obtaining mental health services at the CSOSA Reentry Center located on H Street NE. A DMH Forensic staff member is co-located at the re-entry site and works with CSOSA, the parole board, and the Department of Employment Services to connect inmates with MHRS to mental health services.

As of September 2008, CSOSA was monitoring or supervising a total 15,243 offenders, including 9,080 probationers and 6,163 supervised releasees or parolees (CSOSA, 2009). The SATB supervises 2,068 offenders with mental health disorders. About a third of these offenders with mental health diagnoses have co-occurring substance abuse disorders and about a fifth of them do not have a permanent place of residence (CSOSA SATB Factsheet).

The Department of Employment Services partnered with CSOSA and the Department of Justice to operate Project Empowerment Plus for felons returning to the District after incarceration. In 2005, the Project Empowerment Plus program served 258 offenders. Eligible participants have current and/or prior offenses that are drug-related or violent and have spent at least one year incarcerated. This program provides family unification and counseling; medical care, including mental health screening, rehabilitation services, and assistance obtaining health insurance; peer support services; and life skills training. The Project Empowerment program model has been expanded to become the Transitional Employment Program, which also aids unemployed District residents in high risk neighborhoods. (Department of Employment Services, 2005).

Substance Abuse Services at Reentry. Upon release, RSAT staff coordinate with APRA to facilitate care (i.e., assessment, voucher and referral to services) for inmates with substance abuse disorders. Inmates are responsible for seeking care by using the voucher.

CSOSA performs drug testing of all supervised offenders at reentry and initially twice weekly for 8 weeks. If an offender tests negative, the frequency of testing decreases to once a week for 12 weeks. (CSOSA Overview Fact Sheet, 2010)

Offenders who violate substance abuse provisions in their parole are required to participate in the Reentry and Sanctions Center (RSC) residential treatment program, located at the Karrick Hall Building on the campus of DC General. The residential center can house 102 clients per month who participate in a 28 day drug treatment program that focuses on substance abuse counseling and life skills development (CSOSA Mental Health Fact Sheet). CSOSA also has a contract with PIW in which offenders can get acute detoxification on site.

Services for Individuals with Co-Occurring Disorders at Reentry. CSOSA has 30 dedicated beds at its RSC dedicated to individuals with co-occurring mental health and substance abuse disorders. This program is for adult male offenders (over age 18) who are considered high risk for criminal activity and who are not acutely psychotic and therefore stable to participate in the program. In addition, they must have a confirmed Axis I mental health illness, documented history of prior admission for co-occurring mental health and substance abuse diagnoses and have at least 7 months remaining in supervision (CSOSA Mental Health Fact Sheet).

DMH provides some funding for the 21 beds at N Street Village, a residential substance abuse program for formerly incarcerated women. DMH pays for its contribution to this program out of local dollars; other funding comes from the N Street Village executive board. Participating women continue to receive mental health care at their CSA and must be MHRS eligible. There are two phases to the program. Phase I occurs at a 12 bed house where women are paired with a case manager to begin assessment and case planning, and are connected with physical, mental health, and social services. This phase lasts approximately three to six months. Phase II occurs at a 9 bed house for women who successfully complete Phase I and continues case management, with a focus on self-sustainment through vocational training and permanent housing . After this six to twelve month phase women are referred to recovery housing, offered at N Street Village, or receive community based services.

5.5 FUNDING FOR DOC SERVICES

DOC receives funding mainly from DC general revenues with $150.1 million out of a total FY2009 budget of $151.1 million funded from this source. The remainder of its budget comes from federal grant funds ($148,000), such as from the US Department of Justice and Intra district transfers ($338,000). Funding for inmate health services (physical and behavioral health) represents almost a fourth of the DOC's 2009 projected budget, or $36.6 million (OCFO, 2010).

As described in Chapter 4, DOC carves out all healthcare services for inmates to Unity. Per contract, Unity provides a continuum of healthcare services, including mental health care and medications, however it provides very little substance abuse treatment.

DOC does provide substance abuse services through its residential substance abuse treatment (RSAT) program. As discussed, this program is an intensive 4 phase program run by the DOC at the DC Jail that includes a residential treatment component (total of 84 beds) and a community based component upon release. For fiscal year 2010, the District was awarded $113,598 for the RSAT program (U.S. Bureau of Justice Assistance, 2010). DOC also gets grant money from the Department of Justice's State Criminal Aliens Program as well as APRA to help fund RSAT. APRA pays for 30 days of community based treatment upon release (it possible to get a 15 day extension) and then the Court Supervision Offender Services Agency (CCOSA) pays for the remaining 6 months of services required by the RSAT program guidelines. DOC provides additional funding to help cover costs.

5.6 YOUTH INVOLVED WITH THE JUVENILE JUSTICE SYSTEM

Estimates suggest that as many as 65 percent of youth in the juvenile justice system have diagnosable mental health conditions. In some cases, youth are placed in short-term detention centers solely for mental health treatment rather than for any particular offense. Often, however, there are insufficient resources in detention centers to adequately address the mental health issues of juveniles in the system (Desai et al., 2006). The number of youth (under the age of 21) residing in juvenile detention centers in 2006 was much higher in the District as compared to the national average (rate of 6.7 per 1,000 youth in the District living in detention settings as compared to a rate of 3 per 1000 nationally (Chandra, 2009). Research has shown that youth detainees have a fourfold increase in the rate of suicide as compared to the general public (Coalition for Juvenile Justice).

This section describes services available for youth in the juvenile justice system including mental health services, substances abuse services, and services available at reentry.

Mental Health Services for Juveniles. After arrest, a juvenile may initially be sent to a detention center prior to being tried for a conviction. The short term juvenile detention center in the District is the Youth Service Center (YSC). This is an 88 bed facility located within the District that temporarily detains youth who have pending court actions or who are awaiting transfers to another facility but who cannot be released to the community setting. Children get an initial

medical and psychiatric screen while at the YSC, and children with acute mental health emergencies are sent to Children's National Medical Center or the Psychiatric Institute of Washington.

In recognition of the high costs associated with placing youths in incarceration, the District, along with several other jurisdictions, has adopted a number of alternative pathways to traditional detention for youth offenders. Through a grant from the Annie E. Casey foundation, the District through its Juvenile Detention Alternatives Initiative (JDAI) has developed a number of sites other than secure detention centers for youths in the juvenile justice system. Using a risk assessment index (RAI), a youth's risk of flight or of committing a repeat offense during the interim period between arrest and trial can be calculated. Low- and medium-risk youths will often be released to home or placed in alternative facilities within the community. These include group residential homes as well as a number of community based monitoring programs that provide additional supportive services such as counseling and mentoring. (Criminal Justice Coordinating Council 2007)

Once a youth has been detained by court action, depending on their risk to the community and mental health needs, youths (excluding those tried as adults) they can be placed in one of four settings:

- *Out of district placements*: High-risk juveniles who need intensive mental health services get placed in residential treatment – since DC does not have a suitable residential program, these juveniles get placed in programs across the U.S.
- *New Beginnings Juvenile Detention Center*: High-risk juveniles that do not need intensive mental health services, receive services through the District's long term juvenile detention center. About one third of District youth that enter the juvenile justice system are committed to a juvenile detention center. Formerly this detention center was Oak Hill an 80-bed juvenile detention facility. The length of stay at Oak Hill ranged from six to 12 months, with an average stay lasting nine months. Approximately 10 juveniles were admitted per day. About 80% of the population at Oak Hill was covered by Medicaid; however, most of the mental health services were funded by DYRS with local dollars. Reportedly almost 50% of the medical needs are mental health related. In November 2009, Oak Hill was closed and a newer detention facility, New Beginnings, was opened in Laurel, MD. New Beginnings has a capacity of 60 beds and is targeted for youth ages 15-18.
- *Community:* Low-risk juveniles who need intensive mental health services receive wraparound services through community providers. Wraparound services are individualized to address a child's specific needs with services varying from child to child. Services are provided through teams that link children and caregivers with a variety of providers including child welfare, health, mental health, educational and juvenile justice service providers to develop and implement comprehensive service and support plans. These services are funded by DMH.
- *Home with care at discretion of caregiver:* Low risk juveniles do not need intensive mental health services are frequently returned home and services are at the discretion of the caregiver.

PIW does have a sub-acute unit that is designed to help reintegrate children in the juvenile justice system into the community. However, children needing more intensive residential treatment are generally sent out of state.

Substance Abuse Services for Juveniles: Juvenile Drug Court Program. Since 1998, the Washington DC Superior Court has operated a Juvenile Drug Court Program, funded through a DOJ grant (through the Justice Programs Office). The program is for juveniles involved in drug offenses that were non-violent and did not involve weapons as well as for juveniles on probation who develop substance abuse issues. The program is sanctions based with the number of sanctions set based on the number of violations.

