FY 2024-2025

COMBINED BEHAVIORAL HEALTH ASSESSMENT AND PLAN

Community Mental Health and
Substance Use Prevention, Treatment, and
Recovery Services Block Grant
(MH & SUPTRS BG)

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

District of Columbia
Department of Behavioral Health

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Overview of the District of Columbia Department of Behavioral Health

The District of Columbia Department of Behavioral Health (DBH) envisions a thriving community where prevention is possible, and recovery from mental health and substance use disorders is the expectation. DBH helps support healthier and stronger communities by working to prevent the onset of mental health and substance use disorders and providing a range of community-based treatment services and recovery supports. DBH also provides crisis services, operates adult and child urgent care clinics, and manages Saint Elizabeths Hospital for 24-hour psychiatric inpatient care.

The mission of DBH is to develop, manage and oversee a public behavioral health system for adults, children and youth and their families that is consumer driven, community based, culturally competent and supports prevention, resiliency and recovery and the overall well-being of the District of Columbia.

The Department of Behavioral Health is leading the District's work to ensure residents have access to high-quality, behavioral health services and the opportunity to lead healthy and fulfilling lives. The strategic goals[1] of the DBH are:

- Goal 1: **Prevention and Early Intervention** promotes behavioral health wellness through prevention and early intervention services and supports.
- Goal 2: **Access to Quality Services** ensures that individuals and families receive high-quality services to meet their unique needs, resulting in access to the right services, at the right time, in the right amount.
- Goal 3: **Recovery and Resilience** builds and supports a community that promotes recovery and resilience to help individuals and families thrive.
- Goal 4: **Partnership, Integration, and Coordination** strengthens community partnerships to better integrate and coordinate services towards a sustained and shared vision of excellence.
- Goal 5: **Leadership, Innovation and Accountability** will transform the District's behavioral health system into a nationally recognized, results-based model of care by promoting a common vision, accountable collective action, research, training and education, transparency, and innovative programs.

Demographically, the District of Columbia is 61.05 square miles and is divided into eight Wards. The Community Mental Health Services Block Grant (MHBG) and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS or SUD BG) will be utilized across the

[1] DBH Strategic Plan 2019, https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/DBH%20Strategic%20Plan.%202019.pdf

entire jurisdiction.

As of April 1, 2020, the District had a population of 689,545 that was 45.8% Black or African American, 45.9% White, 0.6% American Indian/Alaska Native, 4.5% Asian, 0.2% Native Hawaiian/Other Pacific Islander, 11.5% Hispanic/Latino, and 3.0% selecting two or more races.[2]

Nearly 22% of District of Columbia residents are aged 25-34 (148,977) with 16% aged 35-44 and 11% aged 45-54. Females represent 52% and males 48% of the District's population. The female median age is 35.2 and the median age for males is 34.7.[3]

There are 313,594 households and 129,345 families. The average household size is 2.03 persons and 62,787 or 20% of household include children. The average household income is $156, 367 with a median household income of $104,110. [4]

The median household income by race/ethnicity is $161,812 (White). $147,727 (Native Hawaiian/Pacific Islander, $122,201 (Asian), $111,087 (2+ Races), $105,386 (Non-Hispanic/Latino), $94,484 (Hispanic/Latino), $72,268 (Some Other Race), $54,401 (Black/African American), and $50,611 (American Indian/Alaskan Native). [5]

Ten percent or 13,006 of District families fall below poverty with 9,298 (7%) of families below poverty with children. [6]

Additionally, 15% of the District's population is living below the poverty line, with Wards 7 and 8 having the highest levels of poverty at 26% and 30% respectively in 2023. [7] The District's 2023 data on homelessness shows an estimated 4,922 people experiencing homelessness. [8]

Provider and Consumer Landscape

Mental Health

DBH provides an array of mental health services and supports through Health Homes and Mental Health Rehabilitation Services (MHRS) options.

DBH contracts with 53certified providers to deliver mental health services. Four of these providers

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[2] U.S, Census Bureau QuickFacts: District of Columbia, https://www.census.gov/quickfacts/fact/table/washingtoncitydistrictofcolumbia,US/PST045222

[3] DC Health Matters 2023 Demographics, https://www.dchealthmatters.org/demographicdata?id=130951&sectionId=943#sectionPiece_281

[4] Ibid

[5] Ibid

[6] Ibid

[7] Poverty by ward: DC KIDS COUNT data center: Ward Snapshots, https://dckidscount.org/ward-snapshots/ward7/, https://dckidscount.org/ward-snapshots/ward8/

[8] Homelessness in DC, Results from January 25, 2023 Point-in-Time Count, https://community-partnership.org/homelessness-in-dc/

are classified as only a Free-Standing Mental Health (FSMH) clinic; 30 are classified as MHRS-only providers; and 17 are both MHRS and FSMH providers. Ten mental health providers are also certified to provide SUD treatment. In addition, DBH operates adult and child clinics that provide urgent care and crisis emergency services.

Outreach and treatment services related to both mental health and substance use are also provided through the Community Response Team (CRT), outreach contractors funded through the District's State Opioid Response (SOR) grant and locally funded Community Engagement Team.

Substance Use

DBH also contracts with 29 certified providers to deliver treatment and recovery supports for adolescents to adults with substance use disorders (SUD). Seventeen of these providers also are certified to provide mental health treatment. Individuals who want to obtain SUD services go through the Access and Referral Center (ARC) or community intake sites operated by DBH certified treatment providers. In FY 20, all SUD providers were required to provide assessment, intake and referral services, unless a waiver exemption is approved. During the intake process, clients receive an assessment to determine the appropriate level of treatment.

A comprehensive continuum of substance abuse recovery and treatment services, including outpatient, intensive outpatient, residential, detoxification and stabilization, and medication assisted treatment is available within the system of care.

SUD services for adolescents are provided through the Adolescent Substance Abuse Treatment Expansion Program (ASTEP). Two certified substance use disorder treatment providers offer these specialized services. Screening, assessment, outpatient and in-patient treatment, and recovery services and support are provided.

DBH supports four Prevention Centers that conduct community education and engagement activities related to substance use prevention across all eight wards. This includes youth empowerment training, social media outreach and Prevention Centers capacity-building efforts. DBH has developed the Prevention Policy Consortium made up of more than 15 District agencies and national leaders to bolster the substance use prevention infrastructure and system of care.

Consumers

In FY 22, 43,637 individuals obtained mental health or substance use disorder services. DBH experienced a 24 percent increase in mental health services from FY 20 during the height of the pandemic, driven in part by greater use of telehealth. There also was a six percent increase in the number of people who received substance use disorder services compared to FY 21. Of those individuals, 3,188 were served by both MH and SUD providers.[9]

[9] DBH Reports,"MHEASURES Annual FY 22 (Oct 1, 2021-Sept 30, 2022)"

A total of 5,265 residents participated in treatment, primarily in person. Significantly, 61 percent of people who received treatment for substance use disorder services also received mental health treatment.[10] Though there was an increase in utilization, total expenditures for substance use services decreased by eight percent.

A similar proportion of males (47%) and females (53%) received mental health services in FY 22; however, males are a larger share (nearly two-thirds) of consumers received substance use disorder services, and/or both mental health and substance use disorder services.[11]

DBH is transforming publicly funded behavioral healthcare into a whole-person, culturally competent, integrated behavioral health system that ensures services for those who need them, and embracing our role as the state authority responsible for improving population behavioral health outcomes and advancing health equity.

Additionally, DBH is addressing the same challenges facing our country today to strengthen the behavioral health system including addressing workforce shortages, expanding access to care, improving health equity, enhancing child and family well-being, the opioid epidemic, and addressing the mental and emotional impact of the pandemic. We are making meaningful progress on these priorities.

