
**GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL**

**DEPARTMENT OF MENTAL HEALTH
EDUCATIONAL SERVICES**

**REPORT OF INSPECTION
NOVEMBER 2008**



**CHARLES J. WILLOUGHBY
INSPECTOR GENERAL**

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Office of the Inspector General

Inspector General



November 3, 2008

Stephen T. Baron
Director
D.C. Department of Mental Health
64 New York Avenue, N.E., 4th Floor
Washington, D.C. 20002

Dear Mr. Baron:

Enclosed is our final *Report of Inspection of the District of Columbia Department of Mental Health's (DMH) Educational Services*. Comments from DMH on the inspection team's 26 findings and 50 recommendations are included in the report.

In addition, we have enclosed *Compliance Forms* on which to record and report to this Office any actions you take concerning each recommendation. These forms will assist you in tracking the completion of action(s) taken by your staff, and will assist this Office in its inspection follow-up activities. We track agency responses to all conditions cited, and compliance with recommendations made in our reports of inspection. We request that you and your staff establish response dates on the forms and advise us of those dates so we can enter them on our copies of the *Compliance Forms*. We know that in some instances, matters beyond your control such as budget decisions impact on trying to set specific deadlines. We request, however, that you assign *target dates* based on your knowledge and experience regarding particular issues. Please ensure that the *Compliance Forms* are returned to the OIG by the response date, and that reports of "Agency Action Taken" reflect actual completion, in whole or in part, of a recommended action rather than "planned" action.

We appreciate the cooperation shown by you and your employees during the inspection and look forward to your continued cooperation during the upcoming follow-up period. If you have questions or require assistance in the course of complying with our recommendations, please contact me or Alvin Wright, Jr., Assistant Inspector General for Inspections and Evaluations, at (202) 727-2540.

Sincerely,


Charles J. Willoughby
Inspector General

CJW/bh

Enclosure

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November 3, 2008
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The Inspections and Evaluations (I&E) Division of the Office of the Inspector General is dedicated to providing District of Columbia (D.C.) government decision makers with objective, thorough, and timely evaluations and recommendations that will assist them in achieving efficiency, effectiveness, and economy in operations and programs. I&E goals are to help ensure compliance with applicable laws, regulations, and policies, to identify accountability, recognize excellence, and promote continuous improvement in the delivery of services to D.C. residents and others who have a vested interest in the success of the city.

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ACRONYMS

ACRONYMS

CBC	Criminal Background Check
CFSA	Child and Family Services Agency
CSA	Core Service Agency
DCCSA	District of Columbia Community Services Agency
DCMR	District of Columbia Municipal Regulations
DCPS	District of Columbia Public Schools
D/DMH	Director, Department of Mental Health
DHR	Division of Human Resources
DMH	Department of Mental Health
DPM	District Personnel Manual
EHB	Employee Health Branch
GOP	General Operating Procedures
HIPAA	Health Insurance Portability and Accountability Act
I & E	Inspections and Evaluations
IEP	Individualized Education Plan
IPC	Individualized Plan of Care
JRC	Jackie Robinson Center for Excellence in Education
MAR	Management Alert Report
MC	Moten Center
MHA	Mental Health Authority
MHRS	Mental Health Rehabilitation Services
MOU	Memorandum of Understanding
MPD	Metropolitan Police Department

ACRONYMS

MTN	Moten Therapeutic Nursery
MUI	Major Unusual Incident
OA	Office of Accountability
OCTO	Office of the Chief Technology Officer
OIG	Office of the Inspector General
OIT	Office of Information Technology
PES	Psychoeducational Services
PRS	Paul Robeson School
RA	Remittance Advices
RM	Risk Manager
ROI	Report of Inspection
SMHP	School-Based Mental Health Program
SOP	Standard Operating Procedures

ORGANIZATION CHARTS

SMHP ORGANIZATION CHART

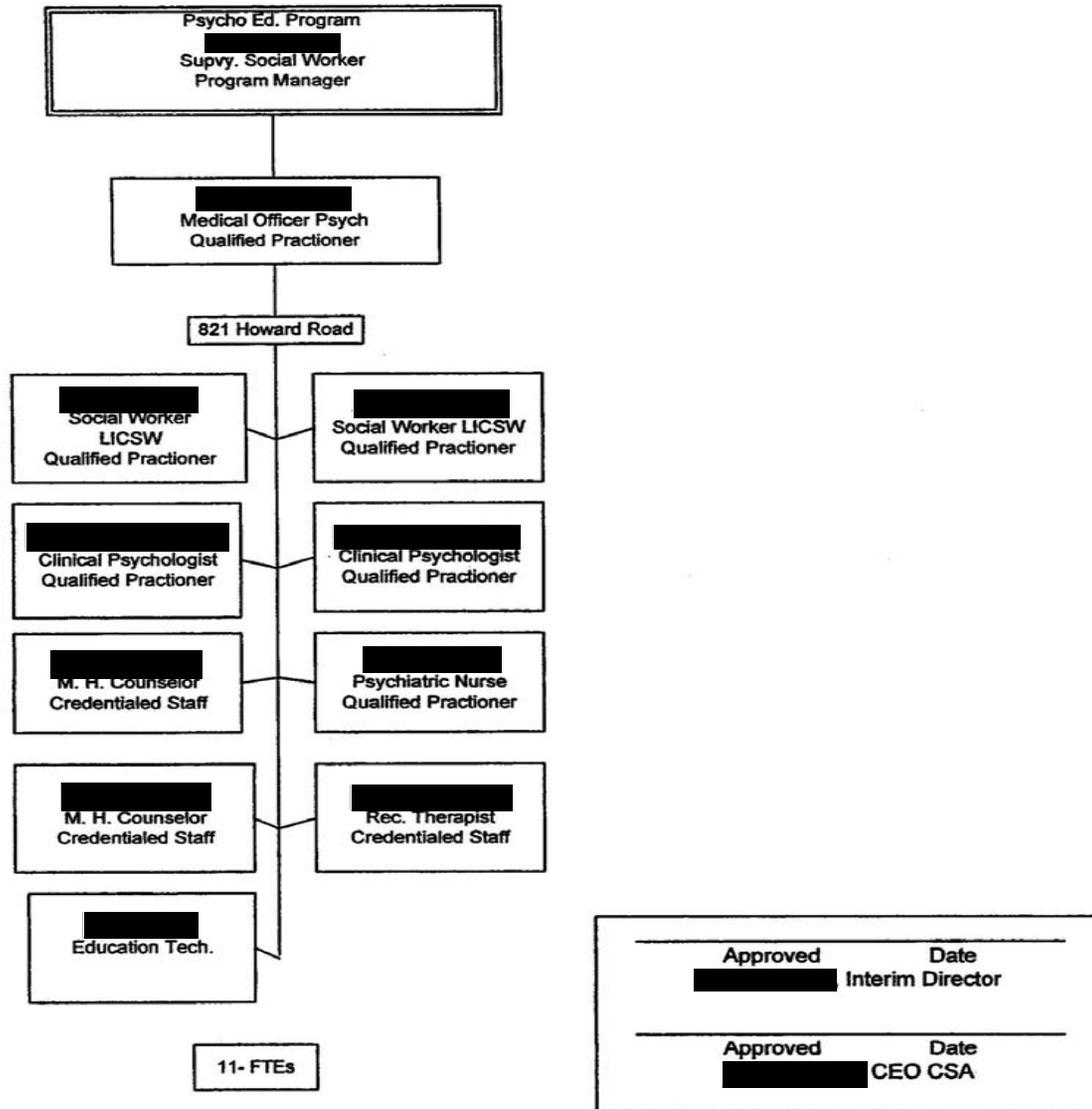
Prevention and Early Intervention Program Table of Organization



PES ORGANIZATION CHART

**Department of Mental Health
CSA - PSYCHO-EDUCATIONAL SERVICES
Table of Organization Chart**

FTE's: 11



DEPARTMENT OF MENTAL HEALTH

Division of Human Resources

Director

Program Specialist

EEO Manager

Program Analyst

Chief, Policy Training & Special Programs Branch

Chief, Operations Branch A

Vacant Chief, Operations Branch B

Labor and Employee Relation Office

Organizational Development Coordinator

Staff Assistant

Human Resources Specialist

Human Resources Specialist

Sr. Human Resources Specialist

Organizational Development Specialist

Human Resources Specialist

Human Resources Specialist

Vacant Human Resources Specialist

Human Resources Specialist

Program Coordinator

Human Resources Specialist

Human Resources Specialist

Human Resources Specialist

Human Resources Specialist

Vacant Human Resources Specialist

Vacant Administrative Assistant

Vacant Human Resources Specialist

Vacant Human Resources Specialist

Human Resources Assistant

Human Resources Assistant

Human Resources Assistant

Vacant Clerical Assistant



Director, Division of Human Resources
08.01.07

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

OVERVIEW

The Inspections and Evaluations (I&E) Division of the Office of the Inspector General (OIG) began an inspection of the District of Columbia Department of Mental Health (DMH) educational services in December 2006. DMH's stated mission is "to develop, support, and oversee a comprehensive, community-based, consumer-driven, culturally competent, quality mental health system." DMH is the District government's primary mental health provider for adults, children, youths, and their families.¹ DMH strives to be responsive and accessible to consumers² by ensuring mental health providers are accountable, and by offering mental health services. DMH offers two programs, the School-Based Mental Health Program (SMHP) and Psychoeducational Services (PES), to provide mental health services for children and youths in public and charter schools.

The educational services inspected were: (1) the SMHP, which provides full-time mental health clinicians to selected District of Columbia Public Schools (DCPS) and public charter schools, and offers an array of mental health services to promote social and emotional development; and (2) the PES programs, which provide treatment and therapy in a regular school setting to special education students in DCPS who experience behavioral, emotional, and academic problems.

OIG inspections comply with standards established by the President's Council on Integrity and Efficiency, and pay particular attention to the quality of internal control.³ The inspection focused on management, internal control, operations, and accountability in key areas, including compliance with DMH policies and procedures, the Health Insurance Portability and Accountability Act (HIPAA),⁴ and District law. The team also focused on the delivery of mental health services and management/employee relations.

During this inspection, the team reviewed DMH's internal policies and procedures; District of Columbia Municipal Regulations (DCMR); the District Personnel Manual (DPM); best practices from the Substance Abuse and Mental Health Services Administration⁵ and the University of California, Los Angeles Center for Mental Health in Schools; relevant documents and reports including the *School Mental Health Program Retrospective Report 2000-2005*; and

¹ In accordance with D.C. Code § 7-1231.14 (b)(1)(Supp. 2005), minors in the District may receive outpatient mental health services without parental/guardian consent for a period of 90 days if: a) the minor is knowingly and voluntarily seeking the service; and b) the provision of services is clinically indicated for the minor's well-being.

² DMH Policy Number 482.1 Section 5b defines "Consumer" as "[a]n adult, child or youth who seeks or receives mental health services or mental health supports funded or regulated by DMH."

³ "Internal control" is synonymous with "management control" and is defined by the Government Accountability Office as comprising "the plans, methods, and procedures used to meet missions, goals, and objectives and, in doing so, supports performance-based management. Internal control also serves as the first line of defense in safeguarding assets and preventing and detecting errors and fraud." STANDARDS FOR INTERNAL CONTROL IN THE FEDERAL GOVERNMENT, Introduction at 4 (Nov. 1999).

⁴ HIPAA ensures that an individual's health information is protected while allowing for the exchange of health information for quality of health care. [Http://www.hhs.gov/ocr/privacysummary.pdf](http://www.hhs.gov/ocr/privacysummary.pdf) (last visited May 27, 2008).

⁵ "The Substance Abuse and Mental Health Services Administration is an agency of the U.S. Department of Health and Human Services. [It focuses] attention, programs, and funding on improving the lives of people with or at risk of mental and substance abuse disorders..." [Http://www.hhs.gov/samhsa/about/1336.html](http://www.hhs.gov/samhsa/about/1336.html) (last visited May 27, 2008).

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applicable best practices from other jurisdictions. Although most DMH and DCPS managers and employees were cooperative and responsive, some individuals were not helpful in providing requested information in a complete and timely manner.

The team conducted over 90 interviews, observed work areas, and reviewed pertinent files and documents. A list of the report's 26 findings and 50 recommendations is included at Appendix 1. The team also issued two Management Alert Reports (MAR-07-I-006 at Appendix 2 and MAR-07-I-001 at Appendix 4) regarding psychological reevaluations and employee background checks, respectively. DMH reviewed the draft of this report prior to publication, and its comments are included in the report.

Key Findings

Deficient Memoranda of Understanding (MOUs) between DMH and DCPS have a negative effect on provision of mental health services. (Page 15) DMH Policy 801.1 (801.1) outlines the procedures for developing and managing the MOUs DMH uses to formalize interagency agreements. Both PES and the SMHP have MOUs with DCPS that contain guidelines for services provided to students. These MOUs, however, are not in line with 801.1 because they do not contain sufficient details concerning the mutual roles and responsibilities of all parties, and the means by which problems are to be resolved. Consequently, interagency communication and collaboration are deficient, working relationships are strained, and the provision of mental health services to students may be negatively affected.

The DMH Division of Human Resources (DHR) allows SMHP clinicians without completed and satisfactory criminal background checks to provide direct services to children and youths. (Page 18) Effective April 13, 2005, the Criminal Background Checks for the Protection of Children Act of 2004 (D.C. Law 15-353, Title II, codified at D.C. Code § 4-1501.01-.11(Supp. 2006)) requires criminal background checks for District government employees who provide direct services to children and youths. The information provided to the team and a review of criminal background checks for all SMHP clinicians indicated that at least four clinicians were providing direct services to children and youths even though SMHP had not received complete and satisfactory criminal background checks from the District of Columbia Metropolitan Police Department (MPD). DHR Standard Operating Procedure (SOP) No. 06-01, dated October 17, 2006, sets forth the procedures for implementing and managing the department's criminal background check program. The team determined that DMH did not adhere to all elements of the SOP. The team also determined that DHR did not prepare a required compliance report at the 6-month interval of the criminal background check program.

DMH has not implemented mandatory drug and alcohol testing for safety-sensitive positions in violation of Chapter 39 of the DPM. (Page 22) Chapter 39 of the DPM requires mandatory drug and alcohol testing for District government employees who are in safety-sensitive positions. As defined by the DPM, SMHP and PES employees are in safety-sensitive positions and should have mandatory drug and alcohol testing prior to appointment and random drug and alcohol tests thereafter. However, clinicians reported that they have not had such testing, and DHR managers confirmed that there are no DMH policies and procedures for such

EXECUTIVE SUMMARY

tests. Random drug and alcohol tests can identify physical conditions that would affect an employee's ability to carry out his or her duties satisfactorily.

Some DMH clinicians feel unsafe during home visits. (Page 23) The SMHP and PES employees conduct home visits to increase family involvement in treatment and improve student well-being. However, some clinicians reported that they do not feel safe during home visits because family members are not always receptive to such visits. A review of the SMHP data indicated that its clinicians conducted 1,019 home visits from September 2002 through May 2007, and PES clinicians conducted 40 home visits between August 2006 and June 2007. However, DMH does not have written policies and procedures that address clinician safety during such visits. The team also found that some SMHP and PES employees do not have DMH cellular phones in case of emergencies during home visits, and must use their personal telephones. Therefore, clinicians who do not own a cellular phone may not be able to make a telephone call in an emergency. The lack of well-conceived, written policies and procedures that address clinician safety during home visits decreases employee safety and increases the risk of District liability.

The SMHP clinicians do not receive annual health screenings as required. (Page 25) DMH policy states that DMH employees providing direct care to consumers are required to have health screenings. According to the policy, the SMHP clinicians are non-high risk employees⁶ who provide direct care to consumers and must receive annual health screenings. The health screening consists of: 1) vital signs checks; 2) height and weight checks; 3) vision and hearing checks; 4) urinalysis (as required); 5) tuberculosis skin test; and 6) hepatitis B vaccine (optional). However, clinicians reported that they were only required to submit to a pre-employment health screening and tuberculosis skin test. The team requested the dates of clinicians' tuberculosis skin tests to determine if they were receiving the test annually as required by DMH policy. According to the information received from DMH, at least 12 of 41 SMHP clinicians did not have results from current tuberculosis skin tests. A DHR manager informed the team that clinicians receive annual health screenings.

DMH does not provide consistent information to clinicians regarding the use of physical intervention when a child or youth is at imminent risk of injury to self or others. (Page 27) Title 22A DCMR Chapter 5 is a regulation distributed to SMHP clinicians when they begin work with the program and provides that clinicians may use physical intervention when a child is at imminent risk of injury to self or others. Contrary to this regulatory guidance, however, the SMHP General Operating Procedures (GOP) indicate that clinicians may not physically restrain a child. The DMH Office of Accountability (OA) reported to the team that clinicians may use physical intervention when a child is at imminent risk of injury to self or others. However, clinicians informed the team that they have been verbally directed by SMHP management not to touch a child under any circumstance. The team learned from SMHP management that the verbal policy is to avoid physical contact with a child in an emergency, but that clinicians are not categorically prohibited from physical intervention. The lack of consistent guidance for the use of physical intervention when a child is at imminent risk of injury to self or

⁶ Non-high risk employees provide direct care to consumers, but do not have direct contact with individuals who are at high risk for tuberculosis, do not collect or manipulate blood samples, and do not administer IV medications.

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others contributes to confusion and puts children and employees at risk. Furthermore, clinicians stated that they are unclear about the support they would receive from DMH if they were the subject of litigation for physically intervening with a child in an emergency or failing to act in an emergency.

DMH's Office of Accountability (OA) does not consistently adhere to the Major Unusual Incident (MUI) reporting procedures stipulated in DMH policy, and, as a result, the safety of children and youths served by the SMHP may be at risk. (Page 29) OA does not accept MUI reports that involve children served by the program unless a SMHP employee is directly involved in an incident (e.g., a clinician physically abusing a child in his or her care). Consequently, OA does not: 1) ensure that appropriate actions are taken in response to all MUI reports involving SMHP children and youths; 2) notify the DMH Director about SMHP MUI reports; 3) investigate MUI reports involving SMHP children and youths as necessary; or 4) maintain copies of all MUI reports involving SMHP children and youths for analysis.

