A System of Care approach to improve identification and access to behavioral health services for families in the District of Columbia:

Collaborating to achieve timely access to high quality services

28th Annual Children's Mental Health Research & Policy Conference
March 24, 2015
Collaborating Partners
### Welcome and Overview

<table>
<thead>
<tr>
<th>Co-Chairs</th>
<th>DC Department of Behavioral Health</th>
<th>DC Child and Family Services Agency</th>
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</thead>
<tbody>
<tr>
<td>Barbara Bazron, PhD</td>
<td>Interim Director</td>
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<tr>
<td>Marie Morilus-Black, LICSW-R</td>
<td>Deputy Director of Office of Well Being</td>
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<tr>
<td><strong>Discussant</strong></td>
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<tr>
<td>Brian Pagkos, PhD, LMSW</td>
<td>Director of Research and Evaluation; Evaluator</td>
<td>CCNY, Inc.</td>
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<tr>
<td><strong>Presentation One</strong></td>
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<tr>
<td>Denise Dunbar, LCSW</td>
<td>Interim Director, Child and Youth Services Division</td>
<td>DC Department of Behavioral Health</td>
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<tr>
<td>Tricia Mills, MA</td>
<td>SOC Interagency Coordinator</td>
<td>DC Department of Behavioral Health</td>
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<tr>
<td>Debra Porchia-Usher, MA, ABD</td>
<td>Deputy Director, Community Partnerships</td>
<td>DC Child and Family Services Agency</td>
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<td><strong>Presentation Two</strong></td>
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<tr>
<td>Sarah Barclay Hoffman, MPP</td>
<td>Project Coordinator, Early Childhood Mental Health</td>
<td>DC Collaborative for Mental Health in Pediatric Primary Care, Children’s National Health System</td>
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<tr>
<td>Melissa Affronti, PhD, LMSW</td>
<td>Sr. Consultant; Evaluator</td>
<td>CCSI, Inc.</td>
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<tr>
<td><strong>Presentation Three</strong></td>
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<tr>
<td>Barbara Parks, MSSA</td>
<td>Clinical Program Administrator</td>
<td>DC Department of Behavioral Health</td>
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<tr>
<td>Meghan Sullivan, PsyD</td>
<td>Program Evaluator</td>
<td>DC Department of Behavioral Health</td>
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</tbody>
</table>
Washington, D.C.
Quick Facts 2013

Facts about the Nations Capital:

- Total Population in DC: 646,449
- Average Income: $66,326
  - Significant income inequality (3rd in the country)
- Race & Ethnicity:
  - Percentage of White 43.4%/ Percentage of African American: 49.5%
  - Hispanic or Latino 10.1% /Asian alone 3.9%
- Percentage of people in poverty: 18.8%
- 83% of Children under 22 y/o are enrolled in Medicaid
- Number of children under 18 years of age: 22.9%
  - Percentage of children in poverty = 29.3%
  - 51% OF CHILDREN under 18 LIVE IN DISTRESSED AREAS of the District
  - (Ward 5, 7 and 8)
  - Median Income in Distress Areas: $27,900

Poverty rate in distress areas: 39% as compare to 18.8% overall
APPROACH-the “ABCs” of The District’s SOC

- **Access and Availability**: Integrate the service initiatives across the District by building a “No Wrong Door” Model that increases access and availability of services to children, youth and families.

- **Build**: Expand the array of Evidence Based Practices (EBPs) and the number of clinicians trained to offer them; build on successes of efforts currently being implemented.

- **Communicate**: Partner with family and youth in leadership activities to shape SOC policy and practice, disseminate SOC values and practices, and decrease the stigma related to mental health services through provider training and community education.

- **Sustain**: SOC through the reinvestment of savings and maximization of Medicaid and other funding streams such as managed care & local dollars.
“No Wrong Door”

- A public approach to behavioral health services
- Children, youth and families will be able to access the full array of services and programs no matter where enter– DMH, DOH, CFSA, DYRS, DCPS, DHS, the Community Collaboratives, etc.
- All entry points collect common intake information and ask behavioral health screening questions
- All entry points utilize common screening instruments and common assessment
- Intake staff at all child/youth serving agencies will be cross trained on what mental health services are available and how to access them
Using a Co-located Staff Model
To Increase Identification and Access for Youth in Child Welfare

Denise Dunbar, MSW, LCSW
District of Columbia Department of Behavioral Health
Co-location Formula

Behavioral Health + Child Welfare → Co-located Team

Using a Co-located Staff Model to Increase Access and Identification
Co-location Evolution

2005
Access Coordinator

2008
Launched Screening

2013
Implementation of Trauma Grant

Linkage, Enrollment & Auth

Screening & Consultation

Policy Changes

Data Sharing, Improved Access

Using a Co-located Staff Model to Increase Access and Identification
Spectrum of Integration

