

**Department of Health and Human Service
Office of Adult Mental Health Services
Third Quarter State Fiscal Year 2012 (April, May June 2012)
Report on Compliance Plan Standards: Community
August 1, 2012**

	Compliance Standard	Report/Update
I.1	Implementation of all the system development steps in October 2006 Plan	As of March 2010, all 119 original components of the system development portion of the Consent Decree Plan of October 2006 have been accomplished or deleted per amendment.
I.2	Certify that a system is in place for identifying unmet needs	See attached <i>Cover: Unmet Needs August 2012</i> and <i>Unmet Needs by CSN for FY'12 Quarter 3 (January, February, March 2012)</i>
I.3	Certify that a system is in place for Community Service Networks (CSNs) and related mechanisms to improve continuity of care	The Department's certification of August 19, 2009 was approved on October 7, 2009.
I.4	Certify that a system is in place for Consumer councils	The Department's certification of December 2, 2009 was approved on December 22, 2009.
I.5	Certify that a system is in place for new vocational services	The Department certification of September 17, 2011 was approved November 21, 2011.
I.6	Certify that a system is in place for realignment of housing and support services	All components of the Consent Decree Plan of October 2006 related to the Realignment of Housing and Support Services were completed as of July 2009. Certification was submitted March 10, 2010. The Certification Request was withdrawn May 14, 2010.
I.7	Certify that a system is in place for a Quality Management system that includes specific components as listed on pages 5 and 6 of the plan	Department of Health and Human Services Office of Adult Mental Health Services Quality Management Plan/Community Based Services (April 2008) has been implemented; a copy of plan was submitted with the May 1, 2008 Quarterly Report.
II.1	Provide documentation that unmet needs data and information (data source list page 4 of compliance plan) is used in planning for resource development and preparing budget requests	Unmet needs reports are posted on the OAMHS website on a quarterly basis in order to inform discussions and recommendations to the Department for meeting unmet needs. Budget submissions to the Governor and the Legislature are in part built on data regarding unmet needs. This is reflected in the financial documents submitted to DAFS.
II.2	Demonstrate reliability of unmet needs data based on evaluation	See <i>Cover: Unmet Needs August 2012</i> and the <i>Performance and Quality Improvement Standards: FY12 Quarter 3 (January, February, March, 2012)</i> for quality improvement efforts taken to improve the reliability of the 'other' and CI unmet resource data.

II.3	Submission of budget proposals for adult mental health services given to Governor, with pertinent supporting documentation showing requests for funding to address unmet needs (<i>Amended language 9/29/09</i>)	The Commissioner and Acting Director of Adult Mental Health advocated for no lapse in funding and authority to use of FY12 Additional Grant money for services in FY13. The Legislature approved those requests.
II.4	Submission of the written presentation given to the legislative committees with jurisdiction over DHHS ... which must include the budget requests that were made by the Department to satisfy its obligations under the Consent Decree Plan and that were not included in the Governor's proposed budget, an explanation of support and importance of the requests and expression of support ... (<i>Amended language 9/29/09</i>)	See above for update.
II.5	Annual report of MaineCare Expenditures and grant funds expended broken down by service area	<i>MaineCare and Grant Expenditures Report for FY11</i> was included in Consent Decree Report last quarter.
III.1	Demonstrate utilizing QM System	See attached <i>Cover: Unmet Needs August 2012</i> and the <i>Performance and Quality Improvement Standards: July 2012</i> for examples of the Department Utilizing the QM system.
III.1a	Document through quarterly or annual reports the data collected and activities to assure reliability (including ability of EIS to produce accurate data)	This quarterly report documents significant data collection and review activities of the OAMHS quality management system.
III.1b	Document how QM data used to develop policy and system improvements	See compliance standards II.3 and II.4 above for examples of how quality management data was used to support budget requests for systems improvement.
IV.1	100% of agencies, based on contract and licensing reviews, have protocol/procedures in place for client notification of rights	Based on contract reviews done in the third quarter of FY' 12, 100 % of the agencies reviewed in OAMHS Field Service Offices (Bangor, Augusta, and Portland) have protocols/procedures in place for client notification of rights, with documentation in provider files maintained within the regional offices. Based in licensing surveys, 100% of licensed mental health agencies have protocols/policies in place for client notification of the <i>Rights of Recipients</i> .
IV.2	If results from the DIG Survey fall below levels established for Performance and Quality Improvement Standard 4.2, 90% of consumers report they were given information about their rights, the Department: (i) consults with the Consumer Council System of Maine (CCSM); (ii) takes corrective action a determined necessary by CCSM; and (iii) develops that	The percentage for standard 4.2 from the 2011 DIG Survey was 89.4% (up from 88.6% in 2010), slightly below the standard of 90%. This data was shared with the CCSM after the last quarterly report in November.

