

# District of Columbia

## UNIFORM APPLICATION

### FY 2016/2017 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

### COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018  
(generated on 11/13/2015 1:27:25 PM)

Center for Mental Health Services  
Division of State and Community Systems Development

## State Information

### State Information

#### Plan Year

Start Year 2016

End Year 2017

#### State DUNS Number

Number 14384031

Expiration Date

#### I. State Agency to be the Grantee for the Block Grant

Agency Name District of Columbia Department of Behavioral Health

Organizational Unit Office of Strategic Planning, Policy and Evaluation

Mailing Address 64 New York Avenue, N.E., 2nd Floor

City Washington, D.C.

Zip Code 20002

#### II. Contact Person for the Grantee of the Block Grant

First Name Tanya

Last Name Royster

Agency Name Department of Behavioral Health

Mailing Address 64 New York Avenue, N.E., 3rd Floor

City Washington, D.C.

Zip Code 20002

Telephone (202) 673-2200

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#### III. Expenditure Period

State Expenditure Period

From

To

#### IV. Date Submitted

Submission Date 9/1/2015 3:02:05 PM

Revision Date 11/13/2015 1:26:33 PM

#### V. Contact Person Responsible for Application Submission

First Name Juanita

Last Name Reaves

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Footnotes:



## State Information

### Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2016

U.S. Department of Health and Human Services  
Substance Abuse and Mental Health Services Administrations  
Funding Agreements  
as required by  
Community Mental Health Services Block Grant Program  
as authorized by  
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
and  
Title 42, Chapter 6A, Subchapter XVII of the United States Code

| Title XIX, Part B, Subpart II of the Public Health Service Act  |   |                  |
|---|---|------------------|
| Section   | Title   | Chapter          |
| Section 1911  | Formula Grants to States  | 42 USC § 300x    |
| Section 1912  | State Plan for Comprehensive Community Mental Health Services for Certain Individuals | 42 USC § 300x-1  |
| Section 1913  | Certain Agreements  | 42 USC § 300x-2  |
| Section 1914  | State Mental Health Planning Council  | 42 USC § 300x-3  |
| Section 1915  | Additional Provisions   | 42 USC § 300x-4  |
| Section 1916  | Restrictions on Use of Payments   | 42 USC § 300x-5  |
| Section 1917  | Application for Grant   | 42 USC § 300x-6  |
| Title XIX, Part B, Subpart III of the Public Health Service Act |   |                  |
| Section 1941  | Opportunity for Public Comment on State Plans   | 42 USC § 300x-51 |
| Section 1942  | Requirement of Reports and Audits by States   | 42 USC § 300x-52 |
| Section 1943  | Additional Requirements   | 42 USC § 300x-53 |
| Section 1946  | Prohibition Regarding Receipt of Funds  | 42 USC § 300x-56 |
| Section 1947  | Nondiscrimination   | 42 USC § 300x-57 |
| Section 1953  | Continuation of Certain Programs  | 42 USC § 300x-63 |
| Section 1955  | Services Provided by Nongovernmental Organizations                                    | 42 USC § 300x-65 |
| Section 1956  | Services for Individuals with Co-Occurring Disorders                                  | 42 USC § 300x-66 |

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

## LIST of CERTIFICATIONS

### 1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

### 2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

### 3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Tanya A. Royster, M.D.

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: Acting Director, Department of Behavioral Health

Date Signed: \_\_\_\_\_

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:



**GOVERNMENT OF THE DISTRICT OF COLUMBIA**

**ADMINISTRATIVE ISSUANCE SYSTEM**


Mayor's Order 2015-196  
August 17, 2015

**SUBJECT:** Appointment — Acting Director, Department of Behavioral Health


**ORIGINATING AGENCY:** Office of the Mayor

By virtue of the authority vested in me as Mayor of the District of Columbia by section 422(2) of the District of Columbia Home Rule Act, approved December 24, 1973, 87 Stat. 790, Pub. L. 93-198, D.C. Official Code § 1-204.22(2) (2014 Repl.), and pursuant to section 5114 of the Department of Behavioral Health Establishment Act of 2013, D. C. Official Code § 7-1141.03 (2014 Supp.), it is hereby **ORDERED** that:

1. **DR. TANYA ROYSTER** is appointed Acting Director, Department of Behavioral Health, and shall serve in that capacity at the pleasure of the Mayor.
2. This Order supersedes Mayor's Order 2015-145, dated May 27, 2015.
3. **EFFECTIVE DATE:** This Order shall be effective *nunc pro tunc* to August 3, 2015.

  
\_\_\_\_\_  
MURIEL BOWSER  
MAYOR

ATTEST:

  
\_\_\_\_\_  
LAUREN C. VAUGHAN  
SECRETARY OF THE DISTRICT OF COLUMBIA

I. State Information

Chief Executive Officer's Funding Agreements, Assurances Non-Construction Programs and  
Certifications (Form 03)  
Fiscal Year 2016/17

U.S. Department of Health and Human Services  
Substance Abuse and Mental Health Services Administrations  
Funding Agreements  
as required by  
Community Mental Health Services Block Grant Program  
as authorized by  
Title XIX, Part B, Subpart I and Subpart III of the Public Health Service Act  
and  
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| Title XIX, Part B, Subpart I of the Public Health Service Act   |   |                  |
|---|---|------------------|
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| Section 1956  | Services for Individuals with Co-Occurring Disorders                                  | 42 USC § 300x-66 |

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State: Washington DC

Name of Chief Executive Officer (CEO) or Designee: Tanya A. Royster, MD

Signature of CEO or Designee: 

Title: Director, Department of Behavioral Health

Date Signed: 08/25/2015  
mm/dd/yyyy

<sup>1</sup> If the agreement is signed by an authorized designee, a copy of the designation must be attached.

# State Information

## Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

|              |                      |
|--------------|----------------------|
| Name         | <input type="text"/> |
| Title        | <input type="text"/> |
| Organization | <input type="text"/> |

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Footnotes:

The Disclosure of Lobbying Activities form is not applicable.

## Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

### Narrative Question:

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Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

**DISTRICT OF COLUMBIA**  
**FY 2016-FY 2017 MENTAL HEALTH BLOCK**  
**GRANT APPLICATION BEHAVIORAL HEALTH**  
**ASSESSMENT AND PLAN**

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## Executive Summary

The Substance Abuse and Mental Health Services Administration (SAMHSA) oversees two (2) major block grants: 1) the Substance Abuse Prevention and Treatment Block Grant (SABG), and 2) the Community Mental Health Services Block Grant (MHBG). This document is the District of Columbia FY 2016-FY 2017 Mental Health Block Grant Application. The District's FY 2016-FY 2017 SABG Application will be submitted under separate cover in accordance with the submission date.

A major component of the MHBG Application is the Behavioral Health Assessment and Plan. It provides information about the: 1) the District of Columbia population characteristics, health status, and homelessness; 2) D.C. Department of Behavioral Health (DBH) including primary organizational components, adult and child and youth service system initiatives, services and supports; 3) adult and child DBH and sub-grantee projects funded by the MHBG; 4) behavioral health data; 5) planning steps (including assessment of strengths of the system in serving various populations, unmet and/or critical gaps in the service system, priority planning initiatives and associated goals, objectives, performance indicators and strategies); 6) expenditure data (District, DBH, and MHBG); 7) key environmental factors and technical plan; 8) behavioral health planning and advisory council input and activities; and public awareness of MHBG application and opportunity to comment.



## I. Overview of the District of Columbia

The District of Columbia is the capital of the United States. Its land area is 61.05 square miles. The U.S. Constitution allows for the creation of a special district to serve as the permanent national capital. The District is not a part of any U.S. state and is governed by an elected Mayor and a 13-member elected Council. The District functions as a state government and a local government.

**A. Population:** The U.S. Census Bureau 2014 estimate for the District of Columbia population is 658,893. The gender, age, and race/ethnicity data source is the U.S. Census Bureau Population Estimates 2013. The education and household data source is the U.S. Census Bureau, American Community Survey (ACS) 2009-2013.

- **Gender:** There are 340,199 females representing 52.6% of the population, and 306,250 males representing 47.4% of the population
- **Age:** The majority of the residents are age 25-64 (380,571) followed by those 18-24 (80,982).

| Age         | Number of People | Percent of Population |
|-------------|------------------|-----------------------|
| Under age 5 | 40,967           | 6.3%                  |
| 5-12        | 45,134           | 7.0%                  |
| 13-17       | 25,373           | 3.9%                  |
| 18-24       | 80,982           | 12.5%                 |
| 25-64       | 380,571          | 58.9%                 |
| 65 and over | 73,422           | 11.4%                 |

- **Race/Ethnicity:** The majority of the residents are African American (319,676) followed by White alone (280,509).

| Race/Ethnicity                                 | Number of People | Percent of Population |
|--|------------------|-----------------------|
| African American or Black                      | 319,676          | 49.5%                 |
| White alone                                    | 280,509          | 43.4%                 |
| White alone, not Hispanic or Latino            | 231,281          | 39.8%                 |
| Hispanic or Latino                             | 65,560           | 10.1%                 |
| Asian alone                                    | 25,047           | 3.9%                  |
| Two or more races                              | 16,635           | 2.6%                  |
| American Indian & Alaska Native alone          | 3,639            | 0.6%                  |
| Native Hawaiian & Other Pacific Islander alone | 943              | 0.1%                  |

- **Educational Attainment:** The majority of residents 25 and over attained professional degrees beyond the bachelor's level followed by those with bachelor's degrees, and high school graduates (includes equivalency). The data is presented in the table that follows.

| Educational Level                           | Number of People | Percent of Population |
|---|------------------|-----------------------|
| High School Graduate (includes equivalency) | 80,898           | 18.8%                 |
| Bachelor's Degree                           | 97,680           | 22.7%                 |
| Other Professional Degrees                  | 127,801          | 29.7%                 |

- **Households:** The table below shows housing structure, ownership, value, and income.

| Household Characteristics              | Number/Rate/Median |
|--|--------------------|
| Housing Units                          | 298,327            |
| Homeownership Rate                     | 42.1%              |
| Housing Units in Multi-Unit Structures | 61.2%              |
| Median Value Home Owner Occupied Units | \$445,200          |
| Median Household Income                | \$65,830           |

- **Family Composition:** The table below shows single parent and married households with and without children.

| Family Characteristics         | Percent of Population |
|--------------------------------|-----------------------|
| Female Single Parent Household | 37.3%                 |
| Married No Children            | 34.4%                 |
| Married With Children          | 19.6%                 |
| Male Single Parent Household   | 8.7%                  |

**B. Health Profile:** The District Department of Health developed and disseminated the first edition of the *District of Columbia Community Health Needs Assessment* (February 28, 2014). It is a comprehensive analysis and review of the health and quality of life of District residents. The tables that follow provide data for key health indicators for the District and the United States (2010 reporting period).

- **Mortality and Life Expectancy** (asterisk notes the District is higher on health indicator)

| Health Indicator  | District of Columbia | United States |
|---|----------------------|---------------|
| Life Expectancy (at birth, age in years)                                  | 77.7                 | 78.7          |
| Leading Causes of Death (age adjusted death rate per 100,000 population): |                      |               |
| Heart Disease   | 239.7*               | 178.5         |
| Cancer  | 193.0*               | 172.5         |
| Accidents   | 36.9                 | 37.1          |
| Cerebrovascular Disease   | 35.5                 | 39.0          |
| Chronic Lower Respiratory Disease   | 27.0                 | 42.1          |
| Diabetes  | 26.7*                | 20.8          |
| HIV Disease   | 21.4*                | 2.6           |
| Alzheimer's Disease   | 20.3                 | 25.0          |
| Homicide/Assault  | 16.9*                | 5.3           |
| Septicemia  | 16.7*                | 10.6          |

- **Maternal and Child Health Outcomes** (asterisk notes the District is higher on health indicator)

| Health Indicator                                   | District of Columbia | United States |
|--|----------------------|---------------|
| Infant Mortality (per 1,000 births)                | 8.0*                 | 6.1           |
| Low Birth Rate (percent of births)                 | 10.2*                | 8.2           |
| Pre-term Birth (percent of births)                 | 10.3                 | 12.0          |
| Teen Birth Rate (per 1,000 women ages 15-19)       | 45.4*                | 34.2          |
| Fertility Rate (births per 1,000 women ages 15-44) | 56.4                 | 64.1          |

- **Chronic Health Indicators** (asterisk notes the District is higher on health indicator)

| Health Indicator  | District of Columbia | United States |
|---|----------------------|---------------|
| <b>Overweight and Obesity (BMI):</b>                                |                      |               |
| Neither Overweight or Obese (percent adults 18 and older)           | 43.7*                | 35.3          |
| Overweight (BMI 25.0-29.9, percent adults 18 and older)             | 33.8                 | 36.2          |
| Obese (BMI 30.0-99.8, percent adults 18 and older)                  | 22.4                 | 27.6          |
| <b>Cardiovascular Diseases:</b>                                     |                      |               |
| Heart Attack or Myocardial Infarction (percent adults 18 and older) | 2.8                  | 4.1           |
| Angina or Coronary Heart Disease (percent adults 18 and older)      | 2.6                  | 4.1           |
| Stroke (percent adults 18 and older)                                | 3.4*                 | 2.6           |
| <b>Diabetes:</b>  |                      |               |
| Diagnosed with Diabetes (percent adults 18 and older)               | 8.3                  | 8.7           |
| <b>Asthma:</b>  |                      |               |
| Current Asthma (percent adults 18 and older)                        | 10.4*                | 9.1           |
| Lifetime Asthma (percent adults 18 and older)                       | 16.0*                | 13.8          |
| Current Asthma (percent children 17 and under)                      | 18.0*                | 8.4           |
| Lifetime Asthma (percent children 17 and under)                     | 22.4*                | 12.4          |

**C. Health Disparities:** Race/ethnic health disparities are presented below.

- Non-Hispanic black infants account for a disproportionate percentage of all infant deaths.
- Hispanic females were expected to live the longest in the District (88.9 years), followed closely by Hispanic males (88.4 years).
- Hispanics newly diagnosed with HIV were more likely to be younger than other racial groups.

- Blacks/African Americans have the highest obesity rates, and are least likely to exercise or consume the recommended serving of fruits and vegetables.
- The crude death rate due to diabetes for Blacks/African Americans was seven (7) times the rate for Whites in 2010.
- Blacks/African Americans were over three (3) times more likely to die from cerebrovascular diseases compared to their white counterparts.

**D. Homelessness:** The Community Partnership for the Prevention of Homelessness (TCP) conducts the Point in Time (PIT) census and survey of persons who are homeless on behalf of the District. This single-day count was conducted on January 28, 2015. There were: 1) 1,593 unaccompanied individuals and 66 persons in families who met the federal definition of “chronic homelessness” (living with disabilities and lengthy or repeated episodes of homelessness), and 2) 7,298 persons experiencing homelessness were counted including: 544 unsheltered (living on the street or places not meant for habitation) and unaccompanied; 5,085 in emergency shelters (2,612 unaccompanied and 2,473 people in 768 families); and 1,669 in transitional housing (665 unaccompanied and 1,004 people in 363 families).

▪ ***PIT Count by Category:***

| Category                    | 2014  | 2015  | Percent Change |
|-----------------------------|-------|-------|----------------|
| Total Number Counted        | 7,748 | 7,298 | -5.8%          |
| Total Number of Individuals | 3,953 | 3,821 | -3.3%          |
| Total Number of Families    | 1,231 | 1,131 | -8.1%          |
| Total Persons in Families   | 3,795 | 3,477 | -8.4%          |
| Total Adults in Families    | 1,559 | 1,428 | -8.4%          |
| Total Children in Families  | 2,236 | 2,049 | -8.4%          |

The decreases are largely due to the District’s continued investment in permanent housing solutions for individuals and families. While the continuum of care continues to see more new individuals and families enter the system, Permanent Supportive Housing and Rapid Rehousing resources have helped increase the rate of exits from homelessness, especially among persons who are chronically homeless. There were 4,415 individuals and 6,129 people in 2,016 families residing in Permanent Supportive Housing, Rapid Rehousing, or other permanent housing for persons who had previously experienced homelessness.

▪ ***Other Characteristics:***

| Characteristic  | Age/Number/Percent |
|---|--------------------|
| Median age unaccompanied homeless persons                 | Age 50             |
| Median age among adults in homeless families              | Age 25             |
| Unaccompanied minors in shelters, transitional housing    | 7                  |
| Served in United States Armed Forces                      | 10%                |
| No income unaccompanied homeless adults                   | 66%                |
| No income adults in homeless families                     | 14%                |
| Adult homeless history of substance use or mental illness | 1 in 5             |
| Adult homeless with substance use and mental illness      | 9%                 |
| Adult homeless with chronic health problem                | 8%                 |
| Adult homeless with physical disability                   | 13%                |

|  |     |
|--|-----|
| Adult homeless history of domestic violence          | 15% |
| Adult homeless domestic violence caused homelessness | 6%  |

## II. Overview of the District of Columbia Department of Behavioral Health

The mission of the Department of Behavioral Health (DBH) is to support prevention, treatment, resiliency, and recovery for District residents with mental health and substance use disorders through the delivery of high quality, integrated services. DBH serves as the District of Columbia State Mental Health Authority and the Single State Agency for substance abuse. The primary components of the DBH organizational structure is described below.

- A. Behavioral Health Authority (BHA):** The BHA supports the overall administrative mission of DBH and encompasses the functions necessary to support the entire system. It is responsible for: 1) establishing priorities and strategic initiatives; 2) system planning and policy development; 3) planning and developing mental health and substance use disorder services; 3) ensuring access to services; 4) monitoring the service system; 5) regulating the providers within the District's public behavioral health system including certifying providers of mental health rehabilitation services, substance abuse treatment centers, and licensing mental health community residential facilities; 6) providing grant or contract funding; and 7) coordinating fiscal services; accountability functions; and information systems.
- B. Office of Programs and Policy (OPP):** The OPP is responsible for the design, delivery, evaluation and quality improvement of behavioral health services and support for children, youth, families, adults, and special populations to maximize their ability to lead productive lives. This includes a variety of services and supports: 1) early childhood and school mental health programs; 2) care coordination; 3) same-day or walk-in services; 4) multicultural outpatient services; 5) physicians practice group; 6) outpatient competency restoration; 7) outpatient forensics; 8) crisis emergency services; 9) homeless outreach; 10) assertive community treatment; 11) supported housing; 12) supported employment; 13) services for individuals who are deaf and for persons who are developmentally disabled with a psychiatric illness; 14) a training institute, community services reviews, applied research and evaluation; two (2) government operated outpatient clinics; 15) development and implementation of substance use disorder treatment services, prevention services, and recovery support services; and 16) the private provider network.
- C. Care Coordination:** The Access Helpline (AHL) is the DBH call center. It is the major point of entry into the behavioral healthcare system. As of June 2015, there were 79,594 incoming and outbound calls. AHL activities include: 1) enrollment for Mental Health Rehabilitation Services (MHRS); 2) authorization for specialty services including Assertive Community Treatment, Community-based Intervention, Intensive Day Treatment, Rehabilitation Day Services and Crisis Stabilization (crisis beds); 3) authorization and review of involuntary hospitalization admissions; 4) crisis response and deployment of emergency response teams for adults (Mobile Crisis Services) and child/youth (Child and Adolescent Mobile Psychiatric Services); 5) discharge planning and disenrollment from MHRS; 6) coordination of services; and 7) 24-hour access to suicide prevention and intervention services. As of June 2015, there were 45,981 Crisis Line inbound calls, 3,265 DBH Suicide Lifeline calls, and 352 calls to the

Washington Metropolitan Area Transit Authority Lifeline (through AHL) for citizens identified within Metro stations who are in need of support.

- D. Provider Relations:** Provides support that enhances the success and effectiveness of the DBH provider network development. This includes both mental health and substance use disorder providers. The services include technical assistance for adult and child providers related to: 1) front desk operations- intake processes, billing and claims operations, coordination of benefits, HIPAA compliance, utilization review and medical records and development of administrative and clinical forms; 2) liaison between providers, DBH and other government agencies including coordinating services, providing information, coordinating meetings between providers and other agencies; 3) primary center for distribution of information to providers; 4) central point for troubleshooting provider problems, issues and concerns or responding to stakeholder issues related to providers; 5) coordinate monthly and semi-annual meetings with individual providers and key DBH staff; and 6) manages provider closures in collaboration with other DBH divisions, providers, stakeholders and third party payers including transition of consumers and closeout payment.
- E. Office of Accountability:** Provides three (3) distinct functions: 1) quality improvement audit- includes oversight of MHRS providers to ensure they meet or exceed the service delivery and documentation standards, substance abuse treatment and recovery services, Mental Health Community Residence Facilities (MHCRF) and comply with applicable District and federal laws and regulations, monitor the provider network, investigate complaints and unusual incidents, and make policy recommendations; 2) certification/licensure-certifies DBH provider agencies, licenses of all MHCRFs, additionally these units monitor provider compliance with DBH regulations and local and federal laws, generates and enforces corrective action plans when necessary, monitors facilities on a regular basis, issuing notices of infraction when necessary; and 3) investigations- conducts major investigations of critical incidents, presents a disposition of the matter, and develops the final investigative report that is submitted to the DBH Director, General Counsel and other appropriate parties, to ensure that the needs and treatment goals of individuals in care are identified and addressed.
- F. Office of Strategic Planning, Policy and Evaluation:** Responsible for coordination and/or development of DBH, District and federal planning initiatives. The functions include: 1) coordinate, in collaboration with program staff, the development of draft regulations, stakeholder input process and publication and dissemination of regulations to support new programs, initiatives and functions; 2) draft DBH policies based upon input received from program and executive staff including identification of need, coordination with program area, review of other policies/regulations/laws, solicitation of comments from staff and stakeholders, finalize, publish and disseminate; 3) management of the DBH grants portfolio including the Substance Abuse and Mental Health Services Administration Mental Health Block Grant; 4) District agency performance planning and management including the development of the DBH performance plan, key performance indicators and Performance Accountability Report; and 5) inter-agency coordination.
- G. Organizational Development:** Consists of the Applied Research and Evaluation (ARE) Unit and the Community Services Review (CSR) Unit.

- **ARE:** Creates data reports for mental health and substance use disorder services and disseminates findings to internal stakeholders. This unit helps create data tracking systems, conducts research studies and program evaluations, and makes recommendations for practice improvement activities. It is responsible for collecting consumer satisfaction data and reporting the findings. ARE produces a semi-annual data report on utilization and expenditures, the *Mental Health Expenditures and Service Utilization Report* (MHEASURE). ARE also conducts analysis on Crisis Intervention Officer (CIO) data.
- **CSR:** Conducts case-based qualitative reviews for use in system performance monitoring. It provides technical assistance to the DBH provider network regarding CSR findings. This unit conducts reviews on child mental health consumers and services (in collaboration with the Child and Family Services Agency), adult mental health consumers and services, and is in the process of creating a tool to assess substance use consumers and services.

**H. Training Institute:** Coordinates and supports the workforce needs of DBH and the community behavioral health providers. It collaborates with other District agencies, learning institutions and community stakeholders to facilitate educational opportunities designed to build a strong behavioral health community. Current interagency partnerships include: 1) **Metropolitan Police Department- Crisis Intervention Officer (CIO)** training and program support (40-hour CIO training 5 times annually and 8-hour CIO Refresher training twice annually) and trains all incoming police recruit classes in behavioral health concepts, resources and crisis response; 2) **Office of Police Complaints-** developing internal safety policies and training to prepare employees for potential crises that may erupt during the complaint process; 3) **Department on Disability Services-** in FY 2015 launched collaborative training to build capacity among behavioral health clinicians to provide services to individuals dually diagnosed with mental illness/substance use disorder and intellectual disabilities; 4) **District of Columbia Public Schools-** launched e-learning course series in FY 2015 to train all public school, public charter school and child development center staff in the screening and referral of youth with emotional and mental health issues; and 5) **Person-Centered Care-** an ongoing initiative to transform the assessment and treatment planning process to improve consumer outcomes throughout the behavioral health system. As of June 2015, more than 4,500 classroom attendees were trained in behavioral health concepts, and over 7,500 continuing education contact hours were awarded to over 1,000 licensed attendees.

**I. Office of Disaster Behavioral Health Services (ODBHS):** Leads emergency preparedness efforts with the guidance of the **Emergency Preparedness Coordinating Committee**. ODBHS develops and implements a plan that ensures DBH is prepared to quickly mobilize and provide behavioral health services in the event of a disaster or emergency. To ensure continuity of consumer care, DBH certified providers and certified community residential facility operators must have internal policies and procedures to prepare for and respond to emergencies, and a written plan to ensure that essential operations continue in the event of an emergency or threat of an emergency. **Behavioral Health Response Teams** provide rapid and effective disaster behavioral health crisis counseling and stress management. They are DBH staff clinicians trained and experienced in providing disaster and emergency behavioral

health assessments, interventions, and referrals for long-term treatment offered in a variety of settings. DBH ***Disaster Behavioral Health Emergency Response Team Certification Program*** provides the critical knowledge areas that allow the responders to work with the public health, law enforcement, and emergency management systems to address the behavioral health consequences during wide spread community incidents. In 2014, ODBHS responded to and received an award for group achievement from the Secretary of the Navy for their role in support to survivors of the Navy Yard Shooting. As of June 2015, 73 people were trained in disaster behavioral health response and there were 90 response team members.

- J. Office of Consumer and Family Affairs:** Works to ensure the rights of people with behavioral health issues are protected including: 1) encourages and facilitates consumer and family input in all aspects of an individual's treatment and plan for recovery; 2) ensures providers post a consumer rights statement and receives and responds to all grievances; 3) provides grievance training for DBH providers; and 4) works with the Office of Disability Rights to sponsor the annual ***Olmstead Conference*** to promote community integration of individuals with disabilities. A 6-week ***Peer Certification Program*** is offered twice a year to train individuals with lived experience to assist others receiving behavioral health services move towards and sustain their recovery. Some peer support staff work within the public behavioral health system. The services provided by the certified peer specialists are Medicaid reimbursable. As of June 2015, 100 individuals with lived experience have been certified through this program. A ***Child-Youth-Family Specialty*** Track has also been developed. As of June 2015 12 family members have been certified. The office will also oversee a peer focused activity center, ***Our Door***, scheduled to open during the first quarter of FY 2016. The purpose of the community peer operated activity center is to: 1) assist people with psychiatric illness who may also have co-occurring substance use disorder and medical conditions, regain control over their lives and their own recovery process; 2) achieve this goal in an environment that is conducive to support for self-directed recovery, advocacy, education, and information and referral services based on consumer experience, knowledge and input; and 3) provide activities that include: recreational and social, educational, Peer Support and Peer Advocacy groups, health education and linkages to medical care including participating in health fairs, community resource identification, assistance with benefits and entitlement applications; improvement of social interpersonal skills and life skills validation (e.g., Wellness Recovery Action Plan (WRAP) classes); and education on consumer rights.
- K. Saint Elizabeths Hospital (SEH):** The SEH provides psychiatric, medical, and psychosocial inpatient psychiatric treatment to adults to support their recovery and return to the community. The Hospital's goal is to maintain an active treatment program that fosters individual recovery and independence as much as possible. In addition, this program manages logistics, housekeeping, building maintenance, and nutritional services at SEH, to ensure the provision of a clean, safe and healthy hospital environment for individuals in care, their families, and staff. The Hospital also ensures staff credentialing and licensing privileges, and provides medication and medical support services to eligible inpatients in order to effectively treat mental illness and enhance recovery. The Hospital is licensed by the District's Department of Health as well as the U.S. Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services.



### III. Overview of Adult Service System

The primary goal for the adult service system is to develop and provide an integrated system of care for adults with serious mental illness and/or co-occurring substance use disorders. DBH contracts with community providers for mental health services and supports. The adult mental health rehabilitation services (MHRS) include: 1) diagnostic/ assessment; 2) medication/somatic treatment; 3) counseling; 4) community support; 5) crisis/emergency; 6) rehabilitation/day services; 7) intensive day treatment, and 8) assertive community treatment (ACT). As of June 2015, there were 37 total MHRS providers that included 25 core service agencies, and 14 adult and child serving agencies.

Also, as of June 30, 2015 there were 15,847 adults age 18 and above, of which 15,707 were seriously mentally ill. Some of the adult system of care behavioral health program initiatives, treatment services and supports are described below.

- A. Integrated Care:** Seeks to reduce the inpatient census and admissions to Saint Elizabeths Hospital by: 1) identifying consumers who need a comprehensive array of services that include mental health, non-mental health, and informal support services to integrate to their fullest ability in their communities and families; 2) coordinates, manages, and evaluates the care for these consumers to improve their quality of life and tenure in a community setting; and 3) provides care management services to individuals with complex mental health needs as well as those discharged from a psychiatric inpatient stay in a community hospital.
- B. Health Homes:** This initiative is a joint effort by the Department of Behavioral Health and the Department of Health Care Finance. The primary goals include: 1) improve care coordination; 2) prevent avoidable hospital and emergency room visits; 3) improve the overall health status of persons with serious mental illnesses; and 4) reduce health care costs. The eligibility requirements are: 1) age 18 or above; 2) Medicaid eligible and enrolled; 3) have a serious mental illness; and 4) may or may not have a co-existing chronic physical condition. During FY 2015 the State Plan Amendment (SPA) was submitted to the Centers for Medicare and Medicaid Services (CMS) for approval. It is anticipated that the Health Homes initiative will be implemented in January 2016.
- C. Crisis Stabilization Beds:** DBH contracts with two (2) community providers for 15 crisis stabilization beds. There are eight (8) beds at Jordan House and seven (7) beds at Crossing Place. As of June 2015, the average quarterly crisis stabilization bed utilization rate was 88.90%.
- D. Crisis Emergency Services:** The Comprehensive Psychiatric Emergency Program (CPEP) is a 24-hour specialty psychiatric unit responsible for assessing and treating individuals with acute and chronic mental illness in or pending psychiatric crisis. It has three (3) components:
  - 1) Psychiatric Emergency Services, 2) Mobile Crisis Services, and 3) Homeless Outreach Program.
  - **Psychiatric Emergency Services (PES):** Medical treatment is available for common medical problems and limited medical testing is conducted. CPEP accepts voluntary patients who come on their own or accompanied by family, friends or healthcare

professionals; and involuntary patients from community settings who are referred by law enforcement, physicians, psychologists or officer-agents. Each patient receives a nursing assessment and a psychiatric evaluation; depending on the clinical presentation, most have a psychosocial assessment and a medical screening. Once a psychiatric evaluation is completed, the patient may be discharged immediately, kept at CPEP for stabilization (up to 72 hours in the Extended Observation Bed unit) or referred for psychiatric hospitalization. As of June 2015, 1,935 unduplicated individuals out of 2,769 visited PES.

- ***Mobile Crisis Services (MCS):*** Provides services to adults experiencing a psychiatric crisis in the community including at home, office or any public area. The team acts quickly as a first responder to adults who are unable or unwilling to travel to receive mental health services and may provide in-field psychiatric assessment, bilingual clinical consultation, medication management, linkages to ongoing services, and follow-up services to assure stability. The team also responds to critical incidents including tragedies and disasters throughout the District. As of June 2015, 861 unduplicated individuals out of 968 received a team visit.
- ***Homeless Outreach Program (HOP):*** Operates as part of the MCS program. Its primary purpose is to provide a variety of mental health outreach services and supports to adults and families who are homeless. These services include: mental health assessments, crisis intervention, care coordination between mental health agencies, and referrals to other services. As of June 2015, 472 unduplicated persons received engagement services out of 1,541. The HOP also provides consultation and training to the provider network working most closely with this population.
- ***Technical Assistance through SAMHSA-*** In May 2015, DBH developed a technical assistance request through the SAMHSA TA Tracker to evaluate and develop strategies to enhance the quality of service delivery and therapeutic efficiency of CPEP's three (3) complementary programs (PES, MCS, and HOP). Other goals included: 1) a review of the literature and/or examples of other state/jurisdiction operation of urban emergency psychiatric services, including the use of evidence-based practices, outcomes and limitations; and 2) development of strategies and roadmap for CPEP to incorporate relevant evidence-based practices and tools into psychiatric care delivery, thereby improving quality and enhancing staff development. The TA request was approved in June 2015. Mark Engelhardt, an expert in both crisis services and homelessness, was the assigned consultant. There was an exchange of documents, a planning conference call, and a 2-day site visit August 6-7, 2015. The consultant report was received at the end of August and was very positive with some short-term follow-up actions.

**E. Mental Health Services Division (MHSD):** Manages the DBH operated mental health services for adults to ensure accessibility and effectiveness of services and cost efficient use of resources. It provides specialized mental health services that are not otherwise readily available within the community provider network. The MHSD programs are described below.

- ***Same Day Urgent Care Clinic Services-*** Provides same day service for walk-in adult mental health consumers who need immediate assessment or medication. Interventions include triage, assessment, supportive counseling, crisis intervention, medication services

and linkage to ongoing services. As of June 2015, the average quarterly unduplicated number of adult intakes at the Same Day Urgent Care Clinic was 1,265.