Eligible youth (i.e., those without weapons or violence related charges) are screened on intake for substance abuse problems. On first appearance before a judge, youth are informed of their option for drug court. If recommended for drug court, a youth is screened a second time to confirm their need for substance abuse services. A status hearing is held within 10 days of the initial screening.

There are 4 paths of entry into the program: 1) intake case (youth agrees to participate in Drug Court during their first status hearing); 2) diagnostic case (youth agrees to participate in Drug Court during sentencing hearing); 3) revocation case (youth agrees to participate in Drug Court in order to avoid revocation of probation); or a 4) consent decree case (youth participates in Drug Court so that charges against them are either diverted or dropped).

The program is a three-phase program that takes at least 12 months for completion, each phase lasting a minimum of 120 days. The program has three phases of treatment:

- *Phase I Treatment*: Participants are involved in a group counseling and meet with a counselor who devises a treatment plan
- *Phase II Maintenance*: Participants engage in special programs that focus on prevention of relapse and transition planning
- *Phase III Transition and Aftercare*: This phase which focuses on vocational training and employment placement.

Services for Juveniles at Reentry. The Project Empowerment Plus, which is now the Transitional Employment administered through the Department of Employment Services is also for high-risk juvenile offenders (14-17).

Funding for DYRS. The FY 2009 budget for the DYRS was $81.6 million. It is funded almost entirely through local dollars, with $81.2 million provided through this mechanism. Another $423,000 is funded through intra-District funds. The majority of the operating budget is dedicated to services for committed youth ($34.2 million) and detained youth ($23.5 million) covering case management, cost of housing and board and community based programs for these

populations.[44] Of that total, just under $6 million was allocated to medical services, including behavioral health care. In the FY2010 budget, behavioral health care was a separate line item, with $1.4 million allocated for behavioral health specific services (out of a total FY2010 medical budget of $4.3 million and total FY2010 operating budget of $90.3 million). (OCFO, 2010)

[44] Committed youth program covers both community-based programs as well as the New Day Residential Program in Laurel Maryland for youth committed to care under DYRS. The detained youth program covers services at community-based programs and at the secure detention center for youth awaiting court hearing.

6. Summary and Conclusion

This working paper serves as a guide to the public behavioral health care system in the District of Columbia. It describes in detail the organization and roles of the key agencies that constitute the core of the system. In the summary that follows, we provide highlights of the public mental health system in D.C.

6.1 DEPARTMENT OF MENTAL HEALTH

Services and Eligibility

DMH provides or finances outpatient, inpatient, emergency, and school-based mental health care.

DMH provides ***outpatient services*** for individuals with severe mental illness through the Mental Health Rehabilitation Services (MHRS) program. Until 2009, DMH was both a funder and direct provider of outpatient mental health services. Its main role now is to fund these services, relying on community-based providers for delivery of care.

- In fiscal year 2009, there were a total of 16,977 individuals in MHRS. The majority of these (11, 921) were covered by Medicaid Fee For Service, followed by persons without insurance (3,779) and those in DC HealthCare Alliance (2,731).
- Persons can enter MHRS care through a number of entry points. The main point of entry is the Access HelpLine, although persons can also directly present to CSAs, enter the system through the DC Jail, or through pretrial services.

For ***inpatient services***, involuntary admissions are provided at one of 4 hospitals: Providence, United Medical Center, St. Elizabeth's and the Psychiatric Institute of Washington. Voluntary admissions in general stay at the hospital of presentation.

DMH provides ***emergency services*** through CPEP for adults and ChAMPS for children. CPEP is accessible by walk-in or via the Metropolitan Police Department. Emergency services can also be obtained at local acute care hospitals. Although DMH subcontracts with Children's National Medical Center for child emergency services, at other acute care hospitals care is not covered by DMH.

DMH funds and delivers ***school-based services*** through the School Mental Health Program. The program was started through a grant from the Departments of Education, Health and Human Services and Juvenile Justice (Safe Schools/Healthy Students Initiative). DMH maintained the program after the end of the grant and recently has begun to bill Medicaid for covered services provided through the SMHP.[45]

[45] The initial grant was $1 million/year and ran from October 1999 through September 2002. Under this initial grant, the program was directed towards 17 DC chartered schools that contracted with DMH to implement the program.

As of FY 2008, the program had grown to include 58 schools, served by 48 DMH funded mental health professionals and involving collaboration with the school system, the Office of the State Superintendent for Education and the Child and Family Services Agency.

Funding

The DMH operating budget in FY 2009 was $231.7 million. Of this amount, $212.4 million was provided through directly appropriated District local dollars. Intra-district funds (funding from other District agencies, such as Child and Family Services Agency) provided smaller amounts of funding, totaling $11.3 million. Federal funds totaled just under $8 million. Private funds and donations to DMH made up $44,000 in FY 2009.

- The largest line item was dedicated to St. Elizabeth's ($102.1 million).

6.2 DEPARTMENT OF HEALTHCARE FINANCING

Services and Eligibility

DHCF administers Medicaid and the Alliance programs in the District. In this role, it determines what behavioral healthcare services are covered by programs and sets reimbursement rates for services.

- Medicaid enrollees may be in a managed care plan or in a fee-for-service plan. Low-income, disabled adults are generally enrolled in Medicaid FFS.
- Four Medicaid MCOs exist in the District: Unison, HealthRight, Chartered, and Health Services for Children with Special Needs (HSCSN). HealthRight and Chartered subcontract their coverage of behavioral health services to Beacon Health Strategies. Unison and HSCSN manage behavioral health services directly.
- HSCSN is a managed care organization targeted to low-income children with disabilities. To be eligible for HSCSN, a child must be under the age of 24, a District of Columbia resident, and be receiving Supplemental Security Income (SSI) disability benefits or have an SSI-related disability, as defined by District DHCF. Enrollment in HSCSN is voluntary; SSI children having the option to remain in fee-for-service Medicaid.
- In 2009, there were approximately 3,429 children enrolled in HSCSN and over 2,000 providers participated in the HSCSN network. (HSCSN, 2009)

Funding

DHCF is the District's Medicaid agency (fee for service and managed care) and administers the Alliance program.

- In FY2009, DHCF made over $1.7 billion in provider payments for Medicaid and Alliance, which accounted for the bulk of its budget.
- DHCF reimburses CSAs for the federal match for Medicaid eligible MHRS services. 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 MCOs serving Medicaid enrollees.
- Financing for the Alliance also comes through DHCF. Though the program currently has no mental health benefit, it does include psychotropic medications. DHCF budgets almost $4 million annually to purchase medications for the approximately 55,000 Alliance beneficiaries; however as of April 2009, Alliance has just one psychotropic medication, Zoloft, on its formulary.

6.3 ADDICTION PREVENTION AND RECOVERY ADMINISTRATION

Services and Eligibility

As part of the D.C. Department of Health, APRA is organizationally separate from DMH. APRA funds a range of substance abuse services, including assessment and referral, detoxification and residential treatment, adult treatment and recovery, and prevention and youth treatment.

- APRA funds substance abuse treatment through two programs, the Drug Treatment Choice Program and the Adolescent Substance Abuse Treatment Expansion Program.
- The Choosing Options for Recovery and Empowerment Program is the primary vehicle through which recovery services are provided. Individuals may be referred to APRA from their primary care or mental health care provider, CPEP, DMH's homeless outreach program, other DMH programs or through the court system; or they may simply walk in for services.
- Life-threatening detoxification is covered under Medicaid and Alliance and may be provided at an acute care hospital.

Funding

In FY 2009, the total APRA budget was approximately $46.3 million. Approximately 70 percent of APRA's budget comes from District of Columbia general revenue funds.

- Most of APRA's treatment and recovery services are jointly funded by federal grants and local dollars.
- Treatment and recovery services for adults represent the largest amount of funding ($27.4) million), followed by prevention activities and adolescent treatment services (the ASTEP program-- $7.7 million), and detoxification and residential services ($7.0 million).

6.4 BEHAVIORAL HEALTH SERVICES AND HOUSING PROGRAMS FOR THE HOMELESS

Services and Eligibility

The District of Columbia has a high proportion of homeless individuals, many of whom have mental health care needs. Both DMH and APRA provide or fund services for these individuals.

- The DMH Office of Homeless Services offers outreach to homeless individuals and helps connect them with social services.
- DMH also works closely with other federal and District agencies, such as HUD and DCHA, to provide housing for persons with mental illnesses. As a result a number of programs exist including rental subsidies/voucher programs, supported living programs, community residential facilities, transitional housing and access to affordable housing units.
- APRA administers grants for community organizations to build transitional housing. There are a number of community-based residential treatment programs that provide residential treatment.