PES did not administer psychological reevaluations on time to several students enrolled in the Jackie Robinson Center for Excellence in Education (JRC). (Page 32) DMH and DCPS managers and employees stated during interviews that reevaluations for several students were overdue, and information provided by both DMH and DCPS confirmed at least 10 overdue reevaluations. In 9 of the 10 cases, the minimum 3-year timeframe for reevaluation had lapsed; in the other case, a child's parent requested a reevaluation, and it was not conducted within 2 months of the parent's request, as required by DCPS policy. According to DMH and DCPS employees, PES did not have the necessary testing equipment to conduct the reevaluations.

The Anasazi Information System is not always accessible at both PES sites. (Page 34) PES clinicians are required to use the Anasazi Information System (Anasazi), a healthcare management software package, to track multiple aspects of client care. The system consists of three components: 1) the Client Data System; 2) the Scheduling System; and 3) the Assessment and Treatment Planning System. The team learned that clinicians at the Moten Therapeutic Nursery (MTN) do not have access to Anasazi. Consequently, they cannot update treatment plans or complete the many other functions that the system allows. Moreover, it was reported to the team that there are employees who still need additional training in the use of Anasazi, and PES computers often do not operate when it rains or snows.

DMH billing reports indicate that DCCSA has over \$1.4 million in outstanding claims for PES services provided to DCPS. (Page 36) The team reviewed DMH billing records and found that PES programs had a combined outstanding claims balance of \$1,481,623 for a combined total of 24,724 hours of mental health services provided by PES clinicians to DCPS students enrolled in 4 PES program sites during fiscal years 2004, 2005, 2006, and 2007.

School-Based Mental Health Program

The SMHP's performance plan does not include measurable goals and objectives for all programs. (Page 44) The SMHP has not established measurable goals and objectives in its performance plan for programs it implements. The National Association of Social Workers

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indicates that measurable goals and objectives should be established in a performance plan so agencies can monitor program effectiveness and compare achievement of objectives from 1 year to the next. Currently, SMHP is not able to provide results concerning the effectiveness and progression of its programs based on measurable goals and objectives.

The SMHP does not have an electronic data system, and data collection is inefficient and ineffective. (Page 46) The SMHP does not have an electronic data system to collect, store, analyze, display, and report program data. The SMHP General Operating Procedures (GOP) require monthly reports of clinical services offered to constituencies who receive services from the program. According to the GOP, reports are to be given to the clinical supervisor, the program evaluator, and the SMHP program manager when requested. The monthly report tracks programmatic data such as the number of referrals, referral sources, clinicians' impressions of children's mental health problems, treatment options, and primary prevention activities. Clinicians collect data manually and submit it to a program evaluator who enters the data on a spreadsheet. This system is inefficient and prone to errors, and the resulting spreadsheet is difficult to read. An electronic data system would allow for timely and accurate data analysis and storage. Moreover, it would allow clinicians and supervisors to view client charts online at the DMH main office and other locations with Internet access. According to information provided by DMH, the organization has been attempting to implement an electronic data system since 2005 without success.

SMHP management encourages family participation in mental health services; however, clinicians report that participation is low. (Page 48) SMHP managers encourage clinicians to involve families in mental health services. The program has three parenting groups and clinicians who provide, among other things, family counseling, parent workshops, and home visits. However, clinicians indicated in interviews and correspondence with the team that families are not consistently involved in their child's mental health services.

Some SMHP clinicians lack fundamental tools necessary to carry out their duties. (Page 50) Multiple schools did not provide clinicians with basic resources, including locking file cabinets, working telephones, computers, or printers. Furthermore, the SMHP did not provide these office resources expeditiously when DCPS was unable to do so, and some clinicians have yet to receive a computer printer. Some clinicians lack consistent Internet access or the ability to send and receive e-mails regularly. Finally, there are not enough program manuals available to clinicians, who must postpone implementation of mental health services as a result.

DCPS does not provide voicemail access for some SMHP clinicians. (Page 53) During the inspection, the team found that clinicians were not able to receive or retrieve voicemail messages. Some voicemail boxes were full and not able to receive any new messages. DCPS did not reset the voicemail boxes of previous employees, and the passwords needed to manage the mailboxes were unknown to DCPS staff. In addition, DCPS did not include voicemail in the budget for clinicians prior to arrival at their appointed schools. Inaccessible voicemail prevents clinicians from receiving telephone messages from parents and other mental health providers.

Some SMHP clinicians do not have a private space to meet with students as required by the MOU. (Page 55) The MOU between DCPS and DMH requires that DCPS provide private

EXECUTIVE SUMMARY

office space with appropriate furniture prior to or immediately after the clinician's arrival at his/her appointed school. For example, one clinician is housed in an office that doubles as a network/telecommunications room where the telephone and computer lines for the school's computer network are located. If there is a network problem, the computer technician has to fix the problem in the clinician's office. Another clinician's office does not allow privacy for consultation because students can see through the large glass window into the clinician's office as they walk past.

Some SMHP employees do not have confidence in internal hiring and promotion practices. (Page 56) In interviews with the team, some SMHP employees indicated that DHR is not communicative or responsive when hiring, and there were large time gaps between interviews and hiring dates. According to DHR's Improved Hiring Process Flow Chart, hiring time should range from 33 days (for a position that is posted 5 days) to 38 days (for a position that is posted 10 days). However, hiring timeframes reported to the team by employees and management ranged from 3 months to 1 year. Moreover, employees stated that vacancies are not always announced to the entire staff, and there are few promotions from within. Employees also indicated that there is no room for professional growth, and promotion policies and procedures are not communicated effectively.

Interviews with some SMHP employees reflect frustration with the lack of employee recognition for meritorious work. (Page 58) During interviews, employees expressed frustration with recognition practices for meritorious work and indicated that morale is low. They also communicated to the team that they do not receive regular communication from DMH upper management, and that they are not treated as important to the mission of the organization.

The DMH main office lacks dedicated workspace and computers for SMHP clinicians. (Page 59) Clinicians are required to report to the DMH main office (64 New York Ave., N.E.) when DCPS is on spring or summer break. Clinicians stated to the team that there is a lack of dedicated workspace and computers at the main office, and it is challenging for them to complete assigned tasks and carry out their duties efficiently and effectively.

There are no documented policies and procedures for secure handling of clinical records removed from schools for clinical review. (Page 59) Clinicians currently undergo clinical record reviews twice a year, during which a client record is randomly selected by a supervisor for evaluation. The clinician is directed to take the client record to wherever his/her supervisor is located, either at the DMH main office or another school. At the time of this inspection, there were no written policies and procedures on securely handling clinical records when removed from school premises.

Psychoeducational Services Programs

Conditions at Moten Center (MC) are unsanitary and some areas are in need of repair. (Page 63) The team noted poor conditions in some areas of MC used for the Moten Therapeutic Nursery (MTN). These areas are unsanitary or unattractive for children and employees who use and work in the observed areas. There also are areas in MC that need to be repaired.

EXECUTIVE SUMMARY

OA inspection report lacks clarity about conditions at JRC. (Page 67) Based on information provided by OA, JRC was one of six sites listed in OA's "Corrective Measure Plan" that summarizes OA's findings from its June 2007 facility surveys of The D.C. Community Services Agency (DCCSA) sites. OA lists several findings in the report. However, OA only mentioned the location of three of the deficiencies, one of which was noted at JRC. Otherwise, the plan is general, and the team was unable to determine if other findings pertained to JRC. In addition, OA did not conduct a facility survey at MTN.

PES could not provide a report of program results. (Page 67) The team requested aggregate data from PES regarding the quality of services and measurable goals. A PES manager indicated that it did not have a report of their results and that they measure the results by extracting the information from the students' clinical records and report cards. However, PES was unable to provide the team with any aggregate data on program results.

JRC clinical records are not properly controlled and maintained. (Page 68) The team observed that the medical records file room for JRC students' mental health records is disorganized. Files and folders were haphazardly stacked on a desk and not filed on either of the designated shelves in the room. The team was unable to easily retrieve some files because they were not in any order. Students' clinical records were haphazardly placed in boxes and kept in a storage room on the second floor of the JRC. Persons who are not authorized to have access to clinical records use the storage room. Although the storage room door was locked when the team arrived to inspect it, once inside the team observed the students' clinical records in plain view in the unattended room, and noted opportunities for unauthorized persons to access or remove records. In addition, the team was unable to locate the "consent to treatment with psychotropic medications" forms in some of the records reviewed. The consent forms that were reviewed were missing signatures, dates, and information that would indicate if medication was administered at school or home.

PES has not consistently held therapy sessions with all JRC students. (Page 71) The team found that in December 2006 and January 2007, PES did not hold therapy sessions with some students and still had not conducted makeup sessions.

PES and DCPS employees fear the size of the JRC site might not be adequate. (Page 73) The team found the JRC site to be clean and safe for both students and DCPS and PES employees alike. DCPS and PES employees reported to the team that although they feel the building is well-equipped and the environment is safe for the students as well as themselves, they did not believe the site would adequately accommodate the full enrollment of 60 students. For example, employees stated that the playground was too small and the only thing the children play is dodge ball or basketball games. In addition, the school would not have enough rooms where the students can sit when they experience a personal crisis.

RECOMMENDATIONS

The OIG made 50 recommendations to DMH to improve the deficiencies noted, establish and implement internal controls, and increase operational efficiency. OIG recommendations

EXECUTIVE SUMMARY

focused on developing written policies and procedures, increasing employee training, improving program operations, increasing staffing, and improving human resources functions.

COMPLIANCE AND FOLLOW-UP

The OIG inspection process includes follow-up with inspected agencies on findings and recommendations. Compliance forms with findings and recommendations will be sent to DMH along with this Report of Inspection (ROI). The I&E Division will coordinate with DMH on verifying compliance with recommendations in this report over an established time period. In some instances, follow-up inspection activities and additional reports may be required.

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Background and Perspective

The Inspections and Evaluations (I&E) Division of the Office of the Inspector General (OIG) began an inspection of the District of Columbia (District) Department of Mental Health's (DMH) School-Based Mental Health Program (SMHP) and Psychoeducational Services (PES) programs in December 2006. The SMHP clinicians provide a full array of mental health services to students in selected District of Columbia Public Schools (DCPS) and public charter schools, as well as their families. The PES programs provide therapy and treatment in special education centers for DCPS students who experience challenges in the regular school setting.

DMH is the District's primary mental health provider for adults, children, youths, and their families. It was established as a cabinet-level department in 2001 and is a subordinate agency, but has independent personnel and procurement authority. DMH's mission is to "develop, support, and oversee a comprehensive, community-based, consumer-driven, culturally competent, quality mental health system."⁷ DMH's Mental Health Authority provides overall leadership and strategic direction for the mental health system. It also regulates certification of Core Service Agencies (CSA) providing Mental Health Rehabilitation Services (MHRS), which are intensive, community-based mental health services. The D.C. Community Services Agency (DCCSA)⁸ is the District-operated CSA. DMH serves more than 7,500 individuals annually through DCCSA and community-based mental health agencies under contract with DMH. Inpatient care for individuals with acute, long-term mental health needs is provided at St. Elizabeths Hospital.⁹

The SMHP seeks to reduce barriers to learning and development by providing mental health services to school-aged children and their families.¹⁰ The program provides full-time mental health clinicians to partner schools in order to promote social and emotional development and to address psychosocial¹¹ and mental health problems. The SMHP currently serves 35 DCPS schools and 11 public charter schools.

The PES program provides therapeutic services at two special education centers for DCPS students who experience behavioral, emotional, or academic problems in a regular school setting. The two centers are the Moten Therapeutic Nursery (MTN) located at 1565 Morris Road, S.E., Washington, D.C., 20020 and the Jackie Robinson Center for Excellence in Education (JRC) located at 821 Howard Road, S.E., Washington, D.C., 20020. As of December 21, 2007, the DMH reported to the OIG that MTN has 2 clinicians providing mental health services to 10 young children who have been diagnosed with emotional problems. Based on

⁷ See http://dmh.dc.gov/dmh/cwp/view,a,3,q,515952,dmhNav_GID,1480,dmhNav,31269,asp (last visited May 27, 2008).

⁸ CSAs (the terms District of Columbia Community Services Agency (DCCSA) and CSA are used interchangeably by DMH) provide mental health services to children, youths, and adults in the District. The CSA is the "clinical home" for each individual and is accountable for the services each individual receives. <http://dmh.dc.gov/dmh/cwp/view,a,3,q,516008.asp> (last visited May 27, 2008).

⁹ See DMH website at <http://dmh.dc.gov/dmh/cwp/view,a,3,q,516064.asp> (last visited May 27, 2008).

¹⁰ See DMH, SCHOOL MENTAL HEALTH PROGRAM ORIENTATION MANUAL, GENERAL OPERATING PROCEDURES FOR SCHOOL MENTAL HEALTH CLINICIANS 1 (2006).

¹¹ The term "psychosocial" is defined as "[i]nvolving aspects of social and psychological behavior [.]". <http://dictionary.reference.com/browse/psychosocial> (last visited May 27, 2008).

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information provided by DMH in December 2007, JRC employs 8 clinicians who provide psychoeducational services for 57 students enrolled in JRC and 18 youths who are enrolled in DCPS schools in the community. The services include crisis intervention and behavior modification, problem solving skills, interpersonal skills, and other self-regulatory and relationship competencies.¹²

According to information from the SMHP, PES, and DCPS, both the SMHP and PES provide quality mental health services that have a positive impact on student well-being. Moreover, the inspection team (team) found SMHP and PES employees to be highly motivated and dedicated to carrying out DMH's mission.

Scope and Methodology

OIG inspections comply with standards established by the President's Council on Integrity and Efficiency, and pay particular attention to the quality of internal control.¹³ During this inspection, the team reviewed DMH's internal policies and procedures, District of Columbia Municipal Regulations (DCMR), the District Personnel Manual (DPM), best practices from the Substance Abuse and Mental Health Services Administration¹⁴ and the University of California's Los Angeles Center for Mental Health in Schools, relevant documents and reports including the *School Mental Health Program Retrospective Report 2000-2005*, and applicable best practices from other jurisdictions.

The team conducted over 90 interviews with DMH employees, interviewed 6 DCPS principals, interviewed parents participating in a support group, observed work areas, and reviewed pertinent files and documents. A list of the report's 26 findings and 50 recommendations is at Appendix 1. The team issued two Management Alert Reports (MAR-07-I-006 at Appendix 2 and MAR-07-I-001 at Appendix 4) regarding psychological reevaluations and employee background checks, respectively.

DMH reviewed the draft of this report prior to publication, and its comments follow each OIG recommendation. The OIG included DMH's comments in their entirety at the end of the finding. DMH submitted four exhibits as part of its responses. The exhibits DMH provided are included at Appendices 9 through 12 as part of the report.

Note: The OIG does not correct an agency's grammatical or spelling errors, but does format an agency's responses in order to maintain readability of OIG reports. Such formatting is

¹² See REACHING, CONNECTING AND UNLOCKING POSSIBILITIES, A HANDBOOK FOR MENTAL HEALTH SERVICES DEPARTMENT OF MENTAL HEALTH WASHINGTON, D.C.

¹³ "Internal control" is synonymous with "management control" and is defined by the Government Accountability Office as comprising "the plans, methods, and procedures used to meet missions, goals, and objectives and, in doing so, supports performance-based management. Internal control also serves as the first line of defense in safeguarding assets and preventing and detecting errors and fraud." STANDARDS FOR INTERNAL CONTROL IN THE FEDERAL GOVERNMENT, Introduction at 4 (Nov. 1999).

¹⁴ "The Substance Abuse and Mental Health Services Administration is an agency of the U.S. Department of Health and Human Services. It focuses attention, programs, and funding on improving the lives of people with or at risk of mental and substance abuse disorder..." [Http://www.hhs.gov/samhsa/about/1336.html](http://www.hhs.gov/samhsa/about/1336.html) (last visited May 27, 2008).

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limited to font size, type, and color, with the following exception: if an agency bolds or underlines text within its response, the OIG preserves these elements of format.

Compliance and Follow-Up

The OIG inspection process includes follow-up with District agencies on findings and recommendations. Compliance forms will be sent to DMH along with the report of inspection, and the I&E Division will coordinate with DMH on verifying compliance with recommendations in this report over an established time period. In some instances, follow-up inspection activities and additional reports may be required.

**Findings and
Recommendations:
KEY FINDINGS**

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1. **Deficient Memoranda Of Understanding (MOUs) between DMH and DCPS have a negative effect on provision of mental health services.**

DMH has MOUs with DCPS that outline the provision of services provided to schools by the SMHP and PES programs. To support the implementation of the SMHP, DMH and DCPS developed a MOU in October 2001 “to establish a set of guidelines whereby school-based mental health services would be provided to selected public schools in the District of Columbia.”¹⁵ The MOU between DMH and DCPS supporting the implementation of PES states that DCPS special education students are provided psychoeducational services through DCCSA’s PES programs.¹⁶

DMH Policy Number 801.1 (Aug. 1, 2005) sets forth the procedures for developing and managing memoranda of understanding. It indicates that DMH MOUs should have, among other information, the following details in the MOUs between DMH and DCPS for the SMHP and PES programs:

- services provided and scope of work;
- obligations and responsibilities of DMH, including contact person, staffing, resources, and services;
- obligations and responsibilities of other District agencies, federal agencies, or private entities, including contact person, staffing, resources, and incident reports; and
- mutual obligations of DMH and District agencies, federal agencies, or private entities.

Further, DMH Policy Number 801.1, Section 8 states, in part:

All MOUs ... shall be monitored by the responsible manager for implementation of activities as delineated within the MOU....

8a. The Responsible Manager shall:

- Monitor the services performed by the District, federal agency, or private entity in compliance with the MOU requirements; and ensure that DMH meets its obligations under MOUs...;
- Serve as contact for the MOU....

Through interviews and document reviews, the team noted that the MOUs between DMH and DCPS do not stipulate the specific roles and functions of DCPS employees as required by DMH Policy Number 801.1, and fail to adequately address important details necessary to successfully implement the MOUs. Furthermore, the MOUs do not sufficiently address the following additional areas:¹⁷

¹⁵ AMENDED AND RESTATED MEMORANDUM OF UNDERSTANDING BETWEEN THE DEPARTMENT OF MENTAL HEALTH AND THE DISTRICT OF COLUMBIA PUBLIC SCHOOL SYSTEM, 1, Feb. 6, 2006.