- ***Physicians Practice Group***- Provides psychiatric services to individuals seen for Urgent Care service and mental health consumers who need medication management only. It also provides psychiatric services to support the DBH private provider network with psychiatrists on-site at provider agencies.
- ***Pharmacy Services***- Provides prescribed medication for mental health consumers who are uninsured or underinsured. As of June 2015, 11,850 prescriptions were filled for 2,008 unduplicated consumers.
- ***Multicultural Services***- Provides culturally and linguistically appropriate mental health services for the diverse, racial and cultural communities in the District. As of June 2015, 210 consumers received services from this program.
- ***Deaf/Hard of Hearing Services***- Provides mental health services for mental health consumers who are deaf and/or hard of hearing. As of June 2015, 36 consumers received services from this program.
- ***Intellectual/Developmental Disability Services***- Provides mental health services for mental health consumers who are also intellectually/developmentally disabled. As of June 2015, 163 consumers received services from this program.

**F. Assessment and Referral Center (The ARC):** Adults access substance use disorder treatment services through the DBH ARC. The client participates in a comprehensive assessment and evaluation to determine the appropriate level of treatment and maintenance of care. The DBH Addiction Prevention and Recovery Administration contracts with approximately 30 providers for a continuum of substance use treatment services that include: detoxification, residential, intensive outpatient, and outpatient.

**G. Intake Points for Behavioral Health Services:** There are four (4) primary intake points for behavioral health services that include: 1) DBH operated programs- The ARC, Comprehensive Psychiatric Emergency Program (CPEP), and Saint Elizabeths Hospital (SEH); 2) DBH contracted program- Court Urgent Care Clinic; 3) Acute psychiatric hospitals- Providence Hospital-Seton House, Psychiatric Institute of Washington, and Washington Hospital Center; and 4) substance use disorder contractors- Community Connections and Family and Medical Counseling Services, Inc.

**H. D.C. Prevention Centers:** DBH funds four (4) DC Prevention Centers (DCPCs) that are designed to strengthen the community's capacity to reduce substance use and prevent risk factors. The DCPCs are dynamic, community-based hubs that serve two (2) wards each and include: 1) Latin American Youth Center (Wards 1 & 2); 2) National Capital Coalition to Prevent Underage Drinking (Wards 3 & 4); 3) Sasha Bruce Youthwork, Inc. (Wards 5 & 6); and 4) Bridging Resources In Communities (Wards 7 & 8). The services include community education, community leadership, and community change. Community education focuses on current, relevant drug use/access information. Community leadership builds the prevention capacity of current and emerging leaders and identifies potential community prevention networks (CPNs) for data-driven planning. It also facilitates the CPNs in the 5-step Strategic Prevention Framework action planning (assessment, capacity building, strategic planning, implementation, and evaluation). Community change involves working with the networks in

action plan development and implementation. The Centers address measures for three (3) outcomes: 1) changes in priority risk and protective factors; 2) community changes (e.g. new policies, programs, and practices that address the prevention needs assessment and action planning); and 3) distal or behavioral outcomes.

- I. Adult Substance Abuse Rehabilitative Services (ASARS):** This initiative began in FY 2013 through a partnership with the Department of Health Care Finance to amend the ASARS State Plan Amendment (SPA) and develop regulations that will allow implementation of Medicaid services and billing. The work continued through FY 2015 as there were delays due to revision of the rules and transitioning to the iCAMS data processing system. It is anticipated that the implementation will begin in FY 2016.
- J. Forensic Outpatient Services:** This service: 1) provides court ordered outpatient competency restoration and evaluations for pre-trial defendants at the adult clinic; 2) provides court ordered evaluations at the D.C. Superior Court for both pre-trial and post-trial defendants; 3) provides medication monitoring and management for Not Guilty By Reason of Insanity (NGRI) individuals who have been discharged from Saint Elizabeths Hospital and reside in the community with an order of conditions; and 4) provides mental health liaisons to the D.C. Superior Court, jails and prisons to link justice involved individuals to services and coordinate care on their behalf.
- ***Pre-Trial and Re-Entry Forensic Services-*** Links pre-trial individuals and returning citizens to mental health services. Also, works to maintain the connection if an individual is incarcerated.
  - ***Court Urgent Care Clinic Services (D.C. Superior Court)-*** Serves individuals in the criminal justice system who are in need of immediate mental health and/or substance use disorder services. Individuals can be referred by a judge, pre-trial officer, probation officer or an attorney. This partnership between D.C. Superior Court, DBH and Pathways to Housing DC (contractor), allows immediate access to support services and establishes linkages to long-term providers to ensure effective treatment alternatives and prevent repeat offenders. A DBH Mental Health Liaison is co-located at the Court to: 1) provide screenings and mental health assessments for the Pre-trial Services Agency (PSA) and makes referrals for mental health services; and 2) authorize ACT services for the Options and D.C. Linkage Plus programs. The data through June 2015 include: 1) 638 total referrals seen; 2) 536 total patient referrals; 3) 139 total discharges; and 4) 142 unique individuals seen.
  - ***Re-entry Program Services-*** These services include: 1) the Options Program operated by Community Connections provides services to individuals with pre-trial supervision requirements or those being released from the D.C. Jail or prison; 2) the Mental Health Specialists located at the D.C. Jail screens and links individuals requiring mental health services or co-occurring substance use disorder programs, and coordinates release planning activities for those already linked to DBH; 3) the D.C. Linkage Plus Program operated by the Green Door serves individuals with misdemeanor and felony charges previously unlinked to mental health services, referrals generally occur within 90 days of release and individuals are seen within 48 hours of referral (made through DBH Jail and Re-entry Coordinators); and 4) the Liaison Coordinator, co-located with the Department

of Employment Services with the Court Services and Offender Supervision Agency (CSOSA), screens and links individuals to services.

- K. D.C. Jail-Women's Facility:** DBH received funds from the Justice Grants Administration (JGA), the State Administering Agency (SAA) that secures and manages federal grant funds related to juvenile and criminal justice for the District. These funds allowed a DBH Re-entry Coordinator to be placed at the D.C. Jail Women's Facility to facilitate women with mental health and/or substance use disorder issues being linked prior to discharge with the appropriate service provider. Women may be newly linked or re-linked to mental health services. As of June 2015, the average quarterly number of women provided services was 76.
- L. Assertive Community Treatment Services:** DBH implements this evidence-based intensive, integrated, rehabilitative, treatment and community-based service provided by an interdisciplinary team to adults with serious and persistent mental illness. DBH ACT teams include a Team Leader, psychiatrist, registered nurse, social worker, certified addictions counselor, peer support specialist, supported employment specialist, and recovery specialist. The services provided include: 1) mental health-related medication prescription, administration, and monitoring; 2) crisis assessment and intervention; 3) symptom assessment, management and individual supportive therapy; 4) substance use treatment for consumers with co-occurring addictive disorder; 5) psychosocial rehabilitation and skill development; 6) interpersonal, social, and interpersonal skill training; and 7) education, support and consultation to consumers' families and their support system, which is directed exclusively to the well-being and benefit of the consumer. There are seven (7) ACT providers that have 21 teams. The Dartmouth Assertive Community Treatment Scale is used annually to review each team. DBH also developed an ACT Review Tool to assess the quality of services provided. DBH has two (2) combined Transition to Independence (TIP) and ACT teams, known as TACT, that target transition age youth (18-29). As of July 2015, 1,750 consumers were being served by ACT teams.
- M. Supported Employment Services:** DBH provides an evidence-based Supported Employment Program designed for adult consumers (age 18 and older) with serious mental illness for whom competitive employment has been interrupted or intermittent as a result of a significant mental health problem. Supported employment involves obtaining a part-time or full-time job where there consumer receives supports in a competitive employment setting and earns at least minimum wage. The services provided to consumers participating in a DBH Supported Employment Program are: intake, assessment, benefits counseling, treatment team coordination, job development, job coaching, follow-along supports, and job club for those on an agency internal waiting list (optional). DBH currently has 10 certified Supported Employment providers with a total of 40 Employment Specialists, each carrying a maximum caseload of 20 clients. The maximum DBH capacity is 800. DBH uses a 14-point fidelity scale to annually review and rate the quality of supported employment services. As of June 2015, 1,113 consumers received supported employment services, 370 were employed, and the average hourly salary was approximately \$11.15. The jobs included dishwasher, housekeeper, mover, welder, receptionist, pressman, self-employed driver, optician, medical assistant, and research assistant.

**N. Supported Housing Services:** DBH has an array of supportive housing options for persons with serious mental illness.

- ***Supported Rehabilitative Residence-*** Provides 24-hour supervision for consumers with severe and persistent mental illness who need an intense level of support to live in the community. The services include: 24-hour awake supervision; assisting the consumer to obtain medical care; providing training and support to assist consumers in mastering activities of daily living; maintaining a medication intake log to ensure that residents take their medications as prescribed; provision of 1:1 support to manage behaviors or perform functional living skills; transportation to doctor's appointments; assistance with money management; and participation in treatment planning, implementation, and follow-up. The FY 2015 capacity is 208.
- ***Supported Residence-*** This service is for individuals who need less intense support to live in the community. Specific services include: on-site supervision when residents are in the facility; medication monitoring and maintenance of a medication log to ensure that medication is taken as prescribed; assistance with activities of daily living; arrangement of transportation; monitoring behaviors to ensure consumer safety, and participation in treatment planning and follow-up. In addition, DBH provides services and supports to assist individuals to transition to living on their own. The FY 2015 capacity is 453.
- ***Supported Independent Living Program-*** Provides an independent home setting with services and supports to assist consumers in transitioning to living on their own. Community support workers conduct weekly home visits and monitoring to ensure that the individual is able to maintain community tenure and move to independent living. DBH manages locally funded programs that offer rental assistance to individuals enrolled in mental health services who live independently. The FY 2015 capacity is 366.
- ***Home First II Housing Subsidy Program-*** Provides housing subsidies for individuals and families who live in an apartment or home of their choice and sign their own leases. Consumers pay 30% of their household income toward their rent and the Home First Program subsidizes the balance of the rental amount. This program is administered by DBH and supported with locally-appropriated funds. The FY 2015 capacity is 1,105.
- ***D.C. Local Rent Supplement Program-*** Designed to increase the number of permanent affordable housing units and provide housing assistance to extremely low-income households, including individuals who are homeless or need supportive services, such as elderly individuals or those with disabilities. It follows the rules and regulations of the federal housing choice voucher program, is administered by the D.C. Housing Authority, and is supported through local funds. The FY 2015 capacity is 60.

**O. Federal Voucher Programs:** The FY 2015 capacity for federal vouchers is 586. They include the following programs:

- ***Shelter Plus Care-*** Provides rental assistance with supportive services for hard-to-serve homeless persons/families with disabilities, primarily those who are seriously mentally ill; have chronic problems with alcohol/drugs; or suffer with HIV/AIDS and related diseases. Tenants pay 30% of their household income toward their rent. In the District, the program is administered by The Community Partnership for the Prevention of Homelessness. A primary requirement is that each dollar of rental assistance must be matched with an equal or greater dollar value of supportive services.

- **Housing Choice Voucher Program-** Formerly Section 8, this federal low income assistance program is administered through the D.C. Housing Authority (DCHA) and via a memorandum of agreement DBH has a set-aside of vouchers for individuals with serious mental illness.
- **Mainstream Housing For People With Disabilities-** The U.S. Department of Housing and Urban Development Mainstream Program provides federal vouchers for individuals with disabilities and is administered through DCHA.
- **Partnerships for Affordable Housing-** This project-based voucher program provides housing for low-income disabled or elderly families and is administered by DCHA.

**P. Homeless Services Initiatives:** As previously noted, the Homeless Outreach Program (HOP) is part of Mobile Crisis Services (MCS) within the Comprehensive Psychiatric Emergency Program (CPEP). The HOP staff conducts targeted outreach and case finding for consumers who reside in locations unfit for human habitation (e.g., streets, abandoned vehicles, buildings); low barrier shelters; transitional programs; and other temporary residences.

- **Case Finding-** The resources for case finding include: 1) street and shelter outreach; 2) adult and family shelters; 3) District agencies and hospitals; 4) general public, consumers and family members; and 5) Metropolitan Police Department and other policing agencies (District Protective Services, Metro, Amtrak, Capitol Hill, U.S. Park, Homeland Security, FBI, Secret Service).
- **General Services-** The HOP provides a variety of services to homeless adults, emancipated minors and adult heads of families throughout the District. They include: 1) engagement; 2) refer, link, re-link to community support services including the DBH provider network; 3) wellness checks; 4) crisis emergency services (assessment, referral for voluntary FD-12, outpatient mental health treatment); 5) ACT referrals; 6) substance use treatment referrals and transportation; 7) medical referrals and transportation; 8) encampment outreach and evaluations; 9) referral to DBH, Department of Human Services and other housing resources; and 10) cold weather outreach (hypothermia) and safety checks.
- **Veteran Services-** The HOP efforts focus on linking veterans to services such as the VA Medical Center, Veterans Administration Supportive Housing (VASH) program, and the VA Community Resource and Referral Center (CRRC). The CRRC works with homeless and at-risk veterans. Those veterans who cannot or will not be linked to the CRRC receive the full complement of HOP services.
- **SSI/SSDI Outreach Access Recovery (SOAR)-** The HOP staff are trained in SOAR. The new staff are also enrolled as part of the new employee orientation and training. Consumers who are eligible and amenable to receive benefits are targeted for quick assessment and enrolled in programs.
- **Interagency Council for the Homeless (ICH)-** DBH is member of this body of government agencies, public partners, homeless advocates, consumers, and former consumers of homeless services) that convenes to address challenges and plan for solutions to improve access to homeless services and end homelessness. DBH participates in numerous ICH committees including the Executive Committee, Strategic Planning, Housing Solutions, Operations and Logistics, and the Winter Planning Process.

- ***Project for Assistance in Transition from Homelessness (PATH) Grant-*** These funds are used to support the DBH Homeless Outreach Program and the Housing Subsidy Program.
- ***“Cooperative Agreement to Benefit Homeless Individuals – States” (the CABHI grant)-*** The District/DBH was awarded a 3-year grant for \$3 million per year to assist individuals who are homeless with mental health and/or substance use disorders obtain housing. The commitment is to house 300 people per year. The funds will be used to: 1) provide care coordination at DBH with outreach through homeless services providers, and 2) the homeless outreach providers will also provide SSI/SSDI Outreach, Access, and Recovery (SOAR) assistance and peer support.

**Q. Older Adult Initiatives:** As of June 30, 2015, there were 6,815 older adults age 50 and above of which 6,805 were seriously mentally ill. The initiatives that are described include: 1) a District planning grant, 2) DBH focused service reviews, and 3) technical assistance through SAMHSA contracted services.

- ***Long-Term Support Services/No Wrong Door (LTSS/NWD) grant-*** The District has a planning grant and is applying for an implementation grant for a LTSS/NWD system of care within the District. The planning has required significant cooperation and communication between the different health and human services agencies with particular emphasis on the work of the Aging and Disability Resource Center (ADRC) housed within the D.C. Office on Aging. DBH is an integral part of this work group and is sharing its Person-Centered Planning development; web-based information portal; and care coordination efforts for individuals in need of long-term supportive services. While this service is for all elderly and disabled in need, the majority of the population that it will benefit will be the elderly.
- ***Adult Reviews-*** The Community Services Review (CSR) Unit initiated a targeted review of older adults receiving day rehabilitative treatment that began in July 2015. This population was chosen by DBH Adult Services staff to further explore the previous Applied Research and Evaluation (ARE) Unit data analysis findings that indicated older adults are the costliest users of day services. The CSR Unit focused review outcomes may: 1) provide answers about the day services utilization cost relationship for older adults; 2) uncover service needs for this demographic that are not obvious; and 3) inform behavioral health service planning for this population. Preliminary activities included reviewing the literature about older adults with psychiatric illness and day service utilization in order to generate focused questions to supplement the Quality Service Review for an Adult Participant: Field Use Version 1. While 87 consumers were identified only eight (8) met the sampling criteria. The review process involves obtaining their written consent and scheduling interviews with all members of their treatment team and key natural supports. Following the development of narrative reports and data analysis, it is anticipated that a report will be disseminated at the end of September 2015.
- ***Older Adult Services and Community Transition-*** Stephen J. Bartels, MD, MS, a geriatric psychiatrist, Director of the Dartmouth Centers for Health and Aging, and a nationally recognized expert, facilitated a half day meeting on August 24, 2012. The participants included the Department Director and program staff, the mental health advisory councils, long-term care advocates, and other District agencies. The discussion addressed the needs, strengths, challenges and opportunities for effective intervention



with older adults in general, and a specific focus on service transition issues involving nursing homes. Dr. Bartels' research and model on core principles for skills teaching has been successful in diverting individuals from nursing home care.

- **Olmstead Presentation-** The Department requested that Dr. Bartels conduct a presentation and co-facilitate the discussion with the District inter-agency committee charged with developing a plan to address the issues raised in the *Thorpe vs. The District of Columbia* Olmstead Case. The plan focuses on supports and services necessary for persons who are disabled living in nursing home facilities to transition to integrated, community-based settings. This half-day meeting was held October 18, 2012.
- **Older Adult Day Services Program-** In March 2013, the Department continued the technical assistance relationship with Dr. Bartels to explore developing an Older Adult Day Services Program. Two (2) models were discussed: 1) an outreach model, and 2) a skills training model. Dr. Bartels assisted the Department staff with scheduling a site visit to a program that was implementing aspects of the models discussed. On June 13, 2013 the Department Senior Deputy Director and the Adult Services Director visited the Boston VINFEN Corporation, lead organization for the Center for Medicare and Medicaid Innovation (CMMI) grant. They were able to discuss with leadership and management various aspects of program operations and implementation. The next step involved a review of the overall Departmental Day Treatment Service programs. The on-site technical consultation with Dr. Bartels occurred August 22-23, 2013. The first day involved site visits to the day treatment facilities. On the second day, Dr. Bartels facilitated a meeting with providers to discuss: 1) positive aspects of program service delivery; 2) areas for improvement in program service delivery; and 3) curricula and/or other things that might be helpful for the programs. The day ended with a meeting with the Department Director. The summary of findings included specific observations about each program and a general finding that *“given the short amount of time that these programs have been implemented, the programs have all achieved remarkable (though varied) progress and would benefit from working together to share successes, challenges, and “lessons learned”. Such a group effort would also be beneficial in working with the Department to collaborate in defining clear goals and benchmarks consistent with age-appropriate, high quality integrated rehabilitative services targeting older adults with serious mental illness.”*

**R. Mental Health Statistics Improvement Program (MHSIP) Survey:** The MHSIP adult consumer survey measures concerns that are important to consumers of publicly funded mental health services. The DBH FY 2015 MHSIP survey is in the data collection phase that is expected to be completed by the end of September 2015. The data reported is for the DBH FY 2014 MHSIP survey. The adult sample size was 445. The findings are reported across the seven (7) domains.

- **Access to Care-** 78% of respondents reported positively to this domain.
- **Participation in Treatment Planning-** 80% of respondents reported participation in this domain.
- **Quality and Appropriateness-** 86% of respondents reported positively to this domain.
- **Social Connectedness-** 71% of respondents reported positively to this domain.
- **Functioning-** 73% of respondents reported positively to this domain.
- **Outcomes-** 69% of respondents reported positively to this domain.

- **General Satisfaction with Services-** 82% of respondents reported positively to this domain.

**S. Adult Mental Health First Aid (MHFA):** Adult MHFA is a public education program that introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and overviews common treatments. It allows early detection and intervention by teaching participants about the signs and symptoms of specific illnesses like anxiety, depression, schizophrenia, bipolar disorder, eating disorders, and addictions. As of June 2015, DBH and community certified MHFA trainers conducted 18 courses training 384 individuals. The trainee affiliations included: colleges and universities, health centers, DBH staff and providers, other behavioral health agencies, certified Peer Specialists, community organizations, U.S. Army, and U.S. Department of Interior staff.

**T. Adult System of Care Mental Health Block Grant (MHBG) Funded Projects:** Several MHBG projects were implemented during FY 2015 that focus on adult populations.

- **Peer Support Services-** There are two (2) projects in this category. 1. Open Arms Housing, Inc. Integration and Expansion of Peer Support Services (PSS) Project goal is to fully integrate PSS at both the Dunbar and Owen House facilities to include on site outreach and engagement, orientation to building and apartment, unit assistance in obtaining rental subsidy, help with activities of daily living, supportive counseling, crisis intervention, and linkage to off-site services, such as mental health treatment, alcohol and drug abuse counseling, and assertive treatment teams. The project targets 20 adult single women on the District's homeless vulnerability list (living on the streets, referred to by the shelters, soup kitchens, day centers, or self-referred). 2. PRS, Inc. Peer Support Training in Whole Health Action Management (WHAM) Project supports hiring a part-time peer Recovery Support Specialist (RSS) including their participation in the WHAM training program, and offering this program at the DC Recovery Academy. Target group includes 48 young adults age 18-25 or older, diagnosed with co-occurring mental illness/substance use disorder, who are unemployed, homeless, involved with the criminal justice system, and/or identify as LGBTQ.
- **Housing Special Populations-** DBH *Supportive Housing for Special Populations Project* provides "bridge" rental subsidies to consumers transitioning from higher levels of care into independent living. The target group involves approximately 17 adults with serious mental illness who are: formerly homeless or at risk of homelessness, pending discharge from Saint Elizabeths Hospital, residing in community residential facilities (CRFs), single-room occupancy (SROs) properties, and/or being released from jail/prison.
- **Housing Women Who Are Homeless-** The Institute of Urban Living - *Hyacinth's Place Project* services include: intensive case management, mental health treatment, job readiness and vocational counseling, substance abuse education/recovery, and medication education. It includes 135 women, 15 residents at Hyacinth's Place plus three (3) cohorts of 40 women each from the waiting list.
- **Housing Adults Who Are Homeless-** Miriam's Kitchen *Mission Possible: Housing the Chronically Homeless Project* serves 4,500 homeless adults overall, a sub-set of 1,250 will receive intensive 1:1 case management services and ultimately 50 chronically homeless adults will be placed in Permanent Supportive Housing.

- ***Week End Socialization Program-*** The *FamilyLinks Outreach Center, Inc. Project* focuses on persons who, because of the challenges presented by their mental illness, are not able and/or not yet ready for regular, salaried employment. The program emphasizes self-care and health, as well as recreation and self-development. It serves 30-35 adults and while the ages vary most are between the ages of 45 and 85.
- ***Trauma and Recovery Initiative-*** The Women's Collective (TWC) *Trauma Recovery and Empowerment Model (TREM) @ TWC Project* involves implementing this model with 20 urban, low-income African American women ages 18 and above, living with HIV/AIDS, psychological and trauma symptoms, and co-occurring substance use disorder.
- ***Creative Expression-*** The *Spoken Word Lens and Pens Creative Expression Project* provides weekly creative writing and photography workshops for 20-25 seriously mentally ill male and female adults in care at Saint Elizabeths Hospital with a focus on the maximum security population.
- ***Primary Health and Behavioral Health Initiatives-*** There are three (3) projects in this category. 1. So Others Might Eat (SOME) *Warm Handover: An Approach to Integrated Health Care Project* that involves providing 70 adults in the SOME Medical Clinic with as many real-time linkages between providers and clients as possible. The goals include: use brief tools to quickly assess mental health conditions or substance use disorders; use Motivational Interviewing to motivate clients to consider taking steps towards positive changes; and link as many clients as possible to needed services they would not otherwise access. 2. Volunteers of America Chesapeake, Inc. *Improving Healthcare for Consumers with Co-occurring Medical, Substance and Mental Health Disorders Program* provides services for 50 adults with mental illness and substance use disorders (including cigarettes) who have been diagnosed with and/or at risk for a somatic/physical illness. 3. The MedStar Health Research Institute *Embedding Psychiatry into Primary Care: Improving the Quality of Behavioral Health Services through an Integrated Care Delivery Model* goal is to improve services by using a co-location model (mental health specialist in the primary care setting). It targets 25 adults age 18 and older who are new patients or coming for a follow-up visit at the MedStar Washington Hospital Center Internal Medicine Ambulatory Care Clinic.
- ***Veteran Initiatives-*** There are three (3) projects in this category. 1. The University of the District of Columbia Foundation *Supporting our Service Members- SOS Project* places emphasis on opportunities for veterans to receive linkages to care related to education and mental health support (and related issues) to address the gaps facing student military personnel. 2. The Work First Foundation *Back to Work Boot Camp Project* goal is to provide 30 individuals who identify as Veterans, Active Duty, National Guard, Reserves, or spouses and/or children, comprehensive case management, employment readiness and placement, and retention services that lead to the self-sufficiency and stability. 3. The Wendt Center for Loss and Healing *Mental Health Services for Veterans, Active Duty Military and Families Project* goal is to help them access effective, culturally sensitive mental health services to overcome obstacles to healthy functioning. The target is 75 veterans, active duty members of the military and their family members over two (2) years. Most participants have been exposed to trauma and are experiencing major depressive disorder, PTSD, and possible co-occurring substance use. Additionally, through the Wendt Center media and outreach component, the project serves the broader

military community in the District through raised public awareness of mental health issues and services.

#### **IV. Overview of Child and Youth Service System**

The primary goal for the child and youth service system is to ensure that all children/youth and their families have access to a coordinated system of care that is easy to navigate, community-based, family-driven, youth-guided, and able to meet their multiple and changing needs. The Child and Youth Services Division (CYSD) is responsible for developing a comprehensive system of care for children, adolescents, transition aged youth and their families, that promotes prevention, early intervention, and treatment.

The Department contracts with community providers for mental health services and supports. The child/youth mental health rehabilitation services (MHRS) include: 1) diagnostic/ assessment; 2) medication/somatic treatment; 3) counseling; 4) community support; 5) crisis/emergency; and 6) community-based intervention.

As of June 30, 2015, there were 3,879 children/youth ages 0-17 in the child system of care, of which 3,257 had serious emotional disturbances. The description that follows includes a variety of services and program initiatives including behavioral health prevention, early intervention, treatment services and supports for children, youth, transition age youth, young adults and families.

- A. Parent Infant Early Childhood Enhancement Program (PIECE):** Provides mental health services to children ages 3-7.6 and their families who present with challenging social-emotional behaviors that are disruptive at home, school and the community. This program seeks to provide comprehensive services to children and families that focus on supporting cognition, language, motor skills, adaptive skills and social emotional functioning. It utilizes a number of treatment modalities as well as evidence based practices (Parent Child Interaction Therapy and Child Parent Psychotherapy). As of June 2015, the total number of cases served was 117 and the total number of new cases was 71.
- B. Healthy Start Project:** A collaboration between the Department of Health and DBH to address the medical and mental health challenges of women who reside in wards 5, 6, 7, and 8, are of childbearing age, and have children from birth to age 2. The focus is to ensure that these women who reside in low income areas have access to comprehensive medical and psychiatric care. The mission for the Healthy Start Project is to reduce infant mortality in the District by improving the emotional, mental and physical health of pre- and postnatal women. As of June 2015, there were 63 active cases (Ward 5=1, Ward 6=1, Ward 7=19, Ward 8=42).
- C. Early Childhood Mental Health Consultation Program – Healthy Futures:** Mental health professionals provide center-based and child and family-centered consultation services to the staff and family members at 26 Child Development Centers (CDCs). Services are provided to improve social-emotional competence among young children and increase the knowledge of children's mental health issues among staff and family members. DBH clinicians also

conduct individual child and classroom observation, screen for the early identification of social-emotional concerns and refer and link children and their families to community resources and mental health services when required. Year 5 outcome data will not be completed until after September 30, 2015. The previous 4-year data indicate: 1) services were provided to approximately 5,200 young children (about 1,300 annually); 2) the expulsion rate for the first 3 years of the evaluation was half the national average of 6.7 children per 1,000; and 3) Year 4 was a landmark year with no expulsions in any of the child development centers receiving Early Childhood Mental Health Consultation services.

**D. Primary Project:** A component of the School Mental Health Program that is an evidence-based, early intervention/prevention program for identified children in Pre-kindergarten (age 4) through 3<sup>rd</sup> grade who have mild problems with social-emotional adjustment in the classroom. Primary Project services are provided to children attending child development centers, and D.C. public and charter schools that receive on-site services from a DBH School Mental Health Program or Healthy Futures clinician. The program has two (2) major components: 1) screening for identification of level of need for service, early intervention/prevention or more intensive service (counseling/therapy); and, 2) intervention for children identified as having mild adjustment problems in the classroom. The “intervention” is a 1:1, non-directive play session provided at school by a trained paraprofessional (Child Associate) under the supervision of a Primary Project Program Manager. As of June 2015, the program data indicate that: 1) 45 sites had Primary Project *Agreements to Proceed*, 28 D.C. public and public charter schools, and 17 child development centers; 2) 4,775 children were screened using the Teacher-Child Rating Scale; 3) 2,456 children screened positive for needing more intensive mental health intervention; 4) 1,067 children screened positive for early intervention/ prevention services (Primary Project); 5) 441 children received Primary Project services; and 6) 292 end-of-year conferences were held with parents/guardians of participating children.

**E. School Mental Health Program (SMHP):** Promotes social and emotional development that addresses psycho-social and mental health problems that become barriers to learning by providing prevention, early intervention, and treatment services to youth, families, teachers and school staff. Services are individualized to the needs of the school and may include screening, behavioral and emotional assessments, school-wide or classroom-based interventions, psycho-educational groups, consultation with parents and teachers, crisis intervention, as well as individual, family and group treatment. As of June 2015, the SMHP operated in 63 schools, 44 D.C. public schools and 19 public charter schools. In FY 2015, DBH began implementation of the Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS). There is no available FY 2015 data for the SMHP at this time. However, data for the FY 2013-FY 2014 school year using the Ohio Scales Problem Severity Score indicate that students, their parents, and clinicians reported a statistically significant reduction of behavioral and emotional symptoms after treatment. Also, the average youth, parent and worker self-report of the child’s problems shifted from the clinical range to the non-clinical range after treatment. Scores on the Functioning Index indicate that youth, parents and clinicians all felt that everyday level of functioning significantly improved after treatment. The average worker report of functioning shifted from the clinical to non-clinical range.

- F. Children Psychiatric Practice Group (PPG):** Provides psychiatric services and consultation for children and adolescents between the ages of 4-21, who have emotional/behavioral and mental health challenges. The PPG serves as a psychiatric safety net for the DBH child serving core service agencies (CSAs). The services are available to children, youth and their families who are residents of the District, receive services within the DBH provider network, are linked to a child serving agency (Child and Family Services Agency, Department of Youth Rehabilitation Services, D.C. Public Schools), and/or court involved. As of June 2015, 334 unduplicated children/youth were served.
- G. Same Day Urgent Care Clinic Services:** Provides same day walk-in services for child/youth mental health consumers who need immediate assessment or medication. As of June 2015, the average quarterly unduplicated number of child/youth intakes at the Same Day Urgent Care Clinic was 53.
- H. Children and Adolescent Mobile Psychiatric Service (ChAMPS):** FY 2015 is year 7 of operation for ChAMPS via DBH contract with Catholic Charities of Washington Behavioral Health Services. The purpose is to provide immediate access to mobile emergency services for children, youth and families experiencing a behavioral or mental health crisis. The service is available 24 hours, 7 days a week for children and youth ages 6 to 18, except for youth who are committed to the Child and Family Services Agency (CFSA) who are served until age 21. The mobile team: 1) provides on-site crisis assessments to determine the mental health stability of a youth and their ability to remain safe in the community; 2) assists in the coordination of acute care assessments and hospitalizations when appropriate; and 3) post-crisis follow-up interventions are conducted up to 30 days after the initial crisis intervention to ensure linkage to DBH mental health providers for ongoing treatment. As of June 2015, the quarterly average number of children/youth served was 225. The unduplicated number served during this period was 726.
- I. Child and Youth Clinical Practice Unit:** This unit conducts early mental health screenings for children entering the child welfare system. It is also responsible for identifying and expanding the availability of evidence-based practices (EBPs) for youth and their families. The current EBPs include the following:
- ***Child Parent Psychotherapy for Family Violence-*** For ages 0-6 with a history of trauma exposure or maltreatment and their caregivers.
  - ***Trauma Systems Therapy-*** For ages 0-19 who have experienced traumatic events and/or who live in environments with ongoing traumatic stress.
  - ***Parent Child Interaction Therapy-*** For ages 2-6 who experience extreme behavioral difficulties with emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns.
  - ***Trauma Focused Cognitive Behavioral Therapy-*** For ages 4-18 and helps children, youth, and their parents overcome the negative effects of traumatic life events and address feelings.
  - ***Multi-Systemic Therapy-*** For ages 10-17 with emphasis on empowering parents/caregivers effectiveness as they assist the child/youth in successfully making and sustaining changes in individual, family, peer and school systems.

- ***Multi-Systemic Therapy for Youth with Problem Sexual Behavior-*** For ages 10-17 and is an intensive family and community based program that addresses factors that influence problem sexual behavior, focusing on the offender's home/family, school, neighborhood and peers.
- ***Adolescent Community Reinforcement Approach-*** For ages 12-22 and seeks to replace environmental influences that have supported alcohol or drug use with prosocial activities and behaviors that support recovery.
- ***Transition to Independence Process-*** An evidence supported model for ages 14-29 that also engages their families and other informal key players in a process that facilitates their movement towards greater self-sufficiency and successful achievement of their goals.
- ***Multi-Systemic Therapy for Emerging Adults-*** DBH is seeking a provider for this service for ages 17-21 with serious mental health conditions and justice involvement, that decreases offending and increases positive transition age role functioning and reduces symptoms.