- Blended Funding
- Memorandum of Understanding
- Co-location of Staff
- Screening Process
- Choice Provider Network
- Children’s Mobile Crisis
- Evidence-Based Practice Initiative
- Cross-match Data Sharing
Co-location Model

Using a Co-Located Staff Model to Increase Access and Identification
Co-located Team & Functions

2 Clinicians
- Behavioral Health Screening
- RED Team Participation
- Clinical Consultation

1 Clinician
- Clinical Consultation
- RED Team Participation
- Liaison with Behavioral Health Provider

Trauma Coordinator
- Oversee Trauma Grant Activities
- Liaison between CFSA and DBH

Access Coordinator
- Linkage, Enrollment, Service Authorization
- Data Tracking

Using a Co-located Staff Model to Increase Access and Identification
Screening Process

Removal Occurs
• Team Notified same time as Child Welfare staff
• Check System for existing enrollment
• Provider Match Protocol
• Provider invited to RED team meeting

Removal RED Team Meeting w/in 24 hours
• Team Member attends Review Evaluate Direct (RED) multidisciplinary team meeting

Family Team Meeting w/in 72
• Family
• Foster Parent
• CPS
• Provider
• Family engagement begins
• First appointment scheduled

Medical and BH Screening
• Ages & Stages Questionnaire – SE (ASQ-SE)
• Strengths Difficulty Questionnaire (SDQ)
• Global Appraisal of Individual Needs – GAIN-SS

Provider staff
• CFSA worker
• Joint Treatment Planning Process

30-Day RED Team
Evolution of The Screening Measures Used

- **2008**: Mental Status Examination (MSE)
- **2009**: - Trauma Symptom Checklist (TSCC)
  - Trauma Symptom Checklist for Young Children (TSCYC)
  - Infant Toddler Social Emotional Assessment (ITSEA)
- **2013**: - UCLA PTSD Reactive Index
- **2014**: - Ages and Stages Questionnaire (ASQ-SE)
  - Strengths Difficulties Questionnaire (SDQ)
  - Global Appraisal of Individual Needs (GAIN-SS)

Using a Co-Located Staff Model to Increase Access and Identification
Child Welfare Removals and Mental Health Screening

Using a Co-Located Staff Model to Increase Access and Identification
Mental Health Screening Data - Results

Screenings of Youth in Child Welfare by Co-located Mental Health Clinicians

<table>
<thead>
<tr>
<th>Year</th>
<th># Eligible</th>
<th># Screened</th>
<th>% Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>586</td>
<td>204</td>
<td>35%</td>
</tr>
<tr>
<td>2011</td>
<td>380</td>
<td>209</td>
<td>56%</td>
</tr>
<tr>
<td>2012</td>
<td>348</td>
<td>166</td>
<td>49%</td>
</tr>
<tr>
<td>2013</td>
<td>301</td>
<td>210</td>
<td>70%</td>
</tr>
<tr>
<td>2014</td>
<td>271</td>
<td>233</td>
<td>86%</td>
</tr>
</tbody>
</table>

Using a Co-Located Staff Model to Increase Access and Identification

Behavioral Health Screening Data
Lessons Learned

- The establishment of regular meetings between DBH, Child Welfare and BH Providers with decision making ability supports expedited system change.

- Memorializing business processes for Staff integration, Screening and data collection protocols supports continuous quality improvement.

- Development of a standard Provider match protocol supports uniform provider assignments based on an established set of criteria.

- BH Providers participation in teaming processes improved information sharing and increased provider-social worker relationship early in the process.

- Early Provider involvement also decreased delays in service initiation and no shows.

- Providers participation in the Family Team meeting (FTM) process provides an opportunity to begin the engagement process with bio-parents, family members and foster parents.

- Having the Co-located team completing enrollment and service authorization immediately after screening, decreased the length of time from screening to linkage.
Connecting the Work

• Safe and Stable Families Initiative
  ➢ Expansion of staff co-location to the Community “Hubs”
  ➢ 4 Behavioral Health Coordinators in five community “Hubs”

• Automation and Integration of Behavioral Health Screening Measures
Universal Intake Form Pilot
Collaborating with non-mental health organizations to screen all youth at intake for early identification of mental health needs and linkages

Tricia Mills, MA
District of Columbia Department of Behavioral Health
Universal Intake Form Pilot

Original intent of the Access Project:
Collaborate with non-mental health organizations to screen all youth at intake for early identification of mental health needs and linkages

Three organizations were involved in the pilot from November 2013 through February 2014:
1. Georgia Avenue Collaborative
2. Mary’s Center
3. DC General, originally Virginia Williams