Behavioral Health Transformation and Integration with Managed Care

DBH and Department of Healthcare Finance (DHCF), the District's Medicaid authority, are collaborating through a multi-year plan to fully integrate behavioral health services into the District's Medicaid managed care program.

DBH and DHCF are now in the Provider Planning and Readiness phase of our multi-year plan to fully integrate behavioral health services into the District's Medicaid managed care program. We first surveyed providers so they could identify their challenges and are responding with multiple technical assistance opportunities and provider forums. One example of the support provided was the development of a Business and Administrative Operations Best Practices Manual. We are working very closely with providers to identify and implement changes in how they will conduct business in the managed care environment. The integration of services will standardize certain operational processes and reduce administrative burdens.

The foundation for whole person care is timely access to both physical and behavioral health data. DBH will require that a provider have a certified electronic health record to capture and enable the transfer of health information. DBH worked with DHCF to obtain grant funding to support providers to implement, enhance or optimize their electronic health records.

[10] Ibid.

[11] Ibid.

In addition, DBH is in the second year of implementation of its Integrated Technology Engine (ITE). The ITE is a technology solution aligned with DBH's business process that will consolidate accurate and timely health data, enabling DBH managers and staff to make informed data-driven decisions supporting the District's vision of population health and whole-person care.

Overview of Mental Health Services

Comprehensive Community-Based Mental Health Service System

DBH has a range of treatment and support services for children, youth, and their families available, including specialized evidence-based practices for youth and families recovering from trauma, emergency care, and ongoing treatment primarily through certified, **community based mental health providers**. Ongoing treatment includes individual, group, and family counseling, diagnostic assessment, medication management, and family support.

In addition, community-based providers are certified to provide **substance use disorder treatment.** The Department also operates a children's clinic, provides services in public and public charter schools, and manages an alcohol, tobacco, and drug prevention and awareness campaign called **DrugFreeYouthDC**.

DBH is invested in supporting a clinician in every public and public charter school within the District. Using a public health approach, the School-based Behavioral Health Program provides a range of prevention, early intervention and treatment services to students in the DC public and public charter schools. The are a total of 253 schools.

DBH has trained providers to offer evidence-based practices with a focus on trauma support proven to improve functioning at home, in school and in the community. In FY 22, DBH added training in three new Evidence-Based Practices (EBPs) for early childhood and youth substance use disorder treatment for infants and youth to age 18 to support families.

For **youth with SED**, DBH continues to offer Community Based Intervention Services which are time-limited, intensive, mental health services delivered to children and youth. CBI services are intended to prevent the utilization of an out-of-home therapeutic resource or a detention of the consumer. In FY 22, the Department provided funding to support workforce stabilization and development initiatives assisting CBI providers to retain and recruit staff required to provide in-person care to children, youth, and their families with social disturbances. Funding was provided in the amount of up to $35,000 for each CBI provider to assist with recruitment and retention efforts to increase capacity to service youth and families in crisis.

To address the **ESMI/FEP population**, DBH implements a Navigate Team approach to address ESMI/FEP treatment. Navigate is a comprehensive intervention program for people who have experienced the first episode of psychosis. This treatment promotes shared decision-making and

uses a team of specialists who work with the client to create a personal treatment plan. It has been used as the foundation for the District's coordinated specialty care (CSC) program.

The number of Transition Age Youth (TAY) aged 16-25 years old in the District of Columbia is approximately 35,924, which is 6% of the overall population. Of the District's young adult population, 54% identify as black, 32% as white, 11% as Hispanic, and the remainder 3% identify as other, while 19% of the overall TAY population aged 18 -24 years old identify as LGBTQ. In 2020, NIMH reported that young adults ages 18–25 had the highest prevalence (21.0%) of any mental illness (AMI), including mental, behavioral, or emotional disorders. NIMH also reported that young adults ages 18-25 (17.0%), had the highest prevalence of experiencing a major depressive episode. National Data indicates that in the U.S., 1 in 10 young adults aged 18-25, experienced a SMI.

In FY 20, 8.1% of the TAY population received treatment and/ or support for a SMI. In FY 20, among 16–25-year-olds seeking services through DBH, 1,997 TAY received a primary diagnosis of major depressive disorder and an additional 902 TAY seeking services through DBH received a primary diagnosis of bipolar disorder, schizophrenia and/or schizoaffective disorder. Of the 2,901 TAY who were diagnosed with a SMI, 40% received treatment. In FY 20, 41% of the TAY youth diagnosed with a SMI were hospitalized and 17% experienced 2+ more hospitalizations due to treatment for a SMI.

The purpose of the FEP Treatment Program for Transition Age Youth is to change the long-term prognosis for young adults coping with schizophrenia by providing an early and effective treatment intervention program for individuals who have experienced their first episode of psychosis. The FEP treatment team consists of a Case Manager, Medication Manager, Individual Resiliency Trainer, Family Education Clinician, Supported Employment and Education Specialist and Peer Specialist.

Specific to FEP, DBH implements:

- NAVIGATE Services: NAVIGATE is a comprehensive intervention program for people who have experienced a first episode of psychosis. Treatment is provided by a team of mental health professionals who focus on helping people work toward personal goals and recovery. More broadly, the NAVIGATE program helps consumers navigate the road to recovery from an episode of psychosis, including supporting efforts to function well at home, on the job, at school, and in the social world.

- Individual Placement and Support/Supported Employment/Education: This evidence-based program is designed to help people with a psychiatric disorder achieve their vocational and educational goals including people who have had a recent psychosis episode.

- Cognitive Behavioral Therapy for Psychosis (CBTp): Cognitive Behavioral Therapy for Psychosis (CBTp) is an evidence-based treatment approach shown to improve symptoms

and functioning in patients with psychotic disorders. CBTp aims to enhance function despite difficult symptoms and experiences such as hallucinations, negative symptoms, thought disturbances, and delusions. CBTp forms a collaborative treatment alliance in which the patient and therapist can explore distressing psychotic incidents and the beliefs the patient has formed about these experiences, with the goal of reducing distress and disability caused by these experiences.

- Assertive Community Treatment (ACT): An evidence-based practice that improves outcomes for people with severe mental illness who are most vulnerable to homelessness and hospitalization.

- TIP and Assertive Community Treatment (TACT): The integration of TIP and ACT has proven very successful with Transition-Aged Youth.

Other EBP that support services to young adults experiencing their first episode of psychosis include:

- Adolescent Community Reinforcement Approach (A-CRA) is a behavioral intervention targeted to transition-age youth with co-occurring mental health and SUD. Research has indicated that A-CRA results in abstinence and recovery from substance use, increased social stability, and improved linkages and participation in continuing care.

- Appreciative Inquiry (AI) *is* differentiated from other change management processes as it begins with interviews in which participants reflect on their positive experiences and discover their capacity to make a difference. Sharing the stories that emerge from the interviews builds appreciation for the value and potential to contribute that is inherent in all human resources. Accumulating positive stories has the effect of changing the grand narrative or self-image of a system.

- TAY Trauma Recovery and Empowerment Model (*TREM)* is a fully manualized 24-to-29 session group intervention for transition-age youth (TAY) who survived trauma and have substance use and/or mental health conditions. This model draws on cognitive–behavioral, skills training, and psychoeducational techniques to address recovery and healing from sexual, physical, and emotional abuse.

- Seeking Safety is an evidenced-based present-focused counseling model to help people attain safety from trauma and/or substance abuse. It can be conducted in group (any size) and/or individual modality.