**J. Clinical Practice and Support Unit:** This unit is responsible for the Assessment Center that provides mental health consultation and support as well as conducts forensic mental health assessments and evaluations for court involved children and youth in the juvenile justice and child welfare systems, and domestic relations cases being heard in the Family Court Division. The unit also provides oversight for the two (2) Care Management Entities (CMEs) that deliver wraparound services aimed at diverting youth from psychiatric residential treatment facilities. In addition the unit provides technical assistance and coaching to certified providers within the network on best practice delivery models and how to integrate the Community Service Reviews (CSR) indicators into supervision. In FY 2015, the Juvenile Adjudicatory Competency Program was established to conduct competency evaluations for youth engaged in the juvenile justice system and provide restoration services.

**K. Residential Treatment Center Reinvestment Program (RTCRP):** Provides clinical monitoring and oversight for children and youth receiving services in psychiatric residential treatment facilities (PRTFs) and children returning to the community from a PRTF. Program monitoring activities include scheduled on-site visits, monthly treatment planning meeting attendance and participation, discharge planning, and post discharge community monitoring. As of June 30, 2015, the RTCRP had completed site visits to the following facilities: Devereux Florida, Gulf Coast Treatment Center, Millcreek, Youth Villages, Coastal Harbor Treatment Center, Liberty Point, the National Deaf Academy, and Devereux Georgia. The RTCRP monitored 87 youth post-discharge to the District, and attended 360 of 365 (99%) treatment team meetings. The RTCRP also attended 74 discharge planning meetings.

**L. Juvenile Behavioral Diversion Program (JBDP):** This program operated within the D.C. Superior Court Juvenile Division began in January 2011. This voluntary program links and engages juveniles in appropriate community-based mental health services and supports. Court-involved juvenile status offenders are given the option of participating in mental health services rather than being prosecuted. The goal is to reduce behavioral symptoms that may contribute to juveniles' involvement with the criminal justice system and to improve their functioning in the home, school, and community. This program is intended for children and

youth who are often served within multiple systems who are at risk of re-offending without linkage to mental health services and other important supports. Participants are enrolled from six (6) months to a year and are required to attend regular court monitoring meetings and participate in mental health services. The capacity for JBDP has been 60 since its inception and based upon a request from the Court, it was expanded to 75 in 2015.

**M. DBH Child and Youth Services Ombudsman Program:** This program was created in FY 2015 with full implementation beginning during FY 2016. The core processes and functions include: 1) educate District residents about behavioral health coverage within the health benefits plan, managed care plan and other behavioral health services options; 2) assist consumers access and navigate behavioral health care services; and 3) support the resolution of problems associated with accessing behavioral health services. In responding to consumer/stakeholder inquiries and complaints the Ombudsman's office will: 1) conduct intake; 2) track inquiries and complaints to determine trends and patterns within the current system of care; 3) track and trend information that is collected to report on system gaps related to service delivery; and 4) review current policies to determine potential gaps and make clear system recommendations for changes.

**N. System of Care Expansion Implementation Project (DC Gateway Project):** This 4-year Substance Abuse and Mental Health Services Administration (SAMHSA) grant focuses on the development and strengthening of the infrastructure and services to children, youth and their families with mental health concerns across the District and across child serving systems. It began in October 2012 following the development of a Strategic Plan supported by a SAMHSA System of Care (SOC) Planning grant and has now completed three (3) quarters of Year 3 implementation. The goals are addressed through five (5) focus areas and each integrates social marketing. They include: 1) improved access to mental health services; 2) parent and youth peer support; 3) functional assessment utilizing the Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS); 4) integration of behavioral health and primary care; and 5) reinvestment strategies to promote sustainability. A description of some of the initiatives follows.

- **DC Mental Health Access Project (DC MAP)-** DBH awarded a contract to Children's National Health System in March 2015 to support ongoing development of behavioral health screening by primary care providers (pediatricians), that includes the DC MAP mental health consultation project. It provides pediatricians with immediate access to mental health and/or psychiatric consultation as children/youth are identified as potentially needing behavioral health services. This project supports pediatricians in competently providing behavioral health care within their practice if appropriate or supports the timely linkage to the right behavioral health services. The education of primary care providers through the learning collaborative also continues as well as educational presentations within the primary care provider's office. This contract also supports the development of a psychiatric medication monitoring committee to the review children/youth prescribed multiple psychotropic medications.
- **Collaboration Across Grants-** The collaboration across the three (3) DBH grants (DC Gateway Project SOC grant, State Youth Treatment grant (SYT), and Now is the Time-Healthy Transitions grant (NITT- HT)) continues. The staff from all three (3) grants are



actively involved with the youth driven work group developing the Youth Peer Specialist training program. SYT and NITT-HT staff attend the SOC Management and Implementation/Roundtable meetings and a SYT Transition Age Youth (TAY) Council meeting includes DC Gateway Project staff. This combined advisory council has broad family and youth involvement along with various community organizations. The DC Gateway Project and the NITT Healthy Transitions Grant collaborated with youth Technical Assistance providers and Youth MOVE National to provide a youth “kick-off” in January 2015. At the M & I/Roundtable meeting the development of culturally appropriate behavioral health programming for the LGBTQI population was discussed. Now a work group is developing recommendations for serving LGBTQI TAY behavioral health needs and will be reporting these recommendations to the SYT/TAY Council.

- **CAFAS/PECFAS-** The *Child and Family Services Agency* (CFSA) implemented the CAFAS/PECFAS for all children/youth in July 2015. This includes children in out-of-home care (foster care, group settings, psychiatric residential treatment facilities, and supervised return to the biological home), and children/youth who remain in their biological home but are receiving services and monitoring through CFSA. The *Department of Youth Rehabilitation Services* (DYRS) administers the CAFAS when a Notice of Intent to Commit is filed and then administers it every 90 days for all committed youth. It is used in the quarterly Team Decision Making (TDM) meeting to identify needs for the plan of care and illustrate change and improvement over time. The *Department of Human Services* (DHS) utilizes the CAFAS for all youth actively enrolled in the Parent and Adolescent Support Services (PASS) and in the Alternatives to Court Experience (ACE) diversion program. DHS utilizes the CAFAS data to measure outcomes of both of these short-term programs. The *Department of Behavioral Health* (DBH) continues to utilize the CAFAS/PECFAS across all 25 child serving providers. Between January 1 and March 20, 2015, 2,123 assessments were completed and from April 1 through June 22, 2015, 1,952 assessments were done. The CAFAS/PECFAS total score is used to inform the types and quantity of services that are automatically approved for inclusion in the child/youth’s plan of care.

**O. Transition Age Youth Initiatives:** Youth and young adult initiatives are coordinated within the DBH Child and Youth Services Division by the Transition Age Youth Coordinator.

- **Now Is The Time (NITT): Healthy Transitions:** The purpose of this SAMHSA grant is to develop a system of care for transition age youth (TAY) and young adults. DBH is the lead agency for this initiative to design and implement a transition age youth (TAY) focused system of care in partnership with key District agencies (CFSA, DYRS, DCPS, Department of Employment Services), core service agencies (CSAs), community-based organizations, health care providers, and family and youth networks. This system of care, called the DC Transition Age Youth Initiative, is for ages 16- 25 with services provided by the DBH CSAs. They will provide TAY specific care planning, wraparound, evidence-based practices and recovery supports, and will employ Transition Specialists specifically trained to diagnose and assess TAY clients and provide customized, individual plans of care to successfully transition them to adulthood. The evidence-based and informed practices and recovery supports to be expanded during this initiative include: 1) a combined Transitions to Independence Process (TIP) and Assertive Community Treatment (ACT) program known as TACT; 2) Adolescent Community

Reinforcement Approach (A-CRA); 3) Supported Employment; and 4) Supportive Housing. This Initiative will also broaden and improve outreach to, and early identification and screening of, TAY with mental health conditions, substance use disorders and co-occurring disorders. Initially the program will target youth, young adults and their families in Wards 7 and 8 (though not to the exclusion of TAY throughout the District) and lessons learned from these wards will be applied as the program systematically expands to other wards. Youth, young adults and their families will inform all aspects of the Initiative including planning, education, outreach and identification, social marketing, and evaluation, and transition age youth will be represented on the key oversight body for the initiative.

- **Transition Age Youth Housing Initiative:** On March 26, 2015, District of Columbia Mayor Muriel Bowser and Deputy Mayor for Health and Human Services Brenda Donald opened Wayne Place, a transition age youth transitional housing facility. Wayne Place is the result of a partnership between DBH and the Child and Family Services Agency (CFSA) to help young men and women between the ages of 18-24, who might otherwise be homeless, build the skills they need to be self-sufficient. This initiative includes life skill training for youth and young adults who need support to live independently and succeed. Wayne Place, a complex of six (6) buildings with 22 two-bedroom apartments, provides the opportunity for 44 young people to live at this facility. Half of the beds are being utilized by youth linked to CFSA and half are linked to DBH. As of July 13, 2015, DBH interviewed 34 applicants and approved 20. CFSA reviewed 22 applicants and approved 17. A total of 56 applications were received and 37 (66%) were approved. Also, a total of 34 transition age youth (20 DBH and 14 CFSA) had moved into Wayne Place. This initiative received partial Mental Health Block Grant funding in FY 2015.

**P. Youth Services Survey for Families (YSS-F):** The YSS-F survey gives parents and/or guardians an opportunity to share their perception of services provided to their children and/or adolescents. The DBH FY 2015 YSS-F survey is in the data collection phase that is expected to be completed by the end of September 2015. The data reported is for the DBH FY 2014 YSS-F survey. The parents/guardians of children/adolescents sample size was 416. The findings are reported across the seven (7) domains.

- **Access to Care-** 77% of respondents reported positively about access.
- **Participation in Treatment Planning-** 83% of respondents reported participation in this domain.
- **Cultural Sensitivity of Provider-** 93% of respondents reported high cultural sensitivity of staff.
- **Social Connectedness-** 89% of respondents reported positively to this domain.
- **Functioning-** 64% of respondents reported positively to this domain.
- **Outcomes-** 66% of respondents reported positively about outcomes for their children.
- **Satisfaction with Services-** 75% of respondents reported positively about general satisfaction for their children.

**Q. Youth Mental Health First Aid:** Primarily designed for adults including family members, caregivers, school staff, health and human services workers, etc., who work with young people 12-25, and is also appropriate as a peer support program for older adolescents. The curriculum spans mental health challenges for youth, review of normal adolescent

development, and intensive guidance through the action plan for both crisis and non-crisis situations. Topics include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including AD/HD), and eating disorders. As of June 2015, DBH and community certified Youth MHFA trainers conducted 18 courses training 459 individuals. The trainee affiliations included: D.C. public and public charter schools, faith-based organizations, university, DBH staff and providers, family organizations, District agencies, prevention centers, health alliances, housing, services for children with special needs, and community organizations.

## **R. Child and Youth System of Care Mental Health Block Grant (MHBG) Funded**

**Projects:** Several MHBG projects were implemented during FY 2015 that focus on children/youth and families.

- **Maternal Mental Health Initiative-** The Mary's Center for Maternal and Child Care, Inc. *Maternal Mental Health (MMH) Program* goal was to establish a formal MMH program to expand upon the detection, referral and treatment of Perinatal Mood and Anxiety Disorders (PMADs) that is already in place at the two (2) clinics in the District. The target population is 1,500 unduplicated perinatal patients.
- **Early Childhood Initiative-** The Latin American Montessori Bilingual Public Charter School (LAMB) *Healthy Communities Project* goal is to provide early childhood prevention and intervention for mental health disorders and potential substance use to 347 students in grades pre-K through 5<sup>th</sup> grade.
- **Women with Dependent Children-** The District Alliance for Safe Housing (DASH), Inc. *Mental Health and Family Wellness Programming Project* support four (4) programs: continuation of Effective Black Parenting evidence-based intervention; an Attachment Program for DASH newer parents who are struggling with their infants given their trauma histories; the addition of a Trauma Recovery and Empowerment Model (TREM) group; and the implementation of the GAIN-SS screening tool. The target group is women with children living at or below the federal poverty, with histories of trauma, mental illness, and co-occurring disorders. The program includes 42 families with 52 dependent children 18 and under.
- **Parent and Child Advocacy-** The Advocates for Justice and Education *DC Behavioral Access Project* goal is to ensure early intervention strategies are employed in response to mental health crisis and behavior issues; community based supports are in place to support healthy integration into the community; and direct advocacy for services in an effort to improve parent engagement and children's access to appropriate mental health services. The activities include 50 parents of children with acute behavioral health concerns; 75 parents trained on topics related to behavioral health disorders; and 5 trainings for parents navigating the system of care.
- **Parent Education-** The Collaborative Solutions for Communities *Parent Education and Support Project (PESP) Recovery Project* enhances the clinical oversight and supervision needed to provide high level substance abuse and mental health counseling, and services to an additional 20 PESP parents.
- **Youth Development Initiative-** The Teens Run DC *Running, Mentoring, and Academic Enrichment Program* implemented two (2) new initiatives to: 1) provide academic support to students, and 2) recruit mentors to support all volunteers in relationship

building and youth development components of the program. The target group is youth ages 11-19 with over 100 total participants and 40 in the intensive program.

- ***Health and Wellness Initiative-*** The Bridges Resources In Communities, Inc. *Promoting Mental Health/Wellness and Drug-Free Living East of the River Project* expands existing drug education services to include mental health specific sessions facilitated by a trained mental health expert with existing ties and experience in the communities served. The target group is 30 youth ages 12- 21 to include 15 Ward 7 and 15 Ward 8 youth and a minimum of 5 Ward 7 parents and 5 Ward 8 parents per month.
- ***Youth Well-Being Initiative-*** The *One Common Unity Fly By Light: Discover Your True Nature (FBL) Project* goal is to address the pervasive culture of psychological and physical violence that surrounds youth in the District. This is achieved by developing high impact programming for youth that provides clear alternatives to violence, increases the self-esteem of participants and helps them to lead mentally stable and emotionally balanced lives. The target group is 80 high risk youth, ages 14 -18 that includes students from four (4) high schools whose issues include chronic depression, re-occurring substance use, previous incarceration, foster care, victims of domestic violence, and discrimination based on sexual orientation.
- ***Youth and Caregivers Support Initiative-*** The Fihankra Akoma Ntoaso (FAN) *Positive Youth Development (PYD) Alumni and Caregiver Support Programs: Expanding Support for Emotional Health Amongst Teens in Foster Care* provides: 1) targeted case management and structured peer group activities to support the emotional health of youth and young adults; 2) extends and expands alumni and caregiver support services; and 3) builds a community based resource system that supports enhanced mental health outcomes for young people who might not take advantage of more traditional mental health services. The target group is 25 current or former foster youth 18-21 who have graduated from FAN's youth programs; and 25 caregivers of teens currently or formerly in foster care to help these family members better support the emotional health of the youth in their care.

## **V. Behavioral Health Data Summary**

The ***Behavioral Health Barometer District of Columbia, 2013*** (first edition) is one of a series of state and national reports that provide a snapshot of behavioral health in the United States. The reports present a set of mental health and substance use disorder indicators measured through data collection efforts sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). A summary of mental health and substance use disorder findings follows.

### **A. Youth Mental Health and Treatment**

- Depression: Past-Year Major Depressive Episode (MDE) among Persons Age 12-17 (2008-2012)- In the District of Columbia about 2,000 youth (6.1% of all youth per year) had at least one MDE within the year prior to being surveyed. The percentage did not change significantly over this period. The District rate of MDE among youth was similar to the national rate in 2011-2012 (District 7.2% and national 8.7%).

- Treatment for Depression: Past-Year Depression Treatment among Persons Age 12-17 with MDE (2006-2012)- About 1,000 youth with MDE (38.4% of all youth with MDE per year) received treatment for their depression within the year prior to being surveyed. The District rate of treatment for depression among youth with MDE was similar to the national rate in 2006-2012.

## **B. Adult Mental Health and Treatment**

- Treatment for Any Mental Illness (AMI): Past-Year Mental Health Treatment/Counseling among Persons Age 18 or Older with AMI (2008-2012)- About 35,000 adults with AMI (38.6% of all adults with AMI per year) received mental health treatment or counseling within the year prior to being surveyed. The District rate of mental health treatment among adults with AMI was similar to the national rate in 2008-2012.
- Serious Mental Illness (SMI): Past-Year SMI among Persons Age 18 or Older (2008-2012)- About 14,000 adults (2.9% of all adults per year) had SMI within the year prior to being surveyed. The District rate of SMI among adults was lower than the national rate in 2011-2012 (District 3.3% and national 4.0%).
- Mental Health Consumers: Reporting Improved Functioning from Treatment Received in the Public Mental Health System (2012)- The adults in the District in 2012 age 18 or older reporting improved functioning was 95.4%, which was higher than the national data at 71.2%. The youth age 17 or younger reporting improved functioning was 68.8%, which is lower than the national data at 70.0%.
- Thoughts of Suicide: Past-Year Serious Thoughts of Suicide among Persons Age 18 or Older (2008-2012)- About 23,000 adults (4.8% of all adults) had serious thoughts of suicide within the year prior to being surveyed. The percentage did not change significantly over this period. The District percentage of adults with suicidal thoughts was similar to the national percentage (District 4.2% and national 3.8%).

## **C. Youth Substance Use**

- Past-Month Illicit Drug Use Persons Age 12-17 (2008-2012)- About 5,000 youth (14.2% of all youth per year) reported using illicit drugs within the month prior to being surveyed. The District rate of illicit drug use among youth in 2011-2012 was higher than the national rate (District 12.6 and national 9.8%).
- Past-Month Cigarette Use Persons Age 12-17 (2008-2012)- About 3,000 youth (7.4% of all youth per year) reported using cigarettes within the month prior to being surveyed. The District rate of cigarette use among youth in 2011-2012 was lower than the national rate (District 4.7% and national 7.2%).
- Mean Age of First Use of Selected Substances Persons Age 12-17 (2008-2012)- The mean age of first marijuana use was 13.9 years, and the mean age of first cigarette use was 13.2 years.

- Persons Age 12-17 Who Perceived No Great Risk from Smoking One or More Packs of Cigarettes a Day (2008-2012)- About 2 in 5 in 2011-2012 perceived no great risk from smoking one or more packs of cigarettes a day, a rate higher than the national rate (District 39.8% and national 34.1%). Also, the District's rate increased from 2008 to 2012.
- Persons Age 12-17 Who Perceived No Great Risk from Smoking Marijuana Once a Month (2008-2012)- About 4 in 5 in 2011-2012 perceived no great risk from smoking marijuana once a month, a rate higher than the national rate (District 79.3% and national 73.0%). Also, the District's rate increased from 2008 to 2012.
- Persons Aged 12-17 Who Perceived No Great Risk from Having Five or More Drinks Once or Twice a Week (2008-2012)- About 1 in 2 in 2011-2012 perceived no great risk from drinking five or more drinks once or twice a week, a rate lower than the national rate (District 56.7% and national 59.8%).

#### **D. Youth and Adult Substance Use and Treatment**

- Persons Aged 12 or Older Past Year Alcohol Dependence or Abuse (2008-2012)- About 59,000 persons (11.3% of all persons in this age group per year) were dependent on or abused alcohol within the year prior to being surveyed. The percentage increased over this period. The District rate of alcohol dependence or abuse was higher than the national rate in 2011-2012 (District 11.7% and national 6.6%).
- Persons Age 12 or Older Past Year Illicit Drug Dependence or Abuse (2008-2012)- About 23,000 persons (4.5% of all persons in this age group per year) were dependent on or abused illicit drugs within the year prior to being surveyed. The percentage did not change significantly over this period. The District rate of illicit drug dependence or abuse was higher than the national rate in 2011-2012 (District 3.5% and national 2.7%).
- Enrollment in Substance Use Treatment Single-Day Counts (2008-2012)- In a single-day count in 2012, 4,217 persons in the District were enrolled in substance use treatment, a decrease from 4,498 persons in 2008.
- Substance Use Problems among Persons Enrolled in Substance Use Treatment Single-Day Count (2012)- Among persons in the District enrolled in substance use treatment in a single-day count in 2012, 50.1% were in treatment for a drug problem only, 10.7% were in treatment for an alcohol problem only, and 39.3% were in treatment for problems with both drugs and alcohol.

#### **VI. Behavioral Health Assessment and Plan - (This Section entered in webBGAS)**

- A. Planning Steps- Strengths, Unmet Needs, Quality and Data Collection Readiness
- B. Planning Tables
- C. Table 1 Priority Areas and Annual Performance Indicators
- D. Table 2 State Agency Planned Expenditures
- E. Table 3 State Agency Planned Block Grant Expenditures by Service

- F. Table 6b MHBG Non-Direct Service Activities Planned Expenditures
- G. Environmental Factors and Plan
- H. State Behavioral Health Council (input on Mental Health Block Grant Application, members, member by type) and opportunity for public comment

## 1. Step 1: Assess the Strengths and Needs of the Service System to Address the Specific Populations

### **Strengths of the Adult Service System**

The overview of the adult service system describes a range of services and initiatives that address the various stages of recovery of individuals with serious mental illnesses and/or substance use disorders. This may include persons with long-term community tenure, crisis community stabilization, crisis emergency stabilization, and periodic inpatient stays in a community hospital.

The primary goal for the adult service system is to develop and provide an integrated system of care for adults with serious mental illnesses and/or co-occurring substance use disorders. In order to address these behavioral health issues DBH contracts with a network of both mental health and substance use disorder providers. With regard to adults with serious mental illnesses, the community providers offer a range of mental health services and supports. The adult mental health rehabilitation services (MHRS) include: 1) diagnostic/ assessment; 2) medication/somatic treatment; 3) counseling; 4) community support; 5) crisis/emergency; 6) rehabilitation/day services; 7) intensive day treatment, and 8) assertive community treatment (ACT).

The DBH adult service system addresses the needs of individuals with serious mental illnesses and/or substance use disorders through a broad array of treatment services, programs, and supports across a variety of settings. All of the services, programs and initiatives that are listed are viewed as strengths of the adult service system. They include but are not limited to: 1) inpatient and community-based services; 2) creation of health homes for adults with serious mental illnesses and may also have a chronic health issue; 3) community crisis stabilization beds; 4) DBH operated community emergency psychiatric services and mobile crisis services; 5) DBH operated community mental health services; 6) DBH operated substance use disorder assessment and referral center; 7) DBH operated and contract operated intake points for behavioral health services; 8) DBH contracted District prevention centers; 9) DBH operated adult substance abuse rehabilitative services; 10) DBH operated and contract operated forensic outpatient services; 11) grant funded DBH District Jail-Women's Facility initiative; 12) evidence-based practices (assertive community treatment services and supported employment services); 13) supported housing services including federal voucher programs; 14) homeless services initiatives; 15) older adult initiatives; 16) Mental Health Statistics Improvement Program Survey; 17) provide adult mental health first aid training; and 18) award Mental Health Block Grant sub-grants for community-based adult system of care projects.

A few of the adult service system strengths are briefly described below to reflect the diversity of treatment services, programs and supports available to adults with serious mental illnesses and/or substance use disorders.

- **Health Homes:** This initiative is a joint effort by DBH and the Department of Health Care Finance. It integrates mental health and physical health to improve the overall health status of individuals with serious mental illnesses. During FY 2015, 14 DBH certified core services agencies (CSAs) were recommended to receive infrastructure development assistance to hire



and train Health Home staff (Director, Nurse Care Manager and Primary Care Liaison) by November 15, 2015. The State Plan Amendment (SPA) was approved by the Center for Medicare and Medicaid Services (CMS) on September 2, 2015. After the start-up phase, Health Homes are scheduled to begin in January 2016 with full implementation by September 2016.

▪ ***DBH Operated Community Clinics:***

1. Mental Health Services Division- The services include same day urgent care clinic, physicians practice group, pharmacy, multicultural services, deaf /hard of hearing services, and intellectual/developmental disability services.
2. Crisis Emergency Services- The Comprehensive Psychiatric Emergency Program (CPEP) has three (3) complementary programs: 1) Psychiatric Emergency Services; 2) Mobile Crisis Services; and 3) Homeless Outreach Program.
3. Assessment and Referral Center (The ARC)- Adults access substance use disorder treatment services through the DBH ARC. The client participates in a comprehensive assessment and evaluation to determine the appropriate level of treatment and maintenance of care.

- ***Forensic Outpatient Services:*** These services include: 1) pre-trial and re-entry services; 2) Court Urgent Care Clinic services (individuals are in immediate need of mental health and/or substance use disorder services); 3) DBH staff located at the jail to provide screening and linkage to services; 4) DBH provider programs that provide services; and 5) DBH Re-entry Coordinator placed at the D.C. Jail Women's Facility to assist women with mental health and/or substance use disorder issues being linked prior to discharge with the appropriate service provider.

- ***Evidence-based Practices:*** These services include assertive community treatment (ACT) and supported employment.

- ***Supported Housing Services:*** The community residential service options range from individuals in need of 24-hour supervision, less intensive community living, to an independent home setting.

**Strengths of the Child and Youth Service System**

The overview of the child and youth service system describes a variety of treatment services, programs, and supports to address serious emotional disturbances and other mental health related issues. They include but are not limited to early intervention, behavioral health prevention, treatment services, programs, and supports for children, youth, transition age youth, young adults and families.

The primary goal for the child and youth service system is to ensure that all children/youth and their families have access to a coordinated system of care that is easy to navigate, community-based, family-driven, youth-guided, and able to meet their multiple and changing needs. DBH

contracts with community providers for mental health services and supports. The child and youth mental health rehabilitation services (MHRS) include: 1) diagnostic/ assessment; 2) medication/somatic treatment; 3) counseling; 4) community support; 5) crisis/emergency; and 6) community-based intervention.

The DBH child and youth service system addresses the mental health and/or behavioral health needs of pregnant women and their infants, children, youth, transition age youth and young adults, and their families through a broad array of treatment services, programs, and supports across a variety of settings. All of the services, programs and initiatives that are listed are viewed as strengths of the child and youth service system. They include but are not limited to: 1) parent infant early childhood enhancement program; 2) healthy start project; 3) early childhood mental health consultation program (child development centers); 4) primary project; 5) school mental health program; 6) children psychiatric practice group; 7) child/youth same day urgent care clinic services; 8) children and adolescent mobile psychiatric service; 9) child/youth clinical practice unit (evidence-based practices); 10) clinical practice and support unit; 11) residential treatment center reinvestment program; 12) juvenile behavioral diversion program; 13) DBH child/youth services ombudsman program; 14) system of care expansion implementation project; 15) transition age youth initiatives; 16) youth services survey for families; 17) youth mental health first aid training; and 18) award Mental Health Block Grant sub-grants for community-based child/youth system of care projects.

A few of the child/youth service system strengths are briefly described below to reflect the diversity of treatment services, programs and supports available to address serious emotional disturbances, other mental health and behavioral health issues.

- ***Behavioral Health Prevention and Early Intervention Services:*** The range of services include: 1) Parent Infant Early Childhood Enhancement Program (comprehensive services to children and families that focus on supporting cognition, language, motor skills, adaptive skills and social emotional functioning; 2) Healthy Start Project (addresses the medical and mental health challenges of women of childbearing age to reduce infant mortality by improving the emotional, mental and physical health of pre- and postnatal women); 3) Early Childhood Mental Health Consultation Program – Healthy Futures (center-based and child and family-centered consultation services to the staff and family members at child development centers); 4) Primary Project (evidence-based, early intervention/prevention program for identified children in Pre-kindergarten through 3<sup>rd</sup> grade who have mild problems with social-emotional adjustment in the classroom); and 5) School Mental Health Program (addresses psycho-social and mental health problems that become barriers to learning by providing prevention, early intervention, and treatment services to youth, families, teachers and school staff).
- ***Same Day Urgent Care Clinic Services:*** Provides same day walk-in services for child/youth mental health consumers who need immediate assessment or medication.
- ***Children and Adolescent Mobile Psychiatric Service (ChAMPS):*** Provides 24-hour access to mobile emergency services for children, youth and families experiencing a behavioral or mental health crisis.

- ***Evidence –based and Evidence Supported Practices:*** These services include: 1) Child Parent Psychotherapy for Family Violence; 2) Trauma Systems Therapy; 3) Parent Child Interaction Therapy; 4) Trauma Focused Cognitive Behavioral Therapy; 5) Multi-Systemic Therapy; 6) Multi-Systemic Therapy for Youth with Problem Sexual Behavior; 7) Adolescent Community Reinforcement Approach; and 8) Transition to Independence Process.
- ***Juvenile Behavioral Diversion Program:*** This program is intended for children and youth who are often served within multiple systems who are at risk of re-offending without linkage to mental health services and other important supports.
- ***System of Care Expansion Implementation Project (DC Gateway):*** This SAMHSA funded grant focuses on the development and strengthening of the infrastructure and services to children, youth and their families with mental health concerns across the District and across child serving systems.
- ***Transition Age Youth Initiatives:***
  1. Now Is The Time (NITT): Healthy Transitions- The purpose of this SAMHSA grant is to develop a system of care for transition age youth (TAY) and young adults.
  2. Transition Age Youth Housing Initiative- This initiative includes life skill training for youth and young adults who need support to live independently and succeed.

## Step 1: Racial or Gender Minorities

In January 2015, District of Columbia Mayor Muriel Bowser and the District of Columbia Public School (DCPS) system Chancellor Kaya Henderson launched a new initiative *Empowering Males of Color*. This initiative is part of the Mayor's effort to advance achievement and opportunity and reduce racial disparities for boys and men of color across the District. Currently, male students of color (African American and Latino boys) make up 43% of the overall DCPS student population and these students as a whole are not meeting their potential. African American male students in particular have the lowest attendance and student satisfaction rates.

In partnership with the White House's *My Brother's Keeper* effort, DCPS will use three (3) key strategies to address the urgent needs of male students of color: 1) mentoring, 2) targeted funding for grants to schools, and 3) a new all-male college preparatory high school.

- ***Mentoring and Fostering a Love of Reading-*** By fourth grade, nearly 50% of African American and Latino males are reading below grade level. To launch this work, DCPS is recruiting 500 volunteers to serve as mentors to males of color throughout the District working to increase the percentage of males of color reading at grade level by the fourth grade. Through partnerships with Reading Partners and Literacy Lab, mentors will volunteer in schools on a weekly basis and help students improve their reading skills. Both Reading Partners and Literacy Lab have proven track records of success with DCPS students. The influx of volunteers will allow these organizations to expand their work in DCPS, help struggling readers and challenge exceptional readers.
- ***Targeted Funding to Schools-*** African American males are the least satisfied with school, with satisfaction rates 16 percentage points lower than the District's most satisfied students. Through this new initiative, DCPS will offer schools the opportunity to create initiatives for males of color to improve academics, as well as support their social and emotional needs. Schools will apply for grants through the "Proving What's Possible" model. The model will allow school leaders to decide what will work best for their school communities. These grants require schools to focus their efforts in one of three (3) areas: academic development, family engagement and social-emotional supports.
- ***New All-Male College Preparatory High School-*** Despite recent gains, African American and Latino males are still graduating at rates lower than their peers; 48% and 57%, respectively. In 2016, DCPS will open a new high school for males of color. Through a partnership with Urban Prep Academies, a highly successful network of all-boys high schools in Chicago, DCPS plans to open the first Urban Prep school in the District. Among Urban Prep's many accomplishments, for five (5) consecutive years 100% of its graduates have been admitted to 4-year colleges and universities. Urban Prep graduates, who come from similar circumstances and backgrounds as DCPS students, enroll and persist in college at rates higher than national averages for African American males.

## **Gender Minorities**

***Mayor's Office of Gay, Lesbian, Bisexual and Transgender Affairs:*** This is a permanent, cabinet-level office within the Office of Community Affairs in the Executive Office of the Mayor, established by statute in 2006 to address the concerns of the District of Columbia gay, lesbian, bisexual and transgender (GLBT) residents. The District's has one of the highest concentrations of GLBT residents in the country with an estimated 7-10% of the population being GLBT. The Office of GLBT Affairs works in collaboration with an Advisory Committee, appointed by the Mayor, to define issues of concern to the GLBT community and find innovative ways of utilizing government resources to help address these issues. The office offers four (4) services: 1) capacity building; 2) outreach; 3) education/training programs; and 4) technical assistance. The following resources are available to the GLBT community: 1) Directory of GLBT Organizations in the District of Columbia; 2) Guide to Community Resources; 3) GLBT Publications; and 4) Employment Opportunities.

## Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

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### Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)<sup>18</sup> HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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<sup>18</sup> <http://www.healthypeople.gov/2020/default.aspx>

### Footnotes:

The two (2) initiatives below have been DBH priorities since the Department's inception on October 1, 2013. They require significant planning, system transformation, and development.

1. Health Homes:

The District has long recognized the need for more integrated behavioral and physical care to improve the overall health status of individuals with serious mental illness. The Centers for Medicare and Medicaid Services (CMS) introduced the Health Home model as a systems approach to allow providers to coordinate and provide access for behavioral and primary health care to these vulnerable individuals. DBH (formerly DMH) determined that using the Health Home model would best enable the provider system to support these individuals in a sustainable and effective way in the community. The agency expects that implementation of Health Homes will lead to greater overall health and compliance with both behavioral and primary care, which will in turn lead to fewer hospitalizations and emergency room visits and an overall enhancement in the quality of life.

