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DISTRICT OF COLUMBIA

Receiver's Plan to Return Control of Mental Health Commission Is Evolving

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Contents

Abbreviations

ACT	assertive community treatment programs
CMHC	Community Mental Health Center
FIP	Final Implementation Plan
HCFA	Health Care Financing Administration
HST	Homeless Support Team
MCOTT	Mobile Community Outreach Treatment Team
MRO	Medicaid Rehabilitation Option
NAM	new antipsychotic medication
NASMHPD	National Association of State Mental Health Directors
SAMHSA	Substance Abuse and Mental Health Services Administration
SDP	Service Development Plan

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United States General Accounting Office
Washington, D.C. 20548

October 30, 2000

The Honorable Tom Davis
Chairman
The Honorable Eleanor Holmes Norton
Ranking Minority Member
Subcommittee on the District of Columbia
Committee on Government Reform
House of Representatives

In 1974, a class action suit filed on behalf of District of Columbia residents with mental illnesses argued that the District's Commission on Mental Health Services' (the commission) practice of treating the majority of the District's mental health patients by institutionalizing them in St. Elizabeths Hospital violated the federal statutory rights of individuals to appropriate treatment in alternative care facilities. In a ruling known as the Dixon Decree, the U.S. District Court for the District of Columbia determined that these individuals had a statutory right to community-based treatment by the least restrictive means.[1] In 1997, the court found that District efforts taken during the previous 22 years had failed to meet the Dixon Decree. Consequently, the judge appointed a receiver to take charge of the commission and carry out the court's orders. On April 1, 2000, the initial receiver was replaced by a transitional receiver who is required to develop a plan to return day-to-day operations of the commission to the District government in early 2001.

Recently, your Subcommittee raised concerns about the receivers' progress in creating a community-based mental health system, and the time frame for shifting control of the commission back to the District of Columbia. To address these concerns, you asked us to (1) describe the receivers' efforts to comply with the Dixon Decree; (2) compare the proposals advanced by the transitional receiver with other mental health systems; and (3) discuss the challenges facing the transitional receiver and the District in developing and implementing a community-based mental health system. To carry out this investigation, we interviewed District officials from the commission and the Office of the Receiver, the Mayor's office, and District agencies

[1]Persons covered under the Dixon Decree include adult residents of St. Elizabeths Hospital, elder residents of St. Elizabeths Hospital, adults and elders who pose a risk of rehospitalization, and mentally ill and homeless individuals. See Dixon v. Weinberger, 405 F. Supp. 974 (D.C.D.C. 1975).

with related programs; mental health and community services providers; client advocacy groups; and other organizations. We also reviewed the history of the Dixon case, documentation provided by the receiver, data from community-based mental health systems and national mental health organizations, and our past work on organizational reform. We conducted our work from July 2000 to September 2000 in accordance with generally accepted government auditing standards.

Results in Brief

Compliance with the Dixon Decree requires a fundamental shift in the District's approach to providing and financing mental health services. Essential to this change is the need for the commission to diminish its role as a direct care provider and assume the more traditional responsibilities of a mental health authority: a purchaser, regulator, and manager of mental health care. While both of the court-appointed receivers identified similar improvements needed to enhance the District's community-based mental health system, the second, or transitional, receiver has taken more decisive action to ensure their implementation. The transitional receiver has relied on strategies that are often modeled after methods used by other states or nationwide. For example, to increase federal funding for mental health services, he has pursued an approach used by more than 30 states to increase the number and scope of services reimbursable by Medicaid. In addition, he has undertaken initiatives based on national models for housing and supported services.

Despite the progress in developing a blueprint for a more accountable and integrated community-based mental health system, the transitional receiver's plan is still evolving, and many formidable implementation challenges remain to be met before—and after—the return of the commission to the District, scheduled to occur by April 1, 2001. By April, many of the receiver's initiatives will be in their earliest stages of implementation, or not yet implemented; thus, the long-term success of these initiatives will be largely unknown. Moreover, successfully integrating these initiatives into the District government will also require improvements in several management systems and processes, including financial and other information systems, personnel, procurement, and contracting. The extent to which the commission and the District separately or jointly address these processes and foster relationships between relevant District agencies will also affect the long-term success of the mental health system. Achieving compliance with the Dixon Decree will require that all of these initiatives—transformation to a community-

based system, modernization and improvements to District operations, and coordination across the District government—be undertaken.