- Trauma Systems Therapy- A comprehensive, phase-based model for treating traumatic stress in children and adolescents ages 6-18 that adds to individually based approaches by specifically addressing the child's social environment and/or system of care.

- Trauma-Focused Cognitive Behavioral Therapy- A psychotherapeutic intervention designed to help children ages 3-18, working with their parents or caregivers, overcome the negative effects of traumatic life events.

- Multi-Systemic Therapy- an intensive community-based treatment for youth ages 12-17 and their families with antisocial behaviors putting them at risk of out-of-home placement, who are living with or returning to a parent/caregiver with whom the youth have a long-term relationship and who is willing to participate in treatment.

- Functional Family Therapy: A family-focused intervention for at-risk and juvenile justice-involved youth ages 11-18.

- Family Supports: Social support from family provides patients with practical help and can buffer the stresses of living with illness.

For **adults with SMI**, the District also delivers Assertive Community Treatment (ACT) to approximately 2300 consumers annually through nine (9) providers running twenty-six (26) teams. ACT teams are expected to function as the full-service care coordination team for medical, psychiatric, vocational, and housing services and support for enrolled consumers. Consumers are identified for care using PATH homeless engagement teams, by providers of outpatient mental health and substance use disorder care, in patient providers and by the individuals themselves and their informal support networks.

DBH is working with mental health providers who manage Assertive Community Treatment (ACT) teams. In FY 22, the District also made available grants up to $58,000 per ACT team to support staff recruitment, retention, and training. As we reshape and better coordinate the components of our crisis services, we are working to ensure ACT teams are part of crisis response and that crisis management is part of treatment planning. DBH will begin implementation of the TMAC protocol in FY 2024. Providers will receive a significant increase in the Medicaid rate for the delivery of ACT using this protocol.

In FY 23 the District developed and implemented the Intensive Care Coordination Team. This team, led by a registered nurse, is comprised of six (6) community behavior support specialists, two (2) registered nurses, and two (2) peer support specialists.

DBH is actively working to realign and expand **crisis services** in alignment with the SAMHSA guidelines. It is important to note, the vast majority of behavioral services in the District of Columbia are provided by community-based organizations that are certified by DBH. In contrast, crisis services, including **someone to talk to** (Access Helpline), **someone to respond** (mobile crisis and the Community Response Team or CRT), and **a place to go** (the Comprehensive Psychiatric Emergency Program or CPEP) are currently provided directly by employees of the Department of Behavioral Health.

DBH's expansion and realignment of crisis services began in earnest in 2020 and 2021 when the nation found itself at a crossroads concerning behavioral health. The COVID-19 pandemic shined a bright light on system vulnerabilities as new mental health challenges have emerged owing to the collective trauma, loss, and stress brought on by the pandemic. Longstanding inequities in access to quality mental health care and services for substance use disorders are ever more apparent. Simultaneously, the nation's reckoning with racial injustice and persistent calls for police reform have highlighted the need to dramatically realign how we respond to individuals experiencing behavioral health crises. DC's Mayor Muriel Bowser launched a 911 call diversion program on June 1, 2021, amidst nationwide calls for police reform prompted us to redouble efforts to move away from an automatic law enforcement response to a health first and clinician led approach to behavioral health crisis.

Here in the District, as with many other jurisdictions across the country, DBH is working to meet the demands of the new behavioral health landscape. To that end, DBH has created a new executive level Chief of Crisis Services and a Deputy Chief position to support the reorganization and expansion of crisis prevention and alternative response options to improve clinical outcomes for individuals experiencing behavioral health crises. Programs that previously sat in different administrations are being brought under a single reporting line to assure optimal alignment and to improve patient experience and outcomes throughout the service continuum. The goal is to ensure that crisis services and the larger system-of-care can achieve the following:

- Prevent crises wherever possible,
- Resolve crises quickly and effectively when they do occur,
- To make the recurrence of a crisis unlikely, and
- To effectively manage crisis services to ensure they are comprehensive, well-coordinated and data driven.

In addition to assuring a high level of coordination within the various crisis program components within Crisis Services there is a desire to enhance collaboration with other DBH program elements "upstream" before crises occur and "downstream" at the end of a discrete crisis episode.

It is incumbent on the District's system to do everything possible to securely connect individuals to continuing care driven by a person-centered plan that reflects an ever deepening and shared understanding of the individual's needs.

DBH implements several evidence-based and evidence supported practices across a variety of settings. This includes mental health, substance use disorder, and integrated health projects. These projects cross the developmental spectrum from infancy to early childhood, early, middle, and late school age, through transition age youth, young adults, and adults.

Mental Health System Data Epidemiology

MHBG estimate of statewide prevalence and incidence rates of individuals with SMI/SED:

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1. Adults with SMI	38,410	36,700
2. Children with SED	4,903	4,860

DBH supervises the operation of all behavioral health providers and set standards for the provision of clinical care throughout the public behavioral health system, which is community-based. DBH provides prevention, intervention, and treatment services and support for children, youth, and adults with mental and/or substance use disorders including emergency psychiatric care, community-based outpatient, and residential services. We are committed to developing innovative and effective person-centered practices that promote community integration, enhance communications with family and peers, and reinforce natural supports for recovery and resilience.

To increase consumers'/clients' ability to successfully integrate into their community, maximize independence, and participate fully in their environment, DBH has several strategic initiatives to facilitate treatment in the least restrictive environment possible:

- Enhanced engagement of community employers to support consumers/clients in securing and maintaining meaningful employment.

- Integration of Free-Standing Mental Health Clinics (FSMHC) into DBH and the District broader service system.

- Supporting treatment interventions that reduce rates of incarceration, when appropriate.

- Conducting regular level of care assessments for consumers in community residential facilities (CRF) to support independence and integration into the community.

- Requiring regular level of care assessments for Assertive Community Treatment (ACT) consumers to ensure access to the appropriate level of placement.

- Conducting Community Integration Team meetings to improve the outcomes for consumers experiencing multiple hospitalizations or other poor treatment outcomes

Additionally, DBH oversees involuntary commitment at community hospitals, and coordinates services that assist individuals transitioning from psychiatric hospitals and nursing homes to community-based behavioral health services.

The Access Helpline is the central point for accessing all DBH community-based services, and Behavioral Health Services Division provides same day urgent care with services including assessments, counseling, medication management, and psychiatric evaluations. Residents can also enroll in services at the offices of certified providers.

DBH monitors a comprehensive array of prevention, early intervention, and community-based behavioral health services and supports for adults, children, youth, and their families that are culturally and linguistically competent, and supports resiliency and recovery. A network of community-based mental health and SUD providers delivers a range of treatment services including crisis services, residential, outpatient treatment, counseling, and community supports.

The Consumer and Family Affairs Administration promotes and protects the rights of individuals with behavioral health disorders, encourages and facilitates consumer and client and family leadership of treatment and recovery plans, and ensures consumer and client voice in the development of the behavioral health system. The administration also promotes consumer and client leadership, manages the peer certification training, and provides expertise on the consumer and client perspective.

Children's Services

To address **children with SED and their families**, the Early Childhood Mental Health Consultation Project, known as the Healthy Futures Program, operates in 107 child development centers located throughout the District. Consultation focuses on improving the overall quality of the program and assisting staff to solve a specific issue that affects more than one child, staff member, or family. The Healthy Futures Program offers child and family-centered consultation services to care providers and family members. In FY 22 and FY 23, Healthy Futures began a treatment pilot for young children and families in eight child development centers. Clinicians were trained in early childhood evidence-based treatments to build capacity to implement treatment in child development centers based on needs identified by center directors and parents.