	corrective action in consultation with CCSM. <i>(Amended language 1/19/11)</i>	
IV.3	Grievance Tracking data shows response to 90% of Level II grievances within 5 days or extension	Standard met Calendar Years 2006, 2007, 2008 and 2009; the 1 st and 3 rd quarters of calendar year (CY) 2010 (data not available for the 2 nd quarter); and the 2 nd , 3 rd and 4 th quarters of CY'11 (no Level II grievances reported in the 1 st quarter of CY 2011). Calendar year '12, 2nd quarter: there was 1 level II grievance, and it was resolved in a timely manner. Met.
IV.4	Grievance Tracking data shows that for 90% of Level III grievances written reply within 5 days or within 5 days extension if hearing is to be held or if parties concur.	Reporting began in the 1 st quarter of calendar year 2008. Standard met, when there was a level III grievance, at 100% through the 3 rd quarter of calendar year (CY) 2011 (data not available for the 2 nd quarter CY10). Standard not met in the 4 th quarter CY11 (1 level 3 grievance). Standard report is every 6 months. January thru June 2012, there was 1 level Grievance Tracking data is updated and reported on every 6 months and is reported by calendar year. This report covers January-June 2012. There were 0 level III grievances.
IV.5	90% hospitalized class members assigned worker within 2 days of request - <u>must be met for 3 out of 4 quarters</u>	See attached <i>Performance and Quality Improvement Standards: July 2012</i> , Standard 5-2.
IV.6	90% non-hospitalized class members assigned worker within 3 days of request - <u>must be met for 3 out of 4 quarters</u>	See attached <i>Performance and Quality Improvement Standards: July 2012</i> , Standard 5-3.
IV.7	95% of class members in hospital or community not assigned within 2 or 3 days, assigned within an additional 7 days - <u>must be met for 3 out of 4 quarters</u>	See attached <i>Performance and Quality Improvement Standards: July 2012</i> , Standard 5-4.
IV.8	90% of class members enrolled in CSS with initial ISP completed within 30 days of enrollment - <u>must be met for 3 out of 4 quarters</u>	Standard met since the 3 rd quarters of FY'08 See attached <i>Performance and Quality Improvement Standards: July 2012</i> , Standard 5-5
IV.9	90% of class members had their 90 day ISP review(s) completed within that time period - <u>must be met for 3 out of 4 quarters</u>	See attached <i>Performance and Quality Improvement Standards: July 2012</i> , Standard 5-6.
IV.10	QM system includes documentation that there is follow-up to require corrective actions when ISPs are more than 30 days overdue	Monitoring of overdue ISPs continues on a quarterly basis. As the data has been consistent over time and the feedback and interaction with providers had lessened greatly, reports are now created quarterly and available