Background

Dramatic changes in public mental health systems in the United States began in the 1960s and 1970s with the shift to community-based care. During this era, state mental hospitals as the primary providers of care and treatment were supplanted by a new emphasis on care in the community. Unfortunately, communities were often not prepared to offer housing, community treatment approaches, vocational opportunities, income supports, or a sense of community support to deinstitutionalized mental patients. Many persons with severe mental illness released from institutions found themselves in residential settings such as group homes or halfway houses, homeless, or in the welfare or criminal justice system. Consequently, advocates nationwide began urging the development of community support systems to address the social welfare needs of individuals with mental illness. Among other services, community support systems included treatments such as new medications and assertive community treatment programs (ACT) that offer a multidisciplinary team approach to treating individuals with serious mental illness.

States have modeled their mental health systems on a framework that centers on the assumption that serious mental illness is a long-term disorder that requires ongoing but flexible community-based treatment and support services, including affordable and stable housing. The continuing shift away from institutionalized care is evident in the decrease in state mental health agency expenditures for inpatient care, from 54 percent of all state mental health expenditures in 1990 to 41 percent in 1997. Between 1990 and 1999, 44 state mental hospitals were closed, reducing the number of state mental hospitals from 263 to 219, compared to 277 in 1970.[2] Further, the Supreme Court ruled in June 1999 that the failure of states to find community placements for individuals with disabilities, forcing them to remain in institutional settings, is a form of discrimination under the Americans with Disabilities Act.[3]

[2]See National Association of State Mental Health Program Directors (NASMHPD) Research Institute, State Profile Highlights: Closing and Reorganizing State Psychiatric Hospitals: 2000 (Alexandria, Va.: Aug. 10, 2000).

[3]This decision, in Olmstead v. L.C., requires states to develop comprehensive plans to end unnecessary institutionalization at a "reasonable pace."

In 1997, federal funds made up 25 percent of state mental health agency funding. Most of the federal money came from Medicaid, a joint federal-state program for low-income families and aged, blind, and disabled people that in 1998 spent about $177 billion to finance health coverage for 41 million individuals. States administer their own Medicaid programs within broad federal requirements and can elect to cover a range of optional populations and benefits. Because Medicaid is an entitlement program, states and the federal government are obligated to pay for all covered services provided to an eligible individual. Each state program's federal and state funding share is determined through a statutory matching formula based on a state's per-capita income in relationship to the national average, with the federal share ranging from 50 to 83 percent.[4] Medicaid covers both required health services (such as inpatient and outpatient services) and the optional services (such as rehabilitation) selected by the states. Reflecting its medical focus, Medicaid mental health services have traditionally been provided by physicians, including psychiatrists, who work at hospitals, clinics, and other organizations; and to a lesser extent by other practitioners, such as psychologists and psychiatric social workers. While Medicaid will cover services provided to individuals in facilities with 16 or fewer beds, the program specifically excludes coverage provided in larger psychiatric institutions (called institutions for mental disease) for adults aged 21 to 64.[5]

Other federal funding sources for public mental health programs account for 5 percent of all state mental health agency funding and include grants overseen by the Substance Abuse and Mental Health Services Administration (SAMHSA). Medicare also pays for limited mental health coverage for individuals over 65 and some individuals younger than 65 who are disabled. States also play an important role in the funding of mental health services, making up 69 percent of state mental health agency-controlled revenues in 1997.

Commission Background

The commission was created on October 1, 1987, when the federally owned and operated St. Elizabeths Hospital was merged into the District's mental health care system. The commission is the largest public provider of mental

[4]In the District of Columbia, the federal government contributes 70 cents of each Medicaid dollar spent.

[5]This limitation was imposed to avoid a shift in financial responsibility from state and local governments, who have traditionally funded these facilities, to the federal government.

health services in the District, treating approximately 10,000 clients annually. The commission must also treat mentally ill individuals who commit criminal offenses in the nation's capitol. The mental health system's focal point is St. Elizabeths Hospital, which provides a wide range of acute care services. The hospital currently has 628 beds divided among three types of inpatient clients: civil (365 beds), criminal (forensic) (243 beds), and children (20 beds).[6] The commission also provides services to individuals through a number of outpatient facilities, including two Community Mental Health Centers (CMHC) and five Mobile Community Outreach Treatment Teams (MCOTT). Other District agencies, such as the Departments of Health, Housing, and Corrections, Child and Family Services Agency, and D.C. public schools may also provide mental health and other types of services to persons with severe mental illness.

The commission's proposed operating budget for fiscal year 2001 is about $224 million, an increase of approximately $19 million over fiscal year 2000. Of the proposed fiscal year 2001 budget, 62 percent is to be funded with local dollars, and the remaining 38 percent from federal and other sources. Of the $85 million from federal and other sources, the federal share of Medicaid represents 70 percent—approximately $60 million—with Medicare making up most of the remainder.