Four indicators used to review success of the form:
1. Knowledge/Readiness of Use of Form: Training surveys
2. Use of the Form in Practice: Tracking of form completion and referrals
3. Barriers/Accelerators to Using the Form: Focus groups
4. Presentation to Access group: Included Providers and Caregivers
## Summary of Results from Training

<table>
<thead>
<tr>
<th>Description</th>
<th>Number that Scored 4 or 5 out of 5 (highest)</th>
</tr>
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<tbody>
<tr>
<td>Number that were likely to use the UIF in their work with children and families</td>
<td>20 out of 20 (100%)</td>
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<tr>
<td>Number that felt prepared to use the form; engage families to use the form; and make referrals from form</td>
<td>20 out of 20 (100%)</td>
</tr>
<tr>
<td>Number that would recommend other organizations like theirs to implement the form to improve access</td>
<td>16 out of 20 (80%)</td>
</tr>
<tr>
<td>Number that believed the form would increase children’s access to mental health services</td>
<td>17 out of 20 (85%)</td>
</tr>
<tr>
<td>Number that believed the form would help identify a mental health issue with a youth</td>
<td>20 out of 20 (100%)</td>
</tr>
<tr>
<td>Number that believed the form would lead to an increase in referrals to children’s mental health services</td>
<td>20 out of 20 (100%)</td>
</tr>
</tbody>
</table>

Results of the Training were **Positive**, Suggesting High Levels of **Readiness** and **Likelihood** to **Implement** as well as **Perceived Success** of Using the Form.

Using a Co-Located Staff Model to Increase Access and Identification
Results of Using the Form in Practice

There were a total of 105 forms completed for youth across the three sites.

A Mental Health issue was identified for 26 (25%) of the 105 youth screened.

A Referral was made for 12 (46%) of the 26 youth identified with a MH issue.

A Referral was not made for 14 (54%) of the 26 youth identified with a MH issue.

An appointment was made for 7 (58%) out of the 12 youth with a referral.

An appointment was not made for 5 (42%) out of the 12 youth with a referral.

The Evaluation Team Traced the Usage of the Form Across the Three Sites using a Process Data Collection Form.
A Referral was Not Made for 14 (54%) of the 26 Youth Identified with a MH Issue

An Appointment was Not Made for 5 (42%) out of the 12 with Referral

Top Reasons why a Referral Was Not Made

<table>
<thead>
<tr>
<th>Reason</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow up needed or waiting for more info from caregiver (DBH plans follow up)</td>
<td>6</td>
</tr>
<tr>
<td>Already receiving services</td>
<td>5</td>
</tr>
<tr>
<td>Refused or caregiver did not perceive as issue that needed to be addressed</td>
<td>3</td>
</tr>
</tbody>
</table>

Top Reasons why an Appointment was not Made

<table>
<thead>
<tr>
<th>Reason</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting for call back from agency/provider referred to</td>
<td>2</td>
</tr>
<tr>
<td>Unknown status (missing data)</td>
<td>3</td>
</tr>
</tbody>
</table>
Lessons Learned: Universal Intake Form Pilot

1. A significant effort was made by the DC Gateway Access workgroup to train, mentor and prepare community providers in implementing the screening tool in practice and making decisions from the information on the form.

2. This effort was successful in increasing the capacity for providers to screen for mental health needs of a family unit leading to an increase in identification.

3. Implementation was more successful when the DBH System of Care Interagency Coordinator was able to spend a considerable amount of time with provider teams, learning their practice workflow to effectively integrate the tool into practice.

4. Challenges arose using a data collection tool that was point-in-time as many of the referrals were in an unknown or follow up stage.
Next Steps

• Improvement of Tools and Training based on feedback and evaluation
  • Finalize Universal Intake Form
  • Enhance Training toolkit

• Expansion of Project
  • Expand to all Healthy Families Thriving Communities sites
  • Hiring Co-located DBH staff to serve as consultants to support the work
  • Expand to DHS Shelter and Hotel Programs

• Sustainability
  • Non-mental health providers as co-trainers of toolkit
  • Use Family/Staff co-trainer model
Increasing Access by Narrowing the Front Door
Implementation of community hubs and unified case planning

Debra Porchia-Usher, MA, ABD
District of Columbia Child and Family Services Agency
Narrowing the Front Door: Community “Hubs”

Development of Collaboratives as Community “Hubs”

• Identified sub-contractors to provide evidence-based practices within the communities

• Co-located Behavioral Health Specialists and Infant & Maternal Health Specialists

• Capacity Building (Mini) Grants
Infant and Maternal Health Specialists

- Started September 2014
  - One nurse identified for each Ward 7 & Ward 8
- IMHS are responsible for:
  - providing comprehensive nursing care and case management to young mothers with at least one child under the age of 6
  - assessing their needs,
  - developing a care plan,
  - providing direct care or referring the mother to other community based services based on the need and
  - coordinating, linking and following-up on the health care needs and
  - discharge planning through referrals to the Department of Health or other appropriate District agencies, community resources and other health care provider(s).