¹⁶ TITLE, 1, Jan. 7, 2004.

¹⁷ See UCLA Center for Mental Health in Schools, Program and Policy Analysis, MAKING MOUS MEANINGFUL, CENTER FOR MENTAL HEALTH IN SCHOOLS, available at <http://smhp.psych.ucla.edu/pdfdocs/practicenotes/makingmou.pdf> (last visited May 27, 2008).

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- responsibilities, roles, and functions of teachers, school counselors, and school administrators;
- infrastructure mechanisms for problem solving and communicating;
- evaluation and accountability requirements; and
- standards, quality indicators, and benchmarks.

The MOU generally outlines clinicians' roles within the school; however, it does not specify the roles of DCPS employees. Communication and interagency collaboration could be hindered by the lack of specific details in the MOUs. Additionally, mutual roles and responsibilities may not be understood by all parties, and procedures for addressing problems are not apparent. For example, the SMHP clinicians reported that not all DCPS employees understand clinicians' responsibilities. As a result, DCPS employees ask clinicians to take on responsibilities that are outside the purview of the MOU, such as working with special education students, conducting psychological tests, and monitoring students during lunch and playground activities. Performing DCPS employees' duties reduces the time clinicians can devote to prevention programs and other mental health services. The SMHP clinicians indicated that work relationships become strained when they refuse requests that are outside the purview of the MOU and that SMHP management does not always address these issues effectively or timely.

Although the MOU generally addresses collaboration between DCPS and DMH, clinicians indicated that DCPS employees do not consistently collaborate with SMHP employees. Some clinicians stated that principals will not meet with them about programming, and some teachers will leave the classroom when clinicians conduct presentations, which can lead to student behavior problems because the teachers have more experience in disciplining the children. The SMHP clinicians also stated that not all teachers reinforce the lessons of the prevention-based programs presented to classes by clinicians.

Students enrolled in the PES schools take part in a mandatory "Behavior Management" program introduced by PES. The PES MOU does not address DCPS and DMH responsibilities for implementation of the behavior modification program. According to PES and DCPS employees, the behavior management program is designed to teach students how to improve their behavior through instructions and rewards from PES and DCPS staff members. For example, students who meet their behavior goals receive JRC play money that they must pay back into the program when they exhibit behavior that is not in line with their behavior goals. The students have scheduled group "circle time"¹⁸ meetings in the morning and afternoon to learn which students have achieved the highest performance. During these meetings, the students use their earned JRC paper money to purchase items of their choice from the school store. A PES clinician reported that DCPS sometimes will have other activities for the students in lieu of behavior management circle time activities. However, according to the PES clinician, when the behavior program is interrupted, students do not receive the full benefit of the program.

A DCPS staff member expressed interest in DMH providing more mental health training. Although the PES MOU generally references training, DCPS staff members want more training opportunities. The MOU does not provide detailed information about the frequency and type of

¹⁸ Student reward activities focused on behavior.

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training that will be offered, but states that DMH will provide “all materials and resources needed to meet the individual mental health needs of the students. . . .”¹⁹ The clinical staff reported that they often spend their own money to buy items needed to conduct therapy and to reward students participating in the behavior management program. The team noted that the SMHP clinicians have also reported using personal funds to buy toys and other items used for programming. The MOUs are not specific about what resources and materials PES and the SMHP will provide.

Recommendation:

That the Director, Department of Mental Health (D/DMH) and DCPS modify the SMHP and PES MOUs to meet the requirements set forth in DMH Policy Number 801.1 and to ensure that all affected DMH and DCPS personnel understand their obligations and responsibilities, and include the following details:

- responsibilities, roles, and functions of teachers, school counselors, and school administrators;
- infrastructure mechanisms for problem solving and communicating;
- evaluation and accountability requirements; and
- standards, quality indicators, and benchmarks.

Agree X Disagree _____

DMH’s Response, as Received:

Action Plan: DMH will schedule a meeting with DCPS administration within the next sixty (60) days to revise the MOU to clarify roles and responsibilities. Please note comments below.

Exceptions: Although DMH agrees with this recommendation, DMH requests the OIG note the following in its final report:

In addition to the MOU, the SMHP enters into an Agreement to Proceed (ATP) with each building principal. The ATP supplements the MOU and includes more specific information tailored to the individual school, including detailed requirements, description of roles, and points of contact for DMH and DCPS. Using the ATP as a guiding document, the SMHP Program Manager and the Clinical Administrator work with building principals to clarify any issues regarding role confusion as they are brought to management’s attention.

This document was shared with the OIG staff during the inspection two school years ago. The ATP has been revised since the OIG evaluation. Both the ATP that he [sic] OIG staff reviewed and the revised ATP are included with this response. DMH requests that the OIG incorporate these documents into the Appendices.

¹⁹ TITLE, 2, Jan. 7, 2004.

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Regarding communication and interagency collaboration, DMH encourages teachers to reinforce prevention-based programs in their curriculum. However, this is DCPS's decision. SMHP has conducted numerous workshops for faculty across its partner schools to reinforce the importance of socio-emotional issues and the connection to learning and will continue to conduct these sessions.

It should not be necessary for clinical staff to buy items to conduct therapy or to support behavior management programs. The SMHP makes these funds available to clinicians for these supplies. The SMHP has provided \$200 per school for therapeutic supplies that has lasted two school years. In addition, this summer the SMHP procured all materials identified as needed to implement the individual prevention/intervention programs and has given these materials to each clinician.

OIG Response: The team reviewed the MOU and the ATP. Additionally, the team discussed collaboration between DCPS and SMHP with school personnel and SMHP employees. However, the team was informed that DCPS employees do not consistently collaborate with SMHP employees. DMH's planned actions meet the intent of the recommendation.

2. The DMH Division of Human Resources (DHR) allows SMHP clinicians without completed and satisfactory criminal background checks to provide direct services to children and youths.

Effective April 13, 2005, the Criminal Background Checks for the Protection of Children Act of 2004 (D.C. Law 15-353, Title II, codified at D.C. Code §§ 4-1501.01-.11 (Supp. 2006)) requires criminal background checks for District government employees who provide direct services to children and youths.

DPM § 412.2 states:

Each current employee in a covered position shall be subjected to an initial criminal background check beginning within forty-five (45) days of the publication in the D.C. Register of the notice of final rulemaking implementing the criminal background requirements of the Act. The personnel authority shall notify each current employee in a covered position that he or she shall be subject to an initial criminal background check under the Act prior to conducting any such check.

Section 417.3 states:

Subject to the approval of the personnel authority, an appointee to a compensated position with a covered child or youth services provider agency may be offered employment contingent upon receipt of a satisfactory criminal background check or traffic record check, or both, and begin working in a supervised setting, prior to receiving the results of the checks, and prior to the

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employing agency making a determination that the appointee meets the requirements of the Act.

While the Act requires new employees without a criminal background check to be supervised, DMH Policy Number 716.4 does not stipulate what constitutes supervision for new or active employees who do not have criminal background checks.

DMH Policy Number 716.4 sets forth the requirements for criminal background checks for certain applicants and employees of DMH. Section 16 of the policy states that “[t]he DMH Division of Human Resources will prepare a compliance report every six (6) months.” The policy stipulates that the compliance report shall include:

- 16a. The number of initial criminal background checks ... conducted for appointees, the number of appointees who were hired upon completion of the check, and the number rejected; and
- 16b. The number of periodic criminal background ... checks conducted for employees ... and any administrative action initiated or taken upon completion of the periodic checks.

On October 24, 2006, DMH entered into a MOU with the Metropolitan Police Department (MPD) regarding criminal background checks for employees and persons under consideration for employment in DMH agencies that provide direct services to children and youths. Under this agreement, MPD is responsible for conducting local and national criminal background checks and for transmitting fingerprint information to the Federal Bureau of Investigation for processing. Each criminal background check is to be processed within 50 days of receipt of each request.

DHR’s Standard Operating Procedure (SOP) No. 06-01, dated October 17, 2006, sets forth the procedures for implementing and managing the DMH’s criminal background check program. The SOP states that the Chief of the Policy, Training and Special Programs Branch is responsible for:

- preparing a compliance report every 6 months in accordance with DMH Policy Number 716.4, Section 16;
- ensuring that the Program Coordinator establishes procedures for criminal background checks receipt and processing; and
- ensuring that the Program Coordinator maintains liaison with managers, supervisors, and operations employees.

The information provided to the team by DHR and a review of criminal background checks for SMHP clinicians indicated that at least four clinicians were providing direct services to children and youths without supervision even though SMHP had not received completed and

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satisfactory criminal background checks from MPD.²⁰ The clinicians were not newly hired by SMHP, but were full-time employees at the July 2006 inception of DMH's background check program. The team also determined that DHR did not prepare a compliance report at the 6-month interval of the criminal background check program in accordance with DMH Policy Number 716.4, Section 16, and that DMH had not received monthly reports from MPD regarding the services provided under the MOU as stipulated in the MOU between the two agencies.

The safety of children and youths receiving direct services from clinicians who do not have complete and satisfactory background checks may be at risk. Additionally, the District may be liable if a clinician without a complete and satisfactory criminal background check harms a child or youth for whom she or he is providing direct services.

A Management Alert Report (MAR-07-I-006 at Appendix 2) addressing this issue was sent to DMH. A copy of DMH's response to the MAR is at Appendix 3.

In the response letter to the MAR, DMH stated that it had:

reviewed its policy and the applicable District of Columbia law and rules and has not found any requirement that the criminal background checks must have been completed in order for an active employee to continue to provide direct services. Rather, all applicable provisions require that each employee occupying a covered position shall be required to "submit to" or "apply for" a criminal background check in order to provide direct services, and once having done so, DMH is required to ensure that the criminal background checks are processed. DMH and its clinicians have met this threshold requirement.²¹

The team asserts that both the D.C. Code and the District Personnel Manual (DPM) stipulate that covered child or youth service providers are required to "conduct" criminal background checks and that this includes obtaining the results. It is the results of the criminal background check, not the act of requesting a criminal background check, that ensure the safety of children and youths receiving services from SMHP. Moreover, at the time the MAR was sent to DMH, the organization had not met the threshold requirement of ensuring that the criminal background checks are processed completely, as there remained three clinicians for whom DMH did not have the results.

DMH's response to the MAR also stated:

DMH will follow up with MPD to obtain the status of the CBCs [criminal background checks] for three of the four active clinicians that have continued to provide services

²⁰ All PES clinicians had completed background checks.

²¹ Letter from Stephen T. Baron, DMH Director, to author (undated) (on file with OIG).

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pending the receipt of their CBCs. DMH maintains that allowing the clinicians to continue working pending the receipt of their CBCs was not inconsistent with District of Columbia law and DMH policy.²²

The MAR submitted to DMH did not maintain that the clinicians in question should not be allowed to continue to provide mental health services pending the receipt of completed and satisfactory criminal background checks; rather, it recommended that DMH move expeditiously to obtain all requisite criminal background checks for SMHP clinicians. DMH should have promptly addressed the fact that clinicians were providing direct services to children and youths without supervision and without completed and satisfactory criminal background checks regardless of their status as active employees.

DMH's response to the MAR also stated that it takes MPD 2 to 3 months beyond the 50-day requirement to process criminal background checks requested by DMH. SMHP management reported that it is difficult to place new clinicians at schools in a timely manner due to the time it takes to receive background checks from MPD. The delay prevents clinicians from providing mental health services to schools and may cause potential employees to seek employment elsewhere.

The team will follow-up on DMH's progress in correcting the problems cited in the MAR.

Recommendations:

- (1) That the D/DMH move expeditiously to obtain all requisite criminal background checks for all of the SMHP clinicians.

Agree X – implemented Disagree _____

- (2) That the D/DMH adhere to all elements of DHR SOP No. 06-01.

Agree _____ X Disagree _____

- (3) That the D/DMH amend DHR SOP No. 06-01 to stipulate what constitutes a supervised setting for employees who provide direct services to children and youths and ensure that employees who do not have completed criminal background checks are supervised.

Agree _____ X Disagree _____

- (4) That the D/DMH prepare a compliance report every 6 months in accordance with DMH Policy Number 716.4, Section 16.

Agree _____ X Disagree _____

²² *Id.*

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- (5) That the D/DMH collaborate with MPD to identify ways to expedite criminal background checks, and research the feasibility of using a contract service provider to conduct criminal background checks if MPD is unable to expedite completion of such checks.

Agree X – completed Disagree _____

DMH's Response, as Received:

DMH has completed CBCs for all SMHP employees and is currently in full compliance. DMH now completes background clearances on all new hires prior to them beginning work with students. Currently the SMHP is not allowing any staff that has not been cleared through a CBC to work independently with the students. Staff awaiting clearances may conduct needs assessment interviews with staff assigned to the building (teachers, support staff, principals), participate in orientation activities at DMH or observe a cleared clinician in another school. MPD is now sending CBC reports for new hires on an average of ten (10) working days. DMH's Human Resources Division staff has prepared the compliance reports as required by DMH policy and procedures and these reports are on file for review.

3. DMH has not implemented mandatory drug and alcohol testing for safety-sensitive positions in violation of Chapter 39 of the DPM.

Title I of the Child and Youth, Safety and Health Omnibus Act of 2004 (D.C. Law 15 - 353, codified at D.C. Code §§ 1 - 620.31 - .37 (Supp. 2006)) requires mandatory drug and alcohol testing for District government employees in safety-sensitive positions. DPM Chapter 39, Part I, Subpart 3902.1 cites DMH as a District government agency that has safety-sensitive positions.

DPM Chapter 39, Part I, Subpart 3903.1 states that safety-sensitive positions “require the provision of services that affect the health, safety, and welfare of children and youth” Subpart 3903.1 lists multiple duties that affect the welfare of children and youths, including:

- individual counseling;
- group counseling;
- assessment, case management, and support services;
- psychological assessment services;
- therapeutic services, including individual, group, and play therapy;
- healthcare services, including mental health; and
- public safety services, including counseling and education intervention about safety, crime prevention, and youth problem-solving.

SMHP and PES clinicians conduct many of the aforementioned services on a regular basis. However, clinicians and management reported to the team that they had not been required to submit to drug and alcohol testing prior to appointment nor had they had random drug and alcohol testing. The team contacted DHR to determine if there were policies and procedures for mandatory drug and alcohol testing and was informed that a drug and alcohol testing program

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had not been implemented. Mandatory drug and alcohol testing for clinicians and other DMH employees in safety-sensitive positions helps ensure the health and safety of children and youths.

Recommendation:

That the D/DMH develop and implement written policies and procedures for mandatory drug and alcohol testing for safety-sensitive positions.

Agree **X** Disagree _____

DMH's Response, as Received:

Recently the District Office of Human Resources (DCHR) issued a plan for District agencies to follow to implement a mandatory drug testing procedure for all District employees in safety-sensitive positions. DMH is in the process of revising its draft policy to comply with the District's requirements. In addition, DMH is currently developing a MOU with DCHR to implement the plan within DMH. Once the MOU is completed, DMH will notify affected employees and their labor representatives where required, of the screening procedures. DMH expects to fully implement the process within the next ninety (90) days.

4. Some DMH clinicians feel unsafe during home visits.

The purpose of DMH Policy Number 340.4 (Apr. 22, 2005) is “[t]o ensure that mental health services for children and youth are predominantly provided in natural settings, rather than in an office or other mental health provider site.” Section 6 of the policy states that “[a]ll children/youth enrolled with a DMH-certified [DC]CSA and engaged in active treatment shall have direct services provided in the child/youth’s natural setting as much as possible.”²³

Home visits are conducted to increase family involvement in treatment and improve the well-being of children and youths. They afford mental health professionals the opportunity to access information not available in the school setting, including living conditions, family interaction patterns, family values and beliefs, and the social and material resources available to the family. Moreover, home visits provide clinicians the opportunity to conduct individual therapy, family therapy, and case management with parents who are unable to meet at the school due to extenuating circumstances.

a. DMH lacks written policies and procedures that address safety when SMHP and PES clinicians conduct home visits.

The National Association of Social Workers²⁴ writes:

National studies have also quantified the risks faced by social workers. Researchers at the University of Pittsburgh surveyed

²³ PES is part of DCCSA.

²⁴ See <http://www.socialworkers.org/advocacy/alerts/110805.asp> (last visited Oct. 23, 2007).

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1,200 social workers, most of whom said they had been in a work-related violent situation at least once. A 1999 study by the University of Michigan found that of 1,600 social workers, 3 percent had been assaulted by a client and 23 percent had been threatened with assault. One in four said they had a colleague who had been assaulted by a client.²⁵

In its Safety Guidelines (rev. March 1996), the Committee for the Study and Prevention of Violence Against Social Workers remarked that:

Work related violence against social workers is a fact of life. It is pervasive and must be addressed by every school of social work, agency and individual worker. Violence includes physical assault, verbal assault, harassment and the threat of assault. Many occurrences of violence can be anticipated and their impact lessened; some may be prevented entirely. If agencies have well conceived safety policies and procedures in place, client and worker safety will be maximized and the agency's liability will be minimized A written safety plan specific to the function and layout of each agency, or branch or division of an organization must be developed The plan must be reviewed and practiced on a regular basis if it is to be useful²⁶

DMH does not have written policies and procedures that address employee safety during home visits. The team reviewed the SMHP data from September 2002 through May 2007 and learned that clinicians conducted 1,019 home visits. A review of PES data indicated clinicians conducted 40 home visits between August 2006 and June 2007. Some employees reported that they sometimes feel unsafe during home visits because family members are not always receptive to intervention. Employees also indicated that home visits can be difficult to manage because of safety issues. For example, clinicians are reluctant to conduct home visits after a shooting has occurred in a neighborhood. Consequently, some clinicians prefer working in pairs due to safety concerns and some clinicians will not conduct a home visit if they are not joined by a school counselor or another colleague. A lack of well-conceived, written policies and procedures that address safety during home visits may increase safety risks and the risk of District liability. For example, policies and procedures could address how to recognize signs of agitation, when and how to attempt de-escalation, and how to use nonviolent self-defense maneuvers.

b. DMH does not provide all SMHP and PES clinicians with cellular phones for home visits.