		<p>to providers upon request. Providers were notified of this change on May 18, 2011.</p> <p>Providers are notified when reports are run. Some do request copies. Feedback has been minimal.</p>
IV.11	Data collected once a year shows that no > 5% of class members enrolled in CS did not have their ISP reviewed before the next annual review	Once-a-year report (completed January 2012) showed that 4.9% of class members enrolled in CS did not have their ISP reviewed before the next annual review. Those not completed appear to reflect data errors between APS Healthcare and EIS and provider's failure to update the ISP data after their client's are discharged.
IV.12	Certify in quarterly reports that DHHS is meeting its obligation re: quarterly mailings	<p>On May 14, 2010, the court approved a Stipulated Order that requires mailings to be done only semi-annually in 2010, moving to annually in 2011 and thereafter, as long as the number of unverified addresses remains at or below 15%.</p> <p>The most recent mailing was sent in early December 2011. Percentage of unverified addresses remains below 15%. See attached <i>Location Effort Report: Calendar Year 2011</i>.</p>
IV.13	In 90% of ISPs reviewed, all domains were assessed in treatment planning - <u>must be met for 3 out of 4 quarters</u>	<p>Standard met since the beginning of FY'10 though FY12 Second Quarter.</p> <p>Standard was Met for the FY12 fourth quarter (90%).</p> <p>See attached <i>Class Member Treatment Planning Review</i>, Question 2A</p>
IV.14	In 90% of ISPs reviewed, treatment goals reflect strengths of the consumer - <u>must be met for 3 out of 4 quarters</u>	<p>Standard has been met continuously since the first quarter of FY'08.</p> <p>See attached <i>Performance and Quality Improvement Standards: July 2012</i>, Standard 7-1a and <i>Class Member Treatment Planning Review</i>, Question 2B</p>
IV.15	90% of ISPs reviewed have a crisis plan or documentation as to why one wasn't developed - <u>must be met for 3 out of 4 quarters</u>	<p>Standard met since the beginning of FY'09</p> <p>See attached <i>Performance and Quality Improvement Standards: July 2012</i>, Standard 7-1c (does the consumer have a crisis plan) and <i>Class Member Treatment Planning Review</i>, Question 2F</p>
IV.16	QM system documents that OAMHS requires corrective action by the provider agency when document review reveals not all domains assessed	See attached <i>Class Member Treatment Planning Review</i> , Question 6.a.1 that addresses plans of correction.
IV.17	In 90% of ISPs reviewed, interim plans developed when resource needs not	Standard met the 1 st and 2 nd quarters of FY'12 Standard not met 3 rd Quarter FY12, Standard met in 4 th

	available within expected response times - <u>must be met for 3 out of 4 quarters</u>	quarter FY12. See attached <i>Performance and Quality Improvement Standards: July 2012</i> , Standard 8-2 and <i>Class Member Treatment Plan Review</i> , Question 3F.
IV.18	90% of ISPs review included service agreement/treatment plan - <u>must be met for 3 out of 4 quarters</u>	See attached <i>Performance and Quality Improvement Standards: July 2012</i> , Standard 9-1 and <i>Class Member Treatment Plan Review</i> , Questions 4B & C.
IV.19	90% of ACT/ICI/CI providers statewide meet prescribed case load ratios - <u>must be met for 3 out of 4 quarters</u> Note: As of 7/1/08, ICI is no longer a service provided by DHHS.	Community Integration -- standard met since the 2 nd quarter FY'08. ACT – standard met for the 2 nd , 3 rd and 4 th quarters FY'10; the 1 st , 2 nd and 4 th quarters FY'11; and met all 4 quarters of FY'12. See attached <i>Performance and Quality Improvement Standards: July 2012</i> , Standard 10.1 and 10-2
IV.19	90% of ICMs with class member caseloads meet prescribed case load ratios - <u>must be met for 3 out of 4 quarters</u>	ICMs' work is focused on community forensic and outreach services. Individual ICMs no longer carry caseloads. Should this change in the future, OAMHS will resume reporting on caseload ratios.
IV.20	90% of OES workers with class member public wards - meet prescribed caseloads <u>must be met for 3 out of 4 quarters</u>	See attached <i>Performance and Quality Improvement Standards: July 2012</i> , Standard 10-5.
IV.21	Independent review of the ISP process finds that ISPs met a reasonable level of compliance as defined in Attachment B of the Compliance Plan	
IV.22	5% or fewer class members have ISP-identified unmet residential support - <u>must be met for 3 out of 4 quarters</u> and	Standard met for the 1 st , 3 rd and 4 th quarters of FY'09; all quarters of FY'10 and FY'11; and met 1 st , 2 nd , and 3 rd quarters of FY12. See attached <i>Performance and Quality Improvement Standards: July 2012</i> , Standard 12-1
IV.23	EITHER quarterly unmet residential support needs for one year for qualified (qualified for state financial support) non-class members do not exceed by 15 percentage points those of class members OR if exceeded for one or more quarters, OAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status and	Reporting on this standard is done yearly, and was last done in July 2011. Unmet residential support need data for the past year (FY10 Quarter 4, FY11 Quarter 1, 2, & 3) shows that unmet residential support needs for non-class members did not exceed by 15 percentage points those of class members. This report is done yearly. There is no new data at this time.
IV.24	Meet RPC discharge standards (below); or	Standard met since the beginning of FY'08