- Will be co-located at all five of the Health Families/Thriving Communities Collaboratives.
Narrowing the Front Door: Community “Hubs”

Mental Health Specialists

• Started September 2014

• MHS are responsible for:
  – assessing families for co-occurring disorders,
  – referring them for services based on the findings of the assessment
  – and assisting the families with accessing services through the Department of Behavioral Health.

• Will be co-located at Far Southeast, East River, Edgewood/Brookland and Columbia Heights/Shaw Collaboratives.
  – The Specialist at CH/SFSC will cover service areas for both CH/SFSC and GAFSC.
Narrowing the Front Door: Community “Hubs”

Mental Health Specialists

<table>
<thead>
<tr>
<th>Collaborative</th>
<th>Total # of Referrals</th>
<th># Referred by CFSA</th>
<th># Referred by the Collaborative</th>
<th># of Parents Referred</th>
<th># of Children Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSFSC</td>
<td>84</td>
<td>42</td>
<td>42</td>
<td>38</td>
<td>46</td>
</tr>
<tr>
<td>ERFSC</td>
<td>71</td>
<td>15</td>
<td>56</td>
<td>59</td>
<td>12</td>
</tr>
<tr>
<td>CSC/GA</td>
<td>65</td>
<td>32</td>
<td>33</td>
<td>27</td>
<td>38</td>
</tr>
<tr>
<td>EBFSC</td>
<td>41</td>
<td>16</td>
<td>25</td>
<td>29</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>261</td>
<td>105</td>
<td>156</td>
<td>153</td>
<td>108</td>
</tr>
</tbody>
</table>

Co-located Behavioral Health Specialists

Below is a breakdown of the requests for services\[^2]\: 

- Consultation – 92%
- Global Appraisal of Needs Screening (GAINS) – 9%
- Strengths and Difficulties Questionnaire (SDQ) – 6%

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[^1]: This information is as of December 31, 2014. The DBH Specialist is working to finalize the information for January 2014.
[^2]: Totals do not equal 100% as some referrals included more than one service area.
Unified Case Planning

• What have we learned from increasing access?

• How do we move forward to address what we have learned?

• What has been done by partnership to change the way we work together → better outcomes for children and families.
Using a Co-Located Staff Model to Increase Access and Identification
Cross Systems Unified Case Planning (CSUP)

Unified Case Planning is a multiagency initiative led by the Department of Human Services and Child and Family Services. Families involved with multiple social service agencies will have:

1. **One Case Plan:** Each family will have an identified lead agency to coordinate other service systems they are involved with. Families will have one case plan informed by each area expertise (i.e. employment, housing, child protective services, mental health, etc...).

2. **Real Time Information Sharing:** Social Service agency staff will have a means to pull information from their current data system to share across agencies, guiding the unified plan for families (e.g. access to the direct service professional contact information).

3. **Teaming:** Social Service agency staff will have clearly defined roles, including a lead agency provider, with a lead case coordinator, who will ensure that services are coordinated. Coordination efforts will include multi-agency communication plans, teaming meetings, alerts, and case plan development.

4. **Interagency Collocation:** Phase I of Unified Case Planning is Collocation. Currently DHS, DBH and CFSA have staff collocated in target community locations, including Virginia Williams Family Resource Center, DC General, Child and Family Services Agencies and Healthy Families Thriving Communities Collaboratives. This model may have implications for multiple sites to host collocated staff from multiple social service agencies.
Families can be understood as having different levels of need depending on level of system involvement and or other risk factors.

**Level I** families are involved with only one system (or agency) and are not generally a target population for CSUCP
- The majority of families involved with DHS or CFSA fall within this category
- Families who require social service support, but the family is not involved with multiple service agencies (e.g. DBH, CFSA and DHS)

**Level II** families are those involved with two systems, such as DHS and CFSA, but do not require CSUCP
- Families who require social service support will benefit from managed communication or linked case plan type of coordinated case planning but do not require intensive case coordination

**Level III** families are involved with three or more systems, or otherwise determined to meet certain risk criteria or thresholds
- Families will have one case plan that will be informed by all involved systems based on predetermined criteria*
- Agencies will share the data to support the unified case plan through interagency cross match reports, universal intakes, alerts and potentially from some level of shared case notes
- The DC Access System will provide automated real-time support