In FY 22, as part of the Healthy Futures Pilot Initiative funded by America Rescue Plan Act (ARPA) to implement within early childhood programs, DBH invested funding to cover training, consultation, and equipment to implement the Attachment Biobehavioral Catchup (ABC) model, a home visiting model for toddlers and infants 6 months to 2 years of age and their parents who have experienced early adversity such as caregiver mental illness, chemical dependence, or neglect.

To promote the integration of behavioral health and primary care, DBH developed the Quality Improvement Mental Health Learning Collaborative and the DC Mental Health Access in Pediatrics (DC-MAP) program. There are two primary initiatives: 1) annual, universal mental health screening through the pediatric primary care provider and 2) DC Mental Health Access in Pediatrics (DC MAP), a children's mental health consultation program for pediatricians and primary care physician practices.

Through the DCMAP, DBH works with pediatricians to identify problems early and conduct an annual mental health screening within a primary care visit. This initiative promotes the integration of behavioral health and primary care for children and recognizes mental wellness as part of good health. To support the program, DHCF issued a new billing code for mental health screening during

an annual well-child visit. This unique code also allows the collection of data on the number of screens completed and the number of positive screens across the District. Participating practices serve children in all wards and cover approximately 80 percent of the children enrolled in Medicaid. Practices also have access to an on-call child psychiatrist, psychologist, social worker, and a care coordinator for behavioral health consultation regarding diagnosis or medication management.

Targeted Services to Rural and Homeless Populations and to Older Adults

Rural Population

The District of Columbia is an urban setting with a population of 689,545 residents living within 61.05 square miles between the states of Virginia and Maryland. The District does not have any rural populations.

Homeless Populations and Older Adults

The District of Columbia Interagency Council on Homelessness (ICH) is a group of cabinet- level leaders, providers of homeless services, advocates, homeless and formerly homeless leaders that come together to inform and guide the District's strategies and policies for meeting the needs of individuals and families who are homeless or at imminent risk of becoming homeless. The director of the Department of Behavioral Health serves as a member of the ICH. The ICH **Homeward DC 2.0 Strategic Plan (2021-2025) envisions ending long-term homelessness and creating a system that quickly stabilizes households that do experience housing loss and connects them back to permanent housing and quickly as possible**. The Winter Plan describes how District government agencies and providers within the Continuum of Care (CoC) will coordinate to provide hypothermia shelter and other services for those who are homeless consistent with the right of consumers to shelter in severe weather conditions.

The District's CoC provides persons experiencing homelessness or at risk of experiencing homelessness a range of services including homelessness prevention assistance, supportive services, outreach, severe weather and emergency shelter, transitional housing, rapid rehousing, targeted affordable housing, and permanent supportive housing. These services are available to families and unaccompanied individuals with many programs focused on providing service to key subpopulations such as persons living with disabilities, persons experiencing chronic homelessness, veterans, or youth.

Homeward DC 2.0[12], the Interagency Council on Homelessness' second iteration of the District's Strategic Plan (FY 2021 – FY 2025), lays out a community vision:
Homelessness in the District of Columbia will be rare, brief, and nonrecurring. We will eliminate

[12] DC Interagency Council of Homelessness (ICH), Homeward DC 2.0 Strategic Plan (FY2021- FY2025) https://ich.dc.gov/sites/default/files/dc/sites/ich/page_content/attachments/Homeward-DC-Report_FY2021-2025%5B1%5D.pdf

racial inequities in the homeless services system and create systemic fair treatment for all people.

The plan consists of 4 major components. *Homeward DC 2.0*:

- Summarizes the Homeless DC Plan and lessons from the last five years;
- Provides the vision, guiding principles, and building blocks of Homeward DC 2.0;
- Outlines system modeling and housing inventory needs; and
- Shares 100+ strategies supported by twelve strategic goals.

In 2015, Mayor Bowser released *Homeward DC*, a bold vision and strategic plan to end long-term homelessness in Washington, DC. Since its initial release, the District has made significant progress and investments in sustainable solutions to reduce homelessness, especially with regard to family homelessness.

Using a comprehensive approach, the District scaled homelessness prevention services for families; reformed the family shelter system – closing DC General and launching small, service-enriched Short-Term Family Housing programs throughout the city; and expanded rental subsidies for families. This work has led to a reduction in family homelessness in the District, from a peak of nearly 1,500 families experiencing homelessness on any given night as the District began Homeward DC implementation, to just over 400 families as of January 2021 – a 73% decrease.

Homeward DC 2.0 builds on this progress, with a strong focus on realizing similar progress with unaccompanied adult homelessness. Homeward DC 2.0 is the result of a highly collaborative process led by the District of Columbia Interagency Council on Homelessness (ICH), the Community Partnership for the Prevention of Homelessness (TCP), and the ICH's Strategic Planning Committee, including persons with lived experiences of homelessness. The plan presents data collected through the District's Homelessness Management Information System (HMIS) and is supplemented by data from other agencies and systems that play a direct or indirect role in the District's response to homelessness and housing insecurity.

District of Columbia Point-in-Time Count of People Experiencing Homelessness is conducted by the Community Partnership for the Prevention of Homelessness (TCP), a requirement for all jurisdictions receiving federal homeless assistance funding on behalf of the District of Columbia since 2001. This year's count took place on January 25, 2023 and shows an estimated 4,922 people experiencing homelessness.

After several consecutive years of declining PIT counts, the 2023 count data showed an overall 11.6% increase from 2022. This includes a 10.2% increase among unaccompanied individuals and a 12.1% increase among families.

Despite the increase, the 2023 count is lower than the count recorded in 2020 which was the last PIT count held prior to the COVID-19 public health emergency (PHE). **Overall homelessness has**

decreased nearly 23% since prior to the PHE and family homelessness decreased nearly 50%, showing that the District has emerged from the public health emergency with fewer people experiencing homelessness than going into the public health emergency.

The SAMHSA Projects for Assistance in Transition from Homelessness (PATH) grant funds services for adults with SMI experiencing homelessness. DBH administers the grant and funds are utilized to support DBH's Homeless Outreach Program (HOP) and the Housing Subsidy Program.

The HOP conducts street outreach and case finding of consumers who reside in locations unfit for human habitation (e.g., streets, abandoned properties, vehicles); in low barrier shelters; in transitional housing programs; and other temporary living arrangements. HOP provides crisis services, case management, transportation, and services to link individuals to appropriate mental health and substance use treatment.

The HOP will also provide assistance in housing consumers by providing three individuals who are experiencing homelessness with first month's rent and/or a security deposit.

The HOP intends to serve at minimum 450 adult consumers who are literally homeless during the year. The HOP anticipates enrolling 70% of these literally homeless adult consumers (315) during the award year. Services include outreach, case finding, interim case management, assistance in obtaining benefits, SOAR (SSI/SSDI Outreach, Access, and Recovery**)** connection, linkage to comprehensive mental health services and substance use services as well as transportation to initial mental health, medical, or substance use appointments.

Management Systems

A priority topic for SAMHSA is **increasing access to treatment for SMI and SUD using telehealth modalities**. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client- provider interactions.

Currently, DBH is in the process of implementing a Telehealth pilot to distribute smart phones and devices to our most vulnerable and clinically at-risk consumers. This initiative, initially scheduled to be launched last year, was delayed as we explored and resolved legal concerns to ensure compliance with Federal anti-kickback laws. We are now at the point of distributing 300 smart phones to selected consumers to ensure they are connected to a provider and fully engaged in care. We will be tracking the impact of this initiative regarding clinical results and other outcome metrics of those individuals participating in this initiative and make future operational adjustments as necessary.