Funding

Funding for homeless comes from several District agencies including DMH, APRA, HUD, and The Community Partnership for the Prevention of Homelessness.

- For example, the Home First program's budget is approximately $6 million, of which $380,000 is from the federal mental health block grant; approximately $57,000 is from the PATH grant for homeless services; and the rest is local dollars.

6.5 BEHAVIORAL HEALTH SERVICES FOR INDIVIDUALS INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM

Services and Eligibility

The criminal justice system can interface with the behavioral health system on a number of levels. These may include law enforcement's initial response to the scene, after arrest and detention, during pretrial services, at the DC 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, as described below.

- The Metropolitan Police Department participates in crisis training of new recruits to increase awareness of mental health issues so that they can be properly identified at the time of arrest.
- The Pre-Trial Services Agency 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 DOC offers mental health and substance abuse services at the DC Jail. On the jail site the RSAT program is available for persons who voluntarily wish to receive detoxification.

- The juvenile justice population is a particularly high-risk population. There are no residential treatment facilities for high-risk youth with intensive mental health needs in the District, hence these youth are sent to out-of-state facilities.
- The CSOSA Pre-Trial Services 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.

Funding

Funding for behavioral health services and programs for individuals involved with the criminal justice system comes from PSA, DOC, DOJ, and DYRS (juvenile justice)

- PSA financing for outpatient and residential substance abuse treatment services is almost entirely through congressionally-appropriated funds.
- PSA dedicates money from its own budget to provide some services for dually-diagnosed persons ($500K).
- Funding for inmate health services (physical and behavioral health) represents almost a fourth of the DOC's 2009 projected budget, or $36.6 million (OCFO, 2010).
- DOC also gets grant money from the Department of Justice's State Criminal Aliens Program as well as APRA to help fund their residential substance abuse treatment program.
- Funding for youth services is provided through DYRS. The majority of DYRS operating budget ($81.6 million total in FY 2009) is dedicated to services for committed youth ($34.2 million) and detained youth ($23.5 million) covering case management, cost of housing and board and community based programs for these populations.

CONCLUSION

The District of Columbia's public behavioral health system is complex and multilayered. It involves many agencies, service providers, and financing mechanisms and is responsible for services delivered in a broad range of settings. The goal of this working paper was to clarify the nature of this complexity and the way the system operates for policymakers and others interested the nature of complexity and way in which system works. A companion report provides an evaluation of the District's public behavioral health system and identifies challenges facing the system and recommendations for high level priorities to address the challenges.

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APPENDIX A: Interviewees

During the course of our work, we interviewed representatives from the following organizations:

Anchor Mental Health
Beacon Health Strategies LLC
Carnavale Associates LLC
Children's National Medical Center
Community Connections, Inc.
Criminal Justice Coordinating Council
DC Action for Children
DC Addiction Prevention and Recovery Administration
DC Behavioral Health Association
DC Chartered Health Plan, Inc.
DC Child and Family Services Agency
DC Department of Corrections
DC Department of Health
DC Department of Health Care Finance
DC Department of Mental Health
DC Department of Youth Rehabilitation Services
DC Pretrial Services Agency
DC Primary Care Association
George Washington University, Department of Prevention and Community Health,
George Washington University, Midge Smith Center for Evaluation Effectiveness
Green Door
Health Right, Inc.
Health Policy Institute, Georgetown University
Howard University
Health Services for Children with Special Needs (HSCSN)
National Association of State Alcohol and Drug Abuse Directors
Psychiatric Institute of Washington
SOME
St. Elizabeth's Hospital
The Community Partnership
Unison Health Plan
Unity Health Care
Urban Institute
Whitman Walker Clinic

APPENDIX B: The Process of Privatizing District Community Service Agencies

The District of Columbia is currently in the process of privatizing its District Community Service Agencies, transitioning patients from DMH run Community Service Agencies (DC CSAs) to the privately-administered Core Service Agencies (CSAs). The rationale behind privatization was based on Dixon Final Court-Ordered Plan which ordered the DMH to "explore appropriate legal options to enable the DC CSA to operate as an independent non-profit organization. This would enable the Department to focus its leadership efforts on its authority functions, avoid perceptions of favoritism, and provide the DC CSA greater flexibility to operate with an independent Board, budget, and personnel system, etc." (Court-Ordered Plan, pg. 25) Specifically, the Plan required DMH to assess private capacity, willingness and efficiency in providing these services. In December 2008 prior to the transition, DC CSAs actively served 4,174 consumers (3,696 adults and 478 children and adolescents) – nearly 40% of the consumers in the public mental health system.[46]

A report released in 2008 found that the patients served by DC CSAs were similar with regard to level of functioning compared to those seen by private CSAs; however, DC CSAs were generating FFS revenue at less than half the cost as private providers. The report evaluators recommended that DC continued to directly provide specialized services including pharmacy, psycho educational services, and multicultural coordination, but discontinue other CSA services.[47]

Starting in March 2009, DMH has begun transitioning patients from DC CSAs to CSAs. The transition started in March of 2009 with a goal of transitioning 2,500 consumers by August 1, 2009, and the remainder of consumers by March 31, 2010. About 650 individuals are to remain in DC CSA. As of October 2009, DMH was on target for its goal. An obvious challenge with the transition has been the influx of patients to CSAs and psychiatrists. It is often expensive for providers to hire psychiatrists. DMH is deploying psychiatrists to provider sites to help with the transition (it was estimated that with the transition to private CSAs the patient to psychiatrist ratio would rise from 1:200 to 1:443).[48] Two current DMH child psychiatrists will be available to the community providers.

There is a tracking process to ensure that consumers are not lost to follow-up in the transition. The DMH is now paying upfront payments of 50% to CSAs at the time of they receive transitioning patients. Certain services will continue to be provided directly by DMH. For more information on the services provided by DMH, please see Section 2 of the report.

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[46] http://dmh.dc.gov/dmh/frames.asp?doc=/dmh/lib/dmh/pdf/Report_to_the_Council__12-31-08_Final.pdf, Accessed October 16, 2009

[47] From KPMG study, http://dmh.dc.gov/dmh/frames.asp?doc=/dmh/lib/dmh/pdf/Council_Report__10-1-08._Appendix_B.pdf, Accessed October 16, 2009.

[48] From KPMG study, http://dmh.dc.gov/dmh/frames.asp?doc=/dmh/lib/dmh/pdf/Council_Report__10-1-08._Appendix_B.pdf, Accessed October 16, 2009.

APPENDIX C: Patient Flow Through the Comprehensive Psychiatric Emergency Program

The Comprehensive Psychiatric Emergency Program (CPEP) accepts both walk-ins and patients brought in from the Metropolitan Police Department (both voluntary by request and from FT-12), as well as those brought in by friends and families. In FY 2007-2008, CPEP saw about 304 patients per month. About 60% of visits are from police and are involuntary. CPEP also has a mobile crisis unit which refers patients needing more intensive services.

Upon intake, CPEP staff access several data systems to get information about patients. First, the staff looks to see if the patient is already in DMH's system of care and if they are affiliated with a CSA. CPEP staff will alert the CSA of their patient's status and request that the CSA send a case manager to bring them information about the last time the patient visited the CSA, what their medications are, and the last time they saw a psychiatrist. Since CPEP is not currently able to link their system with eCura to access the electronic medical records, they rely on case managers to fax (if a case manager is not available to come to CPEP) vital patient information. CPEP staff can also use SPIS, an information base to find patient name and address. SPIS can also help staff identify if the patient is involved with CFSA or APRA, and check insurance status.

Upon intake, patients are also assessed for mental health and substance abuse disorders to help identify needed services. Substance abuse screening is voluntary. After staff identify patient insurance and needed services, they begin working to identify potential follow-up services that are covered by patient insurance. Patients that require medical clearance are managed by an onsite medical office or may be sent to local hospitals. Once cleared, the patients return to CPEP.

While at CPEP, patients receive brief mental health and substance abuse counseling. One-on-one counseling is provided to all patients, and those that are in extended observation beds can also receive group counseling. Medication for some medical and psychological conditions is offered. However, there is no medication management for substance abuse related medications.

When patients are discharged they are given three days of medication, and a two-week prescription. Everyone that CPEP identifies as needing follow-up for a mental health problem gets linked to a CSA. This involves social workers calling the CSAs to inform them about the patient and arrange appointments for follow-up care. CPEP used to link everyone (including individuals with substance abuse disorders), but has curtailed their efforts to conserve and redirect their limited resources. For individuals identified as noncompliant, CPEP requests that the mobile crisis team follows up and ensures that the patient received follow-up care. If CPEP identifies that a person in crisis did not make it to their follow-up appointment, the mobile crisis team goes to their house and helps them to arrange another follow-up appointment. For some people, the CSA's cannot see them quickly, so they come back to CPEP to renew their prescriptions.