*Criteria:
Data analysis will inform how we prioritize families prior for participation to the April launch:
- TANF recipient and involved with CFSA and DBH
- Homeless or at risk of becoming homeless and involved with CFSA and/or DBH
- Receive support from DDA involved with CFSA and/or Homeless system
- Receive services from DBH, who are non-compliant and involved with multiple systems
Mental Health Integration in Pediatric Primary Care: A Collaborative and Local Approach

DC Collaborative for Mental Health in Pediatric Primary Care

Sarah Barclay Hoffman
Project Coordinator
DC Collaborative for Mental Health in Pediatric Primary Care
Children’s National Health System

Melissa Affronti, PhD, LMSW
Evaluator
Coordinated Care Services, Inc. (CCSI), Rochester, NY
DC Collaborative for Mental Health in Pediatric Primary Care

- **Aim:** To improve the integration of mental health in pediatric primary care for children and adolescents in DC.

- **Engage in initiatives that strive to be:**
  - Collaborative & interdisciplinary
  - Culturally competent
  - Family-focused
  - Developmentally-sensitive
    (focus on early childhood)
Why Primary Care?

The “Primary Care Advantage:”

- Regular (frequent) contact with families
- Family-provider relationship (longitudinal, trusting)
- Opportunity for early identification/prevention
DC Collaborative for Mental Health in Pediatric Primary Care

**Disciplines represented:**
- Advocacy
- Education
- Pediatrics
- Policy
- Psychiatry
- Psychology
- Social Work

**Funding Sources:**
- DC Department of Behavioral Health
- DC Department of Health Title V Block Grant Program
- Howard and Geraldine Polinger Family Foundation
- Dr. Alan B. Zients Pediatric Initiative for Mental Health

- American Academy of Pediatrics (DC Chapter)
- Children’s National Health System
- Children’s Law Center
- DC Department of Behavioral Health
- DC Department of Health
- DC Department of Health Care Finance
- Georgetown University

(Partial Listing)
- DC Behavioral Health Association
- DC Public Schools
- George Washington University
- Health Services for Children with Special Needs (MCO)
- Howard University
- Mary’s Center
- Strong Start DC
- Total Family Care Coalition
- Unity Health Care
- Zero to Three
Annual, Universal Mental Health Screening

• **Goal:** Increase early identification of problems (improve outcomes).

• **Rationale:**
  o Pediatricians will miss a lot of problems without use of a tool¹
  o Many parents will not raise concerns on their own²
  o Problems can be reliably identified early and brief screening in early childhood predicts outcomes in elementary school.³

• **Process:**
  o Parent/youth completes brief questionnaire at annual visit.
  o Scoring, discussion and referrals (as appropriate) by provider.
  o Screening is NOT diagnostic.
Mental Health Screening in DC

- **July 2013:** New DC Medicaid Managed Care Organization (MCO) contracts state primary care providers must use approved screening tool annually (all ages).

- **Approved tools:**
  - 0-12 months: Edinburgh Postnatal Depression Scale (EPDS)
  - 3-66 months: Ages and Stages Questionnaire: Social-Emotional (ASQ:SE)
  - 2-21 years: Strengths and Difficulties Questionnaire (SDQ)
  - 18-21 years: Patient Health Questionnaire-9 (PHQ-9)
  - Received feedback from Community Advisory Board, including family representatives

- **October 2014:** DHCF transmittal to EPSDT providers re: new rates/billing requirements for well child visits, and changes to EPSDT billing manual, including behavioral health screening.
Concerns are Raised…
Now What?

• In DC, most PCPs feel unable to usually meet the needs of children with mental health problems.\(^4\)

• Lack of training, confidence, and knowledge = barriers to identification and management of mental health issues.\(^5\)

• In DC, ~4 out of 5 providers said that their comfort level and knowledge in addressing mental health was worse for children ≤ 5 years than for older children.\(^4\)
Quality Improvement Learning Collaborative

Model for multi-practice learning & measurable improvement

- **Who?** Pediatric practices (16) and providers (~150) (both Learning Collaborative rounds). Practices cover approximately 75% of children on Medicaid.

- **What?**
  - Learning sessions (1 hour webinars)
  - Monthly team leader conference calls
  - Monthly practice team meetings
  - Monthly chart audits to measure progress
  - PDSA cycles to facilitate change
  - Technical assistance from QI and MH coaches
Quality Improvement Learning Collaborative

- **Where?** In provider offices & on the web
- **When?** February – October 2014 (Round 1) & January-June 2015 (Round 2)
- **Why?** Receive support & MOC Credit (ABP, ABFM)
QI Learning Collaborative: Aims

Providers will increase %:

• annual well child visits where an approved screening tool is administered

• mental health screenings that have scored documentation of results

• "positive" mental health screens with an appropriate follow-up plan documented (addressed by provider and/or referred to care)