2. Substance Use Disorder Treatment and Recovery Services

DBH was created from the merger of the District's mental health and addiction systems (the Department of Mental Health and the Department of Health/Addiction Prevention and Recovery Administration/APRA). At that time DOH/APRA had been trying to implement a State Plan Amendment (SPA) approved in 2012 called Adult Substance Abuse Rehabilitation Services (ASARS), which would allow Medicaid reimbursement for certain substance use disorder treatment services. After the merger the decision was made to create new certification standards that would incorporate the requirements of the ASARS SPA and would also reflect the new American Society of Addiction Medicine (ASAM) criteria and the differing Levels of Care. These changes, as well as aligning the certification application with other programs offered by DBH, will allow a higher quality, more person-centered substance use disorder treatment and recovery system in the District of Columbia. Additionally being able to receive Medicaid reimbursement for most of the treatment services will enable DBH to offer additional recovery support services, which were previously funded through a grant, without interruption in services.

## **Step 2: Identify the Unmet Service Needs and Critical Gaps within the Current System**

### **Needs and Gaps within the Adult Service System**

The two (2) initiatives below began prior to the creation of DBH, under the separate mental health and substance use disorder systems, and have remained priorities since the Department's inception on October 1, 2013. They require significant planning, system transformation, and development.

One of the primary needs and critical gaps within the District's health and mental health systems was the lack of health homes. The District Department of Health Care Finance (DHCF) and the Department of Health (DOH) partnered with the DBH predecessor agency, the Department of Mental Health (DMH), to begin the planning process to design health homes tailored to the needs of chronically ill Medicaid beneficiaries who, through better care management and coordination, would most likely experience improved health outcomes and reductions in emergency room visits and avoidable hospital admissions. Through the analysis of Medicaid claims and managed care encounter data, these high-risk Medicaid beneficiaries, many of whom suffered from mental illness, including a serious mental illness or a serious emotional disturbance were identified. Another aspect of the planning process involved determining the co-morbidities of Medicaid beneficiaries with mental health conditions, the utilization patterns of these individuals and the capacity of providers enrolled in the District's Medicaid program to serve as a health home. The District also surveyed states with existing Medicaid health home state plan amendments (SPA) for best practices in health home design and implementation.

A contractor was hired to assist in the process. The initial goal was to seek federal approval from the Centers for Medicare and Medicaid Services (CMS), via a state plan amendment (SPA), to establish health homes beginning in 2014. The District's FY 2014-FY 2015 Mental Health Block Grant Application introduced the establishment of health homes as one of the priority initiatives. The process took longer than anticipated with the SPA not being approved until September 2, 2015. The recommended provider core services agencies (CSAs) start-up phase that involves staff hiring and training is expected to be completed by November 15, 2015. The launch of the District Health Homes initiative will be January 1, 2016 with full implementation by September 2016. This priority initiative is being continued in the District's FY 2016-FY 2017 Mental Health Block Grant Application.

Another primary need and critical gap is related to substance use disorder treatment and recovery services. DBH was created from the merger of the District's mental health and addiction systems (the Department of Mental Health and the Department of Health/Addiction Prevention and Recovery Administration/APRA). Prior to that time DOH/APRA had been trying to implement a State Plan Amendment (SPA) approved in 2012 called Adult Substance Abuse Rehabilitation Services (ASARS), which would allow Medicaid reimbursement for certain substance use disorder treatment services. After the merger the decision was made to create new certification standards that would incorporate the requirements of the ASARS SPA and would also reflect the new American Society of Addiction Medicine (ASAM) criteria and the differing Levels of Care. These changes, as well as aligning the certification application with other programs offered by DBH, will allow a higher quality, more person-centered substance use disorder treatment and



recovery system in the District. Additionally, being able to receive Medicaid reimbursement for most of the treatment services will enable DBH to offer additional recovery support services, which were previously funded through a grant, without interruption in services.

The implementation of Medicaid billing for ASARS was begun in FY 2013 through a partnership with the Department of Health Care Finance to amend the ASARS SPA and develop regulations that would allow implementation of Medicaid services and billing. The work continued through FY 2014. CMS approved the amended SPA in August 2015. The new certification regulations which implemented the SPA were finalized in September 2015 and Medicaid billing is expected to begin by December 1, 2015. DBH is working closely with the Department of Health Care Finance in the implementation of this initiative. This initiative is one of the priority initiatives introduced for the first time in the District's FY 2016-FY 2017 Mental Health Block Grant Application.

### **Needs and Gaps within the Child and Youth Service System**

A primary need and critical gap in the child and youth service system is creating environments more conducive for treatment services, programs and supports for the transition age youth and young adults. This population no longer fits in the child/youth system nor do they fit in the adult system. The adult providers could benefit from technical assistance and training to enhance existing knowledge and skills and/or acquire additional information about effective communication and engagement methods and strategies, treatment services, programs and supports that have demonstrated positive outcomes to address the mental health and/or behavioral health needs of transition age youth and young adults.

The Child and Youth Services Division staff will work with the providers to encourage the transition age youth and young adults to participate in staff led discussions as well as peer focus groups to develop ways to make their experience more relevant to their needs. This may involve communication styles, modifying existing programs and/or creating new ones, and other issues.

The Child and Youth Services Division staff will also seek technical assistance and training for providers as well as ways to provide training experiences to transition age youth and young adults.

## **Step 2: Address Unmet Service Needs and Gaps**

Health Home Initiative: The Department of Behavioral Health (DBH) Health Home Initiative was introduced in the FY 2014-FY 2015 Mental Health Block Application as a priority area. During FY 2015, 14 DBH certified core services agencies (CSAs) were recommended to receive infrastructure development assistance to hire and train Health Home staff (Director, Nurse Care Manager and Primary Care Liaison) by November 15, 2015. The State Plan Amendment (SPA) was approved by the Center for Medicare and Medicaid Services (CMS) on September 2, 2015.

The success of the Health Home Initiative will be determined by each provider program's ability to achieve outcomes as measured by the Centers for Medicare and Medicaid Services (CMS) and DBH Health Home Core Quality Measures. All state Health Home programs are required to use eight (8) CMS Core Health Home quality measures in order to monitor and evaluate their program. They include: 1) Adult BMI Assessment; 2) Ambulatory Care Sensitive Condition Admission; 3) Care Transition – Transition Record Transmitted to Healthcare Professional; 4) Follow-Up After Hospitalization for Mental Illness; 5) Plan – All Cause Readmission; 6) Screening for Clinical Depression and Follow-Up Plan; 7) Blood Pressure Screening; and 8) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. They are derived from and aligned with: 1) the mandatory quality measure reporting requirements included within section 401 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA); 2) the voluntary quality measure reporting requirements within section 2701 of the Affordable Care Act; and 3) the mandatory quality measure reporting requirements within section 3502 of the Affordable Care Act. The purpose of the core set is to assess individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes specific to the provision of health home services.

The District has also identified local measures that will augment the federally mandated data set. These seven (7) Health Home Quality Metrics for Reporting include: 1) Prevention Quality Indicators Inpatient Utilization; 2) Emergency Department Utilization; 3) Tobacco Cessation Screening; 4) Tobacco Cessation; 5) Individual Rehabilitation Plan; 6) Individuals With Regular Physical Health Exams/Checkups; and 7) Consumer Satisfaction.

The data related to the CMS and the District Core Health Home quality measures will be collected beginning January 2016.

# Planning Steps

## Quality and Data Collection Readiness

### Narrative Question:

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Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

*Please indicate areas of technical assistance needed related to this section.*

Please use the box below to indicate areas of technical assistance needed related to this section:

There are no identified technical assistance needs at this time.

Footnotes:

States must answer the questions below to help assess readiness for Client Level Data collection.

1. Briefly describe the state's data collection and reporting system and what level of data can be reported currently (e.g., at the client, program, provider, and/or other levels).

DBH recently implemented a new electronic mental health record (iCAMS) that allows for clinical documentation, as well as billing. Information can be extracted at the client, program, and provider level. Because not all contracted providers are entering information directly into iCAMS, the data has to be combined in an SQL server data warehouse. Because the data from the previous billing system already resides in this warehouse, this will minimize the recoding needed to continue reporting on CLD. Unlike the previous system, iCAMS allows for historical information to be pulled, so DBH will now be able to report on status at intake and at discharge (or at the time of reporting).

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

DBH's iCAMS system is exclusively for mental health clients. There is a separate system for substance use clients.

3. Is the state currently able to collect and report on the draft measures at the individual client level (that is, by client served, but not with client-identifying information)?

Yes, DBH is currently able to collect and report on client level data. DBH used the MH-TEDS format in FY14 and FY15 to report client level data out of our previous data system. DBH will continue to report on MH-TEDS out of iCAMS.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

DBH will work to report on more measures than in the past, including status at intake and discharge/time of report, now that iCAMS allows for this history.

## Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Health Home Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

The primary goals include: 1) improve care coordination; 2) prevent avoidable hospital and emergency room visits; 3) improve the overall health status of persons with serious mental illnesses; and 4) reduce health care costs.

Objective:

The Department of Behavioral Health (DBH) announced a Request for Applications (RFA) to provide infrastructure development assistance to DBH-certified core services agencies (CSAs) to hire and train Health Home staff including the Health Home Director, Nurse Care Manager and Primary Care Liaison by November 15, 2015.

Strategies to attain the objective:

Establish a review committee to review all provider applications. Select recommended and approved providers. The selected providers will hire and train Health Home staff including the Health Home Director, Nurse Care Manager and Primary Care Liaison by November 15, 2015.

### Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Complete the start-up phase and begin services by January 2016.

Baseline Measurement: There is no baseline measure. The initial phase of the Health Homes initiative is the start-up phase that includes the following timeline: 1) State Plan Amendment approval- September 2015; 2) Initial health homes identified- September 2015; 3) Start-up grants issued- September 2015; 4) Health Home teams in place- November 2015; 5) Training begins- November 2015; and 6) Services begin- January 2016.

First-year target/outcome measurement: The first-year target/outcome measurement depends upon the responses to the RFA. The initial health homes will be identified in September 2015.

Second-year target/outcome measurement: The second-year target/outcome measurement depends upon the responses to the RFA. The initial health homes will be identified in September 2015.

Data Source:

The DBH data source is the Integrated Care Application Management System (iCAMS). Health Home providers will participate in a series of trainings beginning in November 2015. Several trainings will focus on the use of iCAMS, information management, data analytics and data driven decision making in support of the activities of the Health Home.

iCAMS will be populated with consumer information including initial and periodic health status updates and risk assessments, via interfaces to entities such as: 1) District federally qualified health centers (FQHCs)- most utilize their own electronic health record solution; 2) District hospitals- leverage the Encounter Notification Service (ENS) available to health information exchanges; 3) District Medicaid Management Information Systems (MMIS)- periodic Medicaid encounter data will be generated and uploaded into iCAMS; 4) other administrative systems such as the District of Columbia Access System (DCAS)- the District's integrated eligibility determination system, and Web Infrastructure for Treatment Services (WITS)- the system used to track delivery of SAMHSA-funded substance abuse services by authorized providers; and 5) high-volume labs and pharmacies for electronic lab results and medication prescription fills.

iCAMS will support the following essential Health Home functions: 1) initial screening and health/functional assessment, risk analysis and stratification; 2) proactive alerts to Health Home providers, at a minimum, for emergency room utilization, inpatient hospitalization, visits to certain provider types and when a consumer does not obtain a medication refill; 3) Comprehensive Care Plan (CCP) development enhanced by best practices and real-time intelligence about a consumer/client's health status ( e.g. potential drug-to-drug interactions, multiple allergies, evidence gathered from patients with similar conditions; and 4) provide ability for multiple Health Home team members to access the CCP in a secured system.

Description of Data:

The Centers for Medicare and Medicaid Required Health Home Core Quality Measures: 1) Adult body mass index (BMI) assessment; 2) Ambulatory care-sensitive condition admission; 3) Care transition – transition record transmitted to health care professional; 4) Follow-up after hospitalization for mental illness; 5) Plan - all cause readmission; 6) Screening for clinical depression and follow-up plan; 7) Blood pressure screening; and 8) Initiation and Engagement of alcohol and other drug dependence treatment. See Attachments under Priority Areas and Annual Indicators for table with Health Home data descriptions for items 1-8.

Data issues/caveats that affect outcome measures::

Once the DBH Health Homes initiative has been fully implemented, the Department will be able to determine any data issues/potential caveats that affect the outcome measures.

Priority #: 2  
Priority Area: Substance Use Disorder Treatment and Recovery Standards  
Priority Type: SAT  
Population(s): Other (Adolescents w/SA and/or MH, Adults with/SA)

Goal of the priority area:

To allow Medicaid reimbursement for certain SUD treatment services and raise the standard of care across all SUD treatment and recovery services through the implementation of new certification standards for SUD providers in the District.

Objective:

To obtain Medicaid reimbursement for certain SUD treatment services in FY 2016.

Strategies to attain the objective:

- a. The District has promulgated new certification regulations that will allow Medicaid billing for certain treatment services; raises the quality of care for all treatment and recovery services; and allows greater person-centered care by increasing the Levels of Care LOCs that can be offered to people in need of SUD treatment.
- b. DBH will train the providers on the new standards and certification requirements, and on the new data management system being implemented for the SUD providers which will both enhance the capacity to provide better care and allow for greater integration with the mental health services.
- c. DBH is offering grant funding to SUD providers in the public SUD system to hire the additional licensed practitioner(s) that may be necessary for providers to meet the new certification requirements.
- d. DBH will also be offering on-site Technical Assistance as providers implement the new standards.

#### Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Complete the start-up phase and receive first applications by October 1, 2015.  
Baseline Measurement: There is no baseline measure. The Rule is effective September 4, 2015 and first applications are due October 1, 2015.  
First-year target/outcome measurement: 1. All currently certified providers who continue to provide SUD services are certified under the new Chapter 63. 2. Fifty percent (50%) of all treatment services provided to eligible Medicaid clients are paid using Medicaid reimbursement.  
Second-year target/outcome measurement: Ninety percent (90%) of all treatment services provided to eligible Medicaid clients are paid using Medicaid reimbursement.

Data Source:

The DBH data source is the Integrated Care Application Management System (iCAMS). The SUD providers will participate in a series of trainings beginning in November 2015. Several trainings will focus on the use of iCAMS, information management, data analytics and data driven decision making in support of the activities of SUD providers. iCAMS will be populated with consumer information including initial SUD assessment diagnosis and treatment related, via interfaces to entities such as: 1) District hospitals- leverage the Encounter Notification Service (ENS) available to health information exchanges; 3) District Medicaid Management Information Systems (MMIS)- periodic Medicaid encounter data will be generated and uploaded into iCAMS; 4) other administrative systems such as the District of Columbia Access System (DCAS)- the District's integrated eligibility determination system, and Web Infrastructure for Treatment Services (WITS)- the system used to track delivery of SAMHSA-funded substance abuse services by authorized providers; and 5) high-volume labs and pharmacies for electronic lab results and medication prescription fills. iCAMS will support the following essential functions: 1) initial screening and SUD assessment, brief/crisis assessments; 2) Treatment planning and service delivery; 3) Clinical Care Coordination planning to enhance by best practices and real-time intelligence about a

consumer/client's health status ( e.g. potential drug-to-drug interactions, multiple allergies, evidence gathered from patients with similar conditions; and 4) provide ability for multiple services providers to access the specific information within a secured system.

Description of Data:

The Quality Assessment Activities in Substance/Mental Health-Related Care include: 1) Initiation and engagement of alcohol and other drug dependence treatment; 2) Enrollment and admission; 3) Treatment; and 4) Readmission. See Attachments under Priority Areas and Annual Indicators for data descriptions for SUD Treatment and Recovery Standards for items 1-4.

Data issues/caveats that affect outcome measures::

Once the DBH SUD Treatment and Recovery Standards are fully implemented, the Department will be able to determine any data issues/potential caveats that affect the outcome measures.

Footnotes:



| Centers for Medicare and Medicaid Required Health Home Core Quality Measures          |  |  |   |
|---|--|--|---|
| Topic   | Measure  | Numerator /Denominator   | Likely Data Source  |
| <b>1. Adult body mass index (BMI) assessment</b>                                      | Percentage of individuals 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year.   | <b>Numerator Description</b><br><br>Body mass index documented during the measurement year or the year prior to the measurement year<br><br><b>Denominator Description</b><br><br>Members 18-74 of age who had an outpatient visit   | Medicaid Claims/ Medical Record                               |
| <b>2. Ambulatory Care-Sensitive Condition Admission</b>                               | Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 populations under age 75 years.<br><br><a href="http://www.guideline.gov/content.aspx?id=15067">http://www.guideline.gov/content.aspx?id=15067</a>   | <b>Numerator Description</b><br><br>Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years<br><br><b>Denominator Description</b><br><br>Total mid-year population under age 75  | Medicaid Claims/ Medical Record                               |
| <b>3. Care Transition – Transition Record Transmitted to Health care Professional</b> | Care transitions: percentage of individuals , regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.<br><br><a href="http://qualitymeasures.ahrq.gov/content.aspx?id=15178">http://qualitymeasures.ahrq.gov/content.aspx?id=15178</a>    | <b>Numerator Description</b><br><br>Members for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge<br><br><b>Denominator Description</b><br><br>All members , regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care | Medicaid Claims (Denom.)<br><br>Survey/ Medical Record (Num.) |
| <b>4. Follow-Up After Hospitalization for Mental Illness</b>                          | Mental health: percentage of discharges for individuals 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 and 30 days of discharge<br><br><a href="http://qualitymeasures.ahrq.gov/content.aspx?id=14965">http://qualitymeasures.ahrq.gov/content.aspx?id=14965</a> | <b>Numerator Description</b><br><br>An outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 and 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial  | Medicaid Claims   |

| Centers for Medicare and Medicaid Required Health Home Core Quality Measures |   |   |   |
|--|---|---|---|
| Topic  | Measure   | Numerator /Denominator  | Likely Data Source                            |
|  |   | <p>hospitalizations that occur on the date of discharge.</p> <p><b>Denominator Description</b></p> <p>Individuals 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year</p> |   |
| <b>5. Plan - All Cause Readmission</b>                                       | For individuals 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. | <p><b>Numerator Description</b></p> <p>Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination</p> <p><b>Denominator Description</b></p> <p>Count the number of Index Hospital Stays for each age, gender, and total combination</p>   | Medicaid Claims                               |
| <b>6. Screening for Clinical Depression and Follow-up Plan</b>               | Percentage of individuals aged 18 years and older screened for clinical depression using a standardized tool and follow-up documented.  | <p><b>Numerator Description</b></p> <p>Total number of members from the denominator who have follow-up documentation</p> <p><b>Denominator Description</b></p> <p>All members 18 years and older screened for clinical depression using a standardized tool</p>   | Medical Record                                |
| <b>7. Blood Pressure Screening</b>   | Number and percent of individuals 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (140</90) during the measurement year   | <p><b>Numerator Description</b></p> <p>Number of individuals ages 18-85 with a diagnosis of hypertension who's most recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both systolic and diastolic BP must be &lt;140/90mmHg</p>   | <p>Medicaid Claims</p> <p>/Medical Record</p> |

| Centers for Medicare and Medicaid Required Health Home Core Quality Measures |  |  |  |
|--|--|--|--|
| Topic  | Measure  | Numerator /Denominator   | Likely Data Source                     |
|  |  | <b>Denominator Description</b><br><br>All individuals ages 18-85 with a diagnosis of hypertension A member is considered as having hypertension if there is at least one outpatient encounter with such a diagnosis during the first six months of the measurement year.   |  |
| 8. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment  | <p>Percentage of individuals with a new episode of alcohol or other drug (AOD) dependence who received the following:</p> <ul style="list-style-type: none"> <li>Initiation of AOD treatment.</li> <li>Engagement of AOD treatment.</li> </ul> | <p><b>Numerator:</b></p> <p>Initiation of Alcohol and other Drug (AOD) Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis.</p> <p>Engagement of Alcohol and other Drug (AOD) Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).</p> <p>Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.</p> <p><b>Denominator:</b> Individuals 13 years of age and older as of December 31 of the measurement year with a new episode of alcohol or other drug (AOD) during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.</p> | Medicaid Claims/<br><br>Medical Record |

| Quality Assessment Activities in Substance/Mental Health-Related Care    |  |   |                                    |
|--|--|---|------------------------------------|
| Topic  | Measure  | Numerator /Denominator  | Likely Data Source                 |
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | <p>Percentage of individuals with a new episode of alcohol or other drug (AOD) dependence who received the following:</p> <ul style="list-style-type: none"> <li>Initiation of AOD treatment.</li> <li>Engagement of AOD treatment.</li> </ul> | <p><b>Numerator:</b></p> <p>Initiation of Alcohol and other Drug (AOD) Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, or outpatient visit, intensive outpatient encounter, within 14 days of diagnosis.</p> <p>Engagement of Alcohol and other Drug (AOD) Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, or intensive outpatient encounters with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).</p> <p>Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.</p> <p><b>Denominator:</b> Individuals 13 years of age and older as of December 31 of the measurement year with a new episode of alcohol or other drug (AOD) during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.</p> | Medicaid Claims/<br>Medical Record |
| Enrollment and Admission   | Percentage of patients treated in an inpatient substance abuse facility and admitted for treatment within <b>7 days</b> of screening and assessment.   | <u>Directionality:</u> Increase   |                                    |

| Quality Assessment Activities in Substance/Mental Health-Related Care |  |  |                    |
|---|--|--|--------------------|
| Topic   | Measure  | Numerator /Denominator   | Likely Data Source |
|   |  | <u>Weight:</u> Standard<br><br><u>Data Type (formula):</u><br>Percentage<br><br><u>Numerator Name:</u><br>Number of Adults Assessed and enrolled into treatment<br><br><u>Denominator Name:</u> Total number of adults enrolled within 7ds of screening and assessment                                 |                    |
| <b>Treatment</b>  | Percentage of patients receiving substance abuse treatment services  | <u>Measure Type:</u><br><br><u>Directionality:</u> Increase<br><br><u>Weight:</u> Standard<br><br><u>Data Type (formula):</u><br>Percentage<br><br><u>Numerator Name:</u><br>Number of Adults who successfully complete treatment<br><br><u>Denominator Name:</u><br>Total number of adults discharged |                    |
| <b>Readmission</b>  | Percentage of patients treated in inpatient substance abuse facilities who are readmitted for treatment within <b>7 days</b> of discharge. | <u>Directionality:</u> Increase<br><br><u>Weight:</u> Standard<br><br><u>Data Type (formula):</u>  |                    |

| Quality Assessment Activities in Substance/Mental Health-Related Care |         |  |                    |
|---|---------|--|--------------------|
|   |         |  |                    |
| Topic   | Measure | Numerator /Denominator   | Likely Data Source |
|   |         | <p>Percentage</p> <p><u>Numerator Name:</u><br/>Number of Adults</p> <p>Not completing treatment</p> <p><u>Denominator Name:</u> Total<br/>Number of adults Readmitted<br/>within <b>14 days</b></p> <ul style="list-style-type: none"> <li>• Readmitted within <b>15 days</b></li> <li>• Readmitted within <b>30 days</b></li> <li>• Readmitted within <b>180 days</b></li> </ul> |                    |

## Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

| Activity   | A.Substance Abuse Block Grant | B.Mental Health Block Grant | C.Medicaid (Federal, State, and Local) | D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.) | E.State Funds | F.Local Funds (excluding local Medicaid) | G.Other      |
|--|-------------------------------|-----------------------------|--|--|---------------|--|--------------|
| 1. Substance Abuse Prevention* and Treatment   |                               |                             |  |  |               |  |              |
| a. Pregnant Women and Women with Dependent Children*                                     |                               |                             |  |  |               |  |              |
| b. All Other   |                               |                             |  |  |               |  |              |
| 2. Substance Abuse Primary Prevention  |                               |                             |  |  |               |  |              |
| 3. Tuberculosis Services   |                               |                             |  |  |               |  |              |
| 4. HIV Early Intervention Services   |                               |                             |  |  |               |  |              |
| 5. State Hospital  |                               |                             | \$6,484,646                            | \$7,495,422  | \$0           | \$159,875,642                            | \$1,087,550  |
| 6. Other 24 Hour Care  |                               | \$0                         | \$6,109,944                            | \$600,000  | \$0           | \$12,477,864                             | \$0          |
| 7. Ambulatory/Community Non-24 Hour Care   |                               | \$1,668,854                 | \$12,728,148                           | \$4,954,342  | \$0           | \$27,492,498                             | \$9,693,380  |
| 8. Mental Health Primary Prevention**  |                               | \$0                         | \$0                                    | \$0  | \$0           | \$423,700                                | \$0          |
| 9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award) |                               | \$93,392                    | \$368,504                              | \$0  | \$0           | \$1,544,958                              | \$0          |
| 10. Administration (Excluding Program and Provider Level)                                |                               | \$92,782                    | \$6,328,402                            | \$0  | \$0           | \$165,135,154                            | \$0          |
| 11. Total  | \$0                           | \$1,855,028                 | \$32,019,644                           | \$13,049,764   | \$0           | \$366,949,816                            | \$10,780,930 |

\* Prevention other than primary prevention

\*\* It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

### Footnotes:

Projection is for FYs 2016/2017 (10/1/2015-9/30/2017) as Districts 12 month FY period runs 10/1 thru 9/30.

Upload Under Table 2 Planned Expenditures in response to -

Please review your MHS priorities -- they should reflect what the state identified as priorities in the needs assessment

## **Step 2: Address Unmet Service Needs and Gaps**

Health Home Initiative: The Department of Behavioral Health (DBH) Health Home Initiative was introduced in the FY 2014-FY 2015 Mental Health Block Application as a priority area. During FY 2015, 14 DBH certified core services agencies (CSAs) were recommended to receive infrastructure development assistance to hire and train Health Home staff (Director, Nurse Care Manager and Primary Care Liaison) by November 15, 2015. The State Plan Amendment (SPA) was approved by the Center for Medicare and Medicaid Services (CMS) on September 2, 2015.

The success of the Health Home Initiative will be determined by each provider program's ability to achieve outcomes as measured by the Centers for Medicare and Medicaid Services (CMS) and DBH Health Home Core Quality Measures. All state Health Home programs are required to use eight (8) CMS Core Health Home quality measures in order to monitor and evaluate their program. They include: 1) Adult BMI Assessment; 2) Ambulatory Care Sensitive Condition Admission; 3) Care Transition – Transition Record Transmitted to Healthcare Professional; 4) Follow-Up After Hospitalization for Mental Illness; 5) Plan – All Cause Readmission; 6) Screening for Clinical Depression and Follow-Up Plan; 7) Blood Pressure Screening; and 8) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. They are derived from and aligned with: 1) the mandatory quality measure reporting requirements included within section 401 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA); 2) the voluntary quality measure reporting requirements within section 2701 of the Affordable Care Act; and 3) the mandatory quality measure reporting requirements within section 3502 of the Affordable Care Act. The purpose of the core set is to assess individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes specific to the provision of health home services.

The District has also identified local measures that will augment the federally mandated data set. These seven (7) Health Home Quality Metrics for Reporting include: 1) Prevention Quality Indicators Inpatient Utilization; 2) Emergency Department Utilization; 3) Tobacco Cessation Screening; 4) Tobacco Cessation; 5) Individual Rehabilitation Plan; 6) Individuals With Regular Physical Health Exams/Checkups; and 7) Consumer Satisfaction.

The data related to the CMS and the District Core Health Home quality measures will be collected beginning



# Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015      Planning Period End Date: 6/30/2017

| Service  | Expenditures |
|--|--------------|
| Healthcare Home/Physical Health                      | \$956,678    |
| General and specialized outpatient medical services; |              |
| Acute Primary Care;                                  |              |
| General Health Screens, Tests and Immunizations;     |              |
| Comprehensive Care Management;                       |              |
| Care coordination and Health Promotion;              |              |
| Comprehensive Transitional Care;                     |              |
| Individual and Family Support;                       |              |
| Referral to Community Services;                      |              |
| Prevention Including Promotion                       | \$           |

|   |    |
|---|----|
| Screening, Brief Intervention and Referral to Treatment ;                           |    |
| Brief Motivational Interviews;  |    |
| Screening and Brief Intervention for Tobacco Cessation;                             |    |
| Parent Training;  |    |
| Facilitated Referrals;  |    |
| Relapse Prevention/Wellness Recovery Support;                                       |    |
| Warm Line;  |    |
| Substance Abuse Primary Prevention  | \$ |
| Classroom and/or small group sessions (Education);                                  |    |
| Media campaigns (Information Dissemination);  |    |
| Systematic Planning/Coalition and Community Team Building(Community Based Process); |    |
| Parenting and family management (Education);  |    |
| Education programs for youth groups (Education);                                    |    |
| Community Service Activities (Alternatives);  |    |
| Student Assistance Programs (Problem Identification and Referral);                  |    |

|   |    |
|---|----|
| Employee Assistance programs (Problem Identification and Referral);                               |    |
| Community Team Building (Community Based Process);  |    |
| Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental); |    |
| Engagement Services   | \$ |
| Assessment;   |    |
| Specialized Evaluations (Psychological and Neurological);   |    |
| Service Planning (including crisis planning);   |    |
| Consumer/Family Education;  |    |
| Outreach;   |    |
| Outpatient Services   | \$ |
| Individual evidenced based therapies;   |    |
| Group Therapy;  |    |
| Family Therapy ;  |    |
| Multi-family Therapy;   |    |

|   |           |
|---|-----------|
| Consultation to Caregivers;                       |           |
| Medication Services                               | \$        |
| Medication Management;                            |           |
| Pharmacotherapy (including MAT);                  |           |
| Laboratory services;                              |           |
| Community Support (Rehabilitative)                | \$805,568 |
| Parent/Caregiver Support;                         |           |
| Skill Building (social, daily living, cognitive); |           |
| Case Management;                                  |           |
| Behavior Management;                              |           |
| Supported Employment;                             |           |
| Permanent Supported Housing;                      |           |
| Recovery Housing;                                 |           |
| Therapeutic Mentoring;                            |           |
| Traditional Healing Services;                     |           |

|   |    |
|---|----|
| Recovery Supports                       | \$ |
| Peer Support;                           |    |
| Recovery Support Coaching;              |    |
| Recovery Support Center Services;       |    |
| Supports for Self-directed Care;        |    |
| Other Supports (Habilitative)           | \$ |
| Personal Care;                          |    |
| Homemaker;                              |    |
| Respite;                                |    |
| Supported Education;                    |    |
| Transportation;                         |    |
| Assisted Living Services;               |    |
| Recreational Services;                  |    |
| Trained Behavioral Health Interpreters; |    |

|   |    |
|---|----|
| Interactive Communication Technology Devices;   |    |
| Intensive Support Services                      | \$ |
| Substance Abuse Intensive Outpatient (IOP);     |    |
| Partial Hospital;                               |    |
| Assertive Community Treatment;                  |    |
| Intensive Home-based Services;                  |    |
| Multi-systemic Therapy;                         |    |
| Intensive Case Management ;                     |    |
| Out-of-Home Residential Services                | \$ |
| Crisis Residential/Stabilization;               |    |
| Clinically Managed 24 Hour Care (SA);           |    |
| Clinically Managed Medium Intensity Care (SA) ; |    |
| Adult Mental Health Residential ;               |    |
| Youth Substance Abuse Residential Services;     |    |
| Children's Residential Mental Health Services ; |    |

|   |             |
|---|-------------|
| Therapeutic Foster Care;                      |             |
| Acute Intensive Services                      | \$          |
| Mobile Crisis;                                |             |
| Peer-based Crisis Services;                   |             |
| Urgent Care;                                  |             |
| 23-hour Observation Bed;                      |             |
| Medically Monitored Intensive Inpatient (SA); |             |
| 24/7 Crisis Hotline Services;                 |             |
| Other   | \$          |
| Total   | \$1,762,246 |

**Footnotes:**

Correction has been to reflect a two year spending period (FYs 16 and 17)

## Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015      Planning Period End Date: 6/30/2017

| Service  | Block Grant |
|--|-------------|
| MHA Technical Assistance Activities  |             |
| MHA Planning Council Activities  |             |
| MHA Administration   | \$46,391    |
| MHA Data Collection/Reporting  |             |
| MHA Activities Other Than Those Above  | \$881,429   |
| Total Non-Direct Services  | \$927,820   |
| Comments on Data:<br><input type="text"/>  |             |
| Footnotes:<br>Projection is for FYs 2016/2017 (10/1/2015-9/30/2017) as Districts 12 month FY period runs 10/1 thru 9/30. |             |



# Environmental Factors and Plan

## 1. The Health Care System and Integration

### Narrative Question:

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Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.<sup>26</sup> Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.<sup>27</sup> It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.<sup>28</sup> Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The [Framingham Heart Study](#) produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence-based practices<sup>29 30</sup> that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.<sup>31</sup> Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.<sup>32</sup> In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.<sup>33</sup> Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.<sup>34</sup> Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.<sup>35</sup> In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.<sup>36</sup>

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.<sup>37</sup> Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.<sup>38</sup> Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes<sup>39</sup> and ACOs<sup>40</sup> may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.<sup>41</sup> Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.<sup>42</sup>

One key population of concern is persons who are dually eligible for Medicare and Medicaid.<sup>43</sup> Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.<sup>44</sup> SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.<sup>45</sup> Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.<sup>46</sup> SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.<sup>47</sup> It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.<sup>48</sup>

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.<sup>49</sup> Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.<sup>50</sup>

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.<sup>51</sup> However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.