There are several common outcomes for patients once they are discharged from CPEP:

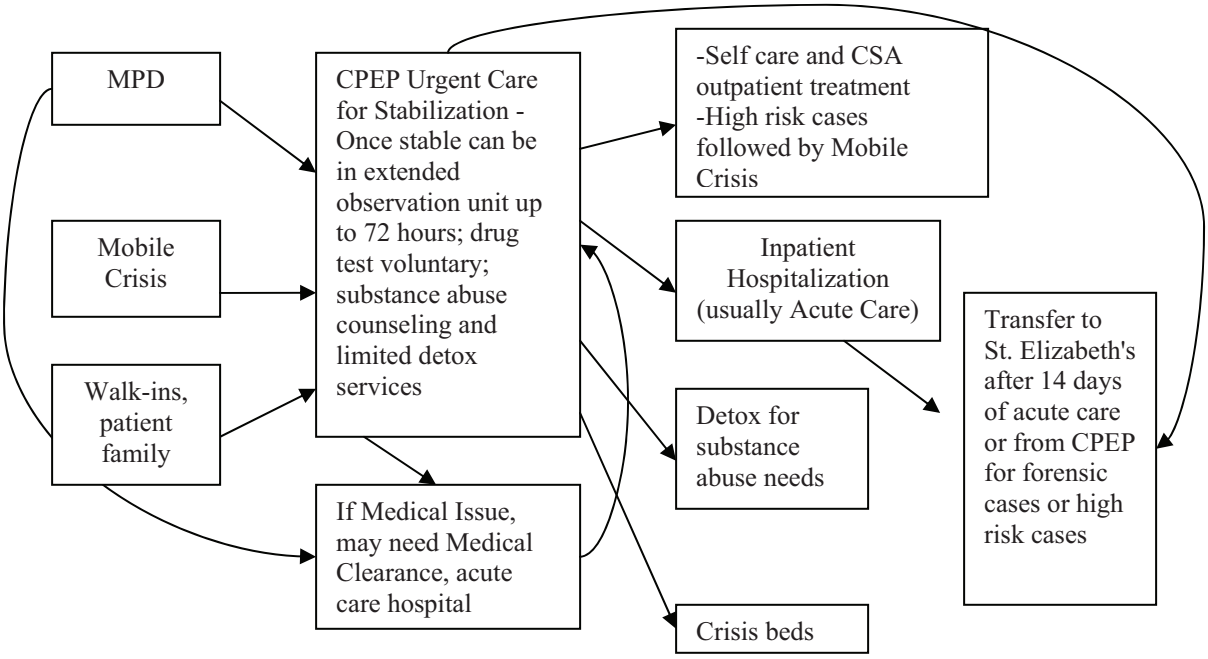
- *Transfer to a mental health facility* – When patients need admission, they can go to a number of places based on insurance. Involuntary patients go to either Providence or

United Medical Center if uninsured. Insured involuntary patients go to PIW. In general PIW won't take Medicaid adults due to the IMD exclusion. Patients who are forensic cases under arrest will go to the John Howard ward at St. Elizabeth's that has a locked unit.

- *Release into the community* – CPEP's mobile crisis unit can follow up on persons who were discharged from CPEP.
- *Transfer to St. Elizabeth's* – Persons who are known to St. Elizabeth's system as needing a higher level of care or who have been in inpatient acute facilities for 14 days can go to St. Elizabeth's by transfer.
- *Transfer to a crisis bed* – Crisis beds were identified as a step-down from CPEP and the least restrictive way to supervise someone in crisis. Crisis beds keep individuals in their communities and allow them the flexibility to attend treatment programs and work. CPEP has contracts with Jordan House and Crossing Place for a total of 15 crisis beds. DMH covers up to 14 days in a crisis bed. Patients cannot go from a hospital to a crisis bed.
- *Transfer to detox or APRA substance abuse services* – Detox services are voluntary. If a patient is suffering from a serious alcohol overdose CPEP staff will call 911 so the patient can be transferred to an acute care center for treatment.

The flow described above is presented visually in Figure C.1 (below).

Figure C.1. Patient Flow Into and Out of CPEP



In fiscal year 2007 to 2008, there were 3,621 visits to CPEP. Of these 2,491 were unduplicated cases (25% of persons had more than one admission). On average from 2007 to 2008, there were 302 visits per month. Forty percent of the visits were discharged to self-care. Thirty percent of visits resulted in admissions to hospitals; 71% of these cases were to community hospitals. Seven percent of persons were discharged with a recommendation of detox services, however of these only 38% received or were admitted to APRA detox services. On discharge 48.3% went to UMC, 38.4% went to PIW, 7.2% went to Providence, 5.3% went to Washington Hospital Center, 2.5% went to the VA, and 0.2% went to Sibley. Eighty two percent of the admissions were involuntary, 13% were voluntary, 3% were committed outpatients, and 0.4% were committed inpatients (with unauthorized leave). [49]

[49] CPEP End of the Year Report for 2008.

APPENDIX D: Drug Formularies by Insurance (listed by generic name)

Unison Health Plan Psychiatric Drug Formulary

Alcohol Deterrants
acamprosate
disulfiram
naltrexone

Anxiety
Benzodiazepines
alprazolam QL
chlordiazepoxide
clonazepam (not wafers)
clorazepate
diazepam QL
lorazepam QL
oxazepam QL

Miscellaneous
buspirone
clomipramine
fluvoxamine

Attention Deficit Hyperactivity Disorder (ADHD)
amphetamine/dextroamphetamine mixed salts*
amphetamine/dextroamphetamine
mixed salts ext-rel*
atomoxetine* QL ST
dextroamphetamine* QL
dextroamphetamine ext-rel*
methylphenidate* QL
methylphenidate ext-rel*
methylphenidate ext-rel* QL
*Patients 21 years of age or older require Medical Exception.

Bipolar Disorder
divalproex sodium delayed-rel (Minumum age 2)
divalproex sodium ext-rel QL
lithium carbonate
lithium carbonate ext-rel tabs

Depression
Monoamine Oxidase Inhibitors (MAOI)
tranylcypromine

Selective Serotonin Reuptake Inhibitors (SSRI s)
citalopram
fluoxetineparoxetine
sertraline QL

Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)
desvenlafaxine ST
duloxetine QL ST
venlafaxine QL
venlafaxine XR QL ST

Tricyclic Antidepressants (TCAs)
amitriptyline
amoxapine
desipramine
doxepin
imipramine HCL
nortriptyline

Tricyclic Antidepressant/Phenothiazine combination
amitriptyline/perphenazine

Miscellaneous Agents
bupropion
bupropion ext-rel QL
maprotiline
mirtazapine tabs (not soltabs)
trazodone

Insomnia
Benzodiazepines
flurazepam QL
temazepam QL
triazolam QL

Non-benzodiazepines
chloral hydrate
diphenhydramine OTC
zaleplon QL
zolpidem QL

Narcotic Antagonists
buprenorphine PA QL
buprenorphine/naloxone PA QL
naltrexone

Anti-Psychotics
Atypicals
aripiprazole tablets QL*
clozapine*
olanzapine tablets QL*
quetiapine QL*
risperidone QL*
risperidone QL (Not M-Tabs)*
ziprasidone QL*
*Covered for members 5 years of age and older.

Miscellaneous
chlorpromazine
fluphenazine
fluphenazine decanoate
haloperidol
haloperidol decanoate
loxapine
perphenazine
thioridazine
thiothixene
trifluoperazine

Source: Unison Healthplan Preferred Drug List. 2010.
http://www.unisonhealthplan.com/Plans/CapitalArea_UnisonDCHFP/Members/Documents/Pharmacy/DC%20formulary-member.pdf
(Note physicians can submit a pharmacy override form for non-formulary medications subject to approval.)