DMH Policy Number 811.1A, Section 5b stipulates that “[c]ellular telephones will be restricted to officials who routinely travel on District government business ...; and/or [t]here

²⁵ [Http://www.socialworkers.org/advocacy/alerts/110805.asp](http://www.socialworkers.org/advocacy/alerts/110805.asp) (last visited May 14, 2008).

²⁶ [Http://www.socialworkers.org/profession/centeridl/violence.htm](http://www.socialworkers.org/profession/centeridl/violence.htm) (last visited May 14, 2008).

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must be a need to make government business related calls from locations where ... safety issues are of concern (e.g., in the field or during consumer home visits).”

As of the writing of this report, the team found that not all of the SMHP and PES clinicians are assigned DMH cellular phones for home visits. For example, PES has only one cellular phone for clinician on-call use and does not provide cellular phones for clinicians to use if there is an emergency during a home visit. Rather, clinicians are expected to use their personal cellular phones. Employees who do not own a cellular phone may not be able to make a call in an emergency and their safety may be at risk.

Recommendations:

- (1) That the D/DMH develop and implement written policies and procedures that address safety during home visits and require reevaluation of policies and procedures should an incident related to safety occur during a home visit.

Agree X Disagree _____

- (2) That the D/DMH provide training that addresses safety and nonviolent crisis intervention techniques during home visits.

Agree X – implemented Disagree _____

- (3) That the D/DMH make cellular phones available to all employees when they conduct home visits.

Agree X – implemented Disagree _____

DMH’s Response, as Received:

SMHP staff was trained in non-violent crisis intervention February 23 and March 2 of 2007. SMHP conducted a training on effective practices related to performing home visits for staff in June 2008. Dr. Raymond Brown, who is a community psychiatrist and Walter Mitchell, who is a mental health specialist, facilitated the session. The focus of the training was on safety and engagement practices. SMHP also identified a group of clinicians to help draft home visitation procedures and practice guidelines for SMHP staff. The SMHP will coordinate with Dr. Brown to conduct follow up training based upon the recommendations from the work group.

As an extra measure, DMH provided all SMHP staff with cell phones in September 2007. These phones are provided to the staff for all business use, not just for home visits. Staff is expected to carry the cell phones during their entire tour of duty.

5. The SMHP clinicians do not receive annual health screenings as required.

DMH Policy Number 716.1, Section 4a (Oct. 21, 2003) states that “[i]ndividuals who are employed ... in DMH positions involving direct care to DMH consumers are required to have ...

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annual/biannual health screenings.” High-risk employees receive biannual health screenings and non-high risk employees receive annual health screenings. Health screenings include:

- vital signs checks;
- height and weight checks;
- vision and hearing checks;
- urinalysis (if required);
- tuberculosis skin tests; and
- hepatitis B vaccine injections (optional).²⁷

The team contacted the Employee Health Branch (EHB)²⁸ and requested the dates of tuberculosis skin tests for 41 clinicians²⁹ to determine if they received the test annually as required by DMH policy. EHB located 28 of the 41 health files requested by the team.³⁰ Of the 28 health files located, 12 indicated that clinicians did not have current tuberculosis skin tests on file.³¹ The team followed up with SMHP management to ask if employees receive annual health screenings and was referred to DMH’s DHR. The team then asked DHR management and an EHB employee if the SMHP clinicians receive annual health screenings and was informed that they are given the same. However, an EHB employee explained that it is incumbent upon employees to schedule their health screenings and that many of the SMHP employees have not done so. Moreover, clinicians reported that they were only required to submit to pre-employment health screenings and tuberculosis skin tests. Therefore, DMH cannot systematically identify employees with health conditions that would render them incapable of performing their duties because it does not ensure that annual health screenings are conducted as mandated by policy.

Recommendation:

That the D/DMH ensure that all employees who provide direct care to DMH consumers undergo required annual/biannual health screenings.

Agree **X** Disagree

²⁷ See DMH Policy Number 716.1, Section 7b. DMH Policy Number 716.1, Section 5a defines “direct care” as “direct contact involving treatment, care or physical contact with DMH consumers, or any contact in close proximity to DMH consumers.” Section 5f defines “non-high risk employees” as “employees ... who work in a program that provides direct care to consumers.”

²⁸ The Employee Health Branch is a subunit of the DMH DHR and houses employee health files.

²⁹ Forty-one clinicians were employed by SMHP at the time of this inspection.

³⁰ EHB was unable to locate the remaining 13 files because it did not have access to employees’ social security numbers to search for the files. The 28 files that were located were found through a manual search or because the employee’s name was in an EHB file that lists dates of employees tuberculosis skin tests.

³¹ All PES clinicians had updated health screenings.

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DMH's Response, as Received:

DMH Response/Action Plan:

DMH's Human Resources Division will work with the SMHP staff to identify any current clinicians who need a health screening and arrange for that screening and establish a schedule for annual and bi-annual screenings.

6. **DMH does not provide consistent information to clinicians regarding the use of physical intervention when a child or youth is at imminent risk of injury to self or others.**

The SMHP Orientation Manual provided to all clinicians when they begin work in the program includes 22A DCMR Chapter 5. These regulations serve as a guide for the use of physical intervention for DMH mental health consumers.³² It states that “[r]estraints include devices and techniques designed and used to control a consumer’s behavior in an emergency...,”³³ and defines an emergency as a situation in which “a consumer experiences a mental health crisis and is presenting an imminent risk of serious injury to self or others.”³⁴

Further, 22A § 511.1 lists physical holds as a form of physical restraint and states:

A physical hold is the application of physical force by a trained or qualified staff person without the use of any mechanical device, for the purpose of restraining free movement of a consumer’s body. A physical hold does not include briefly holding without due force a consumer in order to calm or comfort him or her, or holding a consumer’s hand to safely escort him or her from one [area] to another.

Section 511.2 provides that a trained staff member may use a physical hold for up to 15 minutes in order to restrain a consumer, even without a physician’s order. Conversely, the SMHP General Operating Procedures (GOP), also in the SMHP Orientation Manual, instructs clinicians to “[r]efrain from use of physical restraints.”³⁵

Contrary to 22A DCMR Chapter 5, clinicians reported to the team that the SMHP management verbally instructed them not to touch children under any circumstances and to contact the School Resource Officer³⁶ when a crisis arises during which physical intervention may be necessary. In order to determine what policies and procedures clinicians should follow in relation to physical intervention, the team contacted the DMH Office of Accountability

³² According to 22A DCMR § 599, consumers include adults, youth, and children seeking or receiving mental health services in the District

³³ 22A DCMR § 500.4

³⁴ *Id.* § 500.6

³⁵ DMH, SCHOOL MENTAL HEALTH PROGRAM ORIENTATION MANUAL, GENERAL OPERATING PROCEDURES FOR SCHOOL MENTAL HEALTH CLINICIANS 1 (2006).

³⁶ School security officers.

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(OA).³⁷ OA reported that clinicians may physically intervene when a child is at imminent risk of injury to self or others. The team also followed up with SMHP management and was informed that the program's policy is to avoid physical contact with a child in an emergency, but that clinicians are not categorically prohibited from physically intervening to protect themselves or others. This contradicts what multiple clinicians reported to the team in interviews.

The SMHP provided training to clinicians in nonviolent crisis intervention on February 23 and March 2, 2007. The program content included "Introduction to Physical Control and Restraint." Some clinicians reported that the training appeared to contradict the verbal instruction they received from management not to touch children under any circumstances.

There are no clear DMH policies on the use of physical restraint, and clinicians expressed concern for the safety of children and youths because they have been directed not to physically intervene, even in an emergency. They believe that the lack of consistent guidance on the use of physical intervention contributes to discrepancies in the use of such interventions by clinicians and puts clinicians and children at risk. For example, some clinicians indicated that they would not touch a child under any circumstances because of the verbal directive from the SMHP management, while others stated that they would intervene in the case of an emergency because of safety concerns. The team acknowledges that ideally, a clinician will call the School Resource Officer for intervention when a child is at imminent risk of injury to self or others. However, this is not always possible. For example, a child could be in a physical altercation with another child and only a clinician is present. If the clinician does not intervene because of the verbal directive from the SMHP management, both children are at risk of injury.

In addition to safety concerns, clinicians expressed concern about liability. Clinicians stated that they are in a "catch-22" situation. They said they are liable if they intervene when a child is at imminent risk of injury to self or others, and they are liable for failure to act if they do not intervene in such situations and a child is injured. Moreover, clinicians indicated that they are not sure if DMH would support them if they were the subject of litigation for physically intervening or for failing to act in an emergency.

The team noted that although SMHP provides 22A DCMR Chapter 5 to clinicians as a guide for the use of physical intervention, the regulation does not specifically address a situation similar to SMHP's, where DMH employees provide services in a non-DMH, non-mental health setting. As a result, the regulation does not adequately address the needs of SMHP, DCPS, and the children whom both entities serve. The team also found that the use of physical intervention is not addressed in the MOU between SMHP/DMH and DCPS. As such, DMH lacks program-specific policies and procedures that address the unique relationship between SMHP and DCPS.

³⁷ OA certifies mental health service providers; licenses mental health residential facilities; develops and oversees quality initiatives; reviews unusual incidents and consumer complaints; and develops and implements policies.

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OA does not accept MUI reports that involve children served by the SMHP unless a SMHP employee is directly involved in an incident (e.g., a clinician physically abusing a child in his or her care) despite the fact that SMHP clinicians make numerous abuse and neglect referrals to the Child and Family Services Agency (CSFA)³⁸ each year.

For mental health consumers who do not participate in the SMHP, DMH Policy Number 480.1A (Dec. 22, 2005) requires submission of MUI reports to OA for “serious incidents that pose a significant danger, or that are likely to result or have resulted in serious consequences to the health and safety of the consumer/individual.”³⁹ In addition, OA receives verbal and written notification of MUI reports to ensure consumer/individual safety.⁴⁰ DMH policy lists the categories of MUI reports and included in this list are abuse of a consumer, neglect of a consumer, and sexual activity among children and youths.⁴¹ DMH policy also stipulates that OA must be verbally informed of any MUI report that involves notification to a law enforcement agency, a public children’s services agency (e.g., CSFA), or puts the health and safety of a consumer at risk.⁴²

OA provides critical services and information to DMH managers following a MUI report. For example, OA investigates the causes of incidents, develops follow-up actions to reduce their recurrence, and maintains copies of MUI reports for trends analyses. As DMH Policy Number 480.1A, Section 4 states:

The review and reporting of incidents is essential to ensuring consumer/individual safety through investigation of causes and incidents and developing remedial actions to reduce their occurrence. A delineation of incident reporting procedures is an important element in a risk management program.

The team reviewed a MUI report dated October 23, 2006, that was forwarded to OA by a SMHP clinician regarding youths engaging in sexual activity in the clinician’s office during a brief absence. The MUI report was returned to the SMHP on November 2, 2006, marked “Not DMH consumers” even though the incident involved a youth receiving mental health services from a clinician.

In order to determine what types of MUI reports from the SMHP are reviewed by OA, the team requested MUI reports from September 2003 to June 2007. OA produced four MUI reports from SMHP personnel. One report concerned a clinician who, according to a DCPS investigation, used corporal punishment on a student. The second report described a clinician who was physically attacked and robbed off school premises. The third report regarded a child

³⁸ The Child and Family Services Agency is a public child’s service agency that safeguards the rights and protects the welfare of children whose parents/guardians are unable to do so.

<http://cfsa.dc.gov/cfsa/cwp/view,a,3,q,5206663,cfsaNav,%7C31319%7C.asp> (last visited May 14, 2008).

³⁹ DMH Policy Number 480.1A, Section 5a.

⁴⁰ *Id.* 1 § 6a.

⁴¹ *Id.* § 7.

³⁴ *Id.* § 8d.

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who threatened to make a false report that a clinician had strangled him/her. The fourth report concerned an employee whose purse was stolen by an unknown suspect.

Although OA gave the team only four reports from the SMHP for a 4-year period, review of the SMHP data indicated a number of referrals to CFSA for abuse and neglect: 49 from September 2006 through May 2007; 40 in the 2005-2006 school year; 42 in the 2004-2005 school year; and 38 in the 2003-2004 school year. Due to the number of suspected cases of abuse and/or neglect reported to CFSA and the lack of MUI reports for such cases, the team sought clarification from SMHP regarding the lack of adherence to DMH Policy Number 480.1A. The team learned that SMHP does not report suspected cases of abuse and/or neglect to OA through the MUI report process; rather, the program tracks CFSA referrals in a monthly report and on a log in the progress notes in a client's clinical record. A SMHP quality assurance team also meets monthly and may address unusual incidents during this meeting. SMHP management informed the team that OA does not accept most MUI reports from the program despite management's and clinicians' desire to receive information from OA about how to address issues outlined in a MUI report. OA and SMHP employees indicated to the team that DMH does not consider children and youths served by the SMHP to be consumers because they do not pay for services and are not in eCura, the DMH system of record. Consequently, OA is not:

- ensuring that appropriate actions are taken in response to all MUI reports involving SMHP children and youths;
- notifying the DMH Director about all of the SMHP MUI reports;
- investigating MUI reports involving SMHP children and youths as necessary; or
- maintaining copies of all MUI reports involving SMHP children and youths for analysis.

In addition to abuse, neglect, and sexual activity, DMH Policy Number 480.1A recognizes other categories of major unusual incidents, including:

- assault with serious injury or sexual assault;
- exploitation;
- restraint;
- serious/suspicious injury;
- suicide attempt; and
- death.

Tracking, investigating when necessary, and analyzing the aforementioned categories and all other categories indicated in DMH Policy Number 480.1A are critical to ensure consumer/individual safety. SMHP children and youths are not afforded the same protections that other DMH consumers receive from MUI reporting, tracking, and response procedures, and their safety may be at risk. Furthermore, OA is not determining if appropriate actions are taken following a MUI report, and SMHP management and clinicians may not receive information from OA regarding how to address a major unusual incident and prevent future ones.

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Recommendation:

That the D/DMH develop a system to ensure that Policy Number 480.1A is applicable to all children and youths served by SMHP and require a MUI report for any SMHP referral to CFSA or MPD.

Agree _____ **X** _____ Disagree _____

DMH's Response, as Received:

The SMHP began providing MUIs on all CFSA/MPD incidents to OA in Fiscal Year 07 and OA now tracks and trends these incidents.

8. PES did not administer psychological reevaluations on time to several students enrolled in the Jackie Robinson Center for Excellence in Education (JRC).

Psychological reevaluations are administered to students to determine a student's learning, behavioral, and mental health functions and needs. Further, reevaluations are conducted to determine a student's eligibility for special education services and to comply with the Individuals with Disabilities Education Act (IDEA).⁴³

JRC students receive an initial evaluation and, as required by IDEA, must be reevaluated at a minimum of every 3 years, unless the parent and the school agree upon another schedule. Title 34 CFR § 300.303 states, in part:

- (a) General. A public agency must ensure that a [reevaluation] of each child with a disability is conducted...
- (1) If the public agency determines that the educational or related services needs, including improved academic achievement and functional performance, of a child warrant a reevaluation; or
- (2) If the child's parent or teacher requests a [reevaluation.]
- (b) Limitation. A [reevaluation] conducted under paragraph (a) of this section...
- (2) Must occur at least once every 3 years, unless the parent and the public agency agree that a [reevaluation] is unnecessary.

⁴³ "The Individuals with Disabilities Education Act (IDEA) is a law ensuring services to children with disabilities throughout the nation. IDEA governs how states and public agencies provide early intervention, special education and related services to eligible infants, toddlers, children and youth with disabilities." [Http://idea.ed.gov/](http://idea.ed.gov/). (last visited Jul. 18, 2007).

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DCPS students with disabilities attend the JRC, which is a PES school site. The students at JRC are covered under IDEA. According to the MOU between DCPS and DMH, “DCPS’ administrative, managerial and supervisory responsibility for the [PES] [p]rogram shall include IDEA compliance.”⁴⁴ PES managers informed the team that although PES is responsible for providing mental health services to the students, DCPS and PES did not originally expect PES to administer reevaluations as part of these mental health services. According to the MOU, DCPS was obligated to comply with IDEA and administer reevaluations to the JRC students. PES managers stated that following requests from DCPS, PES verbally agreed and made a commitment to be responsible for administering the reevaluations to students at JRC, which included providing the mental health staff and necessary testing equipment to administer reevaluations to students. In addition, PES managers and clinicians stated to the team that although PES verbally agreed with DCPS to administer the reevaluations, they were unable to administer them on time and insisted that the responsibility to comply with IDEA still remained with DCPS. Further, PES management indicated that it is DCPS’ responsibility, not PES’ responsibility, to ensure that DCPS maintained IDEA compliance.

DMH and DCPS managers and employees stated during interviews that reevaluations for several students were overdue, and information provided by both DMH and DCPS confirmed at least 10 overdue reevaluations. In 9 of the 10 cases, the minimum 3-year timeframe for reevaluation had lapsed; in the remaining case, a child’s parent requested a reevaluation, and it was not conducted within 2 months as indicated in information provided by a DCPS employee. An OIG Management Alert Report (MAR-07-I-001 at Appendix 4) regarding overdue reevaluations was issued to DMH. A copy of DMH’s response to the MAR is at Appendix 5.

According to DMH and DCPS employees, PES did not have the necessary testing equipment to conduct the reevaluations. DMH employees informed the team that the testing equipment was initially ordered in September 2006, but due to changes in the budget, the initial order was cancelled. In November 2006, a revised order was placed, and the testing equipment was delivered in January and February 2007. Consequently, JRC reevaluations did not begin in December 2006, as required; rather, PES began administering reevaluations in January 2007.

In April 2007, the team followed-up with DCPS to determine if PES completed the reevaluations for the 10 students in question, and DCPS could not show the team documentation that PES had administered reevaluations for 4 of the 10 students. Further, the team found that beyond the 10 original reevaluations that were overdue, reevaluations were overdue for 6 additional students.

The failure to administer psychological reevaluations on time may compromise students’ mental health treatment and continuity of care, and cause the District government to fail to meet IDEA requirements.

⁴⁴ AMENDED AND RESTATED MEMORANDUM OF UNDERSTANDING BETWEEN THE DEPARTMENT OF MENTAL HEALTH AND THE DISTRICT OF COLUMBIA PUBLIC SCHOOL SYSTEM, 2, Jan. 7, 2004.