According to the most recent national data available (fiscal year 1997), the District had the highest per-capita spending for mental health services in the nation at $337 per person. (The second- and third-highest states, New York and Connecticut, spent $113 and $99 per person, respectively.) Some experts attribute the District's relatively high mental health costs to a number of factors, including its unique city-state status, which requires the District to bear costs normally shared by two levels of government; the cost of maintaining St. Elizabeths campus—a national historic landmark—and its associated hospital-based, institutional services; the District's exclusively urban jurisdiction; and high rates of poverty, substance abuse, unemployment, and other indicators of poor mental health.

Under federal and subsequent District control, St. Elizabeths and the commission have been slow to follow the trend of deinstitutionalization

[6]Fewer than 700 individuals currently reside on the campus of St. Elizabeths; over 12,000 considered the campus home in the 1950s. Over the period of the Dixon Decree, the inpatient population at St. Elizabeths fell from 5,912 in 1974 to 765 in 1997, when the first receiver was appointed by the court.

that has occurred in the rest of the country. In 1974, a class action suit filed in the U.S. District Court for the District of Columbia on behalf of individuals with mental illnesses argued that the practice of treating the majority of the District's mental health patients by institutionalization in St. Elizabeths Hospital violated the statutory rights of individuals to appropriate care in alternative care facilities. The court ruled in favor of the plaintiffs in 1975 and continued to oversee District progress in developing a community-based mental health system. In 1997, finding that the District was no closer to a community-based mental health system than it had been 20 years earlier, the court appointed a receiver to bring the system into compliance with the Dixon Decree.[7] The court granted the receiver broad powers, including all powers previously exercised over the commission by the Commissioner, the Director of Human Services, and the Mayor. The receiver also has the authority to hire and fire personnel, negotiate or renew labor contracts, and establish the commission's budget. (App. I summarizes the major court actions related to the Dixon Decree.)

A second or transitional receiver appointed on April 1, 2000, was charged with developing a plan that the District can implement to achieve compliance with the Dixon Decree. Under the court order, the receiver is to transfer control of the commission to the District government between January 1 and April 1, 2001.[8] The involvement of the transitional receiver, however, does not end when control of the commission is transferred back to the District. As described in the March 6, 2000, consent order, the receiver will monitor the District's day-to-day operation of the commission for 6 months following the transfer of control. Within the first 60 days of this 6-month period, the involved parties will present the court with criteria for termination of the case decrees and orders and submit a schedule for

[7]Receivers are appointed to effect compliance with court orders. In this case, the court concluded that "only a receiver provides the Court with enough day to day authority to force compliance without causing confusion and ambiguity in the administration of the Commission." See Dixon v. Barry, 967 F. Supp. 535, 554 (D.C.D.C. 1997).

[8]At the time the transitional receiver was appointed, four other District agencies were also in court-ordered receivership: the Department of Corrections Central Detention Facility Medical Services, the Department of Public and Assisted Housing, the Child and Family Services Agency, and the juvenile justice system of the Department of Human Services. In December 1999, the Mayor appointed an individual to act as his administration's liaison with the commission and other District agencies under receivership. This individual collaborates with each of the receiverships to develop solutions for systemic issues and facilitate the return of the agency to District government.

monitoring the District's progress. After this 6-month period, in order to end the receivership, the transitional receiver must certify that the District has the capacity to implement and is implementing the plan. The transitional receiver will continue to monitor the District's performance and by October 30, 2001, will submit recommendations to the court regarding termination of the court orders.

Compliance Requires a Fundamental Shift in District Mental Health Operations

Compliance with the Dixon Decree requires a fundamental shift in how the District operates its mental health system, a shift that will not be complete when the receivership returns control of the commission to the District by April 1, 2001. Central to this change is the need for the commission to shift its role from a direct provider of mental health services to that of a mental health authority—a purchaser, regulator, and manager of mental health care. Although its provider role will ultimately diminish, the commission may continue to provide some level of acute care as well as fulfill its additional role of providing services to federally detained and committed individuals—services for which it has never been consistently reimbursed. Both receivers developed initiatives aimed at moving the District toward a community-based mental health system. The initial receiver introduced initiatives which sought to change the way the commission delivered services, but development and implementation were slow. The transitional receiver, who took over on April 1, 2000, has taken more decisive action, and has begun to implement a number of community-based initiatives.