Chartered Health Plan Psychiatric Drug Formulary

Anxiety

Benzodiazepines
alprazolam
chlordiazepoxide
clonazepam tabs
diazepam
lorazepam
oxazepam

Miscellaneous
buspirone
clomipramine

Antidepressants

Monoamine Oxidase Inhibitors (MAOIs)
tranylcypromine
phenelzine

Selective Serotonin Reuptake Inhibitors (SSRIs)
citalopram
fluoxetine
paroxetine HCl
paroxetine HCl ext-rel
sertraline
escitalopram

Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)

venlafaxine
duloxetine delayed-rel PA
venlafaxine ext-rel

Tricyclic Antidepressants (TCAs)
amitriptyline
desipramine
doxepin
imipramine HCl
nortriptyline

Miscellaneous Agents
bupropion
bupropion ext-rel
mirtazapine
trazodone

Antipsychotics

Atypicals
clozapine
risperidone
aripiprazole
olanzapine
quetiapine
ziprasidone

Miscellaneous
fluphenazine

fluphenazine decanoate
haloperidol
perphenazine
thioridazine
thiothixene

Attention Deficit Hyperactivity Disorder

amphetamine/dextroamphetamine mixed salts ext-rel
dexmethylphenidate
dextroamphetamine
methylphenidate
methylphenidate ext-rel
methylphenidate ext-rel
dextroamphetamine oral soln
methylphenidate ext-rel
methylphenidate oral soln

Hypnotics

Benzodiazepines
flurazepam
temazepam

Nonbenzodiazepines
chloral hydrate
zolpidem MDL
ramelteon

Mood Stabilizers
lithium carbonate
lithium carbonate extended release

Source: Chartered Healthplan Closed Formulary 2009-2010.
http://www.caremark.com/portal/asset/DC_Chartered.pdf
(Note physicians can submit a pharmacy override form for non-formulary medications subject to approval.)

District of Columbia Healthcare Alliance Psychiatric Drug Formulary

Benzodiazepines
Clonazepam
Alprazolam
Chlordiazepoxide
Diazepam

Flurazepam
Lorazepam

Antidepressants
Amitriptyline
Desipramine
Imipramine
Nortriptyline
Sertraline

Antipsychotic Agents
Chlorpromazine
Fluphenazine
Haloperidol
Thioridazine
Trifluoperazine

Attention Deficit Hyperactivity Disorder
Methylphenidate 10mg

Bipolar Disorder
Lithium Carbonate

Source: District of Columbia Healthcare Alliance: 2008-2009 Formulary. http://www.chartered-health.com/images/PDF_Files/dcha_formulary_2008-2009.pdf

(Note physicians can submit a pharmacy override form for non-formulary medications subject to approval.)

APPENDIX E: Formulary for Community Service Agencies Participating in the Mental Health Rehabilitation Program

CSA FORMULARY

Generic Name (Brand Name)	Forms of Drugs Available	Description
Acetaminophen (Tylenol) Elixir 160mg/5ml	Elixir 160mg/5ml	Analgesic
	Tablets 325mg, 500mg	
	Suppositories 650mg	
Acetaminophen W/Codeine Tablets 325mg with	Tablets 325mg with	Narcotic analgesic
(Tylenol #3	30mg Codeine	and acetaminophen
Controlled Substance		
Acyclovir (Zovirax)	Capsules 200mg, 800mg	Antiviral
Albuterol (Ventolin, Proventil) Inhaler 17mg		Bronchodilator
	Tablets-ER 4mg, 8mg	
	Syrup 2mg/5ml	
Allopurinol	Tablets 100mg and 300mg	Used to treat chronic
		gout
Alprazolam (Xanax)	Tablets 0.25mg, 0.5mg,	Anxiety agent
(Controlled subdstance)	1mg and 2mg	
Aluminum Hydroxide	Suspension 180mg	Used to relieve heart
Magnesium Hydroxide,		burn, sour stomach, or
Simethicone (Mylanta)		acid indigestion.
Amantadine (Symmetrel)	Capsules 100mg	Use to treat type-A infulenza
		infections and neuroleptic
		induced side effects
Amitripryline (Elavil)	Tablets 10mg, 25mg, 50mg,	
	75mg, and 100mg	Antidepressant
Amlodipine Besylate (Norvasc)	Tablets 5mg and 10mg	Cardiac Drug (use for blood
		pressure and to relieve and
		control angina
Amoxapine (Asendin)	Tablets 25mg, 50mg, 100mg,	Antidepressant/Tranquilizer
	and 150mg	
Amoxicillin (	Capsules 250mg, 500mg	Antibiotic
Amoxicillin Clavulanate	Tablets 250mg/125 clav.,	
Potassium (Augmentin)	500mg/125mg clav.,	Antibiotic
	875mg/125mg	
Amphetamine Sulfate/Asparate	Tablets 5mg, 10mg, 20mg, 30mg	Used to treat narcolepsy
Dextroamphetamine sac/dex Sul	Tablets-XR 5mg, 10mg, 20mg,	and attention deficit hyperactivity
Adderall)	and 30mg	disorder
(Controlled Substance)		
Antipyrine/Benzocaine	Otic Solution 15mg	Used in the ear to help relieve
Auralgan)		pain, swelling and redness due
		to infection.

Generic Name (Brand Name)	Forms of Drugs Available	Description
Ariprazole (Abilify)	Tablets 10mg, 15mg, 20mg,	Atypical antipsychotic
	and 30mg	
Artificial Tears (Teargen II)	Opthalmic Solution 15ml	Used as a lubricant to prevent
		irritation or to relieve dryness
		of the eye
Ascorbic Acid	Tablets 250mg, 500mg	Vitamin
Aspirin (Aspirin)	Tablets 81mg (chewable),	Analgesic, anti-inflamatory. Used
	325mg, plain,(buffered of	as a stroke and MI prophylaxis.
	enteric coated)	
Atenolol (Tenormin)	Tablets 50mg and 100mg	Antihypertensive
Atomoxetine (Strattera)	Capsules 10mg, 18mg, 25mg	
	40mg, 60mg	Used to treat Attention-
		Deficit/Hyperactivity Disorder
		(ADH)
Atorvastatin Calcium (Lipitor)	Tablets 10mg, 20mg, and 40mg	Used to lower cholesterol.
		**May cause muscle damage. Monitor
		patients for muscle pain/soreness**
Azithromycin (Zithromax)	Tablets 250mg, 500mg	Antibiotic
Benztropine (Cogentin)	Tablets 0.5mg, 1mg, and 2mg.	Used to treat parkinsons
	Injection 1mg.ml (mesylate	disease (shaking palsy). Also
	injection)	used to control side effects of
		neuroleptics
Betamethasone Valerate	Ointment 0.1% 15gm	
(Valisone)	Lotion 0,1% 50ml	
	Cream 0.1% 15gm and 45gm	Topical Steroid
Bethanechol (Urecholine)	Tablets 10mg and 25mg	Used to treat certain disorders
		of the urinary tract or bladder
Biperiden Akineton)	Tablet 2mg	Used to treat neuroleptic-induced
		side effects and Parkinsons
		disease.
Biscodyl (Dulcolax)	Tablet 5mg (enteric coated).	Laxative
	Suppositories 10mg	
Brimonidine (Alphagen)	Opthalmic Solution 0.2%, 5ml	Used to treat glaucoma
Bromocriptine (Parlodel)	Tablets 2.5mg	Used to treat menstrual problems
		Also used to treat some people
		with Parkinson's disease.
Bupropion (Wellbutrin)	Tablets 75mg, 100mg	Antidepressant
	Tablets-SR	
	Tablets-XL (q24H) 150mg, 300mg	
Buspirone (Buspar)	Tablets 5mg, 10mg, and 15mg	Antianxiety agent
Butalbital/Aspirin/Caffeine	Tablets 100's	Used to treat tension headaches
(Fiorinal)		
Conttolled Substance		
Calcium Carbonate	Tablets 650mg (260mg of	Calcium suppliment, use to
	elemental calcium	relieve heartburn, sour stomach,
		or acid indigestion.