In addition, the DBH has **developed the Integrated Technology Engine** (ITE). The ITE is a technology solution aligned with DBH's business process that **will consolidate accurate and timely health data**, enabling DBH managers and staff to make **informed data-driven decisions**

supporting the District of Columbia's vision of population health and whole-person care.

The ITE, driven by DBH's operational needs and strategic goals, will integrate and host behavioral health related data from multiple systems, providing DBH staff with a user-friendly and secure platform that will promote data validation, data democratization and ownership, utilization of meaningful data, and predictive analytics. The ITE is a data hub that will ingest source data from DBH electronic health records and databases (grants management and certification), DBH certified provider electronic health records (EHRs), DHCF claims data and MCO encounters, the District's eligibility data and will integrate with CRISP DC.

Information from DBH certified providers EHRs will be transmitted to the DBH ITE through a secure provider gateway. DBH has developed at standard provider data extract called the Behavioral Health Supplemental Data (BHSD) set of 86 data elements which augments provider data from other sources to ensure DBH can meet federal reporting requirements and to drive data informed decisions. The BHSD is supported by a comprehensive BHSD Companion Guide which details needed information to submit the extract. The BHSD Companion Guide and subsequently the file extract will be updated annually so that DBH can have the required data to support reporting needs.

Overview of Substance Use Disorder Services

Statewide Plan for Substance Use Primary Prevention, Treatment, and Recovery Services for Individuals, Families and Communities

DBH is targeting support to providers of substance use disorder services with extensive training and technical assistance on person centered care and treatment planning, using nationally recognized medical necessity criteria. DBH worked with the Department of Health Care Finance to provide additional funds to help offset revenue lost during the pandemic.

DBH is on course to open the **new Sobering and Stabilization Center** in late 2023 to support individuals under the influence of alcohol or drugs who require stabilization services and support but do not need to be transported to a hospital emergency department. The District believes the new Sobering Center **will be a low barrier, stepping-stone to ongoing treatment and sustained recovery**. A second Center is planned for development in FY 2024.

The Assessment and Referral Center (ARC), under the Adult Services Administration, provides same day substance use assessments and referral services for adults (21 years and older), seeking publicly funded treatment for substance use disorders and other services. The ARC is a walk-in based facility which conducts treatment assessments, pregnancy screening, **tuberculosis (TB) screening and testing**, **HIV counseling**, **testing and linkage to treatment**. ARC registered nurses and clinicians conduct medical and treatment placement assessments to determine the most appropriate level of care for individuals seeking treatment.

Also, DBH utilizes a mobile van that provides behavioral health outreach and engagement services. The mobile van visit's multiple locations around the District of Columbia, targeting areas with identified increased rates of fatal and non-fatal overdoses, as well as substance use.

The mobile unit is in the process of hiring a registered nurse and a social worker who will have the ability to provide same day assessments and referrals to substance use treatment. **Testing for TB, HIV** and pregnancy will be offered as part of the overall assessment process. To provide greater access to care, the MARC van will also assess for and prescribe buprenorphine.

Primary Prevention

The Substance Use Disorder Prevention, Intervention & Treatment Branch ensures comprehensive prevention systems by developing policies, programs, and services to **prevent the onset of illegal drug use, prescription drug misuse and abuse, alcohol misuse and abuse, underage alcohol, and tobacco use**.

We continue to use its Drug Free Youth DC (**www.drugfreeyouthdc.com**) website as the primary method for disseminating information throughout the District of Columbia and beyond in addition to the DBH Prevention Centers. Included within the site is information on the District's laws as it pertains to substances such as the legalization of marijuana for recreational use and the increase in the age to legally purchase tobacco products from 18 to 21. The website also provides links to all of the District's social marketing strategies aimed at preventing substance use. These social marketing strategies focus on underage drinking, opioid misuse for youth and adults, synthetic drug use for youth and adults, and marijuana use.

During FY 2023, the SUD Prevention Team used discretionary funding to support the redevelopment of social marketing strategies. These newly revised strategies will be housed on the Drug Free Youth DC websites and will be available during information dissemination activities. The DBH Community Engagement Team Manager will continue to serve as the lead for information dissemination along with a team of other individuals supported by the Substance Use Block Grant.

Pregnant Women and Women with Dependent Children

Pregnant Women and Women with Dependent Children have priority access to SUD treatment and are given preference in admission to treatment facilities. In the event the treatment facility requested is at capacity and cannot accept an admission, the assessment center will refer the woman to another program that has the capacity. If no such facility can admit the woman, the assessing provider will make interim services available no later than forty-eight (48) hours after the woman seeks treatment.

DBH has one certified provider specializing in **pregnant and parenting women with children in treatment**. Samaritan Inns' Clark Inn provides 12 beds for women and 16 beds for children as a residential treatment program for women and children. Samarian Inns' Lazarus House is certified

to provide Level 3.1 clinically managed medium-intensity residential, and Mozart Inns is certified to provide Level 3.5, clinically managed high-intensity residential and medication management substance use disorder treatment services to adults.

To ensure the families stay together during the SUD treatment process, Samaritan Inns provides continuity of care with Elisha House, a certified Recovery Support program to include spiritual support services and environmental stability. An array of childcare and support services for women's children are included in the duration of SUD treatment services.

Persons Who Inject Drugs

In 2022, DBH assumed efforts that focus on stopping the spread of HIV/AIDS, hepatitis, and connecting individuals to the health services they need. DBH supports comprehensive harm reduction programs for **persons who inject drugs** (PWID).

Specifically, this includes:

- Syringe services programs (SSPs) that work to **reduce the numbers of PWID who are infected with HIV** in the District.
- Helping to increase the number of District residents who know their HIV and Hepatitis C status.
- Ensuring individuals with **HIV and Hepatitis C have access to care and treatment**.

In calendar year 2022, the four SSPs continued to engage in syringe exchange activities in all eight wards of Washington, DC. In addition to those services, they continued the robust naloxone education and use schema as well as curated services such as the women's wellness initiatives that target women who are experiencing homelessness. They regularly assess the community's concerns by holding routine listening sessions called Community Conversations. Three providers operate mobile units, which help to expand the reach throughout the entire District. Two of the SSPs are operating harm reduction vending machines, which are primarily being managed through a grant by DC Health. There are currently seven operational vending machines that are located in overdose hotspots throughout the District and provide naloxone, fentanyl test strips, safer drug use supplies, condoms and PPE.

Tuberculosis Services

All DBH certified providers including the DBH Assessment and Referral Center (ARC) are required to complete the assessment and referral process for those seeking substance use treatment. As part of the assessment process, **all consumers are screened for tuberculosis** and based on the screening are tested or referred for chest x-rays.

Those consumers that do test positive for TB exposure are linked to either DC Health for further testing and treatment or a local community based medical provider. All consumers seeking residential treatment or withdrawal management are required to be tested for tuberculosis prior to

referral.

Early Intervention Services Regarding HIV

All consumers seeking **SUD treatment at the ARC** or a **certified SUD provider are offered HIV testing as part of the assessment process**. The ARC employs three staff that are trained to provide early intervention HIV services for consumers seeking treatment.

At a minimum all consumers receive HIV education to ensure they are aware of how HIV is transmitted, possible risk factors and options for testing. If the consumer opts for testing, pre and posttest counseling is provided as well as linkage to HIV treatment if they test positive. Staff follow the DC Health protocol for red carpet service for those that test positive.

Group Homes for Persons in Recovery from SUD

In 2023, DBH began providing the low barrier recovery housing to persons or in recovery from opioid use disorder (OUD) and stimulant use disorder (STUD). This housing operates in compliance with Level III/IV National Alliance for Recovery Residences (NARR) standards. In these recovery residences, intensive case management is provided to residents along with access to treatment and other recovery support services. Residents are also supported through restorative policies that allow for residents who have returned to using substances to be held accountable for their actions while not only responding by enforcing punitive actions such as eviction or discharge.