Receiver and the District Face Daunting Task in Making Fundamental Changes to the Delivery of Mental Health Services

Meeting the requirements of the Dixon Decree requires a fundamental shift in the District's approach to mental health services. Currently, the commission is the largest single provider of mental health services in the District, employing close to 2,000 individuals in fiscal year 2000 and, according to commission officials, providing various services to about 10,000 individuals annually. The commission operates both St. Elizabeths Hospital and two community-based mental health centers—a dual responsibility assumed by only 11 states.[9]

In addition to providing inpatient services and direct services in the community, the commission is structured so that fiscal and clinical

[9]According to a 1996 survey conducted by NASMHPD, these 11 states are Connecticut, Delaware, Idaho, Louisiana, Missouri, Nevada, New York, North Dakota, Oklahoma, South Carolina, and Texas. Four states did not respond to the survey.

decisions remain largely centralized. The commission contracts with private providers for housing, employment, case management, and other community-based services. The commission has often used a "slot" system to allocate a defined number of clients to providers and has paid them a fixed rate per client. Under this system, providers do not compete to attract clients and are paid regardless of performance, client satisfaction, or the actual delivery of services. Unlike other community-based providers in the District, which may bill Medicaid directly for their services, commission-contracted service providers bill Medicaid through St. Elizabeths hospital.[10] In order for the commission to move away from its current role as a direct provider of services, community-based providers will need to have the capability to bill Medicaid for the services they provide.[11] Thus, as the commission restructures itself to become more of a mental health authority, these provider-like functions will diminish and be replaced by regulatory and oversight functions.

However, the commission is likely to retain some type of provider role in order to provide mental health services to federally detained and committed individuals.[12] When operation of the hospital was transferred from the federal to the District government in 1987, the Congress mandated that federal agencies referring persons for admission to St. Elizabeths be responsible for the cost of their care and treatment.[13] The commission bills several federal agencies for these costs on a monthly basis, including the U.S. Marshals Service for federal court detainees who are either not guilty by reason of insanity or not competent to stand trial, and the U.S. Secret Service for persons admitted to the hospital as a result of a threat of action against a federal official.

[10]Providers who do not have contracts with the commission or who operate their own mental health clinics may bill Medicaid separately for mental health services. In 1997, D.C. Medicaid spent over $40 million in direct payments to these providers.

[11]In addition, the federal Health Care Financing Administration (HCFA), which oversees the Medicaid program, published a final rule on disaffiliation that, according to consultants, will likely require providers who currently contract with the commission to be individually certified as Medicaid providers and to bill for services independently.

[12]According to a commission official, construction of a new hospital is expected to begin in October 2001. Although its size is uncertain, commission officials estimated that the new facility would house forensic clients and a limited number of longer-term care beds for other clients.

[13]24 USC 225g.

Payment from these federal agencies, however, has been problematic for some time. In 1993, the District filed suit against the United States for payment for these services, seeking reimbursement from the U.S. Marshals Service, the U.S. Secret Service, and other federal agencies.[14] Although the U.S. Marshals Service agreed to a settlement and has made payment in full—about $13 million—for services rendered, other agencies have made sporadic payments or none at all. The lawsuit is in active mediation at this time. For fiscal year 1999, the commission provided close to 13,000 inpatient days of care—or approximately 6 percent of inpatient days—to federal beneficiaries at a cost of about $5 million. With the exception of the U.S. Marshals Service and the U.S. Virgin Islands, no other entity made payments for services during fiscal year 1999.[15]

Both Receivers Focused on Expanding Community-Based Services

The movement from a hospital-based system to a community-based mental health approach not only reflects a change in treatment nationwide, it is a court-ordered requirement. Because the District had not made sufficient progress in implementing such a system, the court ordered the commission to be put into receivership 3 years ago. During this time, the two receivers developed overarching goals aimed at enhancing the District's community-based mental health system. For example, in identifying key priorities for the commission, both receivers cited the need to (1) develop initiatives to increase housing options,[16] (2) take better advantage of Medicaid to finance

[14]The lawsuit identified costs associated with providing services to 56 individuals referred by the U.S. Marshals Service and 147 individuals referred by the U.S. Secret Service. According to commission officials, the U.S. Secret Service continues to refer more individuals to St. Elizabeths Hospital than any other federal agency. In addition to requesting payment for individuals referred to St. Elizabeths by a federal agency, the lawsuit also includes charges that the federal government failed to complete or pay for repairs and renovations to the St. Elizabeths campus.

[15]Once a federal agency has referred individuals to St. Elizabeths, several circumstances limit the District's ability to return the individuals to their states for treatment. For example, according to District law, any public hospital, including St. Elizabeths, is required to accept any person who requires hospitalization if the hospital agrees there is a need for this level of care. In addition, once a person is a resident of St. Elizabeths, District law requires that the individual's original state must be willing to accept him or her prior to a transfer back to the state. According to commission officials, St. Elizabeths has executed compact agreements with many states to facilitate such a transfer; however, in practice, these agreements have been largely unsuccessful.