Generic Name (Brand Name)	**Forms of Drugs Available**	**Description**
Captopril (Capoten)	Tablets 12.5mg, 25mg, and	Use to treat high blood pressure
	50mg	nephropathy, CHF
Carbamazepine (Tegretol)	Tablets 100mg (chewable),	Anticonvulsant
	200mg.	
	Suspension 100mg.5ml	
Carbidopa/Levodopa (Sinemet)	Tablets 100mg Carb/100mg Lev	Used to treat parkinson's
	25mg carb/100mg lev	disease.
	25mg carb/250mg lev.	
Cephalexin (Keflex)	Capsules 250mg, and 500mg	Antibiotic
Chlordiazepoxide (Librium)	Capsule 5mg, 10mg, 25mg	Used to relieve nervousness,
****Controlled Substance****		tension, or treat alcohol
		withdrawal.
Chlorpromazine (Thorazine)	Tablets 25mg, 50mg, 100mg,	Antipsychotic
	and 200mg.	
Ciprofloxacin (Cipro)	Tablets 250mg and 500mg	Antibiotic
Citalopram (Celexa)	Tablets 10mg, 20mg and 40mg	Antidepressant (SSRI)
Clindamycin (Cleocin)	Capsules 150mg,	Antibiotic
	Topical Solution 1% 60ml	
Clomipramine (Anafranil)	Capsules 25mg, 50mg, and	Antidepressant
	75mg	
Clonazepam (Klonopin)	Tablets 0.5mg, 1mg and 2mg	Anticonvulsant and also used
****Controlled Substance****		to treat nervousness & tension.
Clonidine	Tablets 0.1mg, 0.2mg, 0.3mg	Hypotensive agent, and used to
	Patch TTS-1, TTS-2, & TTS-3	treat withdrawal symptoms
Clodipogrel (Plavix)	Tablet 75mg	Antiplatelet agent
Clotrimazole (Mycelex/Lotrimin)	Soution 1% 10ml	Topical Antifungal
	Topical Cream 1% 15gm	
	Vaginal Cream 45gm	
	Troches 10mg 70/box	
Clozaril (Clozapine)	Tablets 25mg and 100mg	Atypical antipsychotic
follow protocol		
Colchicine	Tablet 0.6mg	Used to prevent and/or treat
		attacks of gout
Combivir (Lamivudine/Zidovudine)	Tablets 150mg/300mg	A combination of two necleoside
		reverse transcriptase inhibitors,
		for patients with HIV infection.
Condoms	Available with or without a	Used to protect/prevent
	prescription or requisition.	pregnancy and transfer of STD's
Conjugated Estrogens	Tablets 0.3mg, 0.625mg, and	Hamone replacement
(Premarin)	1.25mg	therapy
	Vaginal Cream 45gm	

Generic Name (Brand Name)	Forms of Drug Available	Description
Clotrimoxazole DS (Septra,	Tablets 800mh/160mg	Antibiotic
Bactrim	respectively	
Cyanocobalamin (Vitamin B-12	Injection 1000mcg/ml	Vitamin
injection)	Tablets 100mcg	
Cyclobenzaprine (Flexeril)	Tablets 10mg	Muscle Relaxant
Cyproheptadine (Periactin)	Tablet 4mg	Antihistamine
Desipramine (Norpramin)	Tablets 10mg, 25mg, 50mg,	Antidepressant
	75mg, and 100mg	
Dextroamphetamine Sulfate	Tablets 5mg	Stimulant used to treat
(Dexedrine)	Spansules 5mg, 10mg & 15mg	narcolepsy and attention
Controlled Drug DEA Schedule II		deficit disorder.
Diazepam (Valium)	Tablets 2mg, 5mg, 10mg	Antianxiety agent
controlled Supstance		
Dicloxacillin (Dynapen)	Capsule 250mg	Antibiotic
Dicyclomine (Bentyl)	Capsules 10mg and 20mg	Used to relieve cramps or
		spasms of the stomach,
		intestines and bladder
Didanosine (Viodex)	Tablets 25mg, 50mg, & 100mg	Antiretroviral
Digoxin (Lanoxin)	Tablets 0.125mg, 0.25mg	Used to improve the strength
		and efficiency of the heart or to
		control rate and rhythm of heart-
		beat.
Diltiazem (Cardizem)	Tablets 30mg & 60mg	Antihypertensive
Diphenhydramine (Benadryl)	Capsules 25mg & 50g	Antihistamine
	Elixir 12.5mg/5ml	
	Injection 50mg/ml	
Diphenoxlate/Atropine (Lomotil)	Tablet 2.5mg	Combination medication used
		along with other measures to
Controlled Substance		treat severe diarrhea
Dipiverfrin Solution (Propine)	Opthalmic Solution 5ml	Used to treat glaucoma
Disulfiram (Antabuse)	Tablet 250mg, & 500mg	Used to help overcome drinking
		problems
Divalproex Sodium (Depakote)	Tablet 125mg, 250mg & 500mg	Anticonvulsant. Also used for
Enteric Coated-Extended Release)		bipolar disorder
Depakote-ER	Depakote-DR 250mg & 500mg	
(Delayed Release q 24 hr)		
Docusate Sodium (Calace)	Capsule 100mg	Laxative
Donepezil (Aricept)	Tablets 5mg 10mg	Used in the treatmeny of mild
		to moderate dementia associat-
		ed with Alzheimer's disease.
Dorzolamide/Timolol (Cosopt)	Opthalmic	Used in the treatment of
		glaucoma

Generic Name (Brand Name)	Forms of drugs Available	Description
Doxazosin (Cardura)	Tablets 1mg, 2mg, & 4mg	Antihypertensive
Doxepin (Sinequan)	Capsules 10mg, 25mg, 50mg,	Antidepressant
	and 75mg	
Doxycycline (Vibramycin)	Capsule 100mg	Antibiotic
Duloxetine HCL (Cymbalta)	Capsules 20mg, 30mg & 60mg	Antidepressant (SSNRI)
Droperidol (Inapsine)	Injection 5mg/2ml	Used to treat psychosis
Enalapril (Vasotec)	Tablets 2.5mg, 5mg, 10mg	Antihypertensive
Erythromycin (Erythrocin/Ilotycin	Tablets 250mg	Antibiotic
	Opthalmic Ointment 3.5mg	
Escitalopram Oxalage (Lexapro)	Tablets 10mg & 20mg	Antidepressant (SSRI)
Eucerin	Cream 4oz	Skin emmollient
Ferrous Sulfate (Iron)	Tablets 324mg	Suppliment used to treat iron
		deficiency anemia.
Fleet Enema	Solution in disposable enema	Laxative
	squeeze bottle 133ml	
Fluconazole (Diflucan)	Tablets 50mg, 100mg	Used to treat serious fungal
		infections
Fluocinonide (Lidex)	Cream 0.05% 15gm	Topical steroid
	Ointment 0.05% 15gm	
Fluoxetine (Prozac)	Capsules 10mg, 20mg	Antidepressant
Fluphenazine (Prolixin, Permitil)	Tablets 1mg, 2.5mg, 5mg, 10mg	Typical antipsychotic
	Injection 2.5mg/ml 10ml vial	
	Deconoate 25mg/ml 5ml vial	
	Concentrate 5mg/ml 120mg	
Fluticasone (Flonase, Flovent)	Nasal Spray 0.05% 16gm	Used for symptomatic treatment
	Oral Inhaler 110mcg. 220mcg	of seasonal allergies.
Fluvoxamine (Luvox)	Tablets 50mg, 100mg	Antidepressant
Fluvastatin (Lescol)	Capsule 20mg	Lowers cholesterol **may cause
		muscle damage**monitor patients
		for muscle pain/soreness.
Folic Acid	Tablet 1mg	Vitamin
Furosemide (Lasix)	Tablets 20mg, 40mg and 80mg	Diuretic
Gabapentin (Neurontin)	Capsules 100mg, 300mg,	Anticonvulsant, also used to
	400mg, 600mg, & 800mg	treat Bipolar Disorder
Galantamine HBr (Reminyl)	Tablets	Use to treat Mild to moderate
		dementia associated with
		Alzheimers desease.
Gemfibrozil (Lopid)	Tablets 600mg	Used to lower cholesterol and
		triglyceride levels
Gentamicin (Garamyci n)	Opthalmic Ointment 3.5gm	Antibiotic
	Opthalmic Solution 5ml	
	Ointment 1% Topical 15gm	

Generic Name (Brank Name	Forms of Drug Available	Description
Glimepiride (Amaryl)	Tablet 4mg	Antidiabetic
Glipizide (Glucotrol)	Tablet 5mg 10mg	Antidiabetic
Glipizide-XL	Tablets 5mg, and 10mg	Antidiabetic
Griseofulvin	Tablet 250mg	Antifungal
Guaifenesin (Robitussin)	Syrup 100mg/5ml 120ml	Expectorant
Guiavenesin-DM	Syrup 100mg/5ml 120ml	Expectorant & Cough
(Robitussin-DM)		suppressant
Haloperidol (Haldol)	Talbets 0.5mg, 1mg, 2mg,	Typical Antipsychotic
	5mg, 10mg & 20mg.	
	Solution 2mg/ml 120ml	
	Injection 5mg/ml	
	Deconoate 50mg/ml 5ml vial	
Hand & Body Lotion	Lotion 240ml	Dry skin
(Lubriderm, Keri Lotion)		
Hemorrhoidal (Anusol)	Suppositories 12's	Use to relieve rectal swelling,
	Ointment 30gm	itching and discomfort
Hemorrhoidal-HC (Anusol-HC)	Suppositories 12's	Used to relieve rectal swelling,
Hydralazine (Apresoline)	Tablets 10mg, 25mg & 50mg	Antihypertensive
Hydrochlorthiazide (Oretic,	Tablets 25mg, 50mg	Diuretic
hydrodiuril	Capsules 12.5mg	
Hydrocortsone	Cream 0.5mg & 1%, 30gm	Topical steroid
	Ointment 0.5% 1%, & 2.5%	
Hydrogen Peroxide	Solution 500mg	Used to cleanse wounds and
		local infections
Hydroxmethylcellulose	Opthalmic Ointment 3.5gm	Used to prevent further
(Lacrilube)		irritation or to relieve dryness of
		the eye
Hydroxyzine (Atarax, Vistaril)	Tablets 10mg 25mg, 50mg	Antihistamine
Ibuprofen (Motrin)	Tablets 400mg, 600mg & 800mg	Used to relieve inflammation,
	Suspension 100mg/5ml 120ml	swelling, stiffness, and pain.
		(NSAID)
Imipramine (Tofranil)	Tablets 10mg, 25mg, 50mg	Antidepressant
Indinavil Sulfate (Crixivan)	Capsules 200mg, 400mg	Antiretroviral, Protease Inhibitor
Indomethacin (Indocin)	Capsules 25mg, 50mg	Used to relieve some symptoms
		caused by arthritis, or gouty
		arthritis. (NSAID)
Insulin, 70/30 (Humuilin/Novulin)	Injection U-100 10ml	Used to control diabetes.
Insulin, Human Lente	Injection U 10ml-100	Used to control diabetes
(Humulin/Novulin-L)		
Insulin, Human NPH	Injection U-100 10ml	Used to control diabetes
(Humulin/Novulin-N)		