Referrals to Treatment

In 2021, DBH the implementation of a medical necessity protocol in conjunction with DHCF to ensure that individuals seeking residential treatment were assessed appropriately. To that end, DBH trained our four residential providers on the use of the ASAM Continuum assessment tool. Additionally, to support the determination of an initial level of care, all SUD providers were trained to utilize the ASAM Co-Triage assessment tool.

In 2023, DBH officially mandated that all certified SUD providers utilize the ASAM Co-Triage and Continuum assessment tools. DBH will provide ongoing training on the implementation and use of the tools as well as training on the ASAM criteria to ensure all providers are versed in the criteria and how to utilize the tools.

Independent Peer Review

DBH has begun the process of developing an independent peer review process. Initially, DBH will review all SUD providers to determine their true level of functioning and programmatic need. Based on this assessment, providers shall be paired to review each other's programs and provide feedback in a written and verbal format.

We are awaiting our Quality Assessment Review (QAR) final report and look forward to working with SAMHSA to ensure proper implementation of the peer review requirement.

Professional Development

In FY 23, the District funded training for current youth SUD providers for Motivational Enhancement Treatment Cognitive Behavioral Therapy (MET-CBT). This initial training equipped staff with techniques and strategies to implement individual and group sessions for youth with SUD.

In FY 24, the District is slated to fund training for the youth SUD providers in the Adolescent Community Reinforcement Approach (A-CRA) to ensure that there are a variety of tools to meet the diverse needs of youth seeking SUD treatment.

Each of the aforementioned trainings include an administrative track for DBH staff to also be trained in order to provide oversight and to support the implementation of evidence-based practices by the youth SUD treatment providers.

Current Organization of Mental Health/Substance Use Disorder System

The Department of Behavioral Health (DBH) plans and develops:

- Mental Health and Substance Use Disorder services;
- Certifies all providers of behavioral health services;
- Ensures timely access to services;
- Monitors the service system;
- Provides on-going technical assistance and training in evidence-based, evidence-informed and best practices to support the delivery of quality care;
- Supports service providers by operating the DBH Fee for Service (FFS) system;
- Provides grant or contract funding for services not covered through the FFS system;
- Regulates the providers within the District's public behavioral health system; and
- Identifies the appropriate number and mix of programs, services, and supports necessary to meet the behavioral health needs of District residents.

The Behavioral Health Authority serves as the State Mental Health Administration (SMHA) and Single State Authority (SSA) for substance use disorders for the District of Columbia. DBH is led by the director, Barbara J. Bazron, Ph.D. who with the executive leadership team oversees approx. 1,250 employees.

The **Office of the Director** leads management and oversight of the public behavioral health system; directs the design, development, communication, and delivery of behavioral health services and supports; and identifies approached to enhance access to services that support recovery and resilience. Included in the Office of the Director are the chief of staff, legislative affairs, human resources, communications, office of the Ombudsman, public engagement and outreach and consumer and family affairs.

The **General Counsel's Office** provides legal advice to the Director on all aspects of DBH operations and activities; drafts, research, and reviews legislation, regulations, and policies that affect the DBH mission and programs; and formulates strategic advice on DBH program development, compliance, and oversight activities.

The Chief Operating Officer leads the **Agency Operations Administration** by providing operational support to DBH programmatic and administrative areas. This Administration is responsible for the business services, including budget and financial management; information technology, claims and billing operations, grants management, including the MH & SUD BG Program; facilities management, records management; and general administrative support.

The **Chief Clinical Officer** supervises and sets standards for the provision of clinical care throughout the agency and public behavioral health system for children, youth, and adults; oversees community hospitals that treat consumers on an involuntary basis; serves as the petitioner in guardianship cases; and oversees the agency's disaster response for the District.

Crisis Services was created to support the reorganization and expansion of crisis prevention and alternative response options to improve clinical outcomes for individuals experiencing behavioral health crises. Operated directly by DBH employees, responsibilities include Access Helpline, mobile crisis and the Community Response Team (CRT), the Comprehensive Psychiatric Emergency Program (CPEP) and disaster behavioral health and support collaboration.

Saint Elizabeths Hospital provides inpatient psychiatric, medical, and psycho-social person-centered 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. Licensed by DC Health, the District's Department of Health, the hospital meets all conditions of participation promulgated by the federal Centers for Medicare and Medicaid Services.

The **Accountability Administration** oversees provider certification, mental health community-residence facility licensure, Medicaid claims audits, program integrity, quality improvement, incident management, major investigations, and compliance monitoring.

The **Policy, Planning, & Evaluation Administration** coordinates DBH's strategy development and performance improvement processes to help advance the mission: to develop, manage and oversee a public behavioral health system for adults, children and youth, and their families that is consumer-driven, community-based, culturally competent and supports prevention, resiliency, and recovery and the overall well-being of the District of Columbia.

The **Adult and Children's Services Administrations** develop, implement, and monitor a comprehensive array of prevention, early intervention, and community-based behavioral health services and supports for adults, children, youth, and their families that are culturally and

linguistically competent and support resiliency and recovery. The components are described below.

The **Adult and Transition-Aged Youth Services Administration** supervise the operation of clinical programs and set standards for the provision of clinical care throughout the public behavioral health system. This includes all services as overseen by DBH as the Health Care Authority (HCA) for the Managed Care Organization (MCO) contract: directly provided assessment, referral, and clinical services; forensic services; the comprehensive emergency psychiatric program; and the disaster behavioral health program.

The **Child, Adolescent & Family Services Administration** offers a range of treatment and support services for children, youth and their families, including specialized evidence-based practices for youth and families recovering from trauma, emergency care and ongoing treatment primarily through certified, community-based mental health providers. Within the CAFS Division, is early childhood services and supports, evidence-based practices, school-based behavioral health, linkage and assessment, crisis services, and youth SUD prevention, treatment, and recovery services.

Under the strategic direction of Deputy Mayor for Health and Human Services, DBH partners with agencies within the **Health and Human Services cluster (Department on Aging and Community Living, Child and Family Services, Department of Disability Services, Department of Health, Department of Health Care Finance, and Department of Human Services)** and throughout government to integrate information and access to behavioral health care and normalize behavioral health treatment as essential to daily living as housing or a job.

Child and youth and adult behavioral health service partners include but not limited to, **Office of the State and Superintendent of Education, D.C. Public Schools**, **D.C. Public Charter Schools**, **Child and Family Services Agency**, **Department of Youth Rehabilitation Services**, **D.C. Superior Court Juvenile Division**, **Court Social Services, the Metropolitan Police Department, Office of Unified Communications (District-wide 311 and 911 all center), DC Department of Fire & Emergency Services, Department of Employment Services, Office of the Deputy Mayor for Planning and Economic Development, Office of the Attorney General, D.C. Interagency Council on Homelessness, D.C. Housing Authority, D.C. Medicaid MCOs, Department of Corrections, Criminal Justice Coordinating Council, Department of Forensic Sciences, Office of the Chief Medical Examiner, All D.C. acute care hospitals and EDs for psychiatric and medical surgical admissions, the (number) providers in the network of care for both substance use and mental health conditions, and the free standing and Federally Qualified Health Centers (FQHC) provider networks.**

Addressing the Needs of Diverse and Minority Populations and Priority Populations

DBH is a recipient of the SAMHSA Community Program for Outreach and Intervention with Youth

and Young Adults at Clinical Risk for Psychosis (CHR-P) grant award. There is an additional focus on closing the gap/disparity for the LGBTQ who in 2016, the National Institute on Minority Health and Health Disparities identified the LGBTQ+ community as a health disparity population.