- Regular screening with a carbon monoxide (CO) monitor
- Smoking cessation classes
- Quit Helplines/Peer supports
- Others \_\_\_\_\_

11. The behavioral health providers screen and refer for:

- Prevention and wellness education;
- Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
- Recovery supports

*Please indicate areas of technical assistance needed related to this section.*

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<sup>26</sup> BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun;49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013;91:102–123

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<sup>27</sup> Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts,

<http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10> Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

<sup>28</sup> Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses>; Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014;71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

<sup>29</sup> 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8); *JAMA*. 2014;311(5):507-520.doi:10.1001/jama.2013.284427

<sup>30</sup> A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: <http://circ.ahajournals.org/>

<sup>31</sup> Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <http://www.cdc.gov/socialdeterminants/Index.html>

<sup>32</sup> Depression and Diabetes, NIMH, <http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5>; Diabetes Care for Clients in Behavioral health Treatment, Oct. 2013, SAMHSA, <http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780>

<sup>33</sup> J Pollock et al., Mental Disorder or Medical Disorder? Clues for Differential Diagnosis and Treatment Planning, *Journal of Clinical Psychology Practice*, 2011 (2) 33-40

<sup>34</sup> C. Li et al., Undertreatment of Mental Health Problems in Adults With Diagnosed Diabetes and Serious Psychological Distress, *Diabetes Care*, 2010; 33(5) 1061-1064

<sup>35</sup> TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, <http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671>

<sup>36</sup> Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011,

[http://www.nami.org/Content/NavigationMenu/State\\_Advocacy/About\\_the\\_Issue/Integration\\_MH\\_And\\_Primary\\_Care\\_2011.pdf](http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf); Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and challenges*. Baltimore, MD: The Hilltop Institute, UMBC.

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<sup>37</sup> Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

<sup>38</sup> Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health> State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice---telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

<sup>39</sup> Health homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

<sup>40</sup> New financing models, [http://www.samhsa.gov/co-occurring/topics/primary-care/financing\\_final.aspx](http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx)

- <sup>41</sup> Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS
- <sup>42</sup> What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>
- <sup>43</sup> Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>
- <sup>44</sup> Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>
- <sup>45</sup> BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707
- <sup>46</sup> TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014;71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013;70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218
- <sup>47</sup> <http://www.nrepp.samhsa.gov/>
- <sup>48</sup> Clarifying Guidance on Peer Support Services Policy, May 2013, CMS, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf>; Peer Support Services for Adults with Mental Illness and/or Substance Use Disorder, August 2007, <http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html>; Tri-Agency Letter on Trauma-Informed Treatment, July 2013, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>
- <sup>49</sup> Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>
- <sup>50</sup> About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>
- <sup>51</sup> Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical Assistance Needs: Develop a strategy to address primary health and behavioral health integration from a system-wide perspective.

Footnotes:

## Environmental Scan and Plan

### 1. The Health Care System Integration

There are several initiatives related to health care system integration.

- **DC Mental Health Access Project (DC MAP):** DBH awarded a contract to Children's National Health System in March 2015 to support ongoing development of behavioral health screening by primary care providers (pediatricians) that includes the DC MAP mental health consultation project. It provides pediatricians with immediate access to mental health and/or psychiatric consultation as children/youth are identified as potentially needing behavioral health services. This project supports pediatricians in competently providing behavioral health care within their practice if appropriate or supports the timely linkage to the right behavioral health services. The education of primary care providers through the learning collaborative also continues as well as educational presentations within the primary care provider's office. This contract also supports the development of a psychiatric medication monitoring committee to review children/youth prescribed multiple psychotropic medications.
- **Health Home Initiative:** This District initiative is a joint effort by the Departments of Behavioral Health (DBH) and Health Care Finance (DHCF). The guiding principles include: 1) focus on person-centered care to include an individualized treatment plan designed to identify and coordinate with physical health and behavioral health services, and provides culturally appropriate services; 2) service delivery accomplished through communication, collaboration and coordination; and 3) data driven decision and evidence-based practices that create positive health outcomes, and increase health status and well-being at the individual and population-based levels. The goals include: 1) improving care coordination; 2) preventing avoidable hospital and emergency room visits; 3) improving the overall health status of persons with serious mental illnesses; and 4) reducing health care costs. The eligibility requirements are: 1) 18 years of age or older; 2) Medicaid eligible and enrolled; 3) have a serious mental illness; and 4) may or may not have a co-existing chronic physical condition. The designated providers are core services agencies within the DBH provider network. The Health Home provider responsibilities include: 1) coordinate and provide access to comprehensive individualized care management, preventive care, behavioral health and primary care, illness management, and community support network; 2) use health information technology to facilitate care coordination; 3) establish continuous quality improvement program; 4) collect and report data; and 5) participate in program evaluation. The implementation is scheduled for January 2016.
- **Minority Aids Initiative Targeted Capacity Expansion Project (MAI-TCE):** The Department of Health (DOH) Addiction Prevention and Recovery Administration (APRA) was a recipient of this SAMHSA grant initially awarded to 12 cities across the nation. The outcomes included: 1) reduce HIV transmission; 2) increase the number of people receiving treatment for substance use disorder, mental health and/or co-occurring disorders; 3) increase the number of people who receive recovery support services post treatment; 4) increase the number of people who know their HIV status; and (5) increase case management services

and referrals to primary HIV care for antiretroviral therapy, primary care and other services for individuals who test positive for HIV. The accomplishments include: 1) creating the DC HIV/Behavioral Health Pathway Network to implement and monitor multiple entry points for HIV/substance use/mental health client assessments, HIV testing, treatment referrals, support linkages and prevention services to the target population; 2) defining high risk target populations; 3) selecting three (3) initial project start-up sites (APRA Assessment and Recovery Center (ARC), Family and Medical Counseling Services, mental health system Access HelpLine); 4) expanding the network to additional partnering sites (La Clinica del Pueblo partnering with Latin American Youth Center, and Community Connections partnering with Unity Health, and Family Medical Counseling Center's Substance Use disorder program); 5) workforce capacity building; 6) co-occurring assessment training; and 7) the DBH Co-occurring Disorders Training Module.

- **District of Columbia Health Benefit Exchange Authority (HBX):** The mission of the HBX is to implement a health care exchange program in accordance with the Patient Protection and Affordable Care Act (PPACA), thereby ensuring access to quality and affordable health care to all District residents. The *Health Benefit Exchange Authority Establishment Act of 2011* establishes the following core responsibilities: 1) enable individuals and small employers to find affordable and easier-to-understand health insurance; 2) facilitate the purchase and sale of qualified health plans; 3) assist small employers in facilitating the enrollment of their employees in qualified health plans; 4) reduce the number of uninsured; 5) provide a transparent marketplace for health benefit plans; 6) educate consumers; and 7) assist individuals and groups to access programs, premium assistance tax credits, and cost-sharing reductions. The HBX is responsible for the development and operation of all core Exchange functions including the following: 1) certification of Qualified Health Plans (QHPs) and Qualified Dental Plans (QDPs); 2) operation of a Small Business Health Options Program (SHOP); 3) consumer support for making coverage decisions; 4) eligibility determinations for individuals and families; 5) enrollment in QHPs; 6) contracting with certified carriers; and 7) determination for exemptions from the individual mandate.
- **District of Columbia Department of Insurance, Securities and Banking (DISB):** The DISB regulates financial-service businesses by administering District insurance, securities and banking laws, rules and regulations. With regard to insurers, DISB provides guidance on the essential health benefits (EHB) benchmark package, including an itemized list of required benefits. The list is grouped by 10 categories required by the Affordable Care Act and includes: 1) ambulatory patient services; 2) emergency coverage; 3) hospitalization; 4) maternity/newborn care; 5) mental health, substance use disorders, behavioral health treatment; 6) prescription drugs; 7) rehabilitative and habilitative services and devices; 8) laboratory services; 9) preventive and wellness services; and 10) pediatric services including oral and vision.



# Environmental Factors and Plan

## 2. Health Disparities

### Narrative Question:

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In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)<sup>52</sup>, [Healthy People, 2020](#)<sup>53</sup>, [National Stakeholder Strategy for Achieving Health Equity](#)<sup>54</sup>, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).<sup>55</sup>

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."<sup>56</sup>

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.<sup>57</sup> This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.<sup>58</sup> In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

*Please indicate areas of technical assistance needed related to this section.*

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<sup>52</sup>[http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

<sup>53</sup><http://www.healthypeople.gov/2020/default.aspx>

<sup>54</sup><http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

<sup>55</sup><http://www.ThinkCulturalHealth.hhs.gov>

<sup>56</sup>[http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

<sup>57</sup><http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

<sup>58</sup>[http://www.whitehouse.gov/omb/fedreg\\_race-ethnicity](http://www.whitehouse.gov/omb/fedreg_race-ethnicity)

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Please use the box below to indicate areas of technical assistance needed related to this section:

Technical Assistance Needs: There are no identified technical assistance needs at this time. DBH will work with DOH to identify behavioral health disparities and potential strategies to address these issues.

Footnotes:



## 2. Health Disparities

The Department of Health (DOH) developed and disseminated the first edition of the *District of Columbia Community Health Needs Assessment* (February 28, 2014). It provides a comprehensive analysis and review of District residents' health and quality of life. The health indicators data highlights some of the disparities for the District when compared to the United States (2010 reporting period). They include: 1) **mortality and life expectancy**- the District is higher on heart disease, cancer, diabetes, HIV disease, homicide/assault, and septicemia; 2) **maternal and child health outcomes**- the District is higher on infant mortality, low birth rate, and teen birth rate;; 3) **chronic health indicators**- the District is higher the cardiovascular diseases stroke; and 4) **asthma**- the District is higher on current asthma for children 17 and younger and adults 18 and older, and is higher on lifetime asthma for the same age groups.

The DOH report also describes race/ethnic health disparities. They include the following:

1. Non-Hispanic black infants account for a disproportionate percentage of all infant deaths.
2. Hispanic females were expected to live the longest in the District (88.9 years), followed closely by Hispanic males (88.4 years).
3. Hispanics newly diagnosed with HIV were more likely to be younger than other racial groups.
4. Blacks/African Americans have the highest obesity rates, and are least likely to exercise or consume the recommended serving of fruits and vegetables.
5. The crude death rate due to diabetes for Blacks/African Americans was seven (7) times the rate for Whites in 2010.
6. Blacks/African Americans were over three (3) times more likely to die from cerebrovascular diseases compared to their white counterparts.

# Environmental Factors and Plan

## 3. Use of Evidence in Purchasing Decisions

### Narrative Question:

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There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP<sup>59</sup> is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General<sup>60</sup>, The New Freedom Commission on Mental Health<sup>61</sup>, the IOM<sup>62</sup>, and the NQF.<sup>63</sup> The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."<sup>64</sup> SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)<sup>65</sup> are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)<sup>66</sup> was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
  - a. Leadership support, including investment of human and financial resources.
  - b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
  - c. Use of financial incentives to drive quality.

- d. Provider involvement in planning value-based purchasing.
- e. Gained consensus on the use of accurate and reliable measures of quality.
- f. Quality measures focus on consumer outcomes rather than care processes.
- g. Development of strategies to educate consumers and empower them to select quality services.
- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
- i. The state has an evaluation plan to assess the impact of its purchasing decisions.

*Please indicate areas of technical assistance needed related to this section.*

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<sup>59</sup> [Ibid, 47, p. 41](#)

<sup>60</sup> United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

<sup>61</sup> The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

<sup>62</sup> Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

<sup>63</sup> National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

<sup>64</sup> <http://psychiatryonline.org/>

<sup>65</sup> <http://store.samhsa.gov>

<sup>66</sup> <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical Assistance Needs: There are no technical assistance needs identified at this time.

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Footnotes:

### 3. Use of Evidence in Purchasing Decisions

The D.C. Municipal Regulations (“DCMR”) is the official compilation of the rules and regulations issued by District of Columbia government agencies and the Council of the District of Columbia. Currently the DCMR contains 31 titles that provide the practices and methods to operate and perform effectively in the District Government.

#### Section 1009 Procurement Planning

1009.1 Agencies shall perform procurement planning and conduct market surveys to promote and provide for full and open competition with due regard to the nature and of the goods and services to be acquired.

1009.2 When full and open competition is not required by law, agencies shall perform procurement planning and conduct market surveys to obtain competition to the maximum extent practicable.

1009.3 The Director shall prescribe procurement planning procedures for the following purposes:

- (a) To ensure that contracts are awarded after full and open competition with adequate procurement planning and availability of funds;
- (b) To ensure that procurement planning addresses the requirement to specify needs, develop specifications, and to solicit offers in a manner that promotes and provide for full and open competition;
- (c) To establish criteria and thresholds at which increasingly greater detail and formality in the procurement planning process is required in those cases in which a written procurement plan must be prepared;
- (d) To ensure that the principles of this section are applied, as appropriate, for all procurements whether or not a written plan is required.
- (e) To review and approve procurement plans and revisions to those plans; and
- (f) To authorize the waiver of standard procurement planning formats in cases of emergency.

1009.4 Procurement planning shall be as soon as an agency need is identified and preferably well in advance of the fiscal year in which the contract award is necessary. In developing the plan, the planner may form a team consisting of those who will be responsible for significant aspects of the procurement, such as contracting, fiscal, legal, and technical personnel, and when applicable, the Department of Small and Local Business Development.

SOURCE: Final Rulemaking published at 35 DCR 1394 (February 26, 1988); as amended by Notice of Emergency and Proposed Rulemaking published at 58 DCR (September 27, 2011)

(EXPIRED); as amended by Notice of Final Rulemaking published at 58 DCR 11071, 11076 (December 23, 2011).

# Environmental Factors and Plan

## 4. Prevention for Serious Mental Illness

### Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.<sup>67</sup> The “Prodromal Period” is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.<sup>68</sup> In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.<sup>69</sup> The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.<sup>70 71</sup> This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

\*\*\*\*It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

*Please indicate areas of technical assistance needed related to this section.*

<sup>67</sup> Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

<sup>68</sup> Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

<sup>69</sup> Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

<sup>70</sup> van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

<sup>71</sup> McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical Assistance Needs: There are no technical assistance needs identified at this time.

Footnotes:

#### 4. Prevention for Serious Mental Illness

The child and youth service system implements a number of prevention and early intervention services. These services include: 1) Parent Infant Early Childhood Enhancement Program (comprehensive services to children and families that focus on supporting cognition, language, motor skills, adaptive skills and social emotional functioning; 2) Healthy Start Project (addresses the medical and mental health challenges of women of childbearing age to reduce infant mortality by improving the emotional, mental and physical health of pre- and postnatal women); 3) Early Childhood Mental Health Consultation Program – Healthy Futures (center-based and child and family-centered consultation services to the staff and family members at child development centers); 4) Primary Project (evidence-based, early intervention/prevention program for identified children in Pre-kindergarten through 3<sup>rd</sup> grade who have mild problems with social-emotional adjustment in the classroom); and 5) School Mental Health Program (addresses psycho-social and mental health problems that become barriers to learning by providing prevention, early intervention, and treatment services to youth, families, teachers and school staff).

Also, the child and youth services program implements a number of evidence-based practices. They include: Child Parent Psychotherapy for Family Violence- for ages 0-6 with a history of trauma exposure or maltreatment and their caregivers; 2) Trauma Systems Therapy- for ages 0-19 who have experienced traumatic events and/or who live in environments with ongoing traumatic stress; 3) Parent Child Interaction Therapy- for ages 2-6 who experience extreme behavioral difficulties with emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns; 4) Trauma Focused Cognitive Behavioral Therapy- for ages 4-18 and helps children, youth, and their parents overcome the negative effects of traumatic life events and address feelings; 5) Multi-Systemic Therapy- for ages 10-17 with emphasis on empowering parents/caregivers effectiveness as they assist the child/youth in successfully making and sustaining changes in individual, family, peer and school systems; 6) Multi-Systemic Therapy for Youth with Problem Sexual Behavior- for ages 10-17 and is an intensive family and community based program that addresses factors that influence problem sexual behavior, focusing on the offender's home/family, school, neighborhood and peers; and 7) Transition to Independence Process- an evidence supported model for ages 14-29 that also engages their families and other informal key players in a process that facilitates their movement towards greater self-sufficiency and successful achievement of their goals.

## Environmental Factors and Plan

### 5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

#### Narrative Question:

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P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.<sup>72</sup> SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded [Recovery After an Initial Schizophrenia Episode \(RAISE\) initiative](#)<sup>73</sup>, a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

*Please indicate areas of technical assistance needed related to this section.*

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<sup>72</sup> <http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf>

<sup>73</sup> [http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm\\_source=rss\\_readers&utm\\_medium=rss&utm\\_campaign=rss\\_full](http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full)

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical Assistance Needs: DBH will work with the SAMHSA technical assistance contractor to continue the work that began in FY 2015.

Footnotes:



## District of Columbia Successes Generated by the 5% Set-Aside

- **The Mandate:** The Substance Abuse and Mental Health Services Administration (SAMHSA) required states to amend their FY 2014-2015 Mental Health Block Grant Behavioral Health Assessment and Plan to outline a process that would describe an evidence-based program that addresses the needs of individuals with early serious mental illness, including psychotic disorders. SAMHSA increased the state's Mental Health Block Grants by 5% to provide funds for this initiative.
- **The Model:** The District of Columbia Department of Behavioral Health (DBH) used an existing service delivery program that combines the Transition to Independence (TIP) model (an evidence supported model) with the Assertive Community Treatment (ACT) model for transition aged youth and young adults (an evidence-based practice), which is called the TACT Program.
- **The Providers:** There are two (2) DBH mental health rehabilitation services (MHRS) providers, Community Connections and Family Preservation Services of DC that operate TACT Programs.
- **The Target Population:** The target population is youth and young adults age 18-29 served by the two (2) TACT Programs.
- **The Budget:** The amount of funds available to the District from the SAMHSA Mental Health Block Grant for evidence-based projects for early intervention (5% set-aside) was \$46,696.00.
- **The Planned Activities:** The primary activities include: 1) a focus group with TIP and TACT programs; 2) first psychosis episode and related training; and 3) a pilot study with the two (2) TACT programs.

**Focus Group:** DBH program staff decided to convene a focus group with the providers in lieu of conducting a survey (the original plan). The purpose of the focus group with the TIP and TACT Programs was to obtain information about services and supports including non-traditional and person-centered services that would enhance successful implementation of these program models and the lives of the youth and young adults served. This activity was convened on August 15, 2014 at the DBH Child and Youth Services Division (CYSD) community site. The co-facilitators were the designated CYSD Program Manager for this initiative and the Program Manager for the Mental Health Block Grant. The discussion topics included: 1) traditional services and supports provided and those most utilized by transition age youth (TAY); 2) non-traditional services and supports provided and those most utilized by TAY; 3) non-traditional services and supports the agencies would like to provide TAY but are not currently available; 4) non-traditional services and supports not currently available that TAY have requested; 5) non-traditional services and supports available through community or other resources that are needed and/or TAY have requested; 6) partnerships developed to access some of the non-traditional services and supports that are available; 7) methods

used to routinely assess TAY level of satisfaction with the services and supports provided; 8) methods routinely used to obtain input from TAY about improving the services and supports provided; 9) access to person-centered funding for TAY and the funding priorities; and 10) process to confirm that TAY agree with agency priorities. The focus group discussions generated important ideas and issues that were summarized.

**First Psychosis Episode Training:** DBH partnered with the National Institute of Mental Health (NIMH) to provide a first episode psychosis (FEP) educational and training event for Department staff, consumers/clients, providers and other community partners. On November 10, 2014 Drs. Amy B. Goldstein and Susan T. Azrin from NIMH conducted a presentation on *Prevention and Early Intervention of Psychosis: Lessons Learned from the NIMH RAISE Project*. The presentation topics included: 1) schizophrenia overview; 2) rationale for early intervention in psychosis; 3) NIMH *Recovery After an Initial Schizophrenia Episode (RAISE)* initiative; 4) Coordinated Specialty Care (CSC) model; 5) financing CSC programs; and 6) next steps. The presentation was quite informative and well received. The event was attended by 52 individuals. Social Workers and Addiction Counselors received continuing education units.

DBH staff also participated in a series of webinars on FEP and related topics. They included:

- *Strategies for Funding Coordinated Specialty Care Initiatives*, June 30, 2015
- *Using the 5% MHBG Set-Aside to Support Programming for First Episode Psychosis: Activities and Lessons Learned from the State of Ohio*, June 29, 2015
- *Lessons Learned in Implementing Models for Early Intervention in Psychosis*, June 5, 2015
- *An Overview of Coordinated Specialty Care (CSC) for Persons with First Episode Psychosis: A Presentation to State Planning Councils*, April 13, 2015
- *Inventory and Environmental Scan of Evidence - Based Practices for Treating Persons in Early Stages of Serious Mental Disorders: Resource Overview*, February 11, 2015
- *First Episodes of Psychosis as it pertains to the Mental Health Block Grant: FEP Modeling Tool*, October 28, 2014
- *First Episodes of Psychosis as it pertains to the Mental Health Block Grant: Definition and Prevalence*, October 22, 2014
- *Community Outreach and Prevention as an Element of Early Intervention in Psychosis*, July 22, 2014
- *Funding Strategies for Early Psychosis Intervention Models*, July 9, 2014
- *Prep for Success: Lessons Learned in Implementing Models for Early Intervention in Psychosis*, June 5, 2014
- *Cognitive Behavioral Therapy and its Use with Persons in Early Stages of Serious Mental Illness*, May 29, 2014
- *Components of Coordinated Specialty Care for First Episode Psychosis: Guidance Related to the 5% Set-Aside*, May 2, 2014

**TACT Program Pilot Study:** DBH contracted with two (2) transition age youth/young adult TACT Programs to conduct a mini-pilot study using a sample of their program

participants. They were each awarded \$23,348.00. The goals of the pilot are to: 1) examine the system's ability to identify FEP onset and the length of time before treatment is received; and 2) use the findings to inform the District's ability to implement Components of a Coordinated Specialty Care for First Episode Psychosis program. The project activities involve: 1) developing a project report that includes a participant profile (onset of FEP and/or other mental health disorders, behavioral and social characteristics); 2) including peer input into the project through focus groups, other forms or activities; and 3) providing project participants with traditional and non-traditional supports, opportunities and experiences that enhance positive growth and development. The projects are underway and will be completed at the end of September 2015.

**Other Related Initiatives:** DBH is involved in two (2) other initiatives related to the pilot study that are described below.

- ***National Council Community of Practice (CoP) on Early Onset Schizophrenia (EOS)***- DBH was accepted into the National Council's CoP on EOS in February 2015 and joined the National Council in early March 2015. The DBH/DC team completed a **strengths, weaknesses, opportunities, and threats (SWOT)** analysis to identify opportunities and barriers to the development of a strategic plan for the implementation of early intervention services in late March 2015. The team has attended all learning opportunities, including the monthly mandatory webinars and one-on-one office hours calls with early onset experts. The DBH/DC team recently partnered with the Washington Community Mental Health Council (another member of the CoP on EOS) to begin peer-to-peer calls focusing on the development of a strategic planning tool that will help each team build capacity and knowledge about first episode psychosis that will ultimately result in more funding from our respective state/District legislatures.
- ***Develop RAISE-like or Other Program-*** Inspired by the RAISE project, DBH set out to develop a local program for early onset schizophrenia. In December 2014, DBH reached out to community partners who share this interest. By January 2015, a working group was created that now includes representatives from the Green Door, Psychiatric Institute of Washington, Children's National Health System, the District's Department of Health Care Finance (DHCF), and DBH. This group has been reviewing prodromal schizophrenia and first episode psychosis initiatives across the country, with the intention of tailoring a program that best meets the needs of the District's at-risk population. The DBH/DC team has reached out to core services agencies (CSAs) and local hospitals in search of a clinical home for an EOS program. The current and planned activities include: 1) the Green Door and the Psychiatric Institute of Washington (PIW) have agreed to pool resources and house the program between their sites; 2) the Green Door and PIW are currently conducting internal needs assessments to determine the amount of start-up money required to bring in requisite staffing, training, and possibly architectural changes to launch a RAISE-inspired EOS program; 3) upon completion of the needs assessment, the DBH/DC team will seek the start-up money through a Block Grant; and 4) DBH has also begun to receive

technical assistance from SAMHSA on identifying funding mechanisms for the non-Medicaid reimbursable EOS program services.

- ***Technical Assistance through SAMHSA-*** In May 2015, DBH developed a technical assistance request through the SAMHSA TA Tracker to support its collaboration with public and private community partners in developing an Early Onset Schizophrenia initiative. Specifically, this partnership would most benefit from technical assistance in identifying viable mechanisms for funding and financially sustaining this initiative in the District. The TA request was approved in June 2015. There have been follow-up discussions with the SAMHSA contractor and the DBH/DC team about the best way to proceed. The DBH/DC team is trying to determine the model that will be implemented.

The goals and outcomes that the DBH/DC team would like to achieve as a result of the technical assistance include:

**Goal 1:** Assess the current status of the Early Onset Schizophrenia initiative financing and sustainability strategies nationwide.

**Outcome:** The DBH/DC team will identify the strategies that can be successfully implemented in the District.

**Goal 2:** Assess the pros and cons of public-private partnerships in financing and sustaining Early Onset Schizophrenia initiatives.

**Outcome:** The DBH/DC team will run a cost-benefit analysis of partnering in the up-front and ongoing financial support of a local Early Onset Schizophrenia initiative.

**Goal 3:** Assess the extent to which Early Onset Schizophrenia services are Medicaid reimbursable in other cities/states.

**Outcome:** All Medicaid reimbursable services will be appropriately billed.

## 5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

### REVISION REQUEST DETAIL:

Please provide

1. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures need to be provided.
2. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose need to be provide, it showed how much each Program is getting but need to be broken down further.
3. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

## **District of Columbia Evidence-Based Practices for Early Intervention (5 percent Set-Aside)**

***Current Status Regarding the District Evidence-Based Practices for Early Intervention (5 percent Set-Aside) Initiative:*** The new contracts for the two (2) provider continuation projects have not been developed. The Department of Behavioral Health has met with the providers to discuss lessons learned from the projects implemented during FY 2015 and the SAMHSA revision information request. The information provided here is based on these discussions and provider draft responses to the SAMHSA issues. It should be noted that while this information will likely be included in the contracts, currently there are no approved and signed contracts.

### ***Issue 1: Description of Planned Activities for 2016 and 2017***

#### Project Continuation

During 2015, DBH launched a pilot project related to the *Evidence-Based Practices for Early Intervention (5 percent Set-Aside) Initiative*. During FY 2016 and FY 2017, DBH will continue the projects initiated in FY 2015 for transition age youth and young adults with the two (2) Transition to Independence Process (TIP) and Assertive Community Treatment (ACT) services known as TACT. These services are being provided as a program by Community Connections and Family Preservation Services.

#### Priorities:

- The projects will recruit more TACT team members to participate in their projects.
- The projects will collect information about mental health histories, first episodes of psychosis (via project participant interviews or other data sources) and other pertinent data.
- The projects will create and implement project participant engagement strategies.
- The projects will provide more non-Medicaid reimbursable services for transition age youth and young adult project participants.

#### Goals:

- The projects will obtain a minimum of 40 project participants.
- The projects will increase the number of completed project participant interviews.

- The projects will continue to develop a profile of project participants to include: age, gender, District ward, marital status, employment status, housing status, length of time receiving TACT services, length of time receiving other services (if available), primary diagnosis, factors associated with not participating and/or dropping out of the project, and the types of non-Medicaid reimbursable services and supports provided.
- The projects will document the chronological age of onset of psychosis, or other types of mental health issues, and/or behavioral health issues. If age data is not available, this information may be obtained from family members or other informant sources. Also, proxies for age may be school level of onset (elementary, middle school, high school, post high school), or a date and age timeline.
- The projects will document the length of time between diagnosis and receipt of interventions including the types of treatment, services, activities and supports.
- The projects will report project successes and challenges related to the transition age youth and young adults engagement in the project.
- The projects will report project successes and challenges related to providing treatment, services, activities and supports to the transition age youth and young adults in the project.

#### Objectives:

- The projects will identify the types of treatment, services, activities, and supports provided to the TACT program transition age youth and young adults including non-Medicaid reimbursable services utilized by the project participants.
- The projects will identify the outcomes associated with the treatment, services, activities and supports provided to the TACT program transition age youth and young adults including non-Medicaid reimbursable services utilized by the project participants.

#### Implementation Strategies:

- The project implementation strategies will include but not be limited to: 1) system indicators (e.g., how to launch the continuation program, steps taken to implement the program, new features added to the program, staff roles, data collection and reporting); 2) participant indicators (e.g., methods used to engage participants in the project, information provided to the project participants, information obtained from the project participants through interviews and/or surveys, focus groups); and 3) non-Medicaid reimbursable services utilization (e.g., methods for determining what services are needed and the services that will be provided including outcomes).
- The projects will identify the project implementation strategies that were most successful.
- The projects will identify the project implementation strategies that were not successful.

#### Performance Indicators:

- The quantitative key performance indicators that will be used to evaluate the success of the project will include but not be limited to: 1) demographic profile of participants; 2) historical interviews and/or other methods to obtain data on emotional and social problems including mental health and behavioral health issues, treatment, services, and supports; 3) participant outcome data related to hospitalizations, arrests, job interviews completed, employment, and school enrollment; and 4) data on non-Medicaid reimbursable services and activities.
- The qualitative key performance indicators that will be used to evaluate the success of the project will include but not be limited to: 1) pre and post project participation surveys; 2)

family participation; 3) project reporting (monthly, final report); and 4) project successes and challenges.

Baseline Measures:

- A number of baseline measures were developed during the FY 2015 pilot project related to the TACT program project participant profile and are included under the Goals section. These measures are described in the pilot project reports.

***Issue 2: A budget showing how the set-aside and additional state or other supported funds, if any.***

The actual categorical budget breakdown will be provided after the new contracts have been developed, approved and signed.

***Issue 3: The states provision for collecting and reporting data, demonstrating the impact of this initiative.***

The data collection will be similar to the pilot program data development and analysis that included demographic data, clinical data, interview data, non-Medicaid reimbursable services data, findings, outcomes, and recommendations. Also, quantitative and qualitative project performance indicators are being added to inform the evaluation of the projects.

## Environmental Factors and Plan

### 6. Participant Directed Care

#### Narrative Question:

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As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them through the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

*Please indicate areas of technical assistance needed related to this section.*

Please use the box below to indicate areas of technical assistance needed related to this section:

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Technical Assistance Needs: There are no identified technical assistance needs at this time.

Footnotes:



## 6. Participant Directed Care

The Department of Behavioral Health (DBH) Person-Centered Project was initially launched in FY 2012 and continues to grow. The goal has been to provide a recovery-oriented and person-centered approach to care by supporting person-centered assessment and treatment planning throughout the system. The initial phase included assembling a person-centered committee of peers and representatives from DBH and community behavioral health provider agencies to plan a comprehensive launch strategy. Additional accomplishments included partnering with Diane Grieder and Neal Adams, national experts in person-centered care and authors of "Treatment Planning for Person-Centered Care," the development of person-centered practice guidelines and the delivery of person-centered instructor training to the entire DBH provider network. As of June 2015, more than 4,500 classroom attendees were trained in behavioral health concepts, and over 7,500 continuing education contact hours were awarded to over 1,000 licensed attendees.

# Environmental Factors and Plan

## 7. Program Integrity

### Narrative Question:

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SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x-55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
  - a. Budget review;
  - b. Claims/payment adjudication;
  - c. Expenditure report analysis;
  - d. Compliance reviews;
  - e. Client level encounter/use/performance analysis data; and
  - f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

*Please indicate areas of technical assistance needed related to this section.*

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical Assistance Needs: The review and development of program monitoring and fiscal monitoring tools.

Footnotes:

## 7. Program Integrity

The Mental Health Block Grant program integrity activities include: 1) adherence to requirements set forth in the District's *City-Wide Grants Manual and Source Book*, 2) Department of Behavioral Health (DBH) policy; and 3) DBH funded programs and sub-grantee award process including DBH fiscal and program monitoring.

**Mayor's Office of Partnerships and Grant Services (OPGS):** This Office serves as the District government's grants clearinghouse in order to effectively administer mandatory policies and procedures that govern the solicitation of competitive grant funds among District agency grant seekers and their prospective grantees and/or sub-grantees. The *City-Wide Grants Manual and Source Book* establishes best practices policies and procedures for the application for, acceptance of, and disbursement of private, federal and local grant funds. The *Sourcebook* also provides an overview of the minimum requirements for the programmatic and financial operation of grants and sub-grants awarded by the District and any of its covered agencies.