Generic Name (Brand Name)	Forms of Drugs Available	Description
Insulin, Human Regular	Injection U-100 10ml	Used to control diabetes
(Humulin/Novulin-R)		
Ipecac Surup	Syrup[30m	Used to produce vomiting as
		treatment in some kinds of
		poisoning.
Ipratropium Bromide (Atrovent)	Inhaler, each actuation	Used to help control symptoms
	delivers 18mcg. 200 inhalations	of lung diseases such as
	per inhaer	bronchial asthma & emphysema
Isometheptine/	Capsules	Used to treat tension and
Dichloralphenazone/.		migraine headaches.
Acetaminophen (Midrin)		
**Controlled Substance		
Isoniazide (I.N.H.)	Tablets 100mg, 300mg	Used to prevent or treat TB
Isopropyl, Alcohol	Solution 70% 500ml	Used for cleansing or
(Rubbing Alcohol)		sterilization
Isosorbide Dinitrate (Isordil)	Tablets 5mg, 10mg, 20mg	Used to treat the symptioms
	Tembids 40mg	of angina
Kaolin-Pectin Mixture	Suspension 240mg	Used to treat diarrhea.
(Kaopectate)		
Ketoconazole (Nizoral)	Tablets 200mg	Antifungal
	Cream 2%	
Lactulose Syrup (Cephulac)	Syrup 10mg/5ml 500ml	Laxative
Lamivudine (Epivir)	Tablets 150mg	Antiretroviral
Lamivudine/Zidovudine	Tablets 150mg/300mg	Combination antiretroviral
(Combivir)		
Lamotrigine (Lamictal)	Tablets 25mg, 100mg, 150mg	
	Chewable 5mg, 25mg	
Lantanoprost Solution (Xalatan)	Opthalmic Solutiion	Used to treat glaucoma
	store in refrigerator	
Levetiraceytam (Keppra)	Tablets 500mg	Anticonfulsant
Levothyroxine (Synthroid)	Tablets 25mcg, 50mcg, 88mcg,	Thyroid hormone replacement
	100mcg, 125mcg, 175mcg,	
	200mcg	
Liothyronine Sodium (Cytomel)	Tablets 25mcg, 50mcg	Thyrooid Harmone replacement
Lisinopril (Zestril, Prinivil)	Tablets 5mg, 10mg, 20mg	Antihypertensive
		ACE Inhibitor
Lithium Carbonate (Eskalith,	Tablets 300mg,	Used to treat bipolar disorder
Lithobid)	450mg (controlled released)	
	Capsules 150mg, 300mg	

Generic Name Brand Name	Forms of Drugs Available	Description
Lithiium Citrate	Syrup 8meq lithium (as citrate	Used to treat bipolar disrder
	equivalent to 300mg lithium	
	carbonate) 5cc 480ml	
Lo/Ovral	Tablets 28/pack	Used to prevent pregnancy
Loperamide HCL (Imodium)	Capsules 2mg	Used to treat diarrhea.
Lorazepam (Ativan)	Tablets 0.5mg, 1mg, 2mg	Antianxiety, hypnotic
**conttrolled substance)	Injection 2mg/ml	
Loxapine (Loxitane)	Capsules 5mg, 10mg, 25mg,	Typical antipsychotic
	50mg	
Meclizine (Antivert)	Tablet 25mg	Used to treat nausea & vomiting
Medroxyprogesterone(Provera)	Tablets 2.5mg, 5mg	Used to ensure proper regulation
		of menstrual cycles, treat endo-
		metriosis, to prevent pregnancy
Memantine (Nemenda)	Tabletds 5mg 10mg	Used to treat mild to severe
		dementia of the alzheimet's type
Metformin (Glucophage)	Tablets 500mg, 850mg, 850mg	Antidiabetic
	1000mg; ER-500mg	
Methylphenidate (Concerta)	Tablets 18mg, 36mg, 54mg	Used to treat attention deficit
(controlled substance)		hyperactivity disorder &
DEA Schedule II		narcolepsy
Methylphenidate (metadate)	Tablets ER 10mg	Used to treat attention deficit
(controlled Substance)		hyperactivity disorder and
DEA Schedule II		narcolepsy
Methylphenidate (Ritalin	Tablets 5mg, 10mg, 20mg	Used to treat attention deficit
(Controlled substance)	SR 20mg	hyperactivity disorder and
DEA Schedule II		narcolepsy
Metoclopramide (Reglan)	Tablets 5mg, 10mg	Antiemetic
Metoprolol (Lopressor)	Tablets 50mg, 100mg	Antihypertensive
Metronidazole (Flagyl)	Tablets 250mg, 500mg	Antibiotic
Milk of Magnesia	Suspension 180ml	Laxative
Mirtazapine (Remeron)	Tablets 15mg, 30mg, 45mg	Antidepressant
Multivitamins	Tablets	Nutritional supplement
	Prenatal 100's	
	Liquid 500ml	
Mupirocin (Bactroban)	Ointment 15gm	Used to treat bacterial infections
		especially impetigo.

Generic Name (Brand Name)	Forms of Drugs Available	Description
Naphazoline-A	Opthalmic Solution with	Used to relieve eye redness and
(Vasocon w/antihistamine)	antazoline 0.5% 15ml	itching due to minor irritations.
Naproxen (Naprosyn)	Tablets 250mg, 375mg, 500mg	Used to relieve arthritis,
		inflammation, swelling, stiffness
		and joint pain. NSAID
Nicotinic Acid (Niacin)	Tablets 50mg, 100mg, 500mg	Used to lower high cholesterol
		and fat levels in the blood, and
		as a nutritional supplement
Nifedipine Extended Release	Tablets 30mg, 60mg, 9mg	Used to treat high blood
(Adalat-CC)		pressure and angina
Nifedipine (Procardia)	Capsule 10mg	Use to treat high blood pressure
		and angina
Nitrofurantoin (Macrodantin,	Capsules 50mg 100mg	Anti-infective, Treatment of UTI
Furadantin)		
Nitroglycerin (Nitrostat,	Tablets 0.3mg, 0.4mg, 0.6mg	Used to treat angina
Transdermal Patches)	Patchers 0.1mg, 0.2mg,	
	0.4mg/hr	
Non-Alcohol/Sugar Free Cough	Syrup 120ml Dextromorphan	Used to relieve coughs due to
Syrup	10mg/Phenylephrine HCL 5mg/	colds or influenza
	Guaifenesin 100mg/5ml	
Nortriptyline (Pamelor)	Capsules 10mg, 25mg, 50mg,	Antidepressant
	75mg	
Nystatin/Triamcinolone	Cream 15gm	Antifungal
(Mycolog II)	Ointment 15gm	
Olanzapine (Zyprexa)	Tablets 2.5mg, 5mg, 10mg,	Atypical antipsychotic
	15mg, 20mg	
	Injection 10mg vials	
****FOR STABLIZATION ONLY--**	Zydis-oral disintegrating tablets	
NO MORE THAT 5 DAY SUPPLY**	5mg, 10mg, 20mg	
Ortho Novum	Tablets 1/35-28	Used to prevent pregnancy
	777-28	
	1/50-28	
Oxycarbazepine (Trileptal)	Tablets 150mg, 300mg, 600mh	Anticonvulsant
Oxybutynin (Ditropan)	Tablet 5mg	Used to decrease muscle
		spasms of the bladder and the
		frequent urge to urinate.
Oxymetazoline Nasal Spray	Spray 15ml	Nasal decongestant
(Afrin)		
Pads, Alcohol Impregnated	Pads, Box of 100	Used for cleansing & sterilization
(Alcohol Wipes)		
Paroxetine HCL (Paxil	Tablets 10mg, 20mg, 30mg,	Antidepressant
	40mg	
Penicillin V Potassium	Tablets 250mg, 500mg	Antibiotic
(V-Cillin)		
Permethrin 1% (Nix)	Liquid Cream Rinse	Used to treat scabies amd
	Rinse/Shampoo	lice infestations
Perphenazine (Trilafon)	Tablets 2mg, 4mg, 8mg	Typical Antipsychotic
Perphenazine/Amitriptyline	Tablets 2/10, 2/25, 4/10, 4/25,	Used to treat nervous, mental
(Triavil, Etrafon)	Apr-50	and emotional conditions