For **LGBTQ TAY**, the preventable gaps in physical and mental health stem from continued social stigma, discrimination, and denial of civil and human rights based on sexual orientation and gender identity.

In 2020, LGBTQ young adults aged 18 to 25represented the highest percentage of those with SMI, followed by adults aged 26-49, then by adults aged 50 or older. Of the individuals reporting SMI, about one-third have not received mental health treatment of any kind in 2020.

Further data by the 2022 Trevor Project survey[13] of 34,000 LGBTQ youth garnered new LGBTQ youth mental statistics. Here is a summary of the findings.

- 50 percent of LGBTQ teens seriously considered suicide during the past year.
- 18 percent made a suicide attempt—twice the average rate of teen suicide attempts in the United States.
- 75 percent of LGBTQ teens experienced symptoms of anxiety in the past year.
- 61 percent experienced symptoms of depression.
- 82 percent of LGBTQ youth wanted mental healthcare in the past year, but 60 percent of those youth were unable to access care.

Lastly, statistics from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the CDC's Youth Risk Behavior Surveillance Survey show that LGBTQ teens have a higher risk of substance abuse than their peers. LGBTQ high school students abuse alcohol at 25 percent higher rates than peers. They are also significantly more likely to report recent alcohol and marijuana use. In addition, LGBTQ teens report using cocaine, ecstasy, meth, and heroin at triple the rates of their peers.

DBH partners with Supporting and Mentoring Youth Advocates and Leaders (SMYAL) to provide **resources and support to LGBTQ youth**. Services include case management (development of personal action plan, weekly check-in meetings, and crisis navigation), supportive services (medical and mental health services, and self –care support), skill development (education, job readiness, and life skills), social support (community outings and access to LGBTQ youth networking), and after care (open line of post program communication between the youth and their case manager for up to 12 months).

The **988 Lifeline** initiated a pilot program in the autumn of 2022 to provide **LGBTQI+** adolescents and young adults with specialized phone, text, and chat support services. People under the age of 25 who contact the 988 Lifeline and desire the option of connecting with a counselor who is

[13] 2022 Trevor Projects survey, https://www.thetrevorproject.org/survey-2022/

especially focused on addressing the needs of LGBTQI+ kids and young adults. Calling, texting, or chatting with a crisis counselor who is trained to assist LGBTQI+ clients and is accessible around the clock is one way to access the specialized services that are now available.

Every episode of victimization in the course of an LGBTQ+ person more than doubles the chance of self-harming behavior, and more than 80% of LGBTQ+ youth have been attacked or threatened at some point in their lives.

Additionally, the **deaf community** has been left out of the conversation on **mental health crisis services**. Understanding how to support this community is essential. AHL call takers get training on how to deal with deaf and hard of hearing who are at a greater risk of suicide utilizing a variety of approaches. AHL are supporting an endeavor to bridge the mental gap with the deaf population by participating in training.

AHL will use a public health approach, to enhance and expand current deaf suicide prevention efforts facilitated by AHL, significant clinical supports and community base outreach and education to internal and external stakeholders.

The CBI-CB model expands capacity to engage in community-based suicide prevention efforts. AHL and internal stakeholders will collaborate in the community to implement CBI-SP through facilitation of community coalitions and local universities such as Gallaudet in the District of Columbia. AHL collaboratively works with key internal and stakeholders to develop, facilitate, and strengthen CBI-CB at community, state, and local levels to advertise 988 to the deaf community.

The Healthy Futures program staff includes five **Spanish bi-lingual** early childhood clinical specialists that serve 22 Spanish speaking early childhood development centers.

Two members of the Healthy Futures leadership team attended the **national Equity in Early Childhood Mental Health Consultation series** presented by Georgetown University. In addition to this series and the Health Futures program's two-year training and consultation on **Equity in Early Childhood** with national leader Lisa Gordon, the Healthy Futures leadership team along with input from clinical staff is creating a **plan to integrate equity trainings for early childhood development center** staff and families to increase awareness of **equity and implicit bias** issues that impact early childhood mental health.

Healthy Futures provides early childhood mental health consultation to child development centers and home providers that accept subsidy and currently serve 107 centers and homes throughout the District. Among the centers that are served include a domestic violence center and centers that include a neurodiverse population.

FQHCs are community-based, and patient directed primary care centers that serve individuals with limited access to healthcare, including **low-income individuals**, the **uninsured and**

underinsured, **immigrants**, those who are **homeless**, and those who live in **public housing**.

FQHCs deliver behavioral health services to their patients to include Community of Hope, which services populations to include homeless, La Clinica Del Pueblo, which serves the **Latino and immigrant populations**, and Mary's Center which is also a DBH-certified Mental Health Rehabilitation Services (MHRS) provider which also serves the Latino and immigrant populations.

The DBH Access Helpline (AHL) has collaborated with the Veteran's Administration (VA) to develop training for local crisis line operators in the management of **Veteran-specific crises calls and education on VA services**. Additionally, AHL has reached out to DC VAMC Suicide Prevention, which offers community-based trainings on the following topics: Understand the Suicide Phenomenon, gain an understanding of the Epidemiology of Suicide Prevention, Identify the Crisis Warning Signs of a Veteran, Understand the Importance of Reviewing the Clinical Record and Veterans in Crisis Management.

The Veterans Crisis Line was also established concurrently with the 2007 Suicide Prevention Act. AHL's training focus is identifying service members, veterans, and their families, promoting connections and enhancing care transitions, and increasing lethal means safety and safety planning are the focus areas. AHL's CoP mission, goal, and task comprehensively aligns with Zero Infrastructure recommendations.

Strengths and Needs of Current System

Strengths

DBH provides a **comprehensive range of treatment and support services for children, youth and their families** including **specialized evidence-based practices** for youth and families recovering from trauma, emergency care and ongoing treatment primarily through certified, community based mental health providers.

In addition, community-based providers are certified to **provide substance use disorder treatment**. The Department also operates a children's clinic, provides services in public and public charter schools, and manages an **alcohol, tobacco and drug prevention and awareness campaign** called DrugFreeYouthDC.

In partnership with the Office of the State Superintendent of Education, DC Public Schools, and DC Public Charter Schools, the Department continues to **expand behavioral health services in public and charter schools** in the District to include prevention, early intervention, and treatment services with the goal to have a school-based clinician at each public and charter school in the District. In school year 22-23, the total landscape is 253 schools.

As a part of the LIVE. LONG. DC., the District's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths (LLDC), the District's goal is to **implement naloxone training into each school** as one of the harm reduction strategies. Naloxone is now available in all DC Public Schools and 67%

of Public Charter Schools. In addition, we are establishing partnerships with private schools.

LLDC provides a blueprint for the opioid work and has multiple stakeholders, both public and private, who work together in Opioid Strategy Groups (OSGs) to implement the plan. The OSGs have developed a revised plan (LLDC 3.0) that includes: 1) a greater focus on saving lives from opioid overdoses by increasing harm reduction activities; 2) developing the peer workforce and a stronger integration of peers with lived experience within organizations, which has proven to be effective in encouraging individuals to get into and stay in treatment; 3) better coordination of treatment and supports to sustain recovery tailored to individual needs, including better coordination of treatment with the criminal justice system; and, 4) engagement with vulnerable populations including pregnant and parenting individuals, youth and young adults, and residents of skilled nursing facilities. LLDC 3.0 continues to emphasize a targeted approach at the community level using data to address the needs at hotspots, which includes the deployment of a mobile unit to meet individuals where they live. LLDC 3.0 consists of six Opioid Strategy Groups (OSGs), each with subsequent strategies related to that area of focus, with a total of 38 strategies.