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- a. PES cannot enter Moten Therapeutic Nursery (MTN) students' clinical data in the computers at MTN because the Anasazi program is not loaded onto the computers used at the MTN .*

The team learned that when clinicians work at the MTN, they do not have access to Anasazi on their computers. Consequently, clinicians must transport MTN clinical records to JRC to enter case information into Anasazi and then take the clinical record back to MTN. This process risks the loss of clinical records. If MTN clinical staff had access to Anasazi, client information could be viewed electronically, case files would not need to be moved from center to center, and confidentiality of protected health information would be maintained.

- b. PES employees complain that recurring weather related technical problems interrupt their use of Anasazi.*

PES employees informed the team that the computers at JRC routinely “freeze up” and shut down if it rains or snows. These occurrences interrupt their work because they cannot access Anasazi to perform required, time-sensitive tasks, such as entering student clinical progress notes, updating treatment plans, or enrolling students in the PES program. Clinicians use Anasazi as a primary means of capturing student mental health treatment history information. An Information Technology employee informed the team that:

If the cables are getting wet when we are hit with inclement weather, then we could see a slowdown or a complete loss of service. Once we are notified that either situation is occurring, we contact OCTO, who manages the overall network for the District. They continuously monitor network performance and will [make] repairs i[f] necessary.

In addition, it was reported to the team that there are employees who still have difficulty using Anasazi and would benefit from additional training or a refresher course in its use.

Recommendations:

- (1) That the D/DMH work with OCTO to provide Anasazi service to the MTN.

Agree _____ **X** _____ Disagree _____

- (2) That the D/DMH instruct OCTO to identify and make the necessary repairs to improve computer reliability during inclement weather.

Agree _____ **X-partially** _____ Disagree _____

- (3) That the D/DMH ensure that all PES employees who need additional Anasazi training receive it.

Agree _____ **X** _____ Disagree _____

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DMH's Response, as Received:

DMH Response/Action Plan:

DCPS closed the MTN site at the end of last school year and is currently renovating it. The renovation is expected to be completed in two (2) years. Students and staff have been relocated to Wilkerson Elementary School and DMH is not aware of any current equipment or connectivity problems. Once the renovations are completed at MTN, the program returns to that site and if the problems reoccur, DMH Office of Information Systems (IT) will perform a review of the computers to insure that the icon to access Anasazi is installed on them and will test them.

When DCCSA staff first reported Anasazi system malfunctions during inclement weather, DMH IT inspected the system, but was not able to determine that the loss of connectivity was weather related. DMH discussed potential sources of the problem with both Verizon (the current network supplier) and the District's Office of the Chief Technology Officer (OCTO) (the potential supplier of DCNet related services) to review all DCCSA sites to improve overall network performance. DMH will continue to work with Verizon and OCTO to determine the cause of any connectivity problem regardless of the site, make repairs or find alternatives for connectivity.

DMH will work with the DCCSA to provide specific training or refresher training for Anasazi users.

10. DMH billing reports indicate that DCCSA has over \$1.4 million in outstanding claims for PES services provided to DCPS.

DCCSA provides mental health services to DCPS students through the PES program. DCCSA receives funding from Medicaid for the services provided to DCPS students in the PES programs. To receive payment for services, PES uses a software program called Provider Connect⁴⁶ and submits claims to Medicaid through this program. The claims are then entered into another software program called eCura.⁴⁷ Subsequently, eCura will approve claims that are in compliance with program payment rules, but reject and issue a denial report for claims that are not in compliance with program payment rules. A member of the DMH claims department will review the denial report to make corrections, and the items they cannot correct are sent back to PES to address and resubmit. Further, per DMH, they submit PES claims "to the District Medicaid agency's fiscal intermediary, [Affiliated Computer Services] ACS for processing, warranting and payment."

⁴⁶ "Provider Connect [is a] web[-]based [computer software program] that allows providers to enroll consumers, request services, submit claims, check status, and update required consumer profile information." KPMG LLP, DEPARTMENT OF MENTAL HEALTH ORGANIZATIONAL ASSESSMENT, 19 (Aug. 4, 2006).

⁴⁷ "eCura is the [computer software] that encompasses provider management, service rates, enrollment, eligibility, claims receipt, claims processing, claims payment (issuance of warrants that are then paid through the accounts payable module of the District's financial management system- SOAR), and services request (authorization) approvals." *Id.*

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The DCCSA, Billing and Payment Policy Number DCCSA 850, Section 2 states, in part:

The DCCSA will maintain the necessary operational capacity to submit claims, document information on services provided, and track payments received. This operational capacity will include the ability to:

- a) Verify eligibility for Medicaid and other third party payers;
- b) Document MHRS (provided by MHRS provider staff and subcontractors);
- c) Submit claims and documentation of MHRS to DMH on a timely basis; and
- d) Track payments for all MHRS provided enrolled or referred consumers.

The team found that a prior management study cited deficient procedures in DMH’s claims processing. In August 2006, a “DMH Organizational Assessment” conducted by an audit and consulting firm, KPMG, noted that “DC CSA [sic] does not submit all potential claims due to various system issues, and the quality of the claims submitted causes them to be rejected, ultimately resulting in Medicaid revenue that cannot be actualized.”⁴⁸

At the time of the inspection, the team reviewed DMH billing records and found that DCCSA PES programs had not received payment from Medical Assistance Administration or local funds for mental health services totaling approximately \$1,481,623 for a combined total of 24,724 hours of mental health service provided to DCPS students. The services were provided to students enrolled at the following PES school sites: MTN, Rose School, Paul Robeson School (PRS), and JRC during fiscal years (FYs) 2004, 2005, 2006, and 2007. Currently, only MTN and JRC remain in operation. The table below provides information regarding the yearly outstanding claims balances by fiscal year for each PES school site.

TABLE 1: YEARLY OUTSTANDING CLAIMS⁴⁹

Fiscal Year	PES Program Sites				Total Amount of Yearly Claims Outstanding
	Moten Therapeutic Nursery	Rose School	Paul Robeson School	Jackie Robinson Center	
2004	\$96,025	\$61,189	\$229,029	\$174,231	\$560,474
2005	\$140,609	\$46,500	\$152,711	\$221,996	\$561,816
2006	\$62,946	\$15,158	\$69,127	\$102,511	\$249,742
2007	\$4,272	\$1,970	N/A	\$103,349	\$109,591
				Overall Total	\$1,481,623

⁴⁸ *Id.* at 29.

⁴⁹ Information in table obtained from DMH and rounded by OIG.

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According to an e-mail from a DCCSA manager, the following are the reasons for the outstanding claims balance for PES programs:

[T]he denial of [claims has] impeded upon our ability to submit authorized claims for payment. This is due in large [part] to the barriers of the eCura system which impacts the submission of claims in Anasazi. As a result of such barriers, this also impacts the collection and posting of payment process.

The [billing staff manually enters record of payments into the District's procurement system] for each consumer, for each unique date of service and for each unique service. Oftentimes, the reception of [Remittance Advices] RAs are not always received in a timely fashion. Currently, the DCCSA receives Remittance Advices⁵⁰ (RAs), which may contain as many as 3,000 plus line items. Once received, each line item has to be posted and processed separately. This process is done by the three (3) billing staff [members] who also must maintain the other billing processes and issues on a daily basis.⁵¹

A combination of outstanding claims and untimely postings of adjudicated claims has contributed to DMH having over \$1.4 million in outstanding claims for PES services provided to DCPS students. DMH's current claims processing activities do not allow DMH to collect and put payment information into the computer in a timely manner, which could result in the agency forfeiting Medicaid funds due to late submission of claims. A PES manager informed the team that PES is working to ensure all RAs are received and processed in a timely fashion. "[In addition,] the billing staff will not be required to manually reconcile claims payments once the implementation of the 835 Automated Payment Tracking System is implemented. The 835 will greatly decrease the time [that] balances remain outstanding and improve the efficiency of payment posting."⁵² In addition, a DMH manager informed the team that DMH was in the process of hiring additional employees who will focus solely on RAs.

Recommendations:

- (1) That the D/DMH ensure that additional employees are hired to process RAs.

Agree _____

Disagree _____

X – see explanation
below _____

⁵⁰ The RA lists claims that have been adjudicated through the District's procurement system, and may be paid in full, partially paid, or denied.

⁵¹ E-mail from PES manager to OIG dated June 27, 2007. (On file with OIG)

⁵² *Id.*

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- (2) That the D/DMH make it a priority to implement the 835 automated payment posting process.

Agree X- completed Disagree _____

- (3) That the D/DMH conduct an analysis of all outstanding PES claims to determine which claims cannot be submitted, and devise an agency-wide strategy for prioritizing and pursuing outstanding claims.

Agree _____ X Disagree _____

- (4) That the D/DMH implement an agency “scorecard” performance measure that addresses PES’ claims collection efforts.

Agree _____ X Disagree _____

DMH’s Response, as Received:

DMH disagrees that additional staff needs to be hired at this time to process remittance advices (835s) because DMH has made improvements in eCura since the OIG’s evaluation of the program that makes hiring additional staff unnecessary.

The eCura system is currently able to automatically post 835s received from ACS. DMH has been processing 835s from ACS since January 1, 2008. The DCCSA now also posts 835s in Anasazi. The Mental Health Authority office and the DCCSA are working together to post and reconcile the payments in both systems.

DMH has been aggressively pursuing all possible revenue from Medicaid. During 2006 through 2007, DMH collected over \$43 million in Medicaid revenue. At this time, DMH cannot disaggregate the revenue collected for the PES program from its overall revenue collection. DMH, therefore, agrees with the recommendation that an analysis of all outstanding PES claims must be done to determine which claims have been paid for the PES program and which claims can still be submitted to Medicaid for payment. DMH is reviewing these claims now and expects to provide an analysis to the OIG at the exit conference when it is scheduled.

Regarding the last recommendation above, the DCCSA has data that identifies the disposition of all claims based on revenue and suspense and has a process to document its collection efforts. In conjunction with the analysis, the DCCSA will improve upon these processes and will make the improved data and processes available for inspection.

**Findings and
Recommendations:**

School-Based Mental Health Program

SCHOOL-BASED MENTAL HEALTH PROGRAM

The School-Based Mental Health Program (SMHP) provides mental health services to children and youths enrolled in selected DCPS and public charter schools so that they may become successful learners.⁵³ The program provides these services by partnering with students, families, community service agencies, private and public agencies, and faith-based organizations. Participating schools are assigned one clinician who provides assessment, treatment, prevention, consultation, training, and case management. Clinicians may be psychologists, social workers, mental health specialists, or mental health counselors, and each has the same job responsibilities.⁵⁴ In addition to clinicians, the program has two supervisory social workers, a supervisory psychologist, an evaluation manager, a program evaluator coordinator, a program manager, and a clinical program administrator.⁵⁵

The SMHP was implemented in October 1999 as a grant-supported program in 17 public charter schools. Due to the success of the initiative, DMH agreed to maintain financial and program management support beyond the 2002-2003 school year when the grant ended.⁵⁶ Sixteen D.C. public schools joined the 10 charter schools that remained in the program after the grant period. In FY 2006, the SMHP expanded from 30 to 42 schools, and currently serves 35 DCPS schools⁵⁷ and 11 charter schools.⁵⁸ DMH continues to provide funding and management. The SMHP and DCPS collaborate to determine which schools will receive services from the program, based on the number of schools on the SMHP waiting list and a school's level of need for mental health services. As of November 2007, there are 14 schools on the waiting list.⁵⁹

The mental health services provided by SMHP clinicians have the following three components:⁶⁰

⁵³ SMHP services are not provided to special education students. "Special education is instruction tailor-made to fit the unique learning strengths, and needs of the individual student with disabilities, from age three through high school. Special education programs and related services focus on academics, special therapeutic and other related services to help the child overcome difficulties in all areas of development."

[Http://www.k12.dc.us/offices/ose/childfind.htm](http://www.k12.dc.us/offices/ose/childfind.htm) (Last visited May 28, 2008).

⁵⁴ Twenty-six clinicians have Masters of Social Work degrees, seven clinicians have Ph.D.s, three have Masters of Arts degrees, two have Bachelor of Arts degrees, one has a Masters Degree in Education, and one has a Masters of Business Administration. A SMHP clinical psychologist can be hired by SMHP while obtaining the required supervision for licensure. A social worker must be licensed to practice social work in the District of Columbia. It is desired, but not required, that mental health specialists and mental health counselors have masters degrees in social work or psychology and be licensed or eligible for licensure. Supervisory psychologists must be licensed in the District.

⁵⁵ The team reviewed personnel files for all SMHP clinicians and determined that each had appropriate certifications and requisite college degrees. Employees reported having position descriptions and receiving performance evaluations. The team examined SMHP turnover rates and found that they were not inordinately higher than national trends.

⁵⁶ The SMHP budget for FY 2007 was \$4,074,382.

⁵⁷ Approximately 22% of all DCPS schools. SMHP recently added four schools to the program.

⁵⁸ Approximately 20% of all charter schools.

⁵⁹ See Appendix 6 for the SMHP waiting list.

⁶⁰ See DMH, SCHOOL MENTAL HEALTH PROGRAM ORIENTATION MANUAL, GENERAL OPERATING PROCEDURES FOR SCHOOL MENTAL HEALTH CLINICIANS 2 (2006).

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- Primary Prevention activities are developed and implemented to prevent mental health problems and promote positive development. They are available to the entire student body, school employees, and parents. Examples include staff development, social skills training groups, and workshops for parents.
- Secondary Prevention activities are targeted interventions (individual and group activities) that are provided on a weekly basis. These interventions are for students who have been identified as needing mental health services through a referral source. The goal is to provide early intervention before a more serious mental health problem develops. Examples include support groups, functional assessments, and dropout prevention programs.
- Clinical Services are provided for children and youths who are experiencing severe or chronic problems and need more intensive services. Examples include individual and family counseling, therapeutic groups, and family preservation programs.⁶¹

To ensure program quality, the SMHP implemented a Continuous Quality Improvement plan, which is designed to collect data, monitor and evaluate services provided to children, assess program performance, and correct deficiencies in programming. A Continuous Quality Improvement committee meets monthly to review core program components, including clinical records, crisis responses, evidence-based programs, monthly report data, staff development, employee recognition, satisfaction survey results, and unusual incidents.

The ratio of clinicians to students varies from school to school. For example, the smallest ratio is 1 clinician to 84 students and the largest is 1 clinician to 1,200 students.⁶² Clinicians may have up to 25 children in their individual caseloads, and during interviews, most clinicians indicated that their caseloads are reasonable.⁶³ From September 1, 2007, through January 1, 2008, 304 students received mental health services from clinicians, and there were 7,479 prevention activities with students. According to the SMHP monthly reports through May of school year 2006-2007, clinicians conducted 5,089 individual counseling sessions, 582 group counseling sessions, 313 family counseling sessions, and 3,842 teacher consultations. However, the monthly reports do not capture clinicians' daily interactions with children. For example, clinicians have lunch with children; greet them in the morning with school staff to facilitate the transition into the classrooms to begin the school day; provide on-the-spot problem-solving strategies in non-structured settings (e.g., cafeteria, hallway, auditorium, and playground); and help students accomplish reparative, relationship-oriented work such as apologizing to an adult or child for negative behavior.

⁶¹ There are no fees for services.

⁶² See Appendix 7 for a list of SMHP partner schools and the approximate number of students enrolled in each school.

⁶³ Clinicians are required to have a caseload of five students by November and a full caseload by January.

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Each SMHP supervisor oversees approximately 14 clinicians. Supervisors provide weekly on-site supervision for at least 1 hour with unlicensed clinicians and bi-weekly on-site supervision with licensed clinicians. Group supervision occurs monthly for a minimum of 1 hour at a SMHP school. Twice a year, supervisors conduct clinical chart reviews and use aggregate data to assess program outcomes. The majority of clinicians stated that they are satisfied with the supervision they receive. However, some clinicians indicated that some managers need more experience working in urban schools, which are often associated with poverty and low student achievement.⁶⁴

Clinicians receive training through the SMHP and the DMH Training Institute. They reported to the team that training is beneficial and spoke highly of training offered at the DMH Training Institute. At the writing of this report, the Institute offered training focused on DMH consumers and their family members. Session topics offered included: family therapy techniques with African-Americans; youth trauma and divorce; and homeless families. Clinicians also receive SMHP-specific training. Training topics included: Impact of Poverty on Youth, provided by the D.C. Fiscal Policy Institute; Grief and Loss, provided by the William Wendt Center for Grief and Loss; Understanding Needs of Youth Whose Families are Coping with Aids, provided by Pediatric AIDS/HIV Care, Inc. and Family Ties; and numerous other training sessions presented by the SMHP management and clinicians.

According to the DMH School Mental Health Program Retrospective Report 2000-2005, a large majority of children, youths, parents, and principals are satisfied with the services offered by the program. The SMHP surveyed participating children, youths, parents, and principals to determine their level of satisfaction with the program. The team noted several key highlights: 1) 100% of school administrators indicated that they would want the SMHP clinicians to return to their school; and 2) all principals either strongly agreed (96.6%) or agreed (3.4%) that clinicians were knowledgeable about mental health issues relevant to students. Of the children surveyed, 90% indicated that their SMHP clinician made them feel better and 88.8% indicated that their clinician helped them make better decisions. Ninety-one percent of parents surveyed indicated that there was improved communication in their families as a result of their children's involvement in the SMHP and 95% indicated that their children's behavior has improved.

During interviews with the team, several principals expressed satisfaction with the program. Although one principal raised concerns with the suitability of the clinician in his or her school, other principals stated that the SMHP clinicians do a good job of working with students and families to change behaviors. They indicated it is beneficial to have someone who is professionally trained providing mental health services to children and their families. The principals, along with management and clinicians, recommended that schools with large populations have more than one clinician to meet the mental health needs of students. According

⁶⁴ See Brian A. Jacob, *The Challenge of Staffing Urban Schools With Effective Teachers: EXCELLENCE IN THE CLASSROOM 3*, available at http://www.futureofchildren.org/information2827/information_show.htm?doc_id=469843 (last visited Mar. 17, 2008.)