Generic Name (Brand Name)	Forms of Drugs Available	Description
Petrolatum, White (Vaseline)	Ointment 20gm	Lubricant. Skin irritations
Phenobarbital	Tablets 15mg, 30mg, 60mg	Used to relieve anxiety or
Controlled Substance		tension or to help control seizures
Phenytoin (Dilantin)	Capsules 100mg	Anticonvulsant
	Tablets (chewable) 50mg	
Phospho-Soda (Fleets Phospha	Liquid 45ml	Laxative
Soda)		
Pioglitazone, (Actose)	Tablets 15mg, 30mg, 45mg	Antidiabetic Agent
Polymixin B/Bacitracin/	Opthalmic Ointment	Antibiotic
Neomycin (Neosporin)	Opthalmic Solution	
	Topical Ointment	
Polymixin B/Bacitracin/	Opthalmic Ointment	Used to treat and help prevent
Hydrocortisone (Cortisporin)	Opthalmic Suspsion	opthalmic or otic infections.
	Otic Solution	
	Otic Suspsension	
Potassium Chloride (Slow-K,	Tablets 8mEq	Potassium supplement
K-Lor)	Tablet 20mEq	
Prednisone	Tablets 5mg, 10mg, 20mg	Used to relieve inflammayion
Primidone (Mysoline)	Tablets 250mg	Anticonvulsant
Prochlorperazine (Compazine)	Tablets 5mg, 10mg	Used to manage nausea and
	Suppositories 25mg	vomiting
Procyclidine (Kemadrin)	Tabletss 5mg	Used to treat parkinson's
		disease and some side effects
		of neuroleptic drugs
Propranolol (Inderal)	Tablets 10mg, 20mg, 40mg,	Used to treat high blood
	60mg, 80mg	pressure ad relieve angina
	LA Capsules 80mg, 120mg,	
	180mg	
Pseudoephedrine (Sudafed)	Tablets 30mg 60mg	Nasal decongestant
	Syrup 20mg/5ml	
Purified Proteine Derivative-PPD	10 test 1ml	Used to detect tuberculosis
(Aplisol)	50 test 5ml	exposure
Pyridoxine (Vitamin B-6)	Tablets 50mg, 100mg	Nutritional supplement
Quitiapine (Seroquel)	Tablets 25mg, 100mg, 200mg	Atypical antipsychotic
Ranitadine (Zantac)	Tablets 150mg	Used for esophageal reflux and
		short term treatment of gastric
		duodenal ulcers.
Resperidone (Risperdal)	Tablets 0.25mg, 0.5mg, 1mg,	Atypical antipsychotic
	2mg, 3mg, 4mg,	
	Solution 1mg/ml 30mg	
**for stabilization only-no more	M-Tabs (oral disintegrating)	
than a 5 day supply**	0.5mg, 1mg, 2mg	
Selenium Sulfate (Selsun)	Lotion 2.5% 120ml	Used to help control the
		symptoms of dandruff and
		seborrheic dermatitis.

Generic Name (Brand Name)	Forms of Drugs Available	Description
Senna Concentrate (Senokot)	Tablets 8.6mg	Laxative
Sertraline (Zoloft)	Tablets 25mg, 50mg, 100mg	Antidepressant
Silver Sulfadiazine (Silvadene)	Cream 1% 20gmq	Used to prevent and treat
		bacterial infections.
Simethicone (Mylicon)	Tablets 80mg	Antiflatulent)
Stavudine (Zerit)	Capsules 20mg, 40mg	Antiretroviral
Syringes, Insulin	Syringes, 1ml units 100	Used to administer insulin
Tamoxifen (Nolvadex)	Tablets 10mg	Used to treat breast cancer and
		to block the effects of the
		hormone estrogen in the body.
Temazepam (Restoril)	Capsules 15mg, 30mg	Used to relieve insomnia.
Controlled Substance		
Tetanus Toxoid	Injection 5ml	Used to prevent tetanus.
Tetracycline (Achromycin)	Capsules 259mg, 500mg	Antibiotic
Theophylline (Theodur)	Tablets 200mg, 300mg	Bronchodilator
	Solution 80mg/15mg	
Thiamine HCL	Tablets 50mg, 100mg	Nutritional supplement
	Injection 100mg/ml	
Thioridazine (Mellaril)	Tablets 10mg, 15mg, 25mg,	Typical antipsychotic
	100mg, 150mg, 200mg	
Thiothixene (Navane)	Capsules 1mg, 2mg, 5mg,	Typical antipsychotic
	10mg, 20mg	
	Concentrate 5mg/ml 120mg	
Tiagabine (Gabitril)	Tablets (film coated) 2mg, 4mg,	Anticonvulsant
	12mg, 16mg, 20mg	
Timolol Maleate (Timoptic	Opthalmic Solution 2.5%, 5%	Used to treat glaucoma
and Timoptic-XE)	Opthalmic Gel 0.25%, 0.5%	
Tolnaftate (Tinactin)	Cream 1% 15mg,	Antifungal
	Powder 1% 45gm	
	Solution 1% 10ml	
Tolterodine Tartrate (Detrol-LA)	Capsules-ER 2mg, 4mg	Treatmet of overactive bladder of
		urge incontinence.
Topiramate (Topamax)	Tablets 25mg, 10mg, 200mg	Anticonvulsant
Trazodone (Desyrel)	Tablets 50mg, 100mg, 150mg	Antidepressant
Tretinoin (Retin A)	Cream 0.05%, 0.1% 20gm	Used to treat certain kinds of
		acne.
Triamcinolone (Kenalog)	Cream 0.1% 15gm	Steroid, topical
	Ointment 0.1% 15gm	

Generic Name (Brand Name)	Forms of Drugs Available	Description
Triamterene/HCTZ (Maxzide)	Tablets 75mg/50mg,	Diuretic
	37.5mg/25mg respectively	
Trifluoperazine (Stelazine)	Tablets 1mg, 2mg, 5mg, 10mg	Typical antipsychotic
Trihexyphenidyl (Artane)	Tablets 2mg, 5mg	Used to treat parkinson's
		disease and side effects from
		neuroleptic drugs
Trimethobenzamide (Tigan)	Capsules 200mg	Antiemetic
	Suppository 200mg	
Tripolidine/Pseudoephedrine	Tablets 2.5mg/60mg	Used to treat nasal congestion
(Actifed)	Syrup 1.25mg/30mg per 5ml	caused by colds and hay fever
Valproic Acid (Depakene)	Capsules 250mg	Anticonvulsant
	Syrup 250mg/5ml 480ml	
Valsartan (Diovan)	Tablets 80mg, 160mg, 320mg	Antihypertensive
Venlafaxine (Effexor)	Tablets 25mg, 37.5mg, 50mg	Antidepressant
	Capsules-XR 37.5mg, 75mg,	
	150mg	
Verapamil (Calan, Isoptin)	Tablets 80mg, 120mg	Antihypertensive
	SR-120mg, 240mg	
Vitamin E	Capsules 400 IU	Vitamin
Warfarin Sodium (Coumadin)	Tablets 1mg, 2mg, 2.5mg, 5mg	Anti-coagulant
Water, Sterile for Injection	1ml 25 per box	Used to dilute or dissolve
		other drugs for injection
Zalcitabine (HVID, DDC)	Tablets 0.275mg, 0.75mg	Antiretroviral
Zidovudine (Retrovir, AZT)	Capsule 100mg	Antiretroviral
Ziprasidone (Geodon)	Capsules 20mg, 40mg, 60mg,	Atypical antipsychotic
	80mg	
	Injection 20mg/ml	
Zolpidem Tartrate (Amien)	Tablets 5mg, 10mg	Used for short term treatment
Controlled Substance		of insomnia