[16]According to commission staff, about 60 percent of patients currently in acute care units in St. Elizabeths could be moved into the community if stable alternative housing were available.

mental health services, (3) establish an administrative infrastructure independent of the District, and (4) assume regulatory and oversight responsibilities that are typically associated with a mental health authority. Despite the introduction of such initiatives, the first receiver made little progress in implementing these and other goals during his 2-year oversight of the commission.

In preparation for the return of the commission to the District by April 2001, the second, or transitional, receiver assumed control on April 1, 2000, and has taken more decisive action to implement a number of community-based initiatives. He also developed broad program goals that should enable the commission to finally comply with the court orders. For example, he has continued efforts to develop and implement a pilot initiative, called Carepoints, which transfers financial and clinical responsibilities for clients to community providers. He has also initiated discussions with local hospitals about the use of available beds for inpatient psychiatric care. Finally, he has made progress in channeling resources into development of an initiative intended to expand provider capacity and increase Medicaid funding for mental health services, termed the Medicaid Rehabilitation Option (MRO).[17] If successful, these initiatives will enhance the responsibility and accountability of community providers and decrease the commission's direct provider role. The commission then will be able to assume more of the responsibilities of a mental health authority, including the oversight and regulation of mental health services in the District.

Most Strategies Adopted by the Transitional Receiver Draw on Approaches Used by Other States

The transitional receiver has drawn on his own and other expert knowledge and experience to shape the development of a community-based mental health system in the District. Although he is still in the process of preparing his implementation plan, the transitional receiver has

[17]Under its rehabilitation option, the Medicaid program allows states to increase the scope and number of mental health services reimbursable by Medicaid.

produced several broad program goals.[18] These goals emphasize the development of infrastructure, capacity, and accountability; the strengthening of partnerships with providers, District agencies, and clients; and the development of a community-based system of care in which the commission acts as a mental health authority rather than as a provider. Strategies being implemented by the transitional receiver include methods actively employed across the nation or in specific states as well as those that are modeled on national trends but adapted to meet the needs of the District. In some cases the strategies adopted or furthered by the receiver are considered "best practices" by mental health experts and other organizations and are often consistent with national trends in mental health care (table 1).

Table 1: Comparison of District Strategies With Other Mental Health Systems

District strategy	Description	Similar models
MRO	• Federal approval is required for an MRO, which increases the number and scope of mental health services reimbursable by Medicaid. • The commission plans to implement the MRO no earlier than March 2001.[a]	• More than 30 states have used an MRO to cover mental health services.
Carepoints	• A single community provider is responsible for the full array of client services, including assessment, inpatient and outpatient services, and housing and employment assistance. • Target enrollment is 300 individuals; current enrollment is approximately 25.	• Carepoints incorporates aspects of programs in other jurisdictions, including Wisconsin; Baltimore, Maryland; and Long Beach, California.
New antipsychotic medications (NAM)	• NAMs offer significantly fewer and less severe side effects than older medications. • As of May 31, 2000, the commission budgeted funds for NAMs to cover 1,800 persons in the District. • The commission plans to increase the number of clients using NAMs to 3,100 or 83 percent of the eligible population by the end of fiscal year 2001.	• Mental health advocates state that access to the newer medications is important to the treatment of mental illness because they have significantly fewer and less-severe side effects than older medications. • Other states have also undertaken efforts to increase the use of NAMs in their mental health community, including Virginia and Texas.

[18] In summary, these goals seek to (1) create the capacity to function as a mental health authority separate from any provider role; (2) build a community-based system of care that maximizes principles of accessibility, recovery, and consumer choice; (3) create infrastructure to support the strategic direction; (4) create and reward a culture of accountability and performance improvement; and (5) forge strong partnerships among District agencies that participate in the provision of services to individuals with mental illness.