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to management, the SMHP is exploring having two full-time clinicians at schools with more than 500 students.

In interviews during a parent support group at one of the SMHP sites, parents indicated that participating in the group provides them with parenting advice, information about mental health, as well as information about mental health resources in the community. The group recommended that every SMHP school have a parent support group.

SMHP data from 2000 through 2005 indicates that clinicians were fostering student improvement in the domains of anger, depression, and disruptive behavior. Current assessments⁶⁵ indicate statistically significant improvement in student levels of anger and depression. Clinicians and managers stated that the SMHP provides quality mental health services and that the program reaches children, youths, and families who would not normally receive mental health services.

11. SMHP's performance plan does not include measurable goals and objectives for all programs.

According to The National Association of Social Workers standards:

At the delivery system level, achieving program improvements and ensuring the equitable allocation of resources depends on reliable aggregate case data to demonstrate needs and service gaps and to document both the absence and presence of problems. Evaluation and quality assurance ensure that intended outcomes of services are attained and that the services are implemented in a consistent manner according to standards.⁶⁶

SMHP's performance plan does not have goals and objectives of desired outcomes that are measurable or expressed in quantitative terms for all of the prevention and intervention programs it implements. These programs are used to help clients cope with risk factors and life skills. For example, SMHP implements RETHINK, a program used to improve peer relationships and manage angry feelings, but there are no quantitative or measurable data to assess the program's performance. Currently, SMHP measures responses from surveys and clinical data results of the clients who participated in the programs. The surveys record client satisfaction and are broken down into five categories: child, youth, parent, teacher/staff, and school administrator. An example of a question from the SMHP client survey for youths is: *My counselor helped me in school... agree or disagree*. The survey only addresses the needs of the clients and if they are being met. It does not answer any questions about the program meeting any expectations or goals that may have been established and/or accomplished. The same can be

⁶⁵ Aggregate data summary provided by SMHP management for assessments conducted during 2006 and 2007.

⁶⁶ NASW STANDARDS FOR SOCIAL WORK CASE MANAGEMENT STANDARD 8. (Case Mgmt. Standards Work Group 1992), available at http://www.socialworkers.org/practice/standards/sw_case_mgmt.asp (last visited Jan. 14, 2008).

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said for other program surveys. An example of an item on the teacher/staff survey is: *Overall my experience with the clinician was... outstanding, excellent, or satisfactory.* The survey will not elicit information about whether the program is meeting specific goals because such measurable goals have not been established by SMHP.

Clinical data show the demographics of the children and test results concerning their behavior, the latter of which is broken down into four categories: depression, anger, aggression, and disruptive behavior. The results from the surveys (child, youth, parent, teacher/staff, and school administrator) and the results of the clinical data have been used to assess the program's progress since its inception and are compiled in the 2000-2005 School Mental Health Program Retrospective Report. The report tracks and details the SMHP client progress from year-to-year. However, it does not indicate SMHP's goals and objectives for all desired outcomes for comparison with actual program performance.

According to managers, when SMHP was created, quantitative goals and objectives were never established to monitor the progress of the program. The only results data were those recorded from the surveys of clients and the clinical data results, which reflect client behavior. These results derive from the 2000-2005 School Mental Health Program Retrospective Report that is viewed as SMHP's performance plan. It presents scientific data of pre- and post-test results from interventions that measure children's behavior or functioning. However, it does not articulate the goals or targets that the SMHP plans to use to measure program performance from year to year.⁶⁷ The report states that "[a] number of the school- and youth-level outcomes that have been noted after the first five years have been developmental, in that the program has grown in size and scope during this period of time. Although quantitative data needed to more comprehensively evaluate the program [are] not available, there are strong qualitative indicators of effectiveness."⁶⁸ Without articulated, planned goals and objectives, SMHP managers are not able to effectively evaluate program performance nor are they able to compare data from year-to-year concerning the progress of the programs. According to the 2000-2005 School Mental Health Program Retrospective Report, DMH seeks to "move into the development of a more sophisticated evaluation of school-based mental health services offered through the SMHP ... [and] the evaluation to this phase of assessments of the program will require additional funds and resources...."⁶⁹

The lack of measurable, established goals and objectives limits SMHP in reporting data that reflect the progress of its programs. The results that are used for the progress report are not a reflection of how the programs have improved, where SMHP would like to improve, and what SMHP is trying to accomplish currently and in the future.

⁶⁷ Two exceptions are the Teen Screen and the STOP suicide grant programs, which have set goals and objectives that are measurable.

⁶⁸ See DMH, School Mental Health Program Progress Report 2000-2005.

⁶⁹ *Id.*

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Recommendation:

That the D/DMH create goals and objectives of desired outcomes that are measurable and incorporate them into the performance plan to continuously evaluate the overall performance of the programs they implement.

Agree X - implemented Disagree _____

DMH's Response, as Received:

The SMHP has developed benchmarks for SY07-08. See attached document, "DC Department of Mental Health School Mental Health (SMHP) Benchmarks, setting forth projected recovery, utilization, screening and suicide prevention services rates, among other measures. SMHP also shared with the OIG inspection team information about its continuous quality improvement committee which meets monthly and reviews a core area of the program each month. Reviews include clinical records, crisis response, clinical outcomes, satisfaction with services, evidence-based program performance, unusual incidents, utilization/productivity, workforce development, needs assessments, employee recognition. Benchmarks have been or are in process of being established for each area.

The SMHP has developed performance standards for its clinicians, which establishes the measurable expectations for the program.

12. The SMHP does not have an electronic data system, and data collection is inefficient and ineffective.

The SMHP GOP require clinicians to "[p]repare monthly reports of clinical services offered" to constituencies (i.e., children, families, teachers, etc.).⁷⁰ According to the GOP, reports are given to the clinical supervisor, the program evaluator, and the SMHP program manager upon request. The monthly report tracks program data such as the number of referrals, referral sources, the number of counseling sessions, clinicians' impressions of children's mental health problems, treatment options, and primary prevention activities.

Clinicians collect data manually and prepare a monthly summary report form. Clinical supervisors assist in checking the forms for accuracy. The report forms are submitted to the program evaluator who enters the data into a spreadsheet. There are no quality assurance mechanisms to ensure the inputted data are correct, and the totals from each page of each clinician's monthly report form are often tabulated with a calculator.

Having a second person enter data from a form on a spreadsheet is time consuming and prone to errors. Clinicians reported that they could spend more time interacting with children if

⁷⁰ DMH, SCHOOL MENTAL HEALTH PROGRAM ORIENTATION MANUAL, GENERAL OPERATING PROCEDURES FOR SCHOOL MENTAL HEALTH CLINICIANS 1 (2006).

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they spent less time manually compiling data for the monthly report. The team found the resulting spreadsheet cumbersome and difficult to interpret. As a result, use, outcome, and trend data are not easily tracked and analyzed, and clinicians and supervisors spend valuable clinical time manually entering and checking data.

An electronic data system would allow for timely and accurate data analysis and storage. Moreover, it would allow clinicians and supervisors to view client charts online at the DMH main office and other locations with Internet access. According to employees, DMH has been attempting to implement an electronic data system for SMHP since 2005. DMH has developed a Statement of Work for a system and adopted a strategy for collecting, storing, analyzing, displaying, and reporting data. It also is evaluating electronic software packages. However, as of the writing of this report, an electronic data system was not in place, and the challenges of manual data collection remained.

Recommendations:

- (1) That the D/DMH expeditiously establish a secure electronic data system for SMHP.

Agree _____ **X** _____ Disagree _____

- (2) That the D/DMH ensure that training is provided for SMHP employees on the use of the electronic data system.

Agree _____ **X** _____ Disagree _____

DMH's Response, as Received:

DMH IT and SMHP staffs have been working together for over a year to create a data base for the SMHP use. Under consideration is the possibility of extending the Anasazi platform or using eCura – two systems already in use at DMH. DMH IT conducted an extensive review of the Anasazi platform with the eCura vendor. If, after this review the determination is made that Anasazi can be used, IT and SMHP staffs will work together to develop a detailed workflow prior to any final implementation of any system and train SMHP staff as part of the implementation process. IT intends to conduct a limited pilot in 2nd Qtr FY09 to determine viability.

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13. SMHP management encourages family participation in mental health services; however, clinicians report that participation is low.

The SMHP GOP state that the program seeks “[t]o foster and develop student and family’s utilization of internal and external resources to promote student’s academic, social and emotional success.”⁷¹ The GOP further states :

[SMHP] will actively collaborate with key stakeholders (students, families, District of Columbia Public and Public Charter Schools, core service agencies, public and private community agencies, and the faith community) to enhance the system of care’s ability to deliver culturally competent and developmentally appropriate services to school-aged children and their families. . . . [C]ontact with family members and other caregivers is a significant aspect of the intervention strategies that will be employed by mental health professionals.⁷²

D.C. Code § 7-1131.09 (2001) states that the DMH Consumer and Family Affairs Officer will “[ensure] the involvement of consumers of mental health services and their family members in the design, implementation, and evaluation of mental health services and mental health supports[.]” Additionally, the DCPS Office of Strategic Planning and Policy seeks to impact systemic change through effective policy, collaboration, and engagement in order to ensure the alignment of key DCPS priorities. As outlined by the 2005 DCPS Master Education Plan, the school system gives priority to family involvement and seeks “broader and deeper parent involvement...” in the school system.⁷³

Numerous variables, including psychological, socioeconomic, language, and ethnic factors affect parental participation in mental health services.⁷⁴ SMHP management encourages clinicians to involve families in all phases of mental health services, and clinicians make good faith efforts to achieve this goal. The SMHP has three parenting groups, and clinicians provide, among other things, family counseling, parent workshops, and home visits. However, clinicians indicated in interviews and correspondence with the team that families are not consistently involved in their child’s mental health services. For example, clinicians report that parents are not consistently involved in prevention programs, the creation of treatment plans, and counseling. Additionally, parents do not always ensure that children keep counseling appointments. According to clinicians, there are several consequences of low family involvement:

⁷¹ DMH, SCHOOL MENTAL HEALTH PROGRAM ORIENTATION MANUAL, GENERAL OPERATING PROCEDURES FOR SCHOOL MENTAL HEALTH CLINICIANS 1 (2006).

⁷² *Id.*

⁷³ DCPS, ALL STUDENTS SUCCEEDING: A MASTER EDUCATION PLAN FOR A SYSTEM OF GREAT SCHOOLS (2006) available at http://www.k12.dc.us/master/MEP_final.pdf. (last visited May 30, 2008).

⁷⁴ See UCLA SCHOOL MENTAL HEALTH PROJECT, CENTER FOR MENTAL HEALTH IN SCHOOLS, PRACTICE NOTES, INVOLVING PARENTS IN COUNSELING, available at <http://smhp.psych.ucla.edu/>. (last visited May 30, 2008).

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- parents are not involved in the development of treatment goals;
- children make no progress or slow progress toward treatment goals;
- clinicians do not receive adequate information about a child's treatment history and medication history;
- children are hesitant to speak openly about family/parent issues;
- teachers are reluctant to become involved in treatment because of the parent's lack of commitment;
- parents do not address changes needed in their behavior; and
- children do not attend counseling sessions consistently.

Clinicians stated that the SMHP needs to address family participation in mental health services strategically. For example, clinicians indicated that they should collaborate amongst each other more to improve family participation and stressed the importance of coordinating all family outreach efforts with school employees and the DCPS central office. To explore collaborative possibilities for the SMHP, the team contacted the DMH Consumer and Family Affairs Officer and was informed that the office sets policy around consumer care and services and promotes family involvement in relation to mental health services, but that office does not collaborate with the SMHP because there are so many other programs involved with the children. The team also contacted the DCPS Office of Strategic Planning and Policy and was informed that there has been a gap in collaboration during the past 2 years. Program officials stated that there is partnership potential between the Office of Strategic Planning and Policy and the SMHP because the office is in the process of establishing a parent partnership initiative.

As pointed out by SMHP management, some researchers in the school mental health field have indicated that the field is in the process of identifying the knowledge and skills needed to effectively engage parents in school-based mental health services. However, best practices indicate that there are strategies to foster family participation in all aspects of the planning and delivery of mental health services. For example, SMHP could involve families in program development, implementation, and assessment and engage families as equal members on committees and advisory boards.⁷⁵ By not fully developing ways to increase family involvement, DMH is not fostering this resource to promote the academic, social, and emotional success of its students.

Recommendation:

That the D/DMH ensure that SMHP develop ways to increase family involvement in mental health services, such as fostering collaboration with the DMH Consumer and Family Affairs Officer and the DCPS Office of Strategic Planning and Policy.

Agree _____ **X** _____ Disagree _____

⁷⁵ See Family Involvement in Expanded School Mental Health Programs Resource Packet, Center for Mental Health Assistance, 2002.

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DMH's Response, as Received:

The SMHP has gone to great lengths to increase family involvement. The SMHP has provided numerous community workshops, has been involved in PTAs and Positive Behavior Intervention & Supports (PBIS) committees. Currently the SMHP has partnered with DCPS in its three parent resource centers to provide parent workshops, resources, groups. In June 2008 the SMHP instituted a parent involvement committee to increase parent participation. The goal of the committee is to foster increased parent involvement. The program has resulted in noted improvements in this area since the OIG inspection took place.

The SMHP recently obtained an additional evidence-based parenting program, "Parenting Wisely" approved by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) for use during the FY 09 school year. Using this CD ROM, SMHP expects to further engage parents on an individual basis or in group settings on principles and skills to manage certain behaviors.

14. Some SMHP clinicians lack fundamental tools necessary to carry out their duties.

The Amended and Restated MOU between DMH and DCPS executed on Feb 6, 2006, states on page 3:

What the School Provides: For the DMH clinician to work effectively, the school must provide a private space, a locking filing cabinet, computer, printer, and a dedicated phone line for each clinician assigned to a school prior to or immediately after the placement of a clinician....

With regard to protected health information, the MOU states on page 5:

Mental Health Records Are Confidential and Not Part of The School Record: All mental health clinicians must abide by the Mental Health Information Act, a statute that dictates how information should be shared and with whom. . . . [O]nly those individuals authorized by the DMH (i.e., a direct clinical supervisor), the student (or the student's guardian), those who have a written authorization for release of information, or those with a court order can have access to information in these records.

The DMH SMHP Agreement to Proceed is a document that outlines the structure for carrying out the program within a school. It allows the SMHP and school principals to review the requirements of the MOU and outlines multiple components of the program, such as referrals, access to children and youths, and program evaluation. The agreement is signed by school principals upon implementation of a school/SMHP partnership to ensure that they

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understand the requirements of the program. It highlights the same resource requirements and confidentiality guidelines as the MOU between DMH and DCPS.

- a. Not all SMHP clinicians received a locking file cabinet, a dedicated office telephone, a computer, or printer in a timely manner when assigned to their schools.*

In FY 2006, SMHP expanded from serving 30 to 42 schools. The expansion was requested by the D.C. Council Committee on Health, which also determined the number of schools to receive services. SMHP management stated that, "Some [selected] schools had been on a waiting list for SMHP, while others were selected to support the consolidation of schools last summer when several buildings closed. This was a request from the DCPS [Chancellor's] office." The expansion happened quickly and not all schools were prepared to receive clinicians. As a result, not all clinicians placed at the additional schools received the office resources outlined in the MOU and the Agreement to Proceed. Furthermore, DMH was unable to provide temporary office resources when DCPS failed to do so.

Some clinicians reported that they never received a locking file cabinet to store protected health information. Additionally, the team observed a file cabinet provided for a clinician that did not have a lock in an office that could not be locked. Confidentiality of student health information cannot be protected without a locking file cabinet. A clinician may be subject to discipline in accordance with Chapter 16 of the DPM on active collective bargaining agreements⁷⁶ if there is a breach of confidentiality, despite his or her best efforts to protect confidentiality. Additionally, the District may be liable if a clinician fails to protect a consumer's health information and the consumer seeks recourse through litigation.

SMHP managers stated that they attempted to obtain DMH cellular phones for clinicians who did not have office telephones, but they could not produce documentation of these requests. The team learned that several clinicians did not receive an office telephone or DMH cellular phone for months after the beginning of the 2006-2007 school year. As a result, clinicians had to rely on personal cellular phones that would not work in offices or other areas located inside the schools. The lack of telephones impeded clinicians' ability to provide responsive care and efficiently interact with those who provide and receive mental health services, as well as with parents. Clinicians' inability to make telephone calls from their offices poses a safety risk. For example, if a clinician is counseling a child who becomes physically out-of-control and the clinician cannot call for outside help, the safety of both the clinician and the child may be at risk.

Clinicians informed the team that they did not receive computers and printers in a timely manner, and some clinicians still do not have printers as of the writing of this report. Clinicians who did not have computers or printers were unable to communicate via e-mail; use the Internet to conduct mental health research in an effective and timely manner; or create and print materials

⁷⁶ See DMH Policy Number 645.1, Section 7. SMHP psychologists and social workers are represented by unions.

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- (3) That the D/DMH and DCPS modify the MOU to make Internet access a required resource that DCPS will provide for clinicians.

Agree _____ **X** _____ Disagree _____

- (4) That the D/DMH assess the need to purchase more manuals for clinicians or make the manuals electronically available for clinicians.

Agree _____ **X** _____ Disagree _____

DMH's Response, as Received:

DMH works very closely with DCPS leadership to ensure that schools selected for the program meet the requirements in the MOU. The SMHP staff communicates with principals to ensure that DCPS provides the required resources for clinicians. DMH secures a verbal and written commitment prior to entering each school. There are some barriers that have been experienced in the actual distribution of these resources by the schools once DMH is in the school. Every effort is made to provide services to the schools while trying to secure the necessary resources. In some cases DMH has terminated agreements with schools that have been unable to meet the requirements.

SMHP has expanded into additional schools by mandate from the D.C. Council and DMH has provided the necessary equipment and supplies to each clinician, including a lap top computer, cell phone, office supplies and therapeutic supplies.

Program manuals are purchased for each program as the budget permits. DMH will determine whether it can make the manuals available electronically.