• where administration of a screening tool is appropriately coded and/or billed

• appropriately using TS modifier for positive screens

• practice readiness to perform annual mental health screenings for culturally diverse patients
Results from Quality Improvement Learning Collaborative Round 1

• **Improvements in practices readiness** to address mental health issues

• **Increased provider confidence** in their ability to perform mental health screening

• 83% of participating providers reported that they will change their care of patients with mental health problems as a result of participating in the learning collaborative

• 100% of providers reported that, due to the project, they felt somewhat or very prepared to identify mental health issues

• Chart reviews indicated improvements in practices:
  • Completing mental health screening (from 11% to 75%)
  • Documenting results (from 26% to 88%)
  • Billing for screening (from 26% to 71%)
Results from Quality Improvement Learning Collaborative Round 1

**MOC Reported Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>Sep/Oct</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Practice Response (Percent)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>MH screening completed?</td>
<td>11%</td>
<td>43%</td>
<td>53%</td>
<td>52%</td>
<td>62%</td>
<td>75%</td>
<td>60%</td>
</tr>
<tr>
<td>Screening scored and documented</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Project Measures</td>
<td>23%</td>
<td>26%</td>
<td>20%</td>
<td>28%</td>
<td>43%</td>
<td>88%</td>
<td>36%</td>
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<tr>
<td>Appropriate Screening tool used</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Billed for MH screening</td>
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</tbody>
</table>

**Overall Response**

- 67%
Child and Adolescent Mental Health Resource Guide
(birth-20 years)

The DC Collaborative for Mental Health in Pediatric Primary Care created the Child & Adolescent Mental Health Resource Guide for use by pediatric primary care providers in the Washington, DC area. This guide aims to provide a comprehensive listing of community behavioral health resources for children and adolescents in the District of Columbia.

To access the full guide, click here. Please check back often for updates.

To access specific sections of the guide, please click below:

- Overview of Guide and Referral Paths
- Quick Reference Sheet for Referrals
- Crisis Services/Inpatient Hospital Units
- Early Childhood (Perinatal - 5 yrs)
DC MAP
(Mental Health Access in Pediatrics)

• **Goals:**
  – Increase collaboration between PCPs and MH providers.
  – Promote mental health within primary care.
  – Improve identification, evaluation, and treatment
  – Promote the rational utilization of scarce specialty mental health resources for the most complex and high-risk children.

• **Services provided:**
  – Phone consultation with child MH experts
  – Brief, time-limited follow-up services
  – Mental health education and training
  – Resource guide maintenance
  – Medication reviews
Provider Contacts Access Line

Speaks with Triage Clinician

If Necessary

Child Psychiatry Telephone Consultation

Telephone Care Coordination (e.g., contacts community providers, assists families by phone)

Triage Clinician Telephone Consultation and Care Coordination

Interim Face-to-Face Psychiatric Consultation

Interim Face-to-Face Care Coordination

Interim Face-to-Face Care Mental Health Consultation
Lessons Learned

- Interdisciplinary, multi-agency
- Start small
- Early involvement/awareness of key stakeholders
- Lay groundwork in advance in practices
- PCPs need support...including in-person
- Discussing MH important regardless of outcome
- Provide incentives
Next Steps

- Launch of DC MAP
- Evaluation
  - DC MAP
  - Follow up interviews w/ providers and families (in collaboration with SOC evaluators CCSI, Inc. and CCNY, Inc.)
  - Screening outcomes/claims analysis
  - Final data on Learning Collaborative
References


5. Horwitz et al., 2007. Barriers to the Identification and Management of Psychosocial Issues in Children and Maternal Depression. *Pediatrics;119;e208-e218*
Primary Project
A “School-Based Intervention

Barbara Parks, MSSA
Clinical Program Administrator Prevention and Early Intervention Program

Meghan Sullivan, PsyD
Program Evaluator
Department of Behavioral Health, School Mental Health Program, Washington, DC
What is “Primary Project”? 

• an evidence-based, early intervention/prevention program 
• developed over 50 years ago by the Children’s Institute, Rochester, New York 
• adopted by Department of Behavioral Health in 2008 
• for children pre-kindergarten through 3rd-grade identified as having “mild” problems with social-emotional adjustment in the classroom, i.e., shy and withdrawn, have limited or poor eye contact, have limited self-confidence, are slightly overactive or distractible, may display mild aggression, at times
What is “Primary Project”?