	<p>if not met document reasons and demonstrate that failure not due to lack of residential support services</p> <ul style="list-style-type: none"> • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master) 	<p>See attached <i>Performance and Quality Improvement Standards: July 2012</i>, Standards 12-2, 12-3 and 12-4.</p>
IV.25	<p>10% or fewer class members have ISP-identified unmet needs for housing resources - <u>must be met for 3 out of 4 quarters</u> and</p>	<p>Standard met for quarters 3rd and 4th of FY'09 and 1st, 2nd and 3rd quarters of FY'10. Percentage for the 4th quarter FY'10 was 10.8%, just above the standard. Standard met for all quarters FY'11 and the 1st, 2nd and 3rd quarter of FY12.</p> <p>See attached <i>Performance and Quality Improvement Standards: July 2012</i>, Standard 14-1</p>
IV.26	<p>Meet RPC discharge standards (below); if not met, document that failure to meet is not due to lack of housing resources.</p> <ul style="list-style-type: none"> • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master) 	<p>Standard 14-4 met since the beginning of FY'09, except for Q3 FY'10</p> <p>Standard 14-5 met for the 2nd, 3rd and 4th quarters of FY'09; the 2nd and 4th quarters of FY'10; all quarters of FY'11; and the 1st and 2nd and 3rd quarters of FY12</p> <p>Standard 14-6 met for the 2nd and 4th quarters of FY'09; the 2nd and 4th quarters of FY'10; all quarters of FY'11; and the 1st and 2nd and 3rd quarters of FY'12.</p> <p>See attached <i>Performance and Quality Improvement Standards: July 2012</i>, Standard 14-4, 14-5 & 14-6</p>
IV.27	<p>Certify that class members residing in homes > 8 beds have given informed consent in accordance with approved protocol</p>	<p>Standard met 2007, 2008, 2009 and 2010 (annual review).</p> <p>OAMHS submitted an amendment request to the court master to modify this requirement on November 23, 2011. The court master approved OAMHS' request to hold the 2011 annual review in abeyance pending a decision on the amendment request.</p> <p>Results reported in <i>Performance and Quality Improvement Standards: July 2010 Report</i>, Standard 15-1</p>
IV.28	<p>90% of class member admissions to community involuntary inpatient units are within the CSN or county listed in attachment C to the Compliance Plan</p>	<p>In FY'10: 1st quarter 88.2% (15 of 17); 2nd quarter 81.8% (9 of 11); 3rd quarter 82.4% (14 of 17); and 4th quarter 90.9% (20 of 22).</p> <p>In FY'11: 88% (22 of 25) in the 1st quarter; 75% (9 of 12) in the 2nd quarter; 78.9% (15 of 19) in the 3rd</p>

		<p>quarter and 80% (12 of 15) in the 4th quarter.</p> <p>In FY12: 76.2% (16 of 21) in the 1st quarter. 63.6% (14 of 22) in the 2nd quarter 77.8% (7 out of 9) in the 3rd quarter</p> <p>See attached <i>Performance and Quality Improvement Standards: July 2012, Standard 16-1 and Community Hospital Utilization Review – Class Members 3rd Quarter of Fiscal Year 2012.</i></p>
IV.29	Contracts with hospitals require compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning	See IV.30 below
IV.30	Evaluates compliance with all legal requirements for involuntary clients and with obligations to obtain ISPs and involve CSWs in treatment and discharge planning during contract reviews and imposes sanctions for non-compliance through contract reviews and licensing	<p>With the curtailment in FY 2010 and the elimination of funding for involuntary hospitalizations other than MaineCare in FY 2011 and FY12, contracts with hospitals are no longer needed.</p> <p>OAMHS is establishing agreements with the hospitals covering the key compliance issues. The status of hospital contracts:</p> <ul style="list-style-type: none"> - All but Maine Med P6 hospital contracts have been encumbered. - Maine Med-P6 is with contract management. - <p>OAMHS continues to perform reviews for involuntary hospitalizations with our Field Office Nurses.</p> <p>Performance and Quality Improvement Standards: July 2012</p>
IV.31	UR Nurses review all involuntary admissions funded by DHHS, take corrective action when they identify deficiencies and send notices of any violations to the licensing division and to the hospital	<p>OAMHS reviews emergency involuntary admissions at the following hospitals: MaineGeneral Medical Center, Spring Harbor Hospital, St. Mary’s Hospital, Mid-Coast Hospital, Southern Maine Medical Center, PenBay Medical Center, Maine Medical Center/P6 and Acadia Hospital.</p> <p>See Standard IV.33 below regarding corrective actions.</p>
IV.32	Licensing reviews of hospitals include an evaluation of compliance with patient rights and require a plan of correction to address any deficiencies.	4th Quarter FY’12: No Rights of Recipients violations.
IV.33	<ul style="list-style-type: none"> • 90% of the time corrective action was taken when blue papers were not completed in accordance with terms 	Standards met for FY’08, FY’09, FY’10 and FY’11; Standards met for the 1 st , 2 nd and 3 rd quarters of FY’12.