15. DCPS does not provide voicemail access for some SMHP clinicians.

The Mayor's Customer Service Operations, Customer Service Standards for Voicemail states:

All employee voicemail boxes should be set-up and ready to accept voice messages. Each voicemail box should never be full and unable to accept new messages.⁷⁹

The inspection revealed that a number of clinicians did not have voicemail accessibility. Some clinicians' voicemail boxes are not set-up and ready to accept voice messages, and they do not have access to their voicemail system. DCPS has not reset the voicemail boxes of previous employees because the passwords are unknown to DCPS staff. Old messages cannot be deleted

⁷⁹ [Http://www.dc.gov/mayor/customer_service/voicemail.shtm](http://www.dc.gov/mayor/customer_service/voicemail.shtm) (last visited Jan. 8, 2008)

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or news messages received. When someone calls a clinician's telephone, the voicemail reflects a previous employee's greeting.

Clinicians informed the team that they do not have voicemail because it was not included in their respective school's budget. A DMH/SMHP manager stated, "Although most schools can accommodate giving each clinician voicemail, some cannot or will not due usually to the cost of having it installed or maintained." Neither the MOU between DCPS and DMH nor the Agreement to Proceed include a requirement for DCPS to provide voicemail to clinicians.

Clinicians who lack voicemail cannot receive information from clients, parents, or legal guardians, District agencies, and other outside entities. Voicemail allows clinicians to receive messages from internal (within DMH) and external (agencies outside of DMH that clients are referred to) providers of mental health services regarding their clients' well-being and allows parents to leave messages of concerns about a child. It also allows clinicians to receive pertinent information from their managers and colleagues concerning work related issues when they are not in the office. Finally, without voicemail, clinicians cannot timely respond to an emergency concerning a client's mental health needs.

Recommendations:

- (1) That the D/DMH ensure that DCPS and the public charter schools provide voicemail for every clinician.

Agree _____ Disagree _____ **X**

- (2) That the D/DMH, DCPS, and the public charter schools revise the MOU and the Agreement to Proceed to include the provision of voicemail for SMHP clinicians.

Agree _____ Disagree _____ **X**

- (3) That the D/DMH work with DCPS and the public charter schools to ensure that voicemail passwords are obtained from employees before they separate from District government service.

Agree _____ Disagree _____ **X**

DMH's Response, as Received:

DMH disagrees with these recommendations requiring DMH to ensure that DCPS provide voice mail for every SMHP clinicians for the following reasons:

First, DMH has provided cell phones to each clinician for business use, including communicating with the students the clinician counsels. DMH believes that with time and

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consistent use, clinicians will not have to rely on DCPS telephones to communicate with students.

Second, DMH is unable to enforce the requirement that DCPS obtain its employees voice mail passwords before they separate from District government. DMH has issued cell phones to each clinician where students can leave voice mails for their clinician if the clinician is not available. Use of the DCPS phones for this purpose is no longer necessary.

OIG Response: At the time of the inspection, some clinicians did not have voicemail accessibility. The OIG agrees with DMH's response that cell phones are a sufficient means of communication between students and clinicians. DMH's actions meet the intent of the recommendations.

16. Some SMHP clinicians do not have a private space to meet with students as required by the MOU.

The MOU states that DCPS is required to:

provide a private space, a locking filing cabinet, computer, printer, and a dedicated phone line for each clinician assigned to a school prior to or immediately after the placement of a clinician at the school.⁸⁰

The team observed that a clinician at one DCPS facility occupies office space that is also used to house computer servers and telecommunications lines for the school's computer network. In addition, there are surplus office supplies and furniture from past employees in the clinician's office. The clinician stated that on one occasion, a computer technician came into the office to repair the computer servers for the school while the clinician was consulting with a student. The clinician had to ask the computer technician to wait in the group seating area of the office so that the consultation could be concluded.

The team was informed that the only office available at the time of one clinician's arrival was the vacant assistant principal's office. It was previously used as a clinician's office. The office did not provide privacy or confidentiality for students because it doubled as the computer network room and was not solely available for the purpose of consultation.

Through observations and interviews, the team learned that another clinician's office space did not afford confidentiality because it had a window adjacent to the school hallway. Although the window was covered with paper, students passing by indicated to SMHP staff that they could still see into the office. Therefore, the confidentiality of students receiving mental health services could be jeopardized.

⁸⁰ AMENDED AND RESTATED MEMORANDUM OF UNDERSTANDING BETWEEN THE DEPARTMENT OF MENTAL HEALTH AND THE DISTRICT OF COLUMBIA PUBLIC SCHOOL SYSTEM, 3, Feb. 6, 2006.

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SMHP managers stated that they inspect the office each clinician is to occupy prior to the clinician's arrival to ensure that DCPS provides a private space for the clinician. In addition, a previous SMHP manager indicated to the team that, "It would be hard to remove a clinician that both the school and the neighborhood rely on so much. It depends on the situation. If a neighborhood and the school need a clinician, then it would make it hard to remove a clinician for not having a dedicated space." Therefore, the clinician has to wait for available private space that seldom becomes available. This leaves the clinician in a predicament of not having a private space essential to conducting mental health services.

The MOU between DCPS and DMH clearly identifies a private space as one of the necessities for a clinician assigned to a school. For some clinicians, it is difficult to fulfill their duties free of interruptions under their current work conditions. In addition, some students are not afforded privacy while receiving consultation services.

Recommendation:

That the D/DMH ensure that DCPS provides all clinicians with a private office solely for the purpose of consultation as agreed upon in the MOU.

Agree X Disagree _____

DMH's Response, as Received:

DMH works with DCPS to ensure private office space is available for clinicians. DMH has withdrawn the program from schools in instances in which they were not able or willing to provide this resource.

17. Some SMHP employees do not have confidence in internal hiring and promotion practices.

According to the DMH Improved Hiring Process Flow Chart, dated May 2005, hiring time should range from 33 days (for a position that is posted for 5 days) to 38 days (for a position that is posted for 10 days). In interviews with the team, SMHP employees indicated that DMH's DHR is not sufficiently communicative or responsive during the hiring process, and there are large gaps between the interview and the date hired. Hiring timeframes reported to the team ranged from 3 months to 1 year. One employee recounted receiving a job offer by telephone for a grade 11 position. However, upon arrival at DHR on the date provided during the telephone conversation, the employee was not recognized, and DHR did not have any of the previously completed paperwork. The employee completed the paperwork a second time but was hired at a grade 9 without explanation. Delays in hiring and confusion about the hiring process may diminish SMHP's ability to recruit and hire competitive, highly-qualified employees.

Employees also indicated that there is no room for professional growth, promotion policies and procedures are not communicated effectively, and there are few promotions from within. They reported to the team that they are not consistently informed about SMHP vacancies

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and there is a perception among some employees that individuals are “hand-picked” for promotions. Employees stated that it is challenging to keep qualified clinicians because there is no room for advancement, and they are frustrated because the only way to progress in one’s career is to leave the SMHP. They reported that morale is low among clinicians.

The team met with three of DMH’s DHR human resource specialists to discuss how vacancies are posted and job candidates are chosen. They reported that when there is a vacancy, DMH posts the position description internally on the Intranet, and an e-mail is sent to managers. Additionally, the specialists indicated that in addition to employees’ computers, there are three computers located in DHR that employees can use to view job descriptions, but it is incumbent upon managers to inform employees of vacancies. They stated that the area of consideration determines whether the hiring pool is made up of individuals internal or external to DMH and that priority is given to individuals who work for DMH. DHR reported that job postings can be department-wide, agency-wide, or unlimited (open to the general public) and that all unlimited postings are announced department-wide. According to the specialists, program managers only interview qualified applicants and DHR determines who is qualified. The names of the qualified applicants are forwarded to management on a certification sheet, and DHR screens applicants every 2 weeks until a selection is made. DHR accepts applications until a position is filled.

The team reviewed personnel folders for several management-level positions that had recently been filled at SMHP and determined that each vacancy had been filled according to DMH stated policies and procedures that the specialists outlined for the team. Specialists stated that if an individual is interested in changing positions or a promotion, he or she should speak with a supervisor. In addition, employees can come to DHR and a representative or front desk personnel will discuss available positions. Despite DHR’s adherence to policies and procedures, some SMHP employees remain uncertain about hiring and promotion practices and perceive that the hiring process takes too long.

Recommendation:

That the D/DMH educate all employees about the hiring and promotion process and ensure that documentation that clearly explains the process is made available.

Agree X Disagree _____

DMH’s Response, as Received:

All staff receives verbal notification of vacancies in staff meetings in addition to email notification of vacant positions. DMH also maintains a list of the positions available on the Human Resources section of the DMH website. All employees have access to the Internet and intranet used to advertise all DMH vacancies. DMH will incorporate this notification description in future orientation for all new hires.

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18. **Interviews with some SMHP employees reflect frustration with the lack of employee recognition for meritorious work.**

DPM Chapter 19, Part I, Subpart 1900.2 states:

It is the policy of the District of Columbia government to recognize and reward employees whose performance is exemplary with monetary incentive awards and non-monetary incentive awards, including tangible and time off awards; and encourage District government agencies to only use incentive awards as a management tool to reward employee results and accomplishments supportive of and consistent with their agency's mission and operating goals.

In addition,

DPM Chapter. 19, Part I, Subpart 1900.3. provides:

An incentive award or a combination of categories of incentive awards may be given to an employee for a suggestion, an invention, a superior accomplishment, length of service, or other meritorious effort that contributes to the efficiency, economy or otherwise improves the operations of the District government.

In interviews with the team, some employees expressed frustration with the lack of recognition for excellent work. They stated that morale is low; management does not consistently provide meaningful recognition for excellent work and takes clinicians for granted; and duties and recognition are given to those who are friendly with management. Employees said that an Employee Recognition Committee, which provides certificates, was created by clinicians, rather than management, but that this committee does not provide adequate recognition. They also stated that it is noted by management when one does not do a good job, but there are no rewards when one excels at his or her job. Employees stated that they do not receive regular communication from DMH upper management and are not treated as important to the mission of the organization. They described feeling like "outsiders."

Recommendation:

That the D/DMH review employee recognition policies, practices, and procedures, and provide incentive awards for meritorious efforts.

Agree X Disagree _____

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DMH's Response, as Received:

SMHP instituted an employee recognition committee in FY 2006. Awards have been given, including travel to a national school mental health conference for the staff member who exhibited outstanding performance. In addition, a staff member sits on the SBMH Continuous Quality Improvement committee as an active member. This person is the Chair and makes specific recommendations regarding employee recognition activities.

19. The DMH main office lacks dedicated workspace and computers for SMHP clinicians.

Clinicians do not regularly work from the main office during the school year. However, they are required to report there when DCPS is on spring or winter break. Clinicians informed the team that there is the lack of dedicated workspace and computers for them at the DMH main office. Currently, there are 3 cubicles with 3 computers each for 42 clinicians. Clinicians indicated that it is challenging to complete assigned tasks and carry out their job duties efficiently and effectively because there is not enough workspace or computers to meet their needs.

Recommendation:

That the D/DMH explore the feasibility of increasing the levels of dedicated workspace and computers for SMHP employees at the DMH main office.

Agree **X** Disagree _____

DMH's Response, as Received:

DMH will issue 45+ lap tops to SMHP staff by November 2008. These systems will be capable of accessing any hardwired network application within DMH and can be used in mobile situations with wireless capability. The wireless capability allows the clinicians a great deal of flexibility in terms of work location and does not tie them unnecessarily to the DMH main office, which is currently facing a challenge in office space capacity. Clinicians can now be at their assigned schools over breaks as long as the school has adequate security and staffing during the breaks. Clinicians are at the main office less frequently, generally monthly. Nevertheless, DMH will assign as many dedicated work spaces as possible once the need is identified.

20. There are no documented policies and procedures for secure handling of clinical records removed from schools for clinical review.

At SMHP, clinicians currently undergo clinical chart reviews twice a year as a form of supervision. During clinical chart reviews, a supervisor randomly selects an individual clinical record for evaluation. The supervisor directs the clinician to take the clinical record from the school premises to the supervisor's location, either at the DMH main office or at another school

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where the supervisor may be located. Employees informed the team that DMH has no written policies and procedures for securely handling clinical records upon removal from a school premise.

A SMHP manager stated, “We have not developed a separate step-by-step written procedure for SMHP staff regarding what to do when removing a record for a chart review since this happens very rarely (chart reviews are conducted 2 times per year). Prior to the reviews the staff are given verbal instructions regarding the record review process and once notified which record has been selected have 24 hours to turn the record over to their clinical supervisor at DMH.”

The lack of written policies and procedures for safeguarding confidentiality when records are removed from the school premises jeopardizes the confidentiality of students. During transport, clinical records could be lost or misplaced. By conducting clinical record reviews on-site, employees and supervisors reduce the chance of losing or misplacing clinical records. Confidentiality of clinical records is essential when providing mental health services and must be maintained at all times.

Recommendations:

- (1) That the D/DMH create written policies and procedures for handling clinical records when they are removed from school premises.

Agree X Disagree _____

- (2) That the D/DMH consider requiring supervisors to conduct clinical records reviews on school premises.

Agree X Disagree _____

DMH’s Response, as Received:

DMH will develop these policies and procedures within the next 120 days. SMHP is planning to conduct all chart reviews at the respective schools rather than remove the files to the main building. In cases where there are security concerns, SMHP will work with the policy division at DMH to develop policies and procedures on the proper handling of clinical records.

**Findings and
Recommendations:
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The DCCSA, Psychoeducational Services (PES) programs provide mental health services to DCPS students at two special education centers and in DCPS schools in the community. Students under the care of PES programs have been diagnosed with emotional disturbances and/or developmental problems⁸¹ that keep them from functioning in a regular educational setting. When students are enrolled in a PES program, they receive an education from teachers experienced with this special population, an experienced staff of qualified practitioners, and a clinical staff that provides the mental health services they need. The two DCCSA special education centers that provide PES programs to DCPS students are the MTN formerly the Therapeutic Nursery Branch, and the JRC. MTN currently serves 10 students, 3 through 6 years of age, through two clinicians. The team requested information as to why the enrollment capacity was low at MTN. In response, DCPS, which is responsible for referrals to the program, provided no other information except that the enrollment capacity at MTN is 10.

JRC, formerly the Adolescent Day Treatment, provides psychoeducational services on site for 57 students between the ages of 6 and 12.⁸² In addition, 18 students between the ages of 12 and 18 receive PES services in their respective schools throughout the District of Columbia. According to PES, the ratio of clinicians to students served by JRC is 1 - 2 clinicians for approximately 15 students. PES management informed the team that clinicians carry a maximum caseload of 20 students; however, based on the team's review of information provided by management, some clinicians had slightly over 20 cases.

Ten employees serve PES students: one psychiatrist, one psychologist, two clinical social workers, one nurse, two mental health specialists who provide case management, one medical records/education technician employee, one staff assistant, and a supervisory social worker who oversees all clinicians. All 10 employees work with JRC students, and 3 of the 10 provide services to both JRC and MTN students. A medical records/education technician employee as well as one social worker and psychiatrist work at MTN once a week for 8 hours each.

Based on the team's review of DMH personnel documents, all PES employees and managers had qualifications and certifications that include advance degrees and a combined total of over 70 years of experience needed to perform their respective duties and responsibilities. In addition, background checks and health screenings for all PES employees are current. The clinicians receive training through the DMH Training Institute. Currently, the Institute offers training focused on DMH consumers and their family members. Over the past 3 years, PES had a high attrition rate among the staff that services DCPS, but management indicated that the current number of clinicians is adequate to provide services to MTN and JRC. During the 2005 to 2006 school year, PES had a staff of 20 who provided mental health services for 4 PES sites (Rose School, Paul Robeson School, JRC, and MTN). DCCSA no longer operates the Rose School or the Paul Robeson School.

The team received feedback from a DCPS manager about the quality of services at PES. The DCPS manager informed the team that the services provided by DMH at JRC have

⁸¹ Clinicians described developmental problems as developmental delays.

⁸² JRC has an enrollment capacity of 60 students.

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improved since the 2006-2007 school year, and JRC students have demonstrated improved behavior and an overall increase in student achievement. The manager also informed the team that the students work harder in school to succeed, referrals regarding discipline have decreased, and the teachers have expressed that they have better teacher-student relationships. In addition, through surveys, parents expressed to DCPS their satisfaction with their children's overall performance. With regard to MTN, a DCPS employee informed the team that although they would like clinicians to have more frequent contacts with MTN students, students are responding to the interventions and are making progress. At the time of this writing, the medical director provides bi-weekly and monthly supervision to the licensed clinicians and weekly supervision to the unlicensed clinicians. Each week the director conducts group supervision/team meetings to review and discuss clinical cases and recommendations. Two clinicians stated that the supervision from the director was beneficial and enabled them to provide better services to the students and their families. A third clinician stated that supervision is fine; however, the clinician did not think it is necessary.

Although the team had some observations not included in this report as findings, they were important enough to bring to the attention of DMH managers by mentioning them here. For example, the team discovered that a MTN student's clinical record was lost and not reported through the proper channels as required by MHRS certification standards DCCSA 700B, Section 4(a) (missing/lost records). The team also observed that "White-out" was used in at least one clinical record, which is not in compliance with MHRS certification standards DCCSA 700A, Section 5c (documentation in the clinical record).

21. Conditions at Moten Center (MC) are unsanitary and some areas are in need of repair.

Title 22A DCMR § 3410.28 states, in part, that each MHRS provider shall comply with the following requirements for facilities management:

- (c) All areas of the MHRS provider's service site(s) shall be kept clean and safe, and shall be appropriately equipped and furnished for the services delivered.
- ...
- (j) Each MHRS provider shall provide physical facilities for all service site(s) which are structurally sound and which meet all applicable federal and District laws and regulations for adequacy of construction, safety, sanitation and health.

The MTN is housed on the first floor in the Moten Center (MC), which is a DCPS school. MTN areas include an office/therapy room (number 116) and 2 classrooms (numbers 117 and 118); an office used by PES clinicians is also located in room 117. A short foyer that contains a washer, dryer, and small kitchen area, joins the classrooms. The restroom and water fountain for both classrooms are located in room 118. DCPS provides the custodial and maintenance services for the MTN. The pictures below provide a glimpse into the MTN classrooms.

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MTN Classroom 117



MTN Classroom 118

Although at first glance the classrooms appear to be clean and safe, during a walk-through of the MTN areas, the inspection team observed and took pictures of the following conditions:

1) Therapy Room 116

- ceiling panels were missing and pipes in the ceiling were exposed;
- a clinician stated that insects often get into the room and a wasp was observed flying around in the room during the team's visit; and
- debris was in the heater, below it, and on the floor.