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District strategy	Description	Similar models
MCOTTs and Homeless Support Team (HST)	• These initiatives offer a comprehensive service delivery model that provides community-based treatment to people with severe and persistent mental illness. • Five MCOTTs and two HSTs provide community-based services to more than 500 individuals. • D.C. Medicaid has requested federal approval to allow Medicaid reimbursement for MCOTT services.	• ACT includes case management, initial and ongoing assessments, psychiatric services, and housing and employment assistance.[b] • At least 35 states have implemented programs based in part on ACT.
Home First II Program	• Provides rental subsidies and community living expenses, emphasizing client choice. • Current enrollment is approximately 310; capacity is 450.	• Supported housing models can be found across the country and in other nations. • Supported housing emphasizes elements such as regular housing, client choice, and appropriate supports, such as self-help; it strives for client independence and integration through community living and enhanced quality of life.
Section 8 Housing	• The commission currently can assist 90 clients with their housing rental costs.	• The federal Section 8 program, funded by the U.S. Department of Housing and Urban Development, assists low-income families, the elderly, and persons with disabilities with renting housing in the private sector. • Mental health advocates cite this program as a primary, mainstream resource for persons with mental and physical disabilities.
Cornerstone, Inc.	• Cornerstone is a nonprofit housing finance intermediary that provides grants and loans to providers to subsidize the purchase of housing for persons with mental illness. • Cornerstone has secured housing for 650. • The commission has awarded $9 million to Cornerstone since 1994.	• The National Technical Assistance Center for State Mental Health Planning recognizes partnerships between state mental health agencies and housing finance and development agencies as a best practice in housing.

[a]Some providers have indicated that the March 2001 implementation of an MRO is not likely.

[b]While the commission has developed these ACT-based programs, mental health advocates noted that programs in place do not have all the elements of a true ACT model.

In some cases, the strategies used by the transitional receiver are tailored specifically to the District's needs and resources. For example, three of the commission's MCOTTs have recently begun to operate group houses based on the Oxford House model for substance abuse. Started in 1975 in Silver Spring, Maryland, the Oxford House model is a democratically self-run independent group home that is typically used by persons with substance abuse problems. The District has adapted this model to serve persons with mental illness. Similar to the national model, residents are provided affordable housing and an opportunity to share in all aspects of house operations.

Finally, to create a mental health authority function separate and distinct from any provider role, the transitional receiver will rely on his experience as Commissioner of Mental Health in Indiana and Texas, and advice from

consultants and other state mental health authorities. While still developing the blueprint for this transformation, he has identified a number of functions that are essential to an authority, including quality improvement and accountability initiatives, such as certification of providers; and financial powers, such as budgeting and procurement. In addition, the transitional receiver intends to tailor national performance standards developed by SAMHSA to meet the District's needs.

Significant Challenges Remain to Comply With the Dixon Decree

Significant challenges remain as the transitional receiver finalizes the District's plans to achieve compliance with the Dixon Decree. The transitional receiver's strategic plan will span a period of 3 to 5 years; thus, at the time of the commission's return to the District, many strategies and initiatives will be only partially implemented or still in a planning stage. For example, plans to enhance Medicaid reimbursement through an MRO and to build a solid base of community providers will, at best, be in the early stages of implementation. The transitional receiver has taken steps to identify needed improvements in the commission's management processes, identifying personnel, procurement, and information systems as key areas that require attention. Finally, the extent to which the commission and the District foster relationships among District agencies relevant to the commission will also affect the long-term success of its mental health system. Achieving compliance with the Dixon Decree will require that all of these initiatives—transformation to a community-based system, modernization of and improvements to District operations, and coordination across District government agencies and services—be undertaken.

Despite Progress, the Success of the Receiver's Plan Will Be Uncertain

Most mental health and community providers, consumer advocacy groups, and other mental health organizations believe the transitional receiver is taking positive steps to build a solid foundation for implementation of the District's community-based mental health system. In general, those we interviewed expressed optimism regarding the efforts of the transitional receiver and noted his ability to be decisive and apply innovative approaches to revamping the District's mental health system. For example, both advocates and providers noted his quick appointment of new financial leadership in response to issues raised in an external management review.[19] Similarly, community organizations complimented his pursuit of the MRO to increase Medicaid funding for mental health services.

However, a few individuals expressed concern that the transitional receiver's longer-term focus may not reform community-based programs that are already under way and in need of improvement. For example, the commission stated in a July 2000 report that clients must receive services at least once every 90 days in order to remain active in community care. However, in the same report, the commission presented data that showed that three of the MCOTTs, which are expected to provide comprehensive services for individuals with severe and persistent mental illness, did not provide direct patient service to 35 of the approximately 310 enrolled clients over a 90-day period. A mental health provider asserts that this lack of contact with clients is unacceptable since MCOTTs currently have a waiting list to enroll.

Most District officials and others with whom we spoke acknowledge that the commission will be in the midst of many changes when control is transferred to the District, leaving the long-term success of the transitional receiver's initiatives unclear. In fact, although the transitional receiver's plan has not yet been finalized, its overarching goals are based on a 3- to 5-year implementation timeframe.