### **Department of Behavioral (DBH) Health Policy 716.6 Screening for Eligibility to Participate in Federal Health Care Programs and to Contract with the District of Columbia Government:**

The Department will not contract with or employ individuals or entities that are ineligible to participate in federal health care programs or are ineligible to contract with the government of the District of Columbia. Section 4d. Exclusion List contains three (3) lists that provide information on any individual or entity excluded from participation in any federal health care program or from contracting with the District of Columbia. They include: 1) the List of Excluded of Individuals/Entities (LEIE) database maintained by the Department of Health and Human Services (DHHS), Office of Inspector General, (OIG) of individuals or entities excluded by the OIG; 2) the General Services Administration (GSA) Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including exclusion actions taken by the OIG; and 3) the District of Columbia Excluded Party List maintained by the District's Debarment and Suspension Panel. The Mental Health Block Grant sub-grantee organizations are screened against these lists.

**Mental Health Block Grant DBH and Sub-Grantee Awards:** The process begins with the notice of funding availability (NOFA) and request for applications (RFA) announcement, which widely distributed and follows the OPGS and *Sourcebook* requirements. The proposals are reviewed that will include the DBH Behavioral Health Council input. The review panel recommendations are forwarded to the DBH Director for review and final approval.

**DBH Mental Health Block Grant Program and Fiscal Monitoring:** The fiscal grant monitors conduct an orientation that addresses issues related to: 1) use of grant funds; 2) administrative requirements; 3) board of directors; 4) audits; 5) reporting requirements; 6) fund disbursement plan; 7) advance invoice submission; 8) expenditure report submission; 9) allowable and unallowable costs; 10) food costs; 11) travel procedures; 12) budget modifications; 13) interest checks; and 14) program close-out. They also collect fiscal information from the sub-grantees, enter the financial information into the DBH financial management system, monitor fiscal activity and reporting, and conduct payment processing. The Mental Health Block Grant Program Manager oversees the programmatic aspects of the DBH programs and sub-grantee

awards. This includes: 1) review and approve the sub-grantee progress and other reports; 2) review and approve sub-grantee requests for program and budget modifications prior to implementing the proposed changes; 2) review the Mental Health Block Grant weekly expenditure report; and 3) work with the sub-grantee and fiscal monitors to resolve any issues related to the project.

# Environmental Factors and Plan

## 8. Tribes

### Narrative Question:

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The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)<sup>74</sup> to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

*Please indicate areas of technical assistance needed related to this section.*

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<sup>74</sup> <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please use the box below to indicate areas of technical assistance needed related to this section:  
This issue is not applicable to the District of Columbia.

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Footnotes:

This environmental factor is not applicable to the District of Columbia.

# Environmental Factors and Plan

## 9. Primary Prevention for Substance Abuse

### Narrative Question:

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Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or



an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
  - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
  - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
  - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
  - a. A statewide licensing or certification program for the substance abuse prevention workforce;
  - b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
  - c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

*Please indicate areas of technical assistance needed related to this section.*

**Footnotes:**

This issue will be addressed under the Department of Behavioral Health Substance Abuse Block Grant.

## Environmental Factors and Plan

### 10. Quality Improvement Plan

#### Narrative Question:

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In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

*In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.*

*Please indicate areas of technical assistance needed related to this section.*

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical Assistance Needs: The development of a behavioral health system-wide CQI Plan.

Footnotes:

## 10. Quality Improvement Plan

States are asked to submit a Continuous Quality Improvement (CQI) Plan for FY 2016-2017.

DBH does not have a formal quality improvement plan. The Department conducts a set of quality improvement activities captured by the quality improvement audit process. It includes oversight and monitoring of the behavior health provider network (mental health and substance use disorder treatment and recovery services) and mental health community residence facilities to ensure compliance with applicable District and federal laws and regulations. Policy recommendations are made in the Provider Scorecard and through the DBH Internal Quality Committee.

# Environmental Factors and Plan

## 11. Trauma

Narrative Question:

Trauma<sup>75</sup> is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems<sup>76</sup>. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach".<sup>77</sup> This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states use SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma<sup>78</sup> paper.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state's policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

*Please indicate areas of technical assistance needed related to this section.*

<sup>75</sup> Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

<sup>76</sup> <http://www.samhsa.gov/trauma-violence/types>

<sup>77</sup> <http://store.samhsa.gov/product/SMA14-4884>

<sup>78</sup> Ibid

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical Assistance Needs: There are no identified technical assistance needs at this time.

Footnotes:



## 11. Trauma

One of the ways that DBH promotes trauma-informed care is through the Child and Youth Services Division Evidence-based Practices initiative called Families First. This is a collaborative effort with the Child and Families Services Agency. At the heart of the Families First program is a commitment to keeping families together, providing community-based treatments proven to work and preventing children from being placed into out-of-home programs.

Families First brings together a range of family-centered mental health treatment and supports appropriate for different age groups. These Evidence-Based Practices are proven to strengthen family life, meet the needs of the children and youth and families who experience depression, anxiety and acting out behavior in reaction to trauma and violence, and help avoid more complex, long-term challenges. District children, youth and their families (including biological, foster and adoptive families and caregivers) and children and youth who are wards of the District living in Maryland and Virginia are eligible for these specialized treatment programs. The Families First services are provided by qualified designated community-based providers who receive comprehensive training and coaching in treatment models that have demonstrated positive outcomes such as restoring responsible behavior for troubled children, helping family members deal with traumatic histories, and improving family interactions.

The current evidence-based and evidence supported practices include: 1) Child Parent Psychotherapy for Family Violence; 2) Trauma Systems Therapy; 3) Parent Child Interaction Therapy; 4) Trauma Focused Cognitive Behavioral Therapy; 5) Multi-Systemic Therapy; 6) Multi-Systemic Therapy for Youth with Problem Sexual Behavior; 7) Adolescent Community Reinforcement Approach; and 8) Transition to Independence Process.

Evidence Based Associates (EBA) is the DBH contractor that assists with developing and sustaining trauma-related and other evidence-based practices. The EBA services include: provider: 1) pre-implementation readiness; 2) training; 3) coaching and implementation; 4) data tracking; and 5) fidelity monitoring. EBA also supports the development of the annual Evidence-Based Practices Conference that started in 2011.

# Environmental Factors and Plan

## 12. Criminal and Juvenile Justice

### Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.<sup>79</sup>

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.<sup>80 81</sup> Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.<sup>82</sup>

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Please indicate areas of technical assistance needed related to this section.

<sup>79</sup> <http://csqjusticecenter.org/mental-health/>

<sup>80</sup> The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman, 2000.

<sup>81</sup> A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

<sup>82</sup> Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical Assistance Needs: There are no identified technical assistance needs at this time.

Footnotes:



## 12. Criminal and Juvenile Justice

The criminal justice initiatives and services are described in detail in the overview of the adult service system. The DBH adult forensic outpatient services include: 1) pre-trial and re-entry services; 2) Court Urgent Care Clinic services (individuals are in immediate need of mental health and/or substance use disorder services); 3) DBH staff located at the jail to provide screening and linkage to services; 4) DBH provider programs that provide services; and 5) DBH Re-entry Coordinator placed at the D.C. Jail Women's Facility to assist women with mental health and/or substance use disorder issues being linked prior to discharge with the appropriate service provider.

The Juvenile Behavioral Diversion Program (JBDP) began in January 2011 and operates within the D.C. Superior Court Juvenile Division. This voluntary program links and engages juveniles in appropriate community-based mental health services and supports. Court-involved juvenile status offenders are given the option of participating in mental health services rather than being prosecuted. The goal is to reduce behavioral symptoms that may contribute to juveniles' involvement with the criminal justice system and to improve their functioning in the home, school, and community. This program is intended for children and youth who are often served within multiple systems who are at risk of re-offending without linkage to mental health services and other important supports. Participants are enrolled from six (6) months to a year and are required to attend regular court monitoring meetings and participate in mental health services. The capacity for JBDP has been 60 since its inception and based upon a request from the Court, it was expanded to 75 in 2015.

# Environmental Factors and Plan

## 13. State Parity Efforts

### Narrative Question:

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MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.<sup>83</sup>

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.<sup>84</sup>

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

*Please indicate areas of technical assistance needed related to this section.*

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<sup>83</sup> <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

<sup>84</sup> Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical Assistance Needs: DHCF is the District agency conducting the analysis and will receive technical assistance from CMS.

Footnotes:

### 13. State Parity Efforts

The Department of Health Care Finance (DHCF), the state Medicaid agency, conducted a preliminary analysis of mental health services offered through DBH. The DHCF determined that the District was in parity with the physical health benefits offered through Medicaid. However, an analysis of the substance use disorder services is pending. DHCF anticipates additional technical assistance from the Centers for Medicare and Medicaid Services (CMS).

# Environmental Factors and Plan

## 14. Medication Assisted Treatment

### Narrative Question:

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There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40<sup>85</sup>, 43<sup>86</sup>, 45<sup>87</sup>, and 49<sup>88</sup>. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

*Please indicate areas of technical assistance needed related to this section.*

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<sup>85</sup> <http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939>

<sup>86</sup> <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>

<sup>87</sup> <http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131>

<sup>88</sup> <http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380>

Please use the box below to indicate areas of technical assistance needed related to this section:

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### Footnotes:

This issue will be addressed under the Department of Behavioral Health Substance Abuse Block Grant.

# Environmental Factors and Plan

## 15. Crisis Services

### Narrative Question:

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In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)<sup>89</sup>,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

#### Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

#### Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

#### Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

*Please indicate areas of technical assistance needed related to this section.*

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<sup>89</sup>Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical Assistance Needs: There are no additional technical assistance needs at this time.

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Footnotes:

## 15. Crisis Services

Child and Youth Crisis Service: This service is called the Children and Adolescent Mobile Psychiatric Service (ChAMPS). FY 2015 is year 7 of operation for ChAMPS via DBH contract with Catholic Charities of Washington Behavioral Health Services. The purpose is to provide immediate access to mobile emergency services for children, youth and families experiencing a behavioral or mental health crisis. The service is available 24 hours, 7 days a week for children and youth ages 6 to 18, except for youth who are committed to the Child and Family Services Agency (CFSA) who are served until age 21. The mobile team: 1) provides on-site crisis assessments to determine the mental health stability of a youth and their ability to remain safe in the community; 2) assists in the coordination of acute care assessments and hospitalizations when appropriate; and 3) post-crisis follow-up interventions are conducted up to 30 days after the initial crisis intervention to ensure linkage to DBH mental health providers for ongoing treatment. As of June 2015, the quarterly average number of children/youth served was 225. The unduplicated number served during this period was 726.

Adult Crisis Services: These services include community crisis stabilization beds and the Comprehensive Psychiatric Emergency Program (CPEP).

- **Crisis Stabilization Beds:** DBH contracts with two (2) community providers for 15 crisis stabilization beds. There are eight (8) beds at Jordan House and seven (7) beds at Crossing Place. As of June 2015, the average quarterly crisis stabilization bed utilization rate was 88.90%.
- **The Comprehensive Psychiatric Emergency Program (CPEP)** is a 24-hour specialty psychiatric unit responsible for assessing and treating individuals with acute and chronic mental illness in or pending psychiatric crisis. It has three (3) components: 1) Psychiatric Emergency Services, 2) Mobile Crisis Services, and 3) Homeless Outreach Program.
  - ***Psychiatric Emergency Services (PES):*** Medical treatment is available for common medical problems and limited medical testing is conducted. CPEP accepts voluntary patients who come on their own or accompanied by family, friends or healthcare professionals; and involuntary patients from community settings who are referred by law enforcement, physicians, psychologists or officer-agents. Each patient receives a nursing assessment and a psychiatric evaluation; depending on the clinical presentation, most have a psychosocial assessment and a medical screening. Once a psychiatric evaluation is completed, the patient may be discharged immediately, kept at CPEP for stabilization (up to 72 hours in the Extended Observation Bed unit) or referred for psychiatric hospitalization. As of June 2015, 1,935 unduplicated individuals out of 2,769 visited PES.
  - ***Mobile Crisis Services (MCS):*** Provides services to adults experiencing a psychiatric crisis in the community including at home, office or any public area. The team acts quickly as a first responder to adults who are unable or unwilling to travel to receive mental health services and may provide in-field psychiatric assessment, bilingual clinical consultation, medication management, linkages to ongoing services, and follow-up services to assure stability. The team also responds to critical incidents including tragedies and disasters throughout the District. As of June 2015, 861 unduplicated individuals out of 968 received a team visit.

- ***Homeless Outreach Program (HOP):*** Operates as part of the MCS program. Its primary purpose is to provide a variety of mental health outreach services and supports to adults and families who are homeless. These services include: mental health assessments, crisis intervention, care coordination between mental health agencies, and referrals to other services. As of June 2015, 472 unduplicated persons received engagement services out of 1,541. The HOP also provides consultation and training to the provider network working most closely with this population.
- ***Technical Assistance through SAMHSA-*** In May 2015, DBH developed a technical assistance request through the SAMHSA TA Tracker to evaluate and develop strategies to enhance the quality of service delivery and therapeutic efficiency of CPEP's three (3) complementary programs (PES, MCS, and HOP). Other goals included: 1) a review of the literature and/or examples of other state/jurisdiction operation of urban emergency psychiatric services, including the use of evidence-based practices, outcomes and limitations; and 2) development of strategies and roadmap for CPEP to incorporate relevant evidence-based practices and tools into psychiatric care delivery, thereby improving quality and enhancing staff development. The TA request was approved in June 2015. Mark Engelhardt, an expert in both crisis services and homelessness, was the assigned consultant. There was an exchange of documents, a planning conference call, and a 2-day site visit August 6-7, 2015. The consultant report was received at the end of August and was very positive with some short-term follow-up actions.



# Environmental Factors and Plan

## 16. Recovery

### Narrative Question:

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The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- |  |   |  |
|--|---|--|
| • Drop-in centers                          | • Family navigators/parent support partners/providers | • Mutual aid groups for individuals with MH/SA Disorders or CODs |
| • Peer-delivered motivational interviewing | • Peer health navigators                              | • Peer-run respite services                                      |
| • Peer specialist/Promotoras               | • Peer wellness coaching                              | • Person-centered planning                                       |
| • Clubhouses                               | • Recovery coaching                                   | • Self-care and wellness approaches                              |
| • Self-directed care                       | • Shared decision making                              | • Peer-run crisis diversion services                             |
| • Supportive housing models                | • Telephone recovery checkups                         | • Wellness-based community campaign                              |
| • Recovery community centers               | • Warm lines  |  |
| • WRAP                                     | • Whole Health Action Management (WHAM)               |  |
| • Evidence-based supported                 |   |  |

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

*Please indicate areas of technical assistance needed related to this section.*

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical Assistance Needs: The development of a behavioral health system-wide Recovery Plan.

Footnotes:

## 16. Recovery

DBH does not have a formal Recovery Plan. There is a draft proposed plan. DBH does, however, provide recovery services. These services include: 1) recovery support evaluation; 2) recovery support management; 3) recovery coaching; 4) life skills support services; 5) spiritual support services; 6) education support services; 7) transportation services (public); 8) recovery social activities; and 9) environmental stability.

## Environmental Factors and Plan

### 17. Community Living and the Implementation of Olmstead

#### Narrative Question:

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The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

*Please indicate areas of technical assistance needed related to this section.*

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical Assistance Needs: There are no identified technical assistance needs at this time.

#### Footnotes:

An Addendum to the Plan is in progress but it is not finalized. It will likely be finalized by the end of September 2015. Also, a substantive revision is planned for FY 2016.

## **DC—One Community For All**

### **An Olmstead Community Integration Plan**

#### **Prepared by the DC Office of Disability Rights**

#### **Introduction and Background**

On June 22, 1999, the United States Supreme Court ruled in *Olmstead v. L.C.*, 527 U.S. 581, that the unjustified segregation or isolation of people with disabilities in institutions may constitute discrimination based on disability in violation of the Americans with Disabilities Act (ADA). Accordingly, the Court held that the ADA requires that States provide community-based treatment for persons with disabilities “when the State’s treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the States and the needs of others with . . . disabilities.” 527 U.S. at 607.

In light of this decision, the District instituted a comprehensive working plan to serve qualified individuals with disabilities in accordance with the Supreme Court’s holding in *Olmstead*. This plan establishes certain goals of the District to ensure that community-based treatment is provided to persons with disabilities, when such treatment is appropriate. However, this plan does not create independent legal obligations on the part of the District.

Mayor Vincent Gray and a wide range of District stakeholders including persons with disabilities directed and supported the Office of Disability Rights to develop the Olmstead Community Integration Plan in accordance with policies and procedures outlined in D.C. Act 16-595 the Disability Rights Protection Act of 2006. The District values its residents with disabilities as contributing members of society and understands the cost-effective benefits of supporting them with integrated, community-based services. The DC Olmstead Community Integration Plan, One Community for All is a policy document that details the rights of each person with a disability to self-determination in the District of Columbia.

***One Community for All*** endeavors to meet the needs and preferences of the individual while allowing him or her to choose where s/he wants to live in the community with the appropriate supports and services consistent with the Olmstead decision and the resources available to the District to serve such individuals, taking into account the needs of others. The Plan is a living document, providing specific goals, action steps, and tools, while allowing for better flexibility and improved services for individuals with disabilities.

Nine (9) District agencies participating in this initiative are responsible for implementing the Plan. These District agencies include: Office of the State Superintendent for Education (OSSE), Office on Aging (DCOA), Department of Youth Rehabilitation

Services (DYRS), Department of Disability Services (DDS), Department of Human Services (DHS), Department of Behavioral Health (DBH), Child and Family Services Agency (CFSA), DC Public Schools (DCPS) and the Department of Health Care Finance (DHCF). These agencies are collaborating in the hope that the District of Columbia will become a national model for providing community services and supports to persons with disabilities.

### **The Fiscal Year (FY) 2015 Plan**

For Fiscal Year 2015 (FY '15), the District's Plan will focus on the programs, services, and outcomes of the following agencies:

- DC Office on Aging (DCOA);
- Department of Behavioral Health (DBH);
- Department on Disability Services (DDS); and
- Department of Healthcare Finance (DHCF).

The above-named agencies provide direct service to a quantifiable population of District residents individually and with other District agencies and community partners. This year's Plan seeks to highlight collaboration among these agencies, as well as the Plan's remaining five (5) participating agencies, to illustrate the wrap-around, holistic approach to support provided by the District to individuals with disabilities who are transitioning into the community of their choice.

This year's Plan is designed to specifically address how these agencies carry out the Primary Service Agency Priorities set forth in the original iteration of DC—One Community for All published in April 2012. .<sup>1</sup>

The FY '15 Plan contains benchmarks for each of the above agencies. Each agency will report quarterly on the number of individuals with disabilities it has assisted in transition. Moreover, each agency will report on any qualitative measures it has taken to promote and support successful integration into community life for people with disabilities. These types of measures will include, but are not limited to the following:

- Outreach and training;
- Internal and external agency publications;
- Development of transition-relevant new community partnerships;
- Fostering of existing transition-relevant community partnerships; and
- Opportunities for input from persons with disabilities being served.

Last, the FY '15 Olmstead Plan will explore avenues to address the most prevalent barrier to successful, lasting transition for the disability community—accessible, affordable housing. To facilitate this effort, the DC Housing Authority (DCHA) and DC

Housing and Community Development (DHCD) will participate or provide comment on all District-wide housing issues related to DC's Olmstead Plan.

## **FY '15 Olmstead Planning Questions and Outline**

Please address the following with respect to the particular population of individuals your agency serves.

### **Setting Priorities**

1. When does your agency consider an individual to be “institutionalized” under the auspices of the Olmstead mandate?
  - ☐ 91 days or more
  - ☐ 181 days or more
  - ☐ 365 days or more
  - ☐ Other: \_\_\_\_\_
2. What policies/procedures does your Agency utilize for identifying individuals ready and invested for transition into the community?
3. How do you communicate with your target population and their families/caregivers/advocates/providers about community-based options?
4. What procedures or policies do you have in place to allow people with disabilities to assess the quality of the supports they receive?
5. What measures has your agency taken to address the needs of the following:
  - a. Children who receive residential services from District agencies but live outside the District of Columbia.
  - b. Adults who receive residential services from District agencies but reside outside the District of Columbia.
  - c. Individuals who are long-term homeless and seeking permanent housing.
  - d. Individuals who are soon to be released from jail/juvenile detention facilities.
  - e. Individuals who are receiving services but still have significant unmet needs which put them **at risk** of placement in non-community-based settings.
  - f. Individuals who do not receive services but are known to have unmet needs that put them at risk for placement in non-community-based settings.
  - g. Individuals not receiving formalized services but live with a family member unable to support them effectively.



### **Interagency Collaboration**

6. Explain specifically how your agency works with other participating agencies, District residents, and community stakeholders. Please identify the agency/agencies (Government and Community-based) and consider the following:
  - a. Recommend community services and supports that allow an individual to select services and supports designed for their specific needs.
  - b. Develop effective and timely transition plans for individuals who are placed in non-community-based settings.
  - c. Conduct outreach on your services or other participating agencies' services specifically geared toward your service population.

### **Addressing Barriers**

7. How does your agency address any or all of the following **barriers** to successful provision of community-based supports for individuals with disabilities? **Note:** address only those populations applicable to your agency's mission and vision.
  - a. Lack of comprehensive information on the supports and services available.
  - b. Impacts of transitioning to life in the community: discrimination, fear, and stigma.
  - c. Unavailability of support services to assist with daily life for individuals with severe disabilities, such as education, transportation, and employment.
  - d. Insufficient numbers of compensated, trained employees to work with the population of people with disabilities.
  - e. Post-discharge into community-based living with subsequent assessment that transition is not meeting the needs of the individual.

## **DC Office on Aging (DCOA) FY 2015 Olmstead Planning Questions and Outline**

### **Setting Priorities**

- 1. When does your agency consider an individual to be “institutionalized” under the auspices of the Olmstead mandate?**

The nursing home transition and hospital discharge teams define “institutionalized” as 91 days or more.

- 2. What policies/procedures does your Agency utilize for identifying individuals ready and invested for transition into the community?**

The Agency receives referrals from individuals seeking services, family caregivers, healthcare professionals, or nursing home social workers. When an individual expresses interest in transitional assistance, a referral is sent to Information and Assistance. The referral is assigned to a transition care specialist.

In addition, there is a screening done by the Transition Care Specialist for potential Money Follows the Person and Aging and Disability Resource Center Nursing Home Transition clients. The screening tool determines if the client is eligible for either nursing home transition through Money Follows the Person (MFP) (client must be a Medicaid beneficiary, be assessed at a nursing home level of care, and have viable housing or a housing voucher) or Aging Disability Resource Center (ADRC) (client does not meet the MFP eligibility requirements, but has expressed interest in leaving a nursing facility).

- If the client is eligible for MFP, he/she will be assigned an MFP Transition Care Coordinator.
- If the client is not eligible for MFP, but expresses interest in transitioning out of a nursing facility, he/she will be assigned a Transition Care Specialist on the Nursing Home Transition team.

- 3. How do you communicate with your target population and their families/caregivers/advocates/providers about community-based options?**

DCOA has a community outreach team that conducts outreach at various sites including Senior Wellness Centers, churches, and community events. The target population is also reached via DC Office on Aging website.

The hospital discharge team communicates directly with our targeted population and their support system via hospital visits, home visits, telephone, and/or email. This team also conducts hospital discharge planning presentations at local hospitals.

**4. What procedures or policies do you have in place to allow people with disabilities to assess the quality of the supports they receive?**

The procedures and policies for persons with disabilities, ages 18-59, is the same as persons 60 and older. Once we have received a case, reviewed options, and linked the individual with necessary resources, we provide case management services for 90 days. After 90 days, a customer satisfaction survey is completed.

**5. What measures has your agency taken to address the needs of the following:**

**a. Children who receive residential services from District agencies but live outside the District of Columbia.**

DC Office on Aging does not provide services to children who receive residential services from local DC agencies.

**b. Adults who receive residential services from District agencies but reside outside the District of Columbia.**

The Nursing Home Transition Team and the Hospital Discharge Team assists adults who have been in a hospital or nursing facility outside the District of Columbia if they have been in the hospitals and nursing facility for 90 days or more, receive community-based Medicaid, and desire to transition back into the District of Columbia. However, if a person does not have Medicaid, both of these teams would work with staff, providing Options Counseling to the individual to inform them of potential resources. Options Counseling provides person-centered counseling to individuals, family members and/or significant others with support in their long-term care decisions to determine appropriate choices. During this process, a written action plan for receiving community resources is developed based on an individual's needs, preferences, values, and circumstances. Follow-up is provided by option counselors to ensure service delivery and customer satisfaction.

**c. Individuals who have been homeless long-term, and are seeking permanent housing.**

Individuals who are experiencing long-term homelessness and seeking housing are referred to DCOA's Housing Coordinator who assists individuals in locating permanent and/or affordable and suitable housing. The housing coordinator works with DC Housing Authority, So Others Might Eat, Pathways to Housing, Green Door, and Housing Counseling Services to locate housing.

**d. Individuals who are soon-to-be released from jail/juvenile detention facilities.**

Individuals who are re-entering the community can contact DC Office on Aging Information and Assistance Department for a referral to the Employment and Training Coordinator. Individuals can also receive other services once identified and/or requested.

**e. Individuals who are receiving services but still have significant unmet needs, which put them at risk of placement in non-community-based settings.**

Individuals receiving services who have significant unmet needs and are at risk of being placed in a non-community based setting can contact the DC Office on Aging Information and Assistance Department for a referral to the appropriate Aging Disability Resource Center ward social worker.

**f. Individuals who do not receive services but are known to have unmet needs that put them at risk for placement in non-community-based settings.**

Individuals receiving services with significant unmet needs and are at risk in being placed in a non-community base setting can contact DC Office on Aging Information and Assistance Department for a referral to the appropriate Aging Disability Resource Center ward social worker.

**g. Individuals not receiving formalized services but who live with a family member unable to support them effectively.**

Individuals not receiving formalized services, but who live with a family member unable to support them effectively are referred to an Options Counselor who works both with the client and caregiver on Long Term Care

options and in-home supports. The caregiver may also be referred to the Lifespan Respite Care program to receive caregiver support and services.

### **Interagency Collaboration**

- 6. Explain specifically how your agency works with other participating agencies, District residents, and community stakeholders. Please identify the agency/agencies (Government and Community-based) and consider the following:**
  - a. Recommend community services and supports that allow an individual to select services and supports designed for their specific needs.**
  - b. Develop effective and timely transition plans for individuals who are placed in non-community-based settings.**
  - c. Conduct outreach on your services or other participating agencies' services specifically geared toward your service population.**

DCOA has expanded access to community-based long-term supports for individuals through a memorandum of understanding (MOU) with the Department of Health Care Finance (DHCF) to provide a comprehensive interdisciplinary program that organizes, simplifies, and provides a “one-stop shop” for access to all public long-term care and support programs. Also DCOA has a memorandum of agreement (MOA) with DHCF and Department of Behavioral Health (DBH) to conduct a preliminary intake of all individuals. In addition DCOA has informal partnerships with Washington Hospital Center Mental Health and House Call Programs, Psychiatric Institute of Washington, DC Long term care Ombudsman office, Adult Protective Services, and Senior Service Network. DCOA has an outreach specialist who facilitates meetings with individuals, and/or families interested in transitioning.

An ADRC Transition Care Specialist prescreens consumers for eligibility, informs individuals about the Elderly and Persons with Disabilities (EPD) Waiver, and provides transition assistance through options counseling individuals, creates a person centered action plan that maps out the services, and provides guidance on community resources to ensure a successful transition back into the community.

### **Addressing Barriers**

- 7. How does your agency address any or all of the following barriers to successful provision of community-based supports for individuals with**

disabilities? **Note:** address only those populations applicable to your agency's mission and vision.

**a. Lack of comprehensive information on the supports and services available**

**b. Impacts of transitioning to life in the community: discrimination, fear, and stigma.**

**c. Unavailability of support services to assist with daily life for individuals with severe disabilities, such as education, transportation, and employment.**

- i. **Challenges** include locating affordable and suitable housing for homeless hospital patients who are medically stable for discharge, as well as obtaining services for non-Medicaid hospital patients in need of long-term in-home support care. Also, there is a challenge in locating affordable transportation services for the disabled population ages 18-59.
- ii. **Solution:** The Hospital Discharge Planning Team and Nursing Home Transition Team continues to work closely with our Housing Coordinator to identify affordable housing options for our participants, as well as work with identified agencies to assist participants with obtaining necessary personal care aide services (in-home support) as quickly as possible. Participants with disabilities ages 18-59 needing transportation are referred to Metro Access.

**d. Insufficient numbers of compensated, trained employees to work with the population of people with disabilities.**

i. DCOA is working on improving partnership with the disability community and disability-focused organizations, and knowledge of disability services through training on the following topics:

Introduction to independent living and services; disability cultural competence; and person-first perspective; Services and resources for people with disabilities.

**e. Post-discharge into community-based living with subsequent assessment that transition is not meeting the needs of the individual.**

- iii. **Challenge:** Due to the length of the Elderly & Persons with Physical Disabilities Waiver Program's application process, some participants do not receive adequate hours of in-home supportive services post-discharge.
- iv. **Solution:** The Hospital Discharge and Nursing Home Transition Teams provide assistance and linkages to the participant and/or his/her family with in-home supportive resources and options counseling.

## **Department of Behavioral Health (DBH) FY 2015 Olmstead Planning Questions and Outline**

### **Setting Priorities**

#### **1. When does your agency consider an individual to be “institutionalized” under the auspices of the Olmstead mandate?**

The Department of Behavioral Health defines “institutionalized” as 181 days or more.

#### **2. What policies/procedures does your Agency utilize for identifying individuals ready and invested for transition into the community?**

The Department of Behavioral Health has a number of policies to support a successful transition to the community. These policies include:

For youth in Psychiatric Residential Treatment Facilities (PRTFs), DBH Policy 200.7 requires a Continued Stay referral. The Continued Stay referral is a clinical packet submitted by the responsible District agency which describes the opinion of the treatment team (to include the youth with his/her parent(s)/guardian(s)) regarding whether or not the youth would benefit from continued treatment within the PRTF or discharge into the community. This policy supports the work of the DBH staff assigned to work with the youth while they are in a PRTF. The staff participates in monthly treatment team meetings for youth in the PRTF.

DBH Policy 525.4 details the practice guidelines for community integration of consumers in institutional settings. This policy provides guidance to community mental health providers who are required to participate in the discharge planning process for consumers who are in institutional settings.

DBH Policy 511.3A TL-174 describes the procedures by which consumers are screened for placement in a nursing facility (NF) using the Preadmission Screening and Resident Review (PASRR), the review of level of care and appropriateness of a NF for those already in a NF, and the discharge and transition process when NF is no longer indicated in the consumer’s level of care.

DBH Policy 200.2B TL-178 establishes specific guidelines to ensure the continuity of care for adult consumers who seek or receive urgent or emergency mental health treatment and supports and/or transfer, as well as adults who are discharged to different levels of care within the mental health system.



**3. How do you communicate with your target population and their families/caregivers/advocates/providers about community-based options?**

The Department operates a 24 hour/7 days a week Access Helpline which links individuals to community based services. The line receives over 60,000 calls per year and is able to link and/or inform callers about the range of community-based services available to them.

In addition, the Department has the following activities:

In FY09, the former Department of Mental health (DMH) through its Office of Consumer and Family Affairs developed a program to utilize individuals who self-identify as mental health clients to assist long term inpatients at Saint Elizabeths Hospital (SEH) transition into the community. The program involves peers in providing 1:1 support and intervention, teaching skills needed to live in the community and being active team members of the evidence-based Critical Time Intervention that assists consumers in their transitions to the community.

Among the other supports, services, and resources offered by peers is working with consumers who have been admitted to psychiatric hospitals including community hospitals, e.g. Psychiatric Institute of Washington, Providence, United Medical Center, and SEH. Some of the key activities of these initiatives are as follows:

- Working with the hospital, community providers, and families to facilitate a smooth transition to the community.
- Providing the highly regarded Wellness Recovery Action Plan (WRAP) services for consumers hospitalized at SEH. WRAP helps individuals who are hospitalized manage their own recovery and health.
- SEH uses trained peer specialists to facilitate recovery groups. SEH uses peer specialists on medication review panels.

For youth at PRTFs, DBH works with the youth and his/her parent(s)/guardian(s)/family within the PRTFs monthly treatment team meetings.

**4. What procedures or policies do you have in place to allow people with disabilities to assess the quality of the supports they receive?**

The Peer Transition Specialist Program is designed to assist consumers who have been long term institutionalized at SEH consider and explore community

living and ultimately assist these consumers in leaving the institutional setting for community-based living.

DBH also has a codified grievance procedure available for individuals to use when they feel they have received inadequate or inappropriate treatment or care.

In addition, DBH funds a Peer-run organization, the Consumer Action Network. This organization is responsible for, among other things, conducting regular consumer surveys at the sites in Washington, D.C. where individuals receive care.

DBH clinical monitors continue to monitor Transition Age Youth (youth ages 18-25) discharged from PRTF into placements outside the District of Columbia when these youths continue to receive District services.

**5. What measures has your agency taken to address the needs of the following:**

**a. Children who receive residential services from District agencies but live outside the District of Columbia.**

DBH clinical monitors continue to monitor youth discharged from PRTF into placements outside of the District of Columbia when these youth continue to receive District services.