	<ul style="list-style-type: none"> • 90% of the time corrective action was taken when 24 hour certifications were not completed in accordance with terms • 90% of the time corrective action was taken when patient rights were not maintained 	See attached <i>Performance and Quality Improvement Standards: July 2012</i> , Standards 17-2a, 17-3a and 17-4a and <i>Community Hospital Utilization Review – Class Members 2nd Quarter of Fiscal Year 2012</i> .
IV.34	<p>QM system documents that if hospitals have fallen below the performance standard for any of the following, OAMHS made the information public through CSNs, addressed in contract reviews with hospitals and CSS providers, and took appropriate corrective action to enforce responsibilities</p> <ul style="list-style-type: none"> • obtaining ISPs (90%) • creating treatment and discharge plan consistent with ISPs (90%) • involving CIWs in treatment and discharge planning (90%) 	<p>The report displaying data by hospital for community hospitals accepting emergency involuntary clients is shared quarterly by posting reports on the CSN section of the OAMHS’s website.</p> <p>See attached report <i>Community Hospital Utilization Review Performance Standard 18-1, 2, 3 by Hospital: Class Members 3rd Quarter of Fiscal Year 2012</i>.</p>
IV.35	No more than 20-25% of face-to-face crisis contacts result in hospitalization – <u>must be met for 3 out of 4 quarters</u>	<p>In FY’10, standard met for the 1st quarter: slightly above for the 2nd (25.7%), 3rd (25.7%) and 4th (26.1%) quarters.</p> <p>In FY’11, standard met for the 1st quarter, with the 2nd (25.6%), 3rd (26.2%) and 4th (26.4%) quarters’ results being slightly above the standard.</p> <p>In FY’12: standard met for the first quarter at 25.5%. standard met for the second quarter at 23% standard met for the third quarter at 23.6%</p> <p>See attached <i>Performance and Quality Improvement Standards: July 2012</i>, Standard 19-1 and <i>Adult Mental Health Quarterly Crisis Report Third Quarter, State Fiscal Year 2012 Summary Report</i>.</p>
IV.36	90% of crisis phone calls requiring face-to-face assessments are responded to within an average of 30 minutes from the end of the phone call – <u>must be met for 3 out of 4 quarters</u>	<p>Starting with July 2008 reporting from providers, OAMHS collects data on the total number of minutes for the response time (calculated from the determination of need for face to face contact or when the individual is ready and able to be seen to when the individual is actually seen) and figures an average.</p> <p>FY12: 1st quarter- Average statewide was met with the average being 28.3 minutes. 2nd quarter- was met with the average being 26.1 minutes. 3rd quarter was met with the average being 25 minutes.</p> <p>See attached <i>Adult Mental Health Quarterly Crisis Report Third Quarter, State Fiscal Year 2012 Summary Report</i>.</p>