Thus, when the commission is returned to District government, several of the transitional receiver's key initiatives will still be in a planning stage or newly implemented. Of particular concern is the MRO, which forms the basis of funding community services and enhances provider autonomy and capability to actively participate in the commission's mental health system. While the current plan is that the MRO will be implemented in March 2001, certain providers have expressed doubt that this can be accomplished so quickly. The commission is still determining which services will be covered under the MRO as well as working with HCFA on implementation issues.[20] With some of the most basic administrative issues yet to be finalized, it is questionable whether community providers will be equipped to bill the Medicaid program—and hence receive reimbursement—by next spring. For example, some providers currently do not have the administrative infrastructure to do the billing and clinical recordkeeping that Medicaid requires.

[19]See Pricewaterhouse Coopers, Commission on Mental Health Services Management Audit (Apr. 13, 2000).

[20]HCFA, in the U.S. Department of Health and Human Services, has oversight responsibility for the Medicaid program.

Similarly, the initiative to expand the number of clients receiving NAMs is also longer-term in nature, with a substantial increase in access to new medications planned by 2001. Finally, certain housing initiatives will continue to evolve over the next several years. Some provider and advocacy organizations expressed concerns that these initiatives need to be farther along in the implementation prior to the transition so that efforts to comply with the Dixon Decree are ultimately successful.

Improvement in Management Processes and Working Relationships Is Essential

Compliance with the Dixon Decree will also hinge on the transitional receiver's and the District's ability to improve management processes and coordination among District agencies who share in the responsibility of providing necessary services to persons with mental illness. A recent external management audit identified several problem areas within the commission, including the lack of (1) a linkage between service delivery goals and the budget process; (2) appropriate training, education, and performance expectations for key management staff; and (3) a strategy to work with providers in building a strong community-based system.

In an effort to improve management processes, the transitional receiver has developed a work plan in response to the management audit and used his authority to create a new commission management structure, recruit qualified managers, and hire at least seven individuals with various types of expertise, including procurement, information systems, and financial management.[21] In addition to issues identified in the audit, the transitional receiver and District officials acknowledged the need to strengthen the commission's management information system, which, according to commission officials, cannot currently produce an accurate count of individuals participating in the District's mental health system.

In addition, District officials acknowledge that historical inefficiencies and problems in District government in areas such as accountability, technology, procurement, and working relationships must be resolved when the District reassumes control of the commission. Recognizing these problems, a District official and the transitional receiver told us that they

[21]Positions filled by the transitional receiver include the Chief Operating Officer, Chief Financial Officer, Director of the Office of Accountability, Director of Community Services Administration, Acting and Deputy Chief Information Officers, and Deputy for Procurement. The Chief Financial Officer has since resigned and will need to be replaced.

continue to discuss these systemic issues and to collaborate on solutions with each other and the plaintiffs' counsel.

Finally, collaboration among the various District agencies that also provide services to this population is critical for a smooth transition and for compliance with the court orders. The transitional receiver reported that he is meeting with all key District agency heads in an effort to create a structure that will allow the development of reformed and accountable systems. For example, he is working with the District's Medicaid agency to implement the MRO and with District child and youth agencies to develop a cross-agency plan for high-risk children in residential care. In addition, the District has worked with SAMHSA to obtain grant funding for a comprehensive system of care for District children with severe emotional disturbances who are at risk of residential placement outside of the District. Commission officials provided examples of other collaborative efforts with the Office of Early Childhood Development, Child and Family Services Agency, and the Deputy Mayor for Children, Youth and Families.

However, additional opportunities for improved collaboration exist. For example, efforts to improve coordination with the D.C. Jail are ongoing, but are not fully developed. Because incarcerated individuals at the D.C. Jail may have a history of mental illness,[22] the commission has a jail liaison that works to link persons being released to community-based services. In addition, the District has a Jail Diversion Task Force, which is charged with developing initiatives (such as police education) that may appropriately divert persons into the commission's mental health system. A successful diversion program could reduce the $2.3 million that the D.C. Jail annually spends to provide mental health services to incarcerated individuals. Coordination with housing agencies in the District could also be strengthened. While a certain level of coordination has occurred, such as joint efforts with the D.C. Housing Authority to apply for Section 8 housing certificates and meetings with high level officials, the commission and others with whom we spoke recognize that more coordination is needed.[23]

Recognizing that interagency coordination is critical, the District, in consultation with the transitional receiver, appointed a transition

[22]In her October 28, 1999, testimony before the U.S. District Court for the District of Columbia, the Director of Mental Health Services at the D.C. Jail said that 63 percent of detainees admitted to the D.C. Jail in June 1998 had some prior mental health history.