Five (5) Components:

1. **screening** for early identification and intervention
2. **intervention** - one-to-one, non-directive (child-led) play sessions with a trained paraprofessional
3. **collaboration with a mental health professional** to enhance the “continuum” of mental health service provision
4. ongoing **supervision, training, and program evaluation**; and
5. **integration** into the school community
Determining Eligibility – The Teacher-Child Rating Scale (T-CRS)

- consists of 32 questions completed by the teacher
- the T-CRS is a valid and reliable measure
  - Alpha and test-retest reliabilities range from .85 to .95
  - Indices of concurrent validity with the CBCL are excellent
  - Predictive validity with school performance is better than many measures
Determining Eligibility – The Teacher-Child Rating Scale (T-CRS)

• reflects the ‘teacher’s perception’ of each child’s classroom performance in the following domains:
  task orientation (e.g. functions well even with distractions, poor concentration)
  behavior control (e.g. accepts imposed limits, disruptive in class)
  Assertiveness (e.g., comfortable as a leader, anxious or worried)
• peer social skills (e.g. makes friends easily, has trouble interacting with peers)
  not ‘time-consuming’ – takes less than 5 minutes
• Assessment Report generates immediately
Primary Project Screening

Teacher-Child Rating Scale results

(31-100%) “Normative” Range

(15-30%) Primary Project Range

(0-14%) Mental Health Range

Parent/guardian Permission Letter sent home

Mental Health Referral to DBH Clinician generated
The “Intervention”

• a play room or area consisting of a special arrangement of expressive toys, i.e., playdoh, dolls, cars, trucks, crayons, markers, puppets, etc.

• the play session is one-to-one, and, non-directive (“child-led”)

• conducted by a “Child Associate”, trained paraprofessional who uses specific communication techniques during the play session in interaction with the child

• 15 or 20-minute play sessions are conducted weekly for 8 to 15 weeks
“I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”

Maya Angelou (1928-2014)
Quoted in the Local Express Newspaper
May 29, 2014
The Child-Child Associate Interaction

• The child-Child Associate ‘relationship’ during play sessions has a total ‘interaction time’ of only 4-8 hours during the school year.

• Yet, the relationship has a powerful IMPACT on the child’s social-emotional development, i.e., decrease in shy and/or withdrawn behaviors, increase in verbal responses, improved decision-making, heightened self-confidence, etc.

• Enhances school-related competencies in four (4) domains, i.e., task orientation, behavior control, assertiveness, and peer social skills.
Benefits of Primary Project

• It’s an evidence-based program
• Provides early:
  • 1) detection of adjustment problems in young children
  • 2) identification of need for mental health intervention
  • 3) intervention to minimize/eliminate adjustment problems
• Promotes pro-social behaviors, i.e., self-regulation, decision-making, positive self-esteem, improved self-confidence, etc.
• Improves school readiness and enhances school-related competencies
• Observable changes at school and home are reported by school staff, clinicians, Child Associates, and, parents/guardians
• The program enhances the DBH “continuum” of school-based mental health services for children
• School-based intervention – occurs during the school day
## Primary Project Screening Results (2008-2013)

<table>
<thead>
<tr>
<th></th>
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<tr>
<td># of sites</td>
<td>12</td>
<td>16</td>
<td>13</td>
<td>30</td>
<td>35</td>
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<tr>
<td># screened</td>
<td>991</td>
<td>1435</td>
<td>835</td>
<td>1445</td>
<td>2664</td>
<td>3031</td>
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<tr>
<td># positive for Primary Project</td>
<td>355 (36%)</td>
<td>522 (36%)</td>
<td>323 (39%)</td>
<td>497 (34%)</td>
<td>579 (22%)</td>
<td>567 (19%)</td>
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<tr>
<td># of participants</td>
<td>164</td>
<td>329</td>
<td>206</td>
<td>269</td>
<td>328</td>
<td>247</td>
</tr>
<tr>
<td># positive - HF/SMHP service</td>
<td>65 (7%)</td>
<td>99 (7%)</td>
<td>105 (13%)</td>
<td>354 (24%)</td>
<td>785 (29%)</td>
<td>868 (29%)</td>
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</table>
Teacher-Child Rating Scale Results
SY 2013-14

- Task Orientation: Pre - 41.4, Post - 48.4
- Behavior Control: Pre - 37.4, Post - 45.7
- Assertiveness: Pre - 50.1, Post - 55.3
- Peer Social Skill: Pre - 53.2, Post - 54.8

n = 238

Primary Project Early Intervention Program
Associate-Child Rating Scale Results
SY2013-14