IV.37	90% of all face-to-face assessments result in resolution for the consumer within 8 hours of initiation of the face-to-face assessment – <u>must be met for 3 out of 4 quarters</u>	Standard has been met since the 2 nd quarter of FY’08. See attached <i>Adult Mental Health Quarterly Crisis Report Third Quarter, State Fiscal Year 2012 Summary Report</i> .
IV.38	90% of all face-to-face contacts in which the client has a CI worker, the worker is notified of the crisis – <u>must be met for 3 out of 4 quarters</u>	Standard has been met since the 1 st quarter of FY’08. See attached <i>Performance and Quality Improvement Standards: July 2012, Standard 19-4 and Adult Mental Health Quarterly Crisis Report Third Quarter, State Fiscal Year 2012 Summary Report</i> .
IV.39	Compliance Standard deleted 1/19/2011.	
IV.40	Department has implemented the components of the CD plan related to vocational services	As of 3 rd quarter of FY’10, the Department has implemented all components of the CD Plan related to Vocational Services.
IV.41	QM system shows that the Department conducts further review and takes appropriate corrective action if PS 26.3 data shows that the number of consumers under age 62 and employed in supportive or competitive employment falls below 10%. <i>(Amended language 1/19/11)</i>	2011 Adult Health and Well-Being Survey: 13.8% of consumers in supported and competitive employment (full or part time).
IV.42	5% or fewer class members have unmet needs for mental health treatment services – <u>must be met for 3 out of 4 quarters</u> and	See attached <i>Performance and Quality Improvement Standards: July 2012, Standard 21-1</i>
IV.43	EITHER quarterly unmet mental health treatment needs for one year for qualified non-class members do not exceed by 15 percentage points those of class members OR if exceeded for one or more quarters, OAMHS produces documentation sufficient to explain cause and to show that cause is not related to class status	Unmet mental health treatment need data for the past year (4 th quarter of FY10 and 1 st , 2 nd , and 3 rd quarters of FY11 shows that unmet mental health treatment needs for non-class members did not exceed by 15 percentage points those of class members. <ul style="list-style-type: none"> • Q4 class members 17.09%, non-class members 16.09% • Q1: class members 16.1%, non-class members 17.81% • Q2: class members 15.37%, non-class members 18.85% • Q3: class members 13.93%, non-class members 18.01% This report is run yearly. There is no new data at this time.
IV.44	QM documentation shows that the Department conducts further review and takes appropriate corrective action if results from the DIG survey fall below the levels identified in Standard # 22-1 (the domain average of positive responses to the	2011 Adult Health and Well-Being Survey: 77% domain average of positive responses.

	statements in the Perception of Access Domain is at or above 85%) (<i>Amended language 1/19/11</i>) and	
IV.45	Meet RPC discharge standards (below); if not met, document that failure to meet is not due to lack of mental health treatment services in the community <ul style="list-style-type: none"> • 70% RPC clients who remained ready for discharge were transitioned out within 7 days of determination • 80% within 30 days • 90% within 45 days (with certain exceptions by agreement of parties and court master) 	Standard met since the beginning of FY'08 See attached <i>Performance and Quality Improvement Standards: July 2012</i> , Standards 21-2, 21-3 and 21-4
IV.46	OAMHS lists in quarterly reports the programs sponsored that are designed to improve quality of life and community inclusion, including support of peer centers, social clubs, community connections training, wellness programs and leadership and advocacy training programs – list must cover prescribed topics and audiences that fit parameters of ¶105.	See attached <i>Performance and Quality Improvement Standards: July 2012</i> , Standard 30
IV.47	10% or fewer class members have ISP-identified unmet needs for transportation to access mental health services – <u>must be met for 3 out of 4 quarters</u>	Standard met for all quarters of FY'08, FY'09, FY'10 and FY'11. Standard met for the 1 st , 2 nd , and 3 rd quarters of FY'12 See attached <i>Performance and Quality Improvement Standards: July 2012</i> , Standard 28
IV.48	Provide documentation in quarterly reports of funding, developing, recruiting, and supporting an array of family support services that include specific services listed on page 16 of the Compliance Plan	See attached <i>Performance and Quality Improvement Standards: July 2012</i> , Standard 23-1 and 23-2
IV.49	Certify that all contracts with providers include a requirement to refer family members to family support services, and produce documentation that contract reviews include evaluation of compliance with this requirement.	100% of contracts include this requirement. Annual contract reviews completed in the 3 rd quarter of FY'12 in all 3 regions addressed this standard with documentation contained in contract files maintained by the regional office.
IV.50	Lists in quarterly reports the number and types of mental health informational workshops, forums and presentations geared to general public that are designed to reduce myths/stigma and foster community integration (cover prescribed list and fit audience parameters)	See attached <i>Performance and Quality Improvement Standards: July 2012</i> , Standard 34.1 and attached <i>Public Education Report January- March 2012</i> .