Children/youth who live outside of the District of Columbia but who receive District services such as youth in the care and custody of Child and Family Services Administration (CFSA) are eligible for services offered through DBH.

**b. Adults who receive residential services from District agencies but reside outside the District of Columbia.**

If adults are being served by another District agency, they are eligible for all DBH services. For example, when consumers are transitioning to a nursing home and have been known to DBH, that provider may stay involved with that individual.

**c. Individuals who are long-term homeless and seeking permanent housing.**

Individuals who are long-term homeless and seeking permanent housing are a priority for a DBH housing voucher.

**d. Individuals who are soon to be released from jail/juvenile detention facilities.**

DBH has a structure in place to coordinate service with the Department of Youth and Rehabilitation Services (DYRS).

**e. Individuals who are receiving services, but still have significant unmet needs which put them at risk of placement in non-community-based settings.**

DBH's Division of Integrated Care has responsibility for ensuring individuals discharged from psychiatric hospitalization are linked to a community provider within seven (7) to thirty (30) days.

DBH has implemented high utilizer meetings for both children and adults to ensure that community services are available to high risk individuals, as well as ensuring that services are well coordinated.

**f. Individuals not receiving formalized services but who live with a family member unable to support them effectively.**

DBH offers crisis services available to any District resident. These include mobile crisis services for adults and youth. These teams of mental health professionals and specialists are available to respond to an individual who is not currently involved with the treatment system. Since police officers are first responders to families that may have an individual experiencing a psychiatric crisis in many situations, DBH has worked with the Metropolitan Police Department (MPD) to develop the Crisis Intervention Officer (CIO) program. Since 2009 DBH and MPD have trained over 600 MPD officers.

In addition, the Department operates two mental health clinics that provide same day or urgent care service to any District resident.

### **Interagency Collaboration**

**6. Explain specifically how your agency works with other participating agencies, District residents, and community stakeholders. Please identify**

**the agency/agencies (Government and Community-based) and consider the following:**

The DBH Child Division works with the Child and Family Services Agency (CFSA), Department of Youth Rehabilitation Services (DYRS), District of Columbia Public Schools (DCPS), Department of Disability Services (DDS), Health Services for Children with Special Needs (HSCSN), the Office of the State Superintendent of Education (OSSE), and the District of Columbia Superior Court (DCSC).

DBH Adult Services has collaborative relationships with Department of Human Services (DHS), Department of Housing and Community Development (DHCD), Department of Housing Authority (DCHA), Metropolitan Police Department (MPD), Department of Disabilities Administration (DDA), Office on Aging, and the Department of Health Care Finance (DHCF).

- a. Recommend community services and supports that allow an individual to select services and supports designed for their specific needs.**

DBH's policies are based on choice and selection of providers according to each individual's desire and need.

- b. Develop effective and timely transition plans for individuals who are placed in non-community-based settings.**

DBH policies require the community providers to be active participants in working with individuals who are in PRTFs, SEH, and nursing facilities.

- c. Conduct outreach on your services or other participating agencies' services specifically geared toward your service population.**

DBH's policies require its provider network to provide outreach to individuals who are living in an institutional setting.

In addition, DBH has worked with other agencies to offer a session called Family Talk which is intended to inform parents of PRTF treatment, discharge, and community-based services. This session has been supported by numerous agencies (including DCPS, DYRS, OSSE, CFSA,

DHCF, DCSC, and Health Services for Children with Special Needs (HSCN)).

### **Addressing Barriers**

- 7. How does your agency address any or all of the following barriers to successful provision of community-based supports for individuals with disabilities? Note: address only those populations applicable to your agency's mission and vision.**

- a. Lack of comprehensive information on the supports and services available.**

DBH keeps its webpage up-to-date to inform the community on its supports and services. In addition, we work with community groups such as Consumer Action Network National Alliance on Mental Illness-DC (NAMI), family groups, and peer operated services to provide information on services and supports available through DBH's network.

- b. Scarcity of accessible, affordable, integrated housing.**

DBH is committed to the availability of accessible, affordable, integrated housing. The agency provides over 800 housing subsidies a year to DBH consumers which are consumer-based, i.e. the consumer can use it for any appropriate housing they choose. Additionally the agency works aggressively to develop accessible, affordable, integrated housing. It has had a partnership with DHCD for the past five years and made more than \$26 million available for the development of new or renovated housing units for the exclusive use of our consumers. More than 181 units have been built and are occupied and an additional 155 units are under development. This is an on-going initiative, and the agency requests additional funding for continued development in its annual budgets.

- c. Unavailability of support services to assist with daily life for individuals with severe disabilities, such as education, transportation, and employment.**

Through a program called Supported Employment, DBH helps people with mental illness find and keep full or part-time jobs in the community. The

jobs pay minimum wage or higher and are based on individual interests and abilities.

**d. Insufficient numbers of compensated, trained employees to work with the population of people with disabilities.**

The Department of Behavioral Health operates the most comprehensive behavioral health training program in the District, called the DBH Training Institute. The Training Institute produces over 150 training events annually. Topics relate to identified system needs determined by agency goals, compliance/audit data, and other sources including needs identified by mental health clients.

**e. Post-discharge into community-based living with subsequent assessment that transition is not meeting the needs of the individual.**

DBH has structure in place to provide support and assistance to providers who are working closely with individuals leaving institutional settings.

## **Department on Disability Services (DDS) FY '15 Olmstead Planning Outline**

### **Setting Priorities**

#### **1. When does your agency consider an individual to be “institutionalized” under the auspices of the Olmstead mandate?**

The Department on Disability Services (“DDS”), Developmental Disabilities Administration (“DDA”) uses 91 days or more for the purposes of the Money Follows the Person (“MFP”) program. However, through policy and procedure, discussed below, every nursing facility referral for a person who receives supports from DDS/ DDA is reviewed by the DDS Human Rights Advisory Committee (“HRAC”), and the agency begins to engage in transition planning for the person to return back to the community immediately, starting from the day of admission.

#### **2. What policies/procedures does your Agency utilize for identifying individuals ready and invested for transition into the community?**

It is DDS’s policy to ensure that all people who receive support from the DDA service system have access to and receive quality supports, services, and health care in the most integrated, least restrictive community-based setting appropriate to their needs. This is reflected in a range of policies and procedures including: Human Rights policy and Human Rights Advisory Committee (the Committee) procedure; Individual Support Plan (“ISP”) policy and procedure; Most Integrated Community Based Setting policy; Out of State Placement policy; and the Nursing Facility Placement policy (all available on-line at <http://dds.dc.gov/page/policies-and-procedures-dda>.)

As an example, the DDS Nursing Facility Placement policy defines acceptable uses for nursing facilities for people with intellectual disabilities who receive supports from DDA as follows:

- The person has a need for a time-limited stay following hospitalization and his or her rehabilitation requires the availability of skilled nursing staff on a twenty-four (24) hour basis. The referral and placement must be directly related to a hospitalization discharge recommendation; or
- The person has a need for medical supports that minimize deterioration in abilities and maximize quality of life and cannot be provided in the individual’s current level of care, nor can it be met in a more intensive community-based alternative, such as an Intermediate Care Facility for Individuals with Intellectual Disabilities (“ICF/IID”); and facility and

community-based interventions are currently unavailable to address the person's medical support needs.

Additionally, the HRAC reviews each proposed nursing facility placement to determine whether it is the least restrictive and most appropriate setting to meet the person's needs. The Committee also establishes the schedule and recommendations for on-going review.

All placement decisions are determined based upon the person's assessed needs and preferences. Developmental Disabilities Administration (DDA) begins transition planning as soon as the person is admitted to a facility to ensure that he or she can return to an integrated, community-based setting, preferably his or her home, as soon as possible, given the person's health condition and need for ongoing medical treatment and therapies. At times, a person may be able to return to a more integrated community setting, but may not be able to return to his or her home because he or she needs an increased level of care, or, if given the length of stay in the nursing facility, the person's placement in a particular residential facility is no longer available. Federal Medicaid rules prohibit payment to the person's residential provider for any days when the person is in a nursing facility. To ensure that people are able to return to their homes, when appropriate, the Medicaid Home and Community-Based Services Waiver for Individuals with Intellectual and Developmental Disabilities ("HCBS IDD Waiver") rates do include a vacancy factor so that providers are able to hold a person's place in the home for short-term stays at a hospital, nursing facility, or other institution.

Finally, it is DDA's practice to use Person-Centered Thinking ("PCT") for all service and support planning. Michael Smull, one of the national experts on PCT, with whom DDS is working closely, describes PCT skills as follows: "At their core all of these skills are about how we can help people who traditionally have led isolated lives, lead ordinary, self-directed lives, within their own communities. The skills are about supporting people as ordinary citizens while recognizing (and accounting for) their unusual support needs." <http://www.nasddds.org/pdf/importanceofpersoncenteredthinking5a.pdf>.

DDA is engaged in implementing PCT throughout not only the agency, but the entire IDD support and service delivery system. DDA currently has five (5) certified PCT trainers on staff, and is training two (2) additional staff members; with additional trainers planned in FY 2015. These trainers offer



ongoing PCT training for DDA staff and provider agencies, both on site at DDS and at provider agencies to facilitate attendance. Once the new trainers are certified, they will assist with providing PCT training to providers, families, and people served by DDA.

**3. How do you communicate with your target population and their families/caregivers/advocates/providers about community-based options?**

DDS communicates with the people we serve and other stakeholders in a variety of ways; including hosting community forums, attending community events, e-mails, the DDS website, and use of social media. We have a stakeholder outreach list that includes more than 700 people, many of whom are grass-top leaders who will help spread the word. As an example, in the spring, we hosted a series of forums to educate the community and receive feedback on proposed changes to the HCBS IDD waiver. We held a community forum at the Gateway Pavillion in Anacostia, accessible to where many of the families of the people we support live. We also presented at Project ACTION!, D.C.'s advocacy group for people with intellectual disabilities and the DC Coalition of Providers of Developmental Disabilities Services among other places. As a result, we received extensive comments on the proposed waiver amendments and made changes, accordingly, to reflect community input.

For people who receive supports from DDA, PCT tools and skills are now an integral part of the ISP pre-planning process. The tools identify the interests, preferences, preferred environments, support requirements, and provide important information for the development of ISP goals and programmatic activities that are meaningful to the person and lead to support delivery in the most integrated, least restrictive setting appropriate to the person's needs. DDA also offers home and community-based services to persons who reside in ICF/IID settings during annual planning meetings and at any other time a person or their support team expresses an interest in home and community-based services.

**4. What procedures or policies do you have in place to allow people with disabilities to assess the quality of the supports they receive?**

DDA has automated all of its performance metrics, and the data we collect is used to provide relevant information to assist consumers in choosing service providers. The system may also be used to evaluate our staff, providers, and

performance on a monthly basis for corrective action and quality improvement initiatives. Additionally, DDA posts the results of our Provider Certification Review process on our website, as well as provider reports cards, and listings of providers who are currently under sanctions. For District licensed facilities, the Department of Health, Health Regulation and Licensing Administration also posts results of its surveys and investigations on its website. In FY 2014, DDA re-joined the National Core Indicators (NCI) project. NCI is a voluntary effort by public developmental disabilities agencies to measure and track their own performance. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. Results are drawn through interviews with people who receive services, and through responses from mailed surveys to families and guardians. The results are prepared by the Human Research Institute (HSRI) and the District will be able to compare its performance against forty (40) other participating states.

RSA provides people or, as appropriate, their representatives with information and support services to assist the person in exercising informed choice. Informed choice begins when the person first contacts RSA to apply for Vocational Rehabilitation (“VR”) services and continues throughout the rehabilitation process. An applicant or a person eligible to receive VR services has the right to exercise informed choice in decisions related to the provision of VR services including: the provision of assessment services, choices among the methods used to procure VR services, the selection of the employment outcome, the specific services needed to achieve the employment outcome, and the entities that will provide the services to help them achieve their employment outcome.

To ensure that the availability and scope of informed choice is consistent, in accordance with 34 C.F.R. § 361.52 (c) (1), the information provided includes:

- Costs, accessibility, and duration of potential services;
- Consumer satisfaction with those services to the extent that information relating to consumer satisfaction is available;
- Qualifications of potential service providers;
- Degree to which services are provided in integrated settings; and
- Outcomes achieved by people working with services providers, to the extent that such information is available.

In FY 2013, DDS RSA added to the Office of Quality Assurance and Compliance two (2) new employees whose primary focus is to monitor the

quality and effectiveness of Supported Employment and Job Placement services provided by RSA's Community Rehabilitation Programs ("CRPs"). A robust monitoring tool was developed to better qualify each CRP's performance. Based on the data submitted to RSA by the CRPs, the Agency develops a Provider Profile showing each provider's performance for the covered time period. Data presented includes:

- Number of referrals per service area;
- Number of referred persons returned to the Agency;
- Number of people placed in employment;
- Number of employed people successfully employed for 90 days through DDS RSA;
- Average number of days between referral and employment;
- Average number of hours worked per week;
- Average hourly pay;

Currently, this information is provided to the VR supervisors and counselors for sharing with people receiving VR services. The agency is developing a CRP module through which this information will be available electronically.

**5. What measures has your agency taken to address the needs of the following:**

**a. Children who receive residential services from District agencies but live outside the District of Columbia.**

DDA works closely with the Child and Family Services Agency ("CFSA"), the Office of the State Superintendent of Education ("OSSE"), the District of Columbia Public Schools ("DCPS"), the Department of Youth Rehabilitation Services ("DYRS") and Health Services for Children with Special Needs ("HSCSN"). Our mission is to identify children who have been placed in out of state residential facilities at least two to three years prior to aging out of such services so that DDA can ensure timely submission and completion of applications for eligibility determinations for adult services. If eligible for adult services, DDA works with the sister agencies, families, guardians, and youth to prepare transitions back to the District for community-integrated supports as indicated based on person-centered planning. DDS is guided by statute, policy, and best practices; it ensures that transitioning youth receive services in Medicaid funded community-integrated services. See D.C. Official Code § 7-761.05(9).

RSA has worked with staff from DCPS, CFSA, and DBH to identify DC youth, receiving secondary education outside of the District, to give them the opportunity to apply to RSA. RSA also provided training to all DBH supervisory staff on the VR process to facilitate effective referral of cases when a youth is transition back to the District from an out-of-state facility. A presentation to provide an overview of the RSA process is planned for DBH staff. RSA has also invited representatives from DBH to provide input and feedback on the development of the RSA Youth in Transition Toolkit, which describes the RSA process and expectations for when a youth applies for RSA services.

**b. Adults who receive residential services from District agencies but reside outside the District of Columbia.**

Since 2007, DDA has returned 263 District residents to District based community-integrated services from out-of-state residential placements. Currently, eleven (11) people remain out-of-state in Medicaid funded home and community-based settings as the DDA worked to honor their preference to remain with long-standing friends and service providers. Four (4) people continue to be served in locally funded settings as a result of agreements with guardians to permit their family members to remain where they have lived, in some cases, for over thirty years. Three (3) people receive specialized, locally funded treatment services out-of-state that are currently unavailable in the District.

**c. Individuals who are long-term homeless and seeking permanent housing.**

For people who are homeless and seeking permanent housing, one of the most important issues is lack of steady and adequate income. RSA's focus is to help them obtain employment, but the reality is that the rehabilitation process can be long, and the need for housing/shelter is acute. Housing stability is a challenge for many of the people RSA serves because they have limited or no income. Currently, 1,874 RSA clients receive SSI or SSDI, while many of the other people served are already relying on family or friends for support.

RSA Counselors provide information at intake about housing and homeless services, which includes information about available programs; and if

necessary, help connect people by making the call and providing transportation to get to the shelter.

RSA also supports many of the related issues that homeless people confront, including access to health care, deficits/gaps in education/literacy, and transportation issues. RSA provides assistance with these services, e.g., health services that are necessary to accomplish a vocational goal can be funded with VR funds. Transportation is provided as an adjunct service with any other service provided. RSA also works with OSSE and adult literacy programs to coordinate services.

For people who are homeless and applying to DDA for supports, DDA uses local funds to provide emergency respite for short-term housing until eligibility can be determined. Once determined, DDA uses person-centered planning to identify community-based residential and other supports that will meet the person's assessed needs. If the person is found ineligible, DDA will connect him or her with appropriate community resources. Occasionally, a person who already receives supports from DDA may become homeless due to illness, hospitalization, or death of his or her primary support person in the home, or because there is an allegation of abuse or neglect by the person's caregiver. In those instances, DDS also uses local or Medicaid funds to provide emergency respite and then uses person-centered planning for long term supports.

**d. Individuals who are soon to be released from jail/juvenile detention facilities.**

DDA supports people eligible for services who are pending release with a full range of housing and supportive services based on person-centered planning.

**e. Individuals who are receiving services, but still have significant unmet needs which put them at risk of placement in non-community-based settings.**

DDA currently does not experience challenges with meeting unmet needs that could place a person at risk of placement in non-community settings except as noted above. In cases where specialized services are not available, it seeks to recruit specialized providers from across the country to develop services in the District to avoid out-of-state placements.

**f. Individuals who do not receive services but are known to have unmet needs that put them at risk for placement in non-community-based settings.**

DDS recently applied for a grant for “Transforming State Long Term Services and Supports (“LTSS”) Access Program and Functions into a No Wrong Door System for All Populations and All Payers. The proposal development process brought together over 20 partners who are committed to working together to create more streamlined and person-centered approaches for people with disabilities and others in need of LTSS. The proposal will also make it easier for people of all ages, disabilities and income levels to learn about and access the services and supports they need. If awarded, this grant will help facilitate access to community-based services and person-centered planning for people with unmet needs who are at risk for placement in non-community based services.

**g. Individuals not receiving formalized services but who live with a family member unable to support them effectively.**

In May 2013, DDA, in partnership with the Developmental Disabilities Council (“DD Council”), was awarded the “National Community of Practice: Supporting Families Throughout the Lifespan” grant. This grant is funded by the Administration on Intellectual and Developmental Disabilities (“AIDD”) and is managed by a partnership between the National Association of State Directors of Developmental Disabilities Services (“NASDDDS”), University of Missouri Kansas City Institute for Human Development (“UMKC-IHD”), Human Services Research Institute (“HSRI”), and the National Association of Councils on Developmental Disabilities (“NACDD”).

The National Community of Practice: Supporting Families Throughout the Lifespan grant provides funding and technical support to develop systems of support for families throughout the lifespan of their family member with an intellectual or developmental disability. “The overall goal of supporting families, with all of their complexity, strengths, and unique abilities is so they can best support, nurture, love, and facilitate opportunities for the achievement of self-determination, interdependence, productivity, integration, and inclusion in all facets of community life for their family members”—  
Building a National Agenda for Supports to Families with Member with I/DD, 2011.

Through this five (5) year grant, DDA, in collaboration with the DD Council, Project ACTION!, the Quality Trust for Individuals with Disabilities, and the Georgetown Center for Excellence in Developmental Disabilities, has convened a team of family members, people with IDD, and other government and community partners, to develop and implement an action plan that ultimately will shape policies and programs that support families. Through our work with the State Team, we have strengthened two-way communications with people with developmental disabilities and their families throughout the lifespan and have begun to identify and address gaps. As an example, a consistent message from families has been about the need for peer-support across disabilities and across the lifespan. The DC Core Team has been working closely with Health Services for Children with Special Needs and the National Parent to Parent to plan the launch of a DC Parent to Parent chapter. We have also identified many parent leaders in the community who participate in the Community of Practice and will share information back and forth within the community. We have seen increased participation by family members at community meetings.

### **Interagency Collaboration**

- 6. Explain specifically how your agency works with other participating agencies, District residents, and community stakeholders. Please identify the agency/agencies (Government and Community-based) and consider the following:**
  - a. Recommend community services and supports that allow an individual to select services and supports designed for their specific needs.**

DDA has extensive and established policies, procedures, and practices that ensure people who apply for services are connected to government and community services. For persons who apply but are found ineligible for services, the DDA intake service coordinator provides information and referral resources based on the information and assessment materials gathered in the eligibility determination process to the person and their allies. These resources include, but are not limited to:

- Department of Human Services, Economic Security Administration (“DHS/ESA”) for Medicaid, Temporary Aid to Needy Families (“TANF”), Supplemental Nutrition Assistance Program (“SNAP”) and other social service benefits;
- RSA



- Office on Aging, Aging and Disabilities Resource Center (“DCOA/ADRC”);
- Department of Behavioral Health (DBH);
- Department of Health Care Finance (“DHCF”) for the Elderly and Person with Physical Disabilities (“EPD”) waiver;
- Housing Authority (“DCHA”);
- Mayors Liaison Services Center ;
- Center for Independent Living (“DCCIL”);
- University Legal Services;
- The Quality Trust for Individuals with Disabilities;
- Mary's Center;
- Consumer Action Network;
- Health Services for Children with Special Needs (“HSCSN”);
- Rachel’s Women’s Center;
- Bread for the City;
- Lifeline Partnership; and
- Columbia Heights/Shaw Family Support Collaborative: Parenting Program.

For persons found eligible, DDA completes numerous assessments and subsequently person-centered planning with the person and their support team. Based on identified needs, the person is provided with an extensive list of formal, informal, government and community services and supports that can meet each need. For paid services, DDA has strict policies and procedures that govern choice of providers from an approved list of qualified providers under the Medicaid programs.

**b. Develop effective and timely transition plans for individuals who are placed in non-community-based settings.**

DDA participates in the MFP program and offers home and community-based services to persons who reside in ICF/IID settings during annual planning meetings and at any other time a person or their allies request home and community-based services. DDA works collaboratively with OSSE, DCPS, CFSA, and DBH to identify people with intellectual disabilities who are placed in non-community-based settings and are or may be seeking transition to community-based services and supports. Once identified, DDA works with the person and sister agencies to



complete eligibility determinations, assessments, person-centered planning, and a transition plan to community services.

DDA is also notified of all nursing home placements within the District for persons who are suspected to have an intellectual or developmental disability through the Preadmission Screening and Resident Review (“PASRR”) process. Upon such notice, DDA conducts a PASRR evaluation and (a) determines if such placement is appropriate, (b) determines if supportive services are required to assist the person to assess the community or receive habilitative supports while in the nursing home, and/or (c) prepares to work on transitioning the person from the nursing home to community supports, if not already known to DDA. Lastly, DDA receives referrals from the ADRC and utilizes its intake service coordination team to assist eligible persons for DDA services to transition from nursing homes to community services.

**c. Conduct outreach on your services or other participating agencies’ services specifically geared toward your service population.**

DDA regularly conducts outreach on services and supports available for people with intellectual disabilities. Outreach venues include, but are not limited to:

- RSA
- HSCSN, including at the June Fair and Family and Community Health Expo
- DC City Wide Transition Fair
- Mayors Disability Awareness Expo
- Public and charter school fairs
- OSSE events such as the Transition Professional Development Series and the OSSE CIRCLES Transition meeting
- DC Superior Court, Pretrial Services, Drug Court
- Seeking Equality Empowerment and Community (“SEEC”)/ Smithsonian Project SEARCH
- Public Defender Service Re-entry Summit

RSA conducts outreach through a number of means:

- RSA has established Memoranda of Agreement with a number of District agencies and community based non-profit social services and health providers. Through these agreements, RSA currently accepts

referrals, conducts intakes, and sees clients at a variety of sites across the District. These include:

- 4 DOES sites
  - 3 Unity Clinics
  - Project Empowerment
  - N Street Village, Inc.
  - Mayor's Liaison Office DC Superior Court
  - Ethiopian Community Center
  - Office of Asian Affairs
  - Salvation Army (Harbor Lights Treatment Program)
  - Aging and Disability Services
  - GW Acute Rehabilitation
  - Washington Literacy Center
  - Independent Living Services (Urban League)
  - Columbia Lighthouse for the Blind
  - Providence Hospital
  - S.O.M.E. Veterans
  - Langston Lane Apartments
  - Community of Hope
  - S.O.M.E
  - Harvest House
  - New Endeavor's for Women
  - Central Union Mission.
- VR counselors from RSA's transition unit visit all District Public High Schools, all Public Charter Schools, the Model Secondary School (Gallaudet University) and all non-public schools that serve transition-aged District youth. The counselors conduct intakes and provide information about services to students, their families, and school staff.
  - RSA developed a number of materials to improve outreach. A printed application for services is widely available in the community. The application is also available on the agency's website. In addition, as indicated above, the agency worked with SchoolTalk, Inc., OSSE, DCPS, DBH, and The Arc to develop a Transition Tool Kit for youth and their families. Lastly, the administration developed an orientation video regarding VR services that is shown at intake and is available on the agency's website.

The outreach efforts over the past year have been successful. RSA has seen continued growth in the number of new referrals. There was an increase from 2,380 referrals in FY 2012 to 3,141 in FY 2013. This increase continued in FY 2014.

### **Addressing Barriers**

**7. How does your agency address any or all of the following barriers to successful provision of community-based supports for individuals with disabilities? Note: address only those populations applicable to your agency's mission and vision.**

**a. Lack of comprehensive information on the supports and services available.**

As part of the 2014-2016 State Plan for Independent Living, the DCCIL plans to create a How-to Information Guide for distribution to the community that will promote understanding of local housing requirements for persons with significant disabilities. The State Independent Living Council ("DCSILC") will advise the RSA and DCCIL in these efforts through community outreach and advocacy, with the end goal of ensuring that the guide bridges the knowledge gaps consumers have on the array of Independent Living services and supports available to them. The DCSILC will also advocate and provide testimony in reference to improved housing opportunities for people with disabilities before the Mayor and DC Council.

**b. Impacts of transitioning to life in the community: discrimination, fear, and stigma.**

DDS works closely with its service provider community to ensure community and neighborhood relations are developed and maintained to help mitigate stigma and negative perceptions among community members, especially as it pertains to NIMBY issues. DDS also presents at community meetings, ANC meetings, and hiring events, for example, to advance education about the rights and contributions of people with disabilities. DDS supports fully community-integrated services and through those efforts has significantly increased the opportunities of persons with disabilities to receive services in settings where people without disabilities live, work, and play, thus advancing the overall awareness and enrichment of our community at-large. DDS is now

working on other media campaigns that will continue to educate our community to embrace and value all members of our city.

**c. Unavailability of support services to assist with daily life for individuals with severe disabilities, such as education, transportation, and employment.**

The most significant deficit in the District's services and support for people with disabilities is for persons with developmental disabilities and brain injury who are not eligible for services from DDA or the EPD waiver program. These are constituents in the program operated by DHCF. Despite its name, DDA is only authorized to serve people with intellectual disabilities, narrowly defined as persons with an IQ of 70 or below and deficits in at least two areas of adaptive functioning such as communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work, established prior to the age of 18 years of age.<sup>ii</sup> Due to the nature of developmental disabilities and brain injuries, these persons require supports and may be at significant risk for institutionalization but are not eligible for any services in the District.

The District remains one of two jurisdictions in the nation to only provide services to people with ID and not DD. DDS has supported expanding its statute to serve people with DD within available appropriations and previously met opposition by the advocacy community as it may lead to waiting lists for services where none existed in the past. Despite this, it is imperative that the District again seek to expand its eligibility under DDA to serve this population to avoid unnecessary institutionalization of persons with DD.

A second under-served population is persons who experience brain trauma and the injury results in significant cognitive impairments. Again, those persons are not eligible for services from DDA if the injury occurred after age 18. Additionally, if they are not physically disabled, they are not eligible for services under the EPD program. The number of persons who experience brain injury is growing via service related injuries, vehicle accidents, and gun violence. As a result, this is another population that often must rely on nursing facilities for support.

Another significant barrier to community living is the absence of the Medicaid Buy-in Program for Working People with Disabilities (“MBI-WPD”) in the District. The MBI-WPD is a program that allows individuals with disabilities to work and get or keep Medicaid. Many persons with significant disabilities are unable to obtain employer-funded private health insurance that provides coverage comparable to Medicaid. The fear of losing Medicaid and/or Medicare is one of the greatest barriers keeping individuals with disabilities from maximizing their employment, earnings potential, and independence. For many Social Security Disability Insurance (“SSDI”) and Supplemental Security Income (“SSI”) beneficiaries, the risk of losing health care through work activity can be a greater work disincentive than the risk of losing cash benefits through work activity.

For people who receive supports from DDA, the DDS HRAC has identified ventilator-use as a systemic barrier to community based living, albeit one that affects a small number of people DDA supports. The HRAC made a recommendation to the DDS Deputy Director for DDA to research barriers and propose solutions. DDS has begun discussions on this issue with DHCF and the Department of Health (“DOH”).

Finally, the RSA Vocational Rehabilitation (“VR”) program is able to provide time limited supports to help people with significant disabilities move to employment. When people need extended supports to maintain employment, RSA attempts to develop a plan including natural supports through its VR program. Long term employment supports are currently available for people with intellectual disabilities through the Home and Community Based Services waiver for People with Intellectual and Developmental Disabilities (“HCBS IDD”) waiver. However, long term supports are more difficult to identify for people with physical or other disabilities, and the EPD waiver currently lacks long-term employment supports in its benefit package. Ticket to Work does provide some job retention support, but for a person who needs ongoing supported employment, this level of support is not adequate.

**d. Insufficient numbers of compensated, trained employees to work with the population of people with disabilities.**

Currently, DDS is not experiencing significant problems with the ability to retain trained employees to work with the population of people with

disabilities. Our current vacancy rate in key service positions working with individuals with intellectual disabilities (service coordination) is approximately 7%, which is a reasonable and expected rate allowing for normal turnover. The current vacancy rate for VR specialists is 13% and this is a bit higher than ideal, but during the recent year it has been very low and the 13% is not a long term rate. DDS keeps the vacancy rates low through active, targeted recruiting.

The ability of the disability service providers to recruit and retain trained individuals is a bit more of a concern particularly in regards to clinical staffing. DDS has taken steps to assist the providers in their staffing by retaining professional services to develop a series of advertisements to recruit clinical professionals into the disability field in the District of Columbia. At this time, we are waiting for service provider input prior to launching the advertising campaign. Additionally, working collaboratively with DHCF, DDS is submitting an amendment to the HCBS IDD waiver that would raise the rates for a number of clinical services in an effort to increase provider capacity in this critical area.

**e. Post-discharge into community-based living with subsequent assessment that transition is not meeting the needs of the individual.**

DDA provides ongoing service coordination for people with intellectual disabilities who transition into community-based services through the HCBS IDD waiver. Through our policy and procedure, there are required post-transition visits by a service coordinator to ensure the transition has gone smoothly. The service coordinator will assess how the person is doing in both their new residential and day/vocational setting and add additional supports or make changes in supports as needed, based upon the person's assessed needs and preferences. DDA has also retained a nurse via its quality assurance project contract with the Georgetown University Center for Excellence in Developmental Disabilities ("UCEDD") whose sole function is to monitor the course of care a person receives while hospitalized or in a nursing home. The nurse then conducts follow-up with the community home setting post-discharge to ensure that all health-related discharge orders are being followed.

As part of the State Plan for Independent Living, the DCSILC has taken on the charge of advocating for city-wide implementation and education to support and campaign to improve transition planning for people who are

on track for discharge from institutional or other restrictive settings. The DCSILC will monitor such planning to ensure that person-centered thinking is the focus of all such planning. The DCSILC will also advise RSA, other District government, and community agencies to achieve an Independent Living services and supports system that ensures planning for independence across the lifespan.

Additionally, the DCCIL provides advocacy and peer support services to people with disabilities.

## **Department of Healthcare Finance (DHCF) FY '15 Olmstead Planning Outline**

### **Setting Priorities**

- 1. When does your agency consider an individual to be “institutionalized” under the auspices of the Olmstead mandate?**

Department of Healthcare Finance (DHCF) defines “institutionalized as 91 days or more.

- 2. What policies/procedures does your Agency utilize for identifying individuals ready and invested for transition into the community?**

DHCF works in partnership with the DC Office on Aging/Aging & Disability Resource Center (DCOA/ADRC) and DDS/DDA Department on Disability Services/Developmental Disabilities Administration (DDS/DDA) to identify individuals ready for and invested in transition. This is consistent with the agency’s Centers for Medicare and Medicaid Services approved Money Follows the Person (MFP) Rebalancing Demonstration Operational Protocol and Memoranda of Understanding between DHCF and DCOA/ADRC on MFP outreach to nursing facilities and operating as the intake and referral entity for the Elderly and Physical Disabilities (EPD) Home and Community-Based Services Waiver.

- 3. How do you communicate with your target population and their families/caregivers/advocates/providers about community-based options?**

Through its MFP Rebalancing Demonstration, DHCF conducts outreach to all District nursing facilities on a monthly basis in collaboration with the DCOA/ADRC. A monthly stakeholder meeting is convened by MFP as well. During FY 2015, the responsibility for convening the stakeholder meeting will be transitioned to DCOA/ADRC, the agency assuming the responsibility for MFP operations for DC residents transitioning from nursing facilities. The Demonstration also offers individualized consultation in service planning meetings about community-based options for residents of Intermediate Care Facilities for people with Intellectual and Developmental Disabilities (ICFs/IDD) at the request of residents and/or DDA service coordinators.



DHCF hosts monthly provider meetings for its EPD Waiver and Medicaid State Plan providers of home and community-based services.