Primary Project Early Intervention Program
MENTAL HEALTH REFERRAL DISPOSITIONS

<table>
<thead>
<tr>
<th>Initial Course of Action</th>
<th>SY 12-13</th>
<th>SY 13-14</th>
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</thead>
<tbody>
<tr>
<td>Consultation with teacher</td>
<td>435</td>
<td>627</td>
</tr>
<tr>
<td>Consultation with SpEd Coordinator, SST Team, other DCPS entity</td>
<td>60</td>
<td>195</td>
</tr>
<tr>
<td>Consultation with DCPS Social Worker</td>
<td>30</td>
<td>158</td>
</tr>
<tr>
<td>Consultation with parent/guardian</td>
<td>109</td>
<td>148</td>
</tr>
<tr>
<td>Consultation with Principal</td>
<td>2</td>
<td>17</td>
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<tr>
<td>Other Consultations conducted with Community Worker, ESL Teacher, Family Member, Nurse, previous DBH Clinician, Psychologist</td>
<td>No specific data</td>
<td>23</td>
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</table>
### MENTAL HEALTH REFERRAL DISPOSITIONS

<table>
<thead>
<tr>
<th>Initial Course of Action</th>
<th>SY 12-13</th>
<th>%</th>
<th>SY 13-14</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student on DBH Clinician Caseload</td>
<td>56</td>
<td>7</td>
<td>63</td>
<td>7</td>
</tr>
<tr>
<td>Student on DCPS Social Worker’s Caseload</td>
<td>30</td>
<td>4</td>
<td>132</td>
<td>15</td>
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<tr>
<td>Referral to other CSA for services</td>
<td>81</td>
<td>10</td>
<td>56</td>
<td>6</td>
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<tr>
<td>Referred to DCPS Social Worker</td>
<td>32</td>
<td>4</td>
<td>25</td>
<td>3</td>
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<tr>
<td>Student ADDED to DBH Clinician Caseload</td>
<td>7</td>
<td>1</td>
<td>22</td>
<td>3</td>
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<tr>
<td>Referral back to Primary Project after clinical review</td>
<td>43</td>
<td>5</td>
<td>11</td>
<td>1</td>
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<tr>
<td>Early intervention/prevention services (Connect with Kids, Too Good For Violence, Social Skills, etc)</td>
<td>56</td>
<td>7</td>
<td>265</td>
<td>31</td>
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<tr>
<td>Parent/guardian refused mental health services</td>
<td>69</td>
<td>9</td>
<td>81</td>
<td>9</td>
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## Co-Chairs

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<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Email</th>
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<tbody>
<tr>
<td>Barbara Bazron, PhD</td>
<td>Interim Director</td>
<td><a href="mailto:Barbara.Bazron@dc.gov">Barbara.Bazron@dc.gov</a></td>
</tr>
<tr>
<td>Marie Morilus-Black, LICSW-R</td>
<td>Deputy Director of Office of Well Being</td>
<td><a href="mailto:marie.morilus-black@dc.gov">marie.morilus-black@dc.gov</a></td>
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## Discussant

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<tr>
<th>Name</th>
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<th>Email</th>
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<tbody>
<tr>
<td>Brian Pagkos, PhD, LMSW</td>
<td>Director of Research and Evaluation; Evaluator</td>
<td><a href="mailto:bpagkos@ccnyinc.org">bpagkos@ccnyinc.org</a></td>
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## Presentation One

<table>
<thead>
<tr>
<th>Name</th>
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<th>Email</th>
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<tbody>
<tr>
<td>Denise Dunbar, LCSW</td>
<td>Interim Director, Child and Youth Services Division</td>
<td><a href="mailto:Denise.dunbar@dc.gov">Denise.dunbar@dc.gov</a></td>
</tr>
<tr>
<td>Tricia Mills, MA</td>
<td>SOC Interagency Coordinator</td>
<td><a href="mailto:tricia.mills@dc.gov">tricia.mills@dc.gov</a></td>
</tr>
<tr>
<td>Debra Porchia-Usher, MA, ABD</td>
<td>Deputy Director, Community Partnerships</td>
<td><a href="mailto:debra.porchiausher@dc.gov">debra.porchiausher@dc.gov</a></td>
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## Presentation Two

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<tr>
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<tbody>
<tr>
<td>Sarah Barclay Hoffman, MPP</td>
<td>Project Coordinator, Early Childhood Mental Health</td>
<td><a href="mailto:Sbhoffma@childrensnational.org">Sbhoffma@childrensnational.org</a></td>
</tr>
<tr>
<td>Melissa Affronti, PhD, LMSW</td>
<td>Sr. Consultant; Evaluator</td>
<td><a href="mailto:maffronti@ccsi.org">maffronti@ccsi.org</a></td>
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## Presentation Three

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<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Barbara Parks, MSSA</td>
<td>Clinical Program Administrator</td>
<td><a href="mailto:barbara.parks@dc.gov">barbara.parks@dc.gov</a></td>
</tr>
<tr>
<td>Meghan Sullivan, PsyD</td>
<td>Program Evaluator</td>
<td><a href="mailto:meghan.sullivan@dc.gov">meghan.sullivan@dc.gov</a></td>
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