[23]See table 1 for a description of the Section 8 program.

coordinator to enhance and facilitate collaboration among the transitional receiver and the multiple District agencies that provide services to persons with mental illness. The transition coordinator will also oversee the transfer of the commission back to District government. In this regard, determining whether the commission will operate as an independent entity or operate as part of the District Department of Human Services remains a key unresolved issue.

Conclusions

For more than 25 years, the District's inability to care for some of its most vulnerable citizens has been the source of repeated judgments and court orders, ultimately resulting in the most recent receivership. Under the transitional receiver, a plan is emerging to provide individuals with severe mental illness with adequate housing, treatment, and care in a community-based setting. Plans are under way to move the District from its longstanding hospital-based system of care to a system that considers the needs of an individual within a framework of a community-based provider responsible for all aspects of mental health and supportive services needs.

However, important decisions must still be made and implementation of various initiatives will be far from complete when the transitional receiver is scheduled to return control of the commission to the District government. Plans to enhance Medicaid reimbursement and build a solid base of community providers—critical steps in creating a community-based mental health system—will be, at best, in the initial stages of implementation. In addition to the uncertain timing of these and other critical initiatives, reforms must be designed and overseen in a manner that ensures that progress will continue as the commission returns to the District. While strategies employed by the District and the transitional receiver draw on the experience and expertise of other mental health systems, they must be implemented within the District—a jurisdiction that acknowledges the need to improve its management processes and interagency coordination capabilities. Progress on these various fronts is critical to the District's ability to comply with the Dixon Decree and provide quality mental health services to eligible individuals.

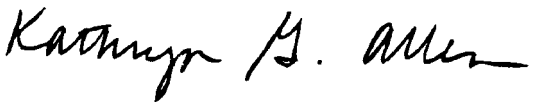
Agency Comments

We provided a draft of this report to the transitional receiver and to the District of Columbia's Special Counsel for Receiverships and Institutional Litigation in the Executive Office of the Mayor for their review and

comment. They concurred with our findings and also offered clarifying and technical comments, which we incorporated as appropriate.

We are sending copies of this report to Dennis R. Jones, Transitional Receiver for the Commission on Mental Health Services; and Grace M. Lopes, Special Counsel for Receiverships and Institutional Litigation for the Executive Office of the Mayor of the District of Columbia. We will also provide copies to others on request.

If you or your staffs have questions about this report, please contact me at (202) 512-7114. This report was prepared by Susan Anthony, Laura Sutton Elsberg, and Emily Gamble under the direction of Carolyn Yocom.



Kathryn G. Allen
Director, Health Care—Medicaid and Private Health Insurance Issues

Major Court Actions Related to District Compliance With the Dixon Decree

Date	Court action
1974	A class action lawsuit was filed in the U.S. District Court for the District of Columbia on behalf of District residents institutionalized at St. Elizabeths Hospital.
1975	The court determined that the District and the federal government had a joint responsibility to provide the plaintiffs "community-based treatment in the least restrictive means." This ruling is known as the Dixon Decree.
1980	To comply with the court order, the involved parties drafted a Final Implementation Plan (FIP) that generally required an assessment of plaintiff class members and periodic reports on progress in establishing a community-based system.
1984	The Congress enacted legislation that required the District to establish an integrated coordinated mental health system by October 1, 1991.[a] The Congress transferred sole responsibility of establishing the required local mental health services to the District.[b]
1992	The court determined no progress had been made to comply with the FIP. The involved parties therefore developed a second approach, known as the Service Development Plan (SDP).
1993	The court appointed a special master to oversee implementation of the SDP.[c]
1995	The court determined that the District was still unable to comply with the terms of the SDP. As a result, the involved parties negotiated a third plan, the Phase I agreement, whose goals the District met.
1996	The parties negotiated and began to implement Phase II, which was significantly broader in scope and required activities such as hiring personnel and developing a homeless service plan.
1996	The District admitted noncompliance with the Phase II plan, and the plaintiffs requested the appointment of a receiver.
1997	On September 10, the court appointed a receiver, ruling that "only a receiver provides the court with enough day to day authority to force compliance without causing confusion and ambiguity in the administration of the commission."
2000	On March 6, with agreement of all parties, a new receiver, referred to by the court as a transitional receiver, was appointed. He officially assumed his role on April 1, and is scheduled to return control of the commission to the District between January 1 and April 1, 2001.

[a]24 USC 225(b)(1) and (2).

[b]24 USC 225b(a)(1).

[c]The special master's powers included the ability to require compliance reports, make formal and informal recommendations to the parties, and mediate disputes.

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