Therapy Room 116
Ceiling Panels Missing



Therapy Room 116
Heater Under the Area of the Missing
Ceiling Panels

2) Classrooms 117 and 118

- ceiling panels were missing and pipes in the ceiling were exposed;

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- the ceiling surface in the restroom was peeling and one section was held in place with tape;
- the light in the restroom was not working and taped on one side; and
- the water fountain was not working and was used to store school supplies.



Classroom 117
Ceiling Panel Missing



Classroom 118
Ceiling Panels Missing and Pipes Exposed



Classroom 118
Restroom Ceiling Light Not Working and Section of Ceiling Held in Place with Tape



Classroom 118
Water Fountain Used to Store School Supplies

The team was informed that due to the condition of the ceiling in the restroom, DCPS instructed PES staff to prohibit the children from using the restroom located in the MTN that has child-size fixtures. Therefore, the teachers or clinicians escorted the children to the restrooms located on the opposite corridor of the first floor that the older students use. The team noted that

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the older students' restrooms did not have child-size fixtures, platforms, or sets of steps to assist MTN children who cannot comfortably use larger fixtures.

The team also observed that the girls' restroom did not have hand soap, and the only stall that had toilet paper (which was on the floor of the stall) was the handicap accessible stall. The door on that stall did not lock for privacy, and it appeared that the latch on the door was attached backwards. The team also noted that the boys' restroom did not have hand soap or toilet paper, and DCPS custodial staff informed the team that toilet paper was not in the restrooms because the students throw it around the restroom. Therefore, each teacher is provided with toilet paper and soap for the students.

The MTN uses the area located directly outside of the classrooms as the children's playground. The team observed that the area has a large hole in the pavement that poses a risk to playing children.



Toilet Paper on Floor of Handicap Accessible Stall



Area Used for MTN Playground

The conditions noted by the team may be hazardous or might contribute to health and hygiene problems for the children and employees who work in the observed areas. DCPS custodial staff at MC stated that "facilities management service requests" for all the areas in question were submitted to DCPS' main office located at 825 North Capitol Street as far back as 2005. However, DCPS was only able to produce a service request for classroom 118, which was for "water dripping from pipe," and provided a copy of the written request for service that included a line item request for repairs to restrooms on the first floor. However, the request did not provide information that would allow the team to determine which restrooms DCPS was referring to in the request. The team observed at least four restrooms on the first floor.

Recommendations:

- (1) That the D/DMH ensure that structural repairs to MTN are completed promptly.

Agree

MTN being renovated by DCPS

Disagree

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DMH's Response, as Received:

DCPS is in the process of renovating MTN and as explained in our earlier response, students and staff have been moved to Wilkerson Elementary School.

(2) That the D/DMH ensure that all MC and MTN students have toilet paper and hand soap for use in the restrooms.

Agree **X** Disagree _____

22. OA inspection report lacks clarity about conditions at JRC.

OA conducts inspections of DCCSA to identify program deficiencies, determine compliance with MHRS standards, and recertify the agency. The inspection is conducted every 2 years and includes a desk review of documents as well as site surveys. In addition, OA reviews clinical operations, unusual incidents, staff competency, quality improvement, and compliance and grievance processes.

OA officials provided the team with a copy of the “Corrective Measure Plan” (Plan) from its June 2007 inspection of DCCSA. Along with a summary of the noncompliance issues OA found during its inspection, the Plan also includes results from six inspected sites, and makes only one specific reference to JRC regarding non-compliance — that the ceiling in the nurse’s office “was broken.” The Plan lists other problems found during the inspection but does not link specific problems to JRC or other specific locations. Consequently, the team could not determine if any of these other problems were found at JRC. The team asked OA officials to provide any other issues of non-compliance found at JRC, but they were not responsive.

Because MTN was not referenced in the “Corrective Measure Plan,” the team asked OA officials for information regarding past inspections of MTN. They responded that OA had not conducted a facilities survey of MTN.

Recommendation:

That the D/DMH ensure that OA officials include MTN in its inspections, and that its “Corrective Measure Plan” reports clearly link the specific problems found to the corresponding location inspected.

Agree **X** Disagree _____

23. PES could not provide a report of program results.

The team requested aggregate data from PES regarding the quality of services and measurable goals for PES to determine if the program was assessing outcomes. As previously indicated, the National Association of Social Workers standards require that “achieving program

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improvements ... depends on reliable aggregate case data Evaluation and quality assurance ensure that intended outcomes of services are attained”⁸³

PES indicated that their measurable goals include decreasing students’ school suspensions by 75% and increasing each student’s grade by one level. When the team asked PES for the performance results with these goals, PES officials indicated that they did not have a report of results but that they measure the results by extracting information from the students’ clinical records and report cards. PES was unable to provide the team with any aggregate data on program performance. However, in an effort to provide the team with information about customer opinions of the PES program, PES furnished 17 completed stakeholder satisfaction surveys from parents. The team analyzed the survey results: a) 13 of 17 respondents indicated their satisfaction with the treatment team, including the case manager; b) 10 of the 13 were satisfied with the treatment team all of the time; c) the remaining 3 were satisfied most of the time.

Recommendation:

That the D/DMH ensure that PES gather aggregate data on program performance against which actual achievement of objectives can be compared.

Agree _____ **X** _____ Disagree _____

DMH’s Response, as Received:

The DCCSA has created a tool, which DCPS has approved to gather aggregate data on the program’s performance.

24. JRC clinical records are not properly controlled and maintained.

As a MHRS provider, DCCSA is responsible for the management, organization, and content of clinical records for the clients the agency treats and serves. PES program providers must ensure that the clinical records of the DCPS students treated in the program are secure, current, and properly filed. All PES program clients “have a clinical record which contains their Diagnostic/Assessments, ...⁸⁴ Individual Plan of Care⁸⁵ (IPC), ... all documentation of treatments and other services received, and appropriate legal documents.”⁸⁶ JRC clinical records are stored in the medical records room at 821 Howard Road, S.E., Washington, D.C. 20020.

⁸³NASW STANDARDS FOR SOCIAL WORK CASE MANAGEMENT STANDARD 8. (Case Mgmt. Standards Work Group 1992), available at http://www.socialworkers.org/practice/standards/sw_case_mgmt.asp (last visited Jan. 14, 2008).

⁸⁴ “Diagnostic/Assessment [is an] intensive clinical and functional evaluation of a consumer’s mental health condition that results in the issuance of a Diagnostic/Assessment report with recommendations for service delivery and may provide the basis for the development of the IRP/IPC.” 22A DCMR § 3415.1.

⁸⁵ “‘Individualized Plan of Care’ or ‘IPC’ – the individualized plan of care for children and youth, which is the result of the Diagnostic/Assessment. The IPC includes the consumer’s treatment goals, strengths, challenges, objectives, and interventions.” *Id.* § 3499.1.

⁸⁶ DMH Policy Number DCCSA 700B Section 2 date (May 23, 2007).

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a. PES does not maintain active clinical records in an organized manner.

The DCCSA Clinical Records Management Policy Number DCCSA 700B, Section 4(c) states, in part: “[t]he Medical Records Administrator is responsible for . . . [a]ssuring that information on enrolled consumers is immediately retrievable [as well as] [r]ecord [o]rganization and [f]ormat.”

The team observed that the clinical records in the medical records file room were disorganized. Files and folders were haphazardly stacked on a desk and not filed on either of the designated shelves in the room. The team was unable to easily retrieve some files. A well-organized filing system is a critical element of government accountability. An employee acknowledged that not all clinical records are filed in an organized manner and cited the lack of space due to the transfer of more students to the JRC as the cause for the current state of the medical records file room. The condition of the medical records file room increases the risk of misplaced confidential information and weakens program security and accountability.

b. JRC students’ purged or inactive clinical records are accessible to unauthorized persons.

Title 22A DCMR § 3410.16 states, in part:

Each MHRS provider shall establish and adhere to policies and procedures for clinical record documentation, security, and confidentiality of consumer and family information, clinical records retention, maintenance, purging and destruction, and for disclosure of consumer and family information, and informed consent that comply with applicable federal and District laws and regulations (Clinical Records policy). The Clinical Records policy shall:

- (a) Require the MHRS provider to maintain all clinical records in a secure and locked storage area

The team observed that JRC students’ purged or inactive clinical records were haphazardly placed in boxes and stored in an unattended locked storage room on the second floor of the JRC. Although the storage room door was locked, the room is used by persons not authorized to have access to clinical records. The team observed the students’ clinical records in plain view in the unattended room, providing opportunity for unauthorized persons to access or remove records. A PES manager informed the team that the room acts as a temporary storage place for clinical records until the records can be transported to a long-term storage location. However, the manager did not know when the records would be transported to long-term storage. Consequently, PES was inadequately safeguarding the confidential information of JRC students and their families from unauthorized persons.

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c. Consent to Treatment⁸⁷ forms were not found in some JRC students' clinical records.

The DCCSA Clinical Records Management Policy Number DCCSA 700B, Section 4(d) states, in part:

Contents. There will be a clinical record for each consumer who is currently involved in or has previously been involved in treatment within the CSA mental health system. The clinical record includes, at a minimum:

...

xiv. Appropriate consents for service

In addition, 22A DCMR § 3410.18 states, in part:

Each MHRS provider shall develop and maintain sufficient written clinical documentation to support each therapy, service, activity, or session for which billing is made which, at a minimum, consists of: ...

- (b) The date, duration, and actual time, a.m. or p.m. (beginning and ending), during which the services were rendered; ...
- (d) The setting in which the services were rendered

As part of his/her mental health services and treatment, a PES psychiatrist prescribes medication for some students to treat or manage conditions diagnosed by a PES clinician. The medication is administered to the student at home or in school by trained personnel, such as a nurse or psychiatrist. When the team reviewed the contents of a sample of clinical files, it did not find the "Consent to Treatment With Psychotropic Medications" forms in four of eight files for all of the dates on which records indicated that medication was administered. A PES clinician informed the team that original consent forms are signed documents and, therefore, should always be maintained in the clinical record, and that the team did not locate some of the consent forms because they were filed incorrectly. In addition to files with missing consent forms, the team observed clinical records that contained consent forms, but information concerning the duration, actual time, or setting in which the medications were administered to the students was not listed on the forms. Further, the actual duration (date on medication to date stopped) recorded on the consent form that the medications were administered did not always match what was written as the doctor's orders.⁸⁸ Lack of a well-organized and complete clinical record may hinder PES' ability to keep track of student progress, treatment, and interventions.

⁸⁷ DCCSA uses Consent to Treatment forms to inform consumers in writing about the mental health services and/or medication(s) that will be used for their treatment for which the consumer's signature (or that of a minor child's parent) is obtained to show acknowledgment and willingness to receive the prescribed treatment. See Consent to Treatment form included at Appendix 8.

⁸⁸ The prescribing physician's orders are given on a form in the clinical record that the psychiatrist or nurse uses to record activities related to administration of medications.

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Recommendations:

- (1) That the D/DMH review filing procedures and space requirements, take steps to expeditiously organize documents and records for accurate retrieval, and securely store records in a central location that is accessible only to authorized personnel.

Agree _____ **X** _____ Disagree _____

- (2) That the D/DMH ensure that an audit of the clinical records maintained by PES is conducted to determine if clinical records are properly maintained according to MHRS/DCCSA policies.

Agree _____ **X** _____ Disagree _____

- (3) That the D/DMH ensure that consent forms regarding the administration of medications are completed, filed, and include all information required by 22A DCMR Chapter 34.

Agree _____ **X** _____ Disagree _____

DMH's Response, as Received:

The DCCSA has taken the following action to ensure that it is in compliance with the MHRS regulations and DCCSA policies on clinical record maintenance and ensure that records can be easily retrieved:

- 1. Reorganized and color coded files to facilitate identification and retrieval.*
- 2. Relocated files for active consumers to a secure file room at 821 Howard Road, SE that only authorized staff have access to.*
- 3. Relocated files for persons discharged from the program to the second floor clinical record file room at 1125 Spring Road, NW.*
- 4. Established a file auditing schedule to determine whether files contain all necessary and current information, including appropriate consent forms for each student.*

25. PES has not consistently held therapy sessions with all JRC students.

DCCSA Policy Number 121, Section 2 (May 29, 2007) states, in part: “[a]ll consumers enrolled in the DCCSA who present a need for . . . Psychotherapy services will receive these services . . .” Furthermore, DCCSA Policy Number 121, Section 3(b) states, in part, that [c]onsumers will be referred to these services according to their needs identified in the [IPC] . . .”

Each student at JRC is required to have an Individualized Plan of Care (IPC) and an Individualized Education Plan (IEP) that mental health providers and educators maintain and which include the planned treatment and activities that the student will receive to help her or him achieve targeted goals and objectives. Members of PES, DCPS, and the parent or guardian of

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the student work together to develop the student's IPC. The IPC is maintained and used as a service tool by PES, and DCPS uses the IEP to help plan the activities that a teacher will use to help the student achieve academically. Both IEP and IPC service plans include psychological services.

A PES manager informed the team that, "The amount and type of services rendered to the student [are] driven by the IEP (DCPS- Individual[ized] Education Plan) and our Treatment Plans. Most of the children's IEPs call for one hour of psychological services per week [.] The majority of the students receive group services [and] we ensure that the child receives the services called for on their IEP. If they miss a session, for what ever reason, the psychological services will be made up during that week or another."

However, upon review of DCPS's lists of "Missed Therapy Sessions" for 2007, the team found that PES either missed or never held therapy sessions with at least 34 students. According to the majority of the lists, teachers were unsure of the dates of the missed sessions, a clinician never saw the student, or a clinician did not provide individual therapy. However, one list indicated that four sessions were missed on January 9, 2007, and another on January 16, 2007. Another list indicated that a student had not had therapy since December 4, 2006. A DCPS manager provided the lists to the team on June 15, 2007. DCPS employees could not identify missed therapy sessions for all students, but did note that in early December 2006 and January 2007, PES clinicians did not hold therapy sessions or conduct make-up sessions for all students.⁸⁹ A PES manager indicated that clinicians should document missed sessions in the clinical record, and reschedule appointments with students. Below is a list of concerns that were presented to the team by both PES and DCPS employees about PES therapy services:

- Teachers complained that clinicians do not hold regular therapy sessions with students.
- DCPS employees stated that students need more individual therapy sessions. However, DMH limits the number of units⁹⁰ that can be provided during the 90-day treatment period cycle. Each year PES revises a student's treatment plan every 90 days, which totals four treatment plans a year. In the treatment plan, the clinician provides 4 units of therapy per hour, which totals 1 hour per week, and 16 units per month.
- PES staff related that there are not enough units permitted in order for staff to provide individual therapy.
- PES staff stated that management directed clinicians to provide group therapy sessions instead of individual therapy sessions because DCCSA could make more

⁸⁹ Although the team requested data regarding the number of missed therapy sessions from PES, the information was not provided. Additionally, PES did not confirm that make-up sessions were conducted.

⁹⁰ "A unit is a measurement used by billing to show the amount of service that has been provided. For most services 15 minutes = one unit. In cases of the Diagnostic assessment one unit= three hours." E-mail from PES dated 8/7/07.

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money with groups. Individual therapy pays \$60 per hour, but group therapy pays \$60 per hour for each student in the group.

- PES employees claimed that PES needs more social workers and psychologists to increase therapy sessions and spend more time with clients.

Without receiving IPC and IEP recommended therapy services, PES and DCPS are not in compliance with the service plans developed for students, and students might not achieve their behavioral and educational goals.

Recommendation:

That the D/DMH ensure missed therapy sessions are made up.

Agree _____ **X** _____ Disagree _____

DMH's Response, as Received:

The program staff makes every effort to see each student and their families as scheduled. If sessions are missed they are rescheduled as soon as the scheduled session is missed.

26. PES and DCPS employees fear the size of the JRC site might not be adequate.

Title 22A DCME § 3410.28 states, in part:

Each MHRS provider shall comply with the following requirements for facilities management:

- (a) Each MHRS provider's service site(s) shall be located and designed to provide adequate and appropriate facilities for private, confidential individual and group counseling sessions in consumer interview rooms.
- (b) Each MHRS provider's service site(s) shall have appropriate space for group activities and educational programs.

Overall, the team found the JRC site to be clean, safe, and accommodating for students, DCPS, and PES employees alike. The following pictures provide a glimpse inside the JRC.

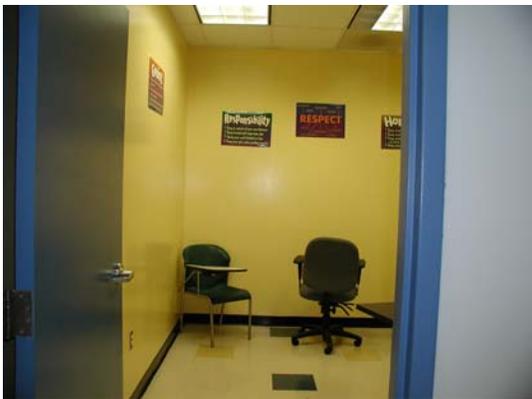
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JRC Student Computer Lab



JRC Library/Speech Therapy Room



JRC Timeout Room Where Students Visit to Reflect on Their Behavior



JRC Classroom



JRC Classroom

DCPS and PES employees reported to the team that although the building is well-kept and the environment is safe for the students as well as themselves, they did not think the site could adequately accommodate students when the school reaches the full enrollment capacity of 60 students and, thus, will not afford PES room to grow. For example, employees stated that the playground is too small, and the only games the children play are dodge ball and basketball. In addition, employees stated that as enrollment at JRC increases, the school will not have enough

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rooms for the children to take a time out after they have experienced a crisis or for other uses, and the cafeteria will be too small.



JRC Playground Area



Another View of JRC Playground Area



JRC Cafeteria

Recommendation:

That the D/DMH evaluate the possible need for a larger or additional site in anticipation of an increase in students.

Agree _____ **X** _____ Disagree _____

DMH's Response, as Received:

The DCCSA is reviewing how to utilize and rearrange the current space to accommodate the current number of children and the potential growth in numbers for the future.