DHCF's web site also features participant handbooks that include home and community-based options for its Medicaid Fee-for-Service beneficiaries and Elderly and Physical Disabilities Waiver Program participants.

**4. What procedures or policies do you have in place to allow people with disabilities to assess the quality of the supports they receive?**

The MFP Rebalancing Demonstration, through its operating agencies, DCOA/ADRC and DDS/DDA, administers a Quality of Life survey immediately before transition from a long term care facility and at 11 and 24 months after discharge from the long term care facility to home and community-based services.

DHCF solicits feedback from people with disabilities during planning and design for home and community-based services. This process provides people with disabilities the opportunity to comment on the quality of services.

**5. What measures has your agency taken to address the needs of the following:**

- a. Children who receive residential services from District agencies but who live outside the District of Columbia.**
- b. Adults who receive residential services from District agencies but who reside outside the District of Columbia.**

Through its MFP Rebalancing Demonstration, DHCF supports transition coordination for Medicaid beneficiaries who are placed in out-of-state nursing facilities and ICFs/IDDs. These referrals come directly or through the Demonstration's operating agencies (DCOA/ADRC, DDS/DDA).

**c. Individuals who are long-term homeless and seeking permanent housing.**

Through its MFP Rebalancing Demonstration, when housing financing is available (either through Housing Choice Voucher or other housing subsidies through the DC Housing Authority), DHCF supports transition coordination for

Medicaid beneficiaries who are long-term homeless and currently residing in a nursing facility, and remain there in large part because they do not have a home to return to.

- d. Individuals who are soon to be released from jail/juvenile detention facilities.**
- e. Individuals who are receiving services, but who still have significant unmet needs which put them at risk of placement in non-community-based settings.**
- f. Individuals who do not receive services but are known to have unmet needs that put them at risk for placement in non-community-based settings.**
- g. Individuals not receiving formalized services but who live with a family member unable to support them effectively.**

Through its MFP Rebalancing Demonstration, DHCF supports individualized consultation for these families when referred by DDS/DDA.

### **Interagency Collaboration**

- 6. Explain specifically how your agency works with other participating agencies, District residents, and community stakeholders. Please identify the agency/agencies (Government and Community-based) and consider the following:**
  - a. Recommend community services and supports that allow an individual to select services and supports designed for their specific needs.**

See responses above regarding the MFP Rebalancing Demonstration. In addition, when it is identified that a participant has a serious and persistent mental illness, the compilation of documentation required for DBH services is initiated by MFP Transition Coordinators (TCs), and review and approval, if appropriate, is facilitated by the TCs.

DHCF has a Memorandum of Agreement with DCOA/ADRC and DBH that outlines roles and responsibilities specifically for the purpose of transitioning nursing facility residents.

- b. Develop effective and timely transition plans for individuals who are placed in non-community-based settings.**

See responses above for the MFP Rebalancing Demonstration.

DHCF has a Memorandum of Agreement with DCOA/ADRC and DBH that outlines roles and responsibilities specifically for the purpose of transitioning nursing facility residents.

- c. Conduct outreach on your services or other participating agencies' services specifically geared toward your service population.**

DCOA/ADRC, Department of Behavioral Health (DBH), DDS/DDA  
See responses above for the MFP Rebalancing Demonstration.

DHCF has a Memorandum of Agreement with DCOA/ADRC and DBH that outlines roles and responsibilities specifically for the purpose of transitioning nursing facility residents.

### **Addressing Barriers**

- 7. How does your agency address any or all of the following barriers to successful provision of community-based supports for individuals with disabilities? Note: address only those populations applicable to your agency's mission and vision.**

- a. Lack of comprehensive information on the supports and services available.**

DCHF has developed accessible, easy-to-read handbooks on Medicaid home and community-based services as noted above, and they are posted on DHCF's Web site.

Monthly face-to-face outreach and meetings as noted above.

- b. Impacts of transitioning to life in the community: discrimination, fear, and stigma.**

Through the MFP Rebalancing Demonstration, in partnership with the DCOA/ADRC, DHCF delivers intensive case management services during the first year after discharge from a nursing facility.

DHCF anticipates that the operationalization of the Peer Counseling MFP Demonstration service through DC Medicaid in FY15 should also help to mitigate these impacts.

**c. Unavailability of support services to assist with daily life for individuals with severe disabilities, such as education, transportation, and employment.**

MFP Project Team members continue to actively participate in several systems change initiatives aimed at increasing community integration for people with disabilities. Among these are the Association of People Supporting EmploymentFirst (APSE) board and membership meetings, the EmploymentFirst Leadership meeting, and the EmploymentFirst Community of Practice meeting.

**d. Insufficient numbers of compensated, trained employees to work with the population of people with disabilities.**

Through its MFP Rebalancing Demonstration, DHCF is discussing partnership with DDS/DDA on person-centered thinking training for day program provider staff that focuses on community integration for FY 2015. DHCF rate setting, and mandatory training requirements for long term care home and community-based service providers addresses this factor on a large scale.

**e. Post-discharge into community-based living with subsequent assessment that transition is not meeting the needs of the individual.**

Through the MFP Rebalancing Demonstration, in partnership with the DCOA/ADRC, the delivery of intensive case management services during the first year after discharge from a nursing facility. These case managers often identify and work to resolve care coordination issues when the transition is not meeting the needs of the individual.

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<sup>i</sup> "District of Columbia Primary Service Agency Priorities," DC—One Community for All pp. 8-9 (April 2012). Available at: [http://odr.dc.gov/sites/default/files/dc/sites/odr/publication/attachments/olmstead\\_community\\_integration\\_initiative.pdf](http://odr.dc.gov/sites/default/files/dc/sites/odr/publication/attachments/olmstead_community_integration_initiative.pdf).

<sup>ii</sup> There are estimated to be 10,000 persons in the District who have developmental disabilities including; autism spectrum disorders, Spina Bifida, cerebral palsy, Down's Syndrome, Prader Willi Syndrome, borderline intellectual deficits, epilepsy, and other neurological disabilities. See Assessment and Analysis of the Service Needs of Washington, D.C. Residents with Intellectual and Developmental Disabilities, June 2011; available online at <http://ddc.dc.gov/sites/default/files/dc/sites/ddc/publication/attachments/FinalReportSupportNeedsDCResidents.pdf>

17. Community Living and the Implementation of Olmstead  
The District's Olmstead Plan is uploaded in this section.

# Environmental Factors and Plan

## 18. Children and Adolescents Behavioral Health Services

### Narrative Question:

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MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.<sup>90</sup> Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.<sup>91</sup> For youth between the ages of 10 and 24, suicide is the third leading cause of death.<sup>92</sup>

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.<sup>93</sup> Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.<sup>94</sup>

According to data from the [National Evaluation of the Children's Mental Health Initiative](#) (2011), systems of care<sup>95</sup>:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

*Please indicate areas of technical assistance needed related to this section.*

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<sup>90</sup> Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

<sup>91</sup> Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

<sup>92</sup> Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from [www.cdc.gov/injury/wisqars/index.html](http://www.cdc.gov/injury/wisqars/index.html).

<sup>93</sup> The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

<sup>94</sup> Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>.

<sup>95</sup> Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

Please use the box below to indicate areas of technical assistance needed related to this section:

While no specific technical assistance needs have been identified, the DBH Behavioral Health Council comments regarding unmet needs or critical gaps in the child and youth service system does suggest some system enhancement needs.

Footnotes:

## 18. Children and Adolescents Behavioral Health Services

The child and adolescent behavioral health services are described in detail under the overview of the child and youth service system.



# Environmental Factors and Plan

## 19. Pregnant Women and Women with Dependent Children

### Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant ([Title XIX, Part B, Subpart II, Sec.1922 \(c\)](#)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at <http://www.samhsa.gov/women-children-families>: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges*.

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
  - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
  - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
  - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
  - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

*Please indicate areas of technical assistance needed related to this section.*

Please use the box below to indicate areas of technical assistance needed related to this section:

### Footnotes:

This issue will be addressed under the Department of Behavioral Health Substance Abuse Block Grant.

## Environmental Factors and Plan

### 20. Suicide Prevention

Narrative Question:

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In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).<sup>96</sup>

*Please indicate areas of technical assistance needed related to this section.*

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<sup>96</sup> [http://www.samhsa.gov/sites/default/files/samhsa\\_state\\_suicide\\_prevention\\_plans\\_guide\\_final\\_508\\_compliant.pdf](http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf)

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical Assistance Needs: Development of a system-wide suicide prevention plan.

Footnotes:

## 20. Suicide Prevention

The District of Columbia suicide data from the Center for Disease Control (CDC) Fatal Injury Reports (1999-2013) shows that the District is ranked 51 in the nation for suicide deaths with a total of 38 deaths at a rate of 5.9 deaths per 100,000. There is no current suicide plan. A plan was developed as part of a SAMHSA youth suicide grant that ended in FY 2013. A website was developed (I AM THE DIFFERENCE) along with marketing materials.

While there is no current suicide prevention plan, DBH implements a number of suicide prevention related activities. DBH provides training for the District Metropolitan Police Department at the Policy Academy. The Crisis Intervention Officer (CIO) training includes SafeTalk (suicide alertness) and is provided 5 times a year. Also, all new recruit training includes SafeTalk and is provided between 7-10 times a year.

The DBH Training Institute held six (6) SafeTalk trainings in calendar year 2014 with 103 trainees. In calendar year 2015 there were 3 classes with 65 trainees. The DBH Access HelpLine is a certified suicide prevention Lifeline. The Washington Metropolitan Area Transit Authority (WMATA) workers have been trained in SafeTalk. Also, the WMATA Suicide Line is housed in the DBH Access HelpLine.

# Environmental Factors and Plan

## 21. Support of State Partners

### Narrative Question:

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The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

*Please indicate areas of technical assistance needed related to this section.*

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical Assistance Needs: There are no identified technical assistance needs at this time.

Footnotes:

## 21. Support of State Partners

The Department of Behavioral Health (DBH) partners with other District agencies to provide mental health and substance use disorder treatment services and supports for children, youth, families, and adults. Some of the partnerships are described below.

- Child and Family Services Agency (CFSA):
  - Trauma screenings and assessments for CFSA involved children.
  - Assessment Center evaluations.
  - Collaborative co-located staff for In-home Mental Health Coordinators.
  - Behavioral health services solicitation for children placed in foster homes in Maryland.
  - Wraparound services provided by a care management entity for children and youth in the custody of CFSA.
  - Choice Providers program services for children and youth in the custody of CFSA.
- Department of Health Care Finance (DHCF):
  - DHCF and DBH are working on the implementation of several initiatives that include Health Homes and Medicaid billing for Adult Substance Abuse Rehabilitative Services (ASARS).
  - Medicaid reimbursement for mental health rehabilitation services (MHRS).
  - Transfer of fee for service (FFS) Day Treatment to the MHRS Day or Intensive Day Treatment.
  - Medicaid reimbursement for services to individuals in care at Saint Elizabeths Hospital and the disproportionate share payment from DHCF.
- Department of Health (DOH):
  - Maternal mental health case management services for women in Wards 5-8.
  - Health Emergency Preparedness and Response Administration- Mental health preparedness training.
- Office of the State Superintendent of Education (OSSE): Wraparound Project services.
- Office of Justice Grants Administration (OJGA)- Deputy Mayor for Public Safety: Co-occurring (mental health and substance use disorder) pilot at a Department of Corrections adult women correctional treatment facility.
- Department of Human Services (DHS): Treatment services for Temporary Assistance for Needy Families (TANF) eligible clients.

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
**Department of Health Care Finance**



**Office of the Senior Deputy Director**

August 24, 2015

Tanya A. Royster, M.D.  
Director  
Department of Behavioral Health  
64 New York Avenue, N.E., Third Floor  
Washington, D.C. 20002

Dear Dr. Royster:

The District of Columbia Department of Health Care Finance (DHCF) is pleased to submit this letter of support for the Department of Behavioral Health (DBH) FY 2016- FY 2017 Mental Health Block Grant Application to the Substance Abuse and Mental Health Services Administration (SAMHSA). DHCF and DBH (formerly the Department of Mental Health) have worked together over the years to bring Medicaid reimbursable mental health treatment and support services to District children, youth and adults. We have now expanded this approach to include substance use disorder treatment services.

Our partnership has created current opportunities in the development stage as well as a range of existing services that include: 1) Health Homes and Medicaid billing for Adult Substance Abuse Rehabilitative Services (ASARS), in process of implementation; 2) Medicaid reimbursement for mental health rehabilitation services (MHRS); 3) transfer of fee-for-service (FFS) Day Treatment to the MHRS Day or Intensive Day Treatment; and 4) Medicaid reimbursement for services to individuals in care at Saint Elizabeths Hospital and the disproportionate share payment from DHCF.

We will continue to partner with DBH to bring innovative, evidence-based and best practice mental health and substance use disorder treatment services and supports to enhance the lives of District of Columbia residents.

Sincerely,

  
Claudia Schlosberg, J.D.  
Medicaid Director/Senior Deputy

cc: Wayne Turnage, Director

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
Child and Family Services Agency



August 30, 2015

Tanya A. Royster, M.D.  
Director  
Department of Behavioral Health  
64 New York Avenue, N.E., Third Floor  
Washington, D.C. 20002

Dear Dr. Royster:

The District of Columbia Child and Family Services Agency (CFSA) is pleased to submit this letter of support for the Department of Behavioral Health (DBH) FY 2016- 2017 Mental Health Block Grant Application to the Substance Abuse and Mental Health Services Administration (SAMHSA). CFSA and DBH (including its predecessor agency the Department of Mental Health) have a longstanding relationship of supporting initiatives and projects of mutual interest.

These projects include but are not limited to: 1) trauma screenings and assessments for CFSA involved children; 2) Assessment Center evaluations; 3) collaborative co-located staff for In-home Mental Health Coordinators; 4) wraparound services provided by a care management entity for children and youth in the custody of CFSA; and 5) Choice Providers program services for children and youth. CFSA is the District of Columbia's public child welfare agency that protects child victims and children at risk of abuse and/or neglect. Services include family stabilization, reunification, foster care, adoption, and supportive community-based services to enhance the safety, permanence and well-being of abused, neglected, and at-risk children and their families in the District of Columbia. The agency seeks to achieve the highest quality community-based preventive and support services, and to expand the network of resources providing services to at-risk children and their families. In this capacity, CFSA have developed relationships with service providers such the Department of Behavioral Health (DBH) to establish a child welfare continuum of care in the District of Columbia.

We strongly support the Department of Behavioral Health (DBH) FY 2016- 2017 Mental Health Block Grant Application to the Substance Abuse and Mental Health Services Administration (SAMHSA). We also look forward to continued collaboration as we address the important service needs of children, youth and families in the District of Columbia.

If you have any questions or require additional information, please don't hesitate to contact Marie Morilus-Black, Deputy Director for the Office of Well Being at 202-442-6002.

Sincerely,

A handwritten signature in black ink, appearing to read "Ray C. Davidson", written over a horizontal line.

Raymond C. Davidson  
Director

Headquarters: 200 I Street, SE ■ Washington, D.C. 20003 ■ 202-442-6100  
[www.cfsa.dc.gov](http://www.cfsa.dc.gov) ■ <http://dc.mandatedreporter.org> ■ [www.adoptdckids.org](http://www.adoptdckids.org)



## Environmental Factors and Plan

### 22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

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Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).<sup>97</sup>

Additionally, [Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. 300x-51\)](#) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

*For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.*

*For MHBG and integrated BHPC: States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.*

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*<sup>98</sup>

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<sup>97</sup><http://beta.samhsa.gov/grants/block-grants/resources>

<sup>98</sup>There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical assistance is needed to fulfill the mandate to monitor, review, and evaluate at least once each year the allocation and adequacy of mental health and substance use disorder services within the District, and use the findings to review the Block Grant Plans and make recommendations. This includes determining the types of data that are relevant to behavioral health services and data interpretation. Technical assistance is also needed to support the overall Goals of the DBH Behavioral Health Council:

1. Ensure that individuals in need of mental health and/or substance use disorder services have access to services;
2. Ensure that consumer and family directed services and supports for the prevention and treatment of mental and substance use disorders maintains a focus on recovery and resilience;
3. Advocate for District residents with mental and substance use disorders and serious emotional disturbance;
4. Support the integration of mental and substance use disorder prevention, treatment and recovery services and supports into overall health services;
5. Reduce disparities in the prevention and treatment of mental and substance use disorders;



6. Strengthen the coordination and collaboration with relevant state and community organizations in order to develop systems of care; and
7. Provide input for the development of the SAMHSA Mental Health and Substance Abuse Block Grants.

Footnotes:

## **Department of Behavioral Health Behavioral Health Council Comments on the District Behavioral Health Assessment and Plan**

The Department of Behavioral Health (DBH), formerly the Department of Mental Health, planning process to transition from a mental health planning and advisory council to a behavioral health planning council was supported by three (3) SAMHSA technical assistance (TA) initiatives. They included: 1) receiving general TA provided to state planning councils that included an on-site TA meeting with the existing planning council (FY 2012-2013 cycle); 2) participating in the state planning council intensive TA National Learning Community that involved monthly conference calls and individual state calls, and an on-site TA meeting with the mental health advisory councils, consumers/clients, family members, advocates, mental health and substance use disorder staff and providers (FY 2013-2014 cycle); and 3) participating in the Leadership Academy and on-site TA (FY 2014-2015 cycle) for the newly created Behavioral Health Council.

On August 19, 2015 the DBH Behavioral Health Council orientation meeting was held. In addition to the council members, the new DBH Acting Director, Dr. Tanya A. Royster, M.D., and the DBH grant program staff participated in the meeting. The co-facilitators were Phillip Lubitz, M.S.W. and Angela Halvorson, M.P., M.S. The presentations generated thoughtful questions, comments and discussion.

### **DBH Behavioral Health Council Comments**

The DBH Behavioral Health Council reviewed and provided comments about the District of Columbia Behavioral Health Assessment and Plan. To facilitate their review, they were given a *Behavioral Health Assessment and Plan Review Comment Guide*. The comments below are organized by the document review sections.

#### **A. Overview of Adult Service System**

##### **1. *Most important adult service system strengths:***

- Accessibility/availability of mental health services.
- Health Homes Initiative, Evidence based practices, Supported Housing services.
- Having the ability to select providers of choice.
- Partnering with providers to develop recovery oriented treatment plans.
- Education, Employment, Housing.
- Evidence Based Practice/ACT.
- Mental Health Services Division-particularly multicultural services.

##### **2. *Most important unmet service needs or critical gaps in the adult service system:***

- Services for people with mental health issues and intellectual/developmental disabilities.
- Being re-traumatized by agencies that lack compassion, integrity and dignity for the individual's overall well-being.
- Lacking cultural competency to the population served (Missing the margin).
- Not enough peer lead groups/organizations.

- Therapy.
- Access to and more support of recovery oriented, integrated supported employment and vocational/educational opportunities.
- More (integrated) wheelchair/disability accessible housing within the entire continuum of supported housing services.

## B. Overview of Child and Youth Service System

### 1. ***Most important child and youth service system strengths:***

- Comprehensive services.
- Parent Infant Early Childhood Enhancement (PIECE) Program has dedicated well trained (in several evidence-based practices) staff (intact team for several years) providing early intervention services to families of children under the age of 6.
- The Children Psychiatric Practice Group (PPG) has three (3) dedicated child psychiatrists that serve as the safety net for several DC core services agencies (CSAs). The PPG provides medication assessments, medication management, same day/urgent care services, and court evaluations.
- The DC Healthy Start program is designed to address the parent child dyad through the strengthening of attachment bonds and to reduce infant mortality. The program works with pre- and post-natal women residing in Wards 5, 6, 7, and 8.
- System of Care Expansion Implementation Project.
- School-based mental health services.
- Prevention and Early Intervention Services.
- Creating multiple access entrances to assess for mental health services.
- Therapy, Parent Education.
- Evidence Based services, ChAMPS, Same Day Urgent Care.

### 2. ***Most important unmet service needs or critical gaps in the child and youth service system:***

- Substance Use Disorder Treatment and Recovery Services.
- Substance abuse treatment options for single parents that enable families to remain together during treatment, if appropriate.
- Better coordination with other systems.
- Coordination with workforce system and provision of employment readiness and supported employment.
- Lack of quality outpatient therapy services for latency age youth.
- Lack of a dedicated mental health center/agency in DC to provide public mental health and behavioral health services for children with Autism Spectrum Disorder (ASD).
- Uneven and inconsistent provision of Individualized Education Plan (IEP) stipulated services in DC Public Schools and Public Charter Schools.
- If the agency could provide tokens and/or fare cards families may be more able to access clinic based services.
- Lack of child psychiatrists at the DC CSAs to provide consistent medication management and psychiatric services to children and adolescents. Lack of nursing staff, and Community Support Workers (CSWs) to support the work of the PPG.

- Need for updated equipment to support the PIECE program's evidence-based practices and day to day operations, e.g., contemporary telephone instruments for conference calls, no intercom system to communicate with parents during coaching sessions.
- Programmatic consideration that more latency age children are using K2 and other substances as the focus of treatment.
- Financial support for the psychoeducational groups conducted by the DC Healthy Start program so that program staff do not have to pay out of pocket for meals/incentives for clients.
- Resources to help homeless services providers navigate the behavioral health system in order to connect and support families with children identified as in need of behavioral health services.
- Family-based integrated services for families that brings together all health and human service providers in support of an integrated plan for families with children receiving behavioral health supports.
- Prevention and Early Intervention Services need the resources to serve 100% of the need.
- Lack of psychiatrists available to meet the growing demand of children mental health needs.
- CSAs have an overload of cases, which only permits the kids to receive Car Wash Services (Which means in and out services just to meet billing expectations).
- Therapy, Family Education.
- Employment, wrap around services (Psychiatrist/Psychologist/PCP, therapy, education, housing)
- More community-based alternatives (therapeutic family-like settings) for youth in crisis that cannot stay with their families (e.g., therapeutic foster care without requiring entry into foster care setting).
- Therapeutic/recovery oriented after school programs that focus on positive youth development.
- Additional focus on continuity of care for hospitalized youth.

C. Other performance indicators the Behavioral Health Council would like DBH to consider in the future:

- Improved interface between the Integrated Care Application Management System (iCAMS) and the Child and Adolescent Functional Assessment Scale/ Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS) in order to more accurately collect data on child/adolescent impairments.
- Addition of the evidence-based practices Parent Child Interaction Therapy (PCIT) and Child Parent Psychotherapy (CPP) to the iCAMS billing platform to reflect the utilization of these practices.
- Number of parents receiving substance abuse treatment through family based programs.
- Becoming innovative in allowing consumers to have virtual access to rate the services they receive.

- The number of youth with serious emotional disturbances that are diverted from the foster care system through use of community based therapeutic settings.
- The percentage of supported housing units that are integrated and accessible.
- The percentage of adults engaged in full or part-time employment or vocational/education activities.
- The percentage of youth with serious emotional disturbances engaged in structured or therapeutic activities between the hours of 3 pm and 7pm.

D. Environmental Factors:

Factor 5: *Evidence-Based Practice for Early Intervention (5%)*

- The continuing emphasis of DBH on investments in early intervention, such as the TACT program, is essential to building a system of care that provides comprehensive, family-focused care starting at the early detection point. This is going in the right direction of reducing out-of-home and more intensive psychiatric interventions.

Public Awareness of Plan and Public Comment

It is the DBH custom to post the District of Columbia FY 2016-FY 2017 Mental Health Block Grant Application on the Department's website. This allows for ongoing review and comment. Also, if there are any major changes the revised document can be posted.

## Environmental Factors and Plan

### Behavioral Health Advisory Council Members

Start Year:

End Year:

| Name                | Type of Membership                        | Agency or Organization Represented                     | Address, Phone, and Fax  | Email (if available)         |
|---------------------|---|--|--|------------------------------|
| Samantha Stevens    | Others (Not State employees or providers) |  | 4520 MacArthur Blvd. NW, Apt 305<br>Washington, DC , DC 20007<br>PH: 202-716-1201            | samanthastevens86@gmail.com  |
| Lynne Person        | Others (Not State employees or providers) |  | 601 E Street, NW T3-314<br>Washington, DC , DC 20049<br>PH: 202-434-2140                     | lperson@aarp.org             |
| Shannon Hall        | Others (Not State employees or providers) |  | 1001 Lawrence Street, NE<br>Washington, DC , DC 20017<br>PH: 202-481-1419                    | dcbehavioralhealth@gmail.com |
| Jennifer Lav        | Others (Not State employees or providers) |  | 220 I Street, NE, Suite 130<br>Washington, DC , DC 20002<br>PH: 202-547-0198                 | jlav@uls-dc.org              |
| Tammi Lambert       | Others (Not State employees or providers) |  | 905 6th Street, S.W., Apt. 708B<br>Washington, DC, DC 20024<br>PH: 202-724-5454              | Lambert.tammi@gmail.com      |
| Marie Morilus-Black | State Employees                           | Child and Family Services Agency                       | 200 I Street, SE<br>Washington, D.C., DC 20003<br>PH: 202-442-6002                           | marie.morilus-black@dc.gov   |
| Michen Tah          | State Employees                           | Criminal Justice Coordinating Council                  | 441 4th Street, NW, Suite 715N<br>Washington, D.C., DC 20001<br>PH: 202-442-9283             | Michen.Tah@dc.gov            |
| Diane Lewis         | State Employees                           | District of Columbia Health Benefit Exchange Authority | 2200 Pennsylvania Ave., NW, 4th Floor East<br>Washington, D.C., DC 20037<br>PH: 202-966-7516 | dlewis@acg-cos.com           |
| Claudia Schlosberg  | State Employees                           | Department of Health Care Finance                      | 441 Fourth Street, NW, 900 South<br>Washington, D.C., DC 20001<br>PH: 202-442-9075           | Claudia.schlosberg@dc.gov    |
| Sakina Thompson     | State Employees                           | Department of Human Services                           | 64 New York Avenue, NE 6th Floor<br>Washington, D.C., DC 20002<br>PH: 202-671-4451           | Sakina.thompson@dc.gov       |

1133 North Capitol

|                      |  |   |  |                                     |
|----------------------|--|---|--|-------------------------------------|
| Adrienne Todman      | State Employees  | District of Columbia Housing Authority          | Street NE<br>Washington, D.C.,<br>DC 20002<br>PH: 202-535-1513   | ATodman@dchousing.org               |
| Sara Tribe Clark     | State Employees  | District of Columbia Office on Aging            | 500 K Street, NE<br>Washington, D.C.,<br>DC 20002<br>PH: 202-535-1367  | Sara.tribe@dc.gov                   |
| Andrew Reese         | State Employees  | Department on Disability Services               | 1125 15th Street,<br>NW, 4th Floor<br>Washington, D.C.,<br>DC 20005<br>PH: 202-442-8606<br>FAX: 202-561-6974 | andrew.reese@dc.gov                 |
| Barbara Bazron       | State Employees  | Department of Behavioral Health                 | 64 New York Avenue, N.E.<br>Washington, D.C.,<br>DC 20002<br>PH: 202-271-2992                                | barbara.bazron@dc.gov               |
| Yuliana Del Arroyo,  | State Employees  | Office of the State Superintendent of Education | 810 First Street NE,<br>9th Floor<br>Washington, D.C.,<br>DC 20002<br>PH: 202-741-0478                       | Yuliana.delarroyo@dc.gov            |
| Cheryl Doby-Copeland | State Employees  |   | 821 Howard Road,<br>SE<br>Washington, DC ,<br>DC 20032<br>PH: 202-698-1836                                   | Cheryl.copeland@dc.gov              |
| Nicole Denny         | State Employees  |   | 2435 Alabama Avenue, SE<br>Washington, DC ,<br>DC 20020<br>PH: 202-671-6140                                  | Nicole.denny@dc.gov                 |
| Evan Langholt,       | Providers  |   | 2100 New York Avenue, NE<br>Washington, DC ,<br>DC 20002<br>PH: 202-269-6333                                 | evan_langholt@uss.salvationarmy.org |
| Julie Kozminski      | Providers  |   | 1220 12th Street, SE,<br>Suite 120<br>Washington, DC ,<br>DC 20003<br>PH: 202-715-7966                       | jkozminski@unityhealthcare.org      |
| Tamara Weissman      | Providers  |   | 1104 Allison Street<br>NW<br>Washington, DC ,<br>DC 20011<br>PH: 202-722-1815                                | tweissman@gafsc-dc.org              |
| Misha Kessler        | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) |   | 3355 16th Street,<br>NW, Unit 510<br>Washington, D.C.,<br>DC 20010<br>PH: 513-520-1346                       | misha.kessler@gmail.com             |
| Effie Smith          | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | Consumer Action Network                         | 1300 L Street, NW,<br>Suite 1000<br>Washington, D.C.,<br>DC 20005<br>PH: 202-842-0001                        | esmith@can-dc.org                   |
| Doris Carter         | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) |   | 915 Allison Street,<br>NW, #201<br>Washington, D.C.,<br>DC 20011<br>PH: 202-832-8336                         | DCarter@calvaryhealthcare.org       |

|                  |  |  |                              |
|------------------|--|--|------------------------------|
| Timothy Robinson | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | 1511 E Street, SE<br>Washington, D.C.,<br>DC 20003<br>PH: 202-569-0151               | Timrobinsonskate64@gmail.com |
| Senora Simpson   | Family Members of Individuals in Recovery (to include family members of adults with SMI)                         | 323 Quackenbos, NE<br>Washington, DC ,<br>DC 20011<br>PH: 202-529-2134               | Ssimps2100@aol.com           |
| Maria Newman     | Family Members of Individuals in Recovery (to include family members of adults with SMI)                         | 1363 Spring Road,<br>NW<br>Washington, DC ,<br>DC 20010<br>PH: 202-865-3796          | m_newman@howard.edu          |
| Miya Wiseman     | Family Members of Individuals in Recovery (to include family members of adults with SMI)                         | 3105 18th Street, NE<br>Washington, DC ,<br>DC 20018<br>PH: 202-270-6173             | Miya714@yahoo.com            |
| Evelyn Sands,    | Parents of children with SED   | 4030 Livingston<br>Road, SE #301<br>Washington, DC ,<br>DC 20032<br>PH: 202-271-6032 | esands231@gmail.com          |
| Donna Flenory    | Parents of children with SED   | 510 Division Avenue,<br>NE<br>Washington, DC ,<br>DC 20019<br>PH: 202-497-3097       | dlflenory@gmail.com          |

Footnotes:



Please identify the Representative of  
State Vocational Rehabilitation Agency  
State Health (MH) Agency  
Medicaid Agency  
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The District of Columbia Department on Disability Services includes the Rehabilitation Services Administration. Andrew Reese, Deputy Director Rehabilitation Services Administration is the Department of Behavioral Health, Behavioral Health Council representative for this District agency.

The District of Columbia Department of Behavioral Health serves as both the State Mental Health Authority and the Single State Agency for substance abuse. The representative to the Department of Behavioral Health, Behavioral Health Council is Barbara J. Bazron, Ph.D. the Senior Deputy Director.

The District of Columbia state Medicaid agency is the Department of Health Care Finance. Claudia Schlosberg, Senior Deputy Director and State Medicaid Director is the representative to the Department of Behavioral Health, Behavioral Health Council.

## Environmental Factors and Plan

### Behavioral Health Council Composition by Member Type

Start Year:

End Year:

| Type of Membership  | Number                         | Percentage |
|---|--------------------------------|------------|
| Total Membership  | 31                             |            |
| Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services) | 4                              |            |
| Family Members of Individuals in Recovery* (to include family members of adults with SMI)                         | 3                              |            |
| Parents of children with SED*   | 2                              |            |
| Vacancies (Individuals and Family Members)  | <input type="text" value="2"/> |            |
| Others (Not State employees or providers)   | 5                              |            |
| Total Individuals in Recovery, Family Members & Others  | 16                             | 51.61%     |
| State Employees   | 12                             |            |
| Providers   | 3                              |            |
| Federally Recognized Tribe Representatives  | 0                              |            |
| Vacancies   | <input type="text" value="0"/> |            |
| Total State Employees & Providers   | 15                             | 48.39%     |
| Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations                                     | <input type="text" value="9"/> |            |
| Providers from Diverse Racial, Ethnic, and LGBTQ Populations  | <input type="text" value="3"/> |            |
| Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations                                | 12                             |            |
| Persons in recovery from or providing treatment for or advocating for substance abuse services                    | <input type="text" value="7"/> |            |

\* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The DBH Behavioral Health Council reviewed the District of Columbia Behavioral Health Assessment and Plan. To facilitate their review, they were given a Behavioral Health Assessment and Plan Review Comment Guide. Their comments addressed issues related to the: 1) most important adult service system strengths; 2) most important unmet needs or critical gaps in the adult service system; 3) most important child and youth service system strengths; 4) most important unmet needs or critical gaps in the child and youth service system; 5) other performance indicators the DBH Behavioral Health Council would like Department to consider in the future; and 6) environmental factors. Their comments are presented under the State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application section. The DBH Behavioral Health Council did not make any recommendations to modify the application.

#### Footnotes:

The DBH Behavioral Health Council has two (2) vacancies related to individuals and family members. DBH has identified two (2) candidates to fill these vacancies. Their membership has not yet been confirmed.