LLDC will continue to:

- Educate District residents and stakeholders on opioid use disorder, its risks, and prevention and harm reduction approaches through coordinated community efforts;
- Support the awareness and availability of, and access to, harm reduction services in the District of Columbia;
- Ensure knowledge of, and equitable access to, high-quality, trauma-informed, recovery-oriented, equity-based SUD treatment;
- Expand reach and impact of the highest quality recovery support services available and promote a recovery-oriented system of care;
- Implement a shared vision between justice and public health agencies to address the needs of individuals who come in contact with the criminal justice system.
- Strengthen the District's opioid response by cultivating a skilled workforce, advancing professional development opportunities, and implementing strategic communication methodologies to drive meaningful change.

DBH is on course to open the **new Sobering and Stabilization Center** to support individuals under the influence of alcohol or drugs who require stabilization services and support but may not need to be the intervention of the hospital emergency room. The goal is to be a l**ow barrier, stepping-stone to ongoing treatment and sustained recovery**.

We offer a **comprehensive array of crisis services** to include someone to talk to (Access Helpline (AHL)), someone to respond (Community Response Team (CRT)), and a place to go (the Comprehensive Psychiatric Emergency Program (CPEP)). As a part of the District's crisis redesign, the Access Helpline has implemented the national 988 dial code for the National Suicide Prevention Lifeline; in collaboration with the District's Office of Unified Communication's (OUC) 911 call center, AHL is currently working to ensure that behavioral health calls received by law

enforcement, but are appropriate for diversion, are transferred from OUC to AHL. In addition, to support the full implementation of the 911 Behavioral Health Call Diversion, DBH has been funded to add an additional 41 staff positions, including 14 new AHL call center staff and 27 new CRT staff.

Furthermore, our Children and Adolescent Mobile Psychiatric Service (ChAMPS) provides **on-site immediate help to children facing a behavioral or mental health crisis** whether in the home, school or community. Services are geared toward children and youth 6-21 years of age. The goal is to stabilize them and avert inpatient hospitalization or placement disruptions in the case of foster children. The mobile crisis teams also make follow up visits and connect family to needed support services.

DBH has a **robust array of outreach and engagement services** through the Office of the Director's Community Engagement team which conducts outreach to the behavioral health community, District residents, and behavioral health providers in the District. In addition, the Community Response Team engages with individuals not connected to care, but not actively engaged with services due to other providers.

In addition, the **youth SUD prevention team** participates in community and health events, gives presentations to organizations and agencies, and responds to requests for training and technical assistance.

DBH has **expanded access to SUD services** through the update of regulations to require **all certified SUD treatment providers to provide assessment and referral services**. Providers must be able to assess and determine the most appropriate treatment level of care based on American Society of Addiction Medicine (ASAM) criteria and refer the consumers upon completion. This change in regulation has decentralized the assessment and referral process from the DBH Assessment & Referral Center (ARC) being the only point of entry to establishing multiple points of entry in the District of Columbia.

We have a **comprehensive array of access points for urgent care** to include our two Urgent Care Clinic located at Howard Road and 35 K Street. Our Howard Road location **services children and young adults ages 4-21 with complex emotional, behavioral, and mental health challenges**. Our 35K location offers **psychiatric assessment, evaluation, counseling, and medication management to adults**. These two locations function as psychiatric safety-net services for those consumers that either cannot access their psychiatrist in a timely manner or need emergency same-day psychiatric services.

Also, the Assessment Center **provides the Superior Court of the District of Columbia with court-ordered, high quality, comprehensive, culturally competent mental health consultation, and psychological and psychiatric evaluations for children and related adults** with involvement in child welfare, juvenile justice, and family court.

Court Urgent Care Clinic (D.C. Superior Court) **identifies and provides immediate services to persons in need of mental health and/or substance abuse assistance who become involved with the Court** as a result of criminal, civil, probate, and/or family proceedings and to **connect them to appropriate mental health**, **substance abuse**, and housing services. Anyone who is directly or indirectly involved with the court, adults/juveniles, housed/unhoused, those with matters before the criminal, civil, family, probate courts, are eligible to receive services.

Based on many years of program operation, the principal recipients in need of this service are adults who walk-in for assessment and short-term care, as well as a small number of juveniles who are court-ordered for emergency evaluation. The ultimate objective is to support D.C. residents who are court involved, minimize recidivism within the criminal justice system, augment justice diversion programs, and triage the behavioral health needs of the consumers served there so they will be connected to appropriate long-term care.

Year	Initial Clinical Services	Subsequent Clinical Services
2022	205	1288
2023 (6 mos.)	101	612

In FY 23 DBH added **Intensive Care Coordination Teams** (ICC) to the Integrated Care Division. These teams are in-person and telephonic engagement teams that work with **consumers who are not enrolled with a DBH mental health or substance use service delivery provider**. The goal is to connect consumers to care within 30 days of the referral. Referrals can come from community stakeholders, family members, other D.C. agencies like the Executive Office of the Mayor, or internally from other DBH departments like the community response teams. Consumers can continue with the Intensive Care Coordination Team past 30 days until they select and begin care with a provider, or until they decide they no longer want the services of the ICC team.

DBH partners and collaborates with sister district agencies via a MOU/MOA to coordinate and provide behavioral health services and resources to better serve district residents who are **impacted by unaddressed behavioral health concerns**.

This collaboration includes the **co-location of mental health clinicians** at designated agencies and/or in the community to assure individuals have access to a full continuum of quality behavioral health services and support. These partnerships promote a No Wrong Door approach to accessing behavioral health services in the District.

Needs

There continues to be a **gap in substance use treatment and recovery services for youth**. One of the District's FQHCs, as well as Children's National Hospital, report that they are seeing an increase in youth experiencing substance use challenges, especially youth of Hispanic descent who are relatively new to the country and are addicted to fentanyl.

DBH currently has two certified youth SUD treatment providers. These two providers provide outpatient treatment services for youth up to age 21. However, the District has not been able to establish higher levels of care for substance use treatment. With the support of COVID Supplemental Block Grant funding as well as ARPA funding, the District is looking to **establish a residential substance use treatment program** in late 2023.

DBH currently has one First Episode Psychosis (FEP) Program that will discontinue programming and treatment services at the end of September 2023. FEP consumers will be transferred with wrap around supportive services and treatment. The District will be **seeking a new FEP provider** which is anticipated to be awarded in October 2023 with the support of MHBG and ARPA funding.

As the District is establishing and building a system of care to addressing early serious mental illness, the District through SAMHSA funding has recently awarded a provider to establish a Clinical High Risk for Psychosis (CHR-P) program for transition-age youth (TAY) or young adults aged 16–25-year-olds, who are at high clinical risk for their first episode of psychosis (FEP), but who have not yet fully experienced psychotic symptoms. The CHR-P Provider will have a stepped care approach, where treatments of differing intensity will be offered, and young adults will learn to manage stress, anxiety, and uncertainty associated with early signs of psychosis. The CHR-P provider will work in close partnership with the newly identified FEP Provider to provide ESMI treatment and supportive services for youth and young adults, ages 16-25, in the District.

The District has **one of the highest rates of opioid fatalities** when compared to States. Through the State Opioid Response (SOR) grant, we are focused on **increasing access to medication for opioid use disorder** (MOUD), **reducing unmet treatment needs**, and **reducing opioid and stimulant overdose-related deaths** in the District through the provision of prevention, treatment, and recovery support services (RSS) to individuals with opioid use disorder (OUD) and stimulant use disorder (STUD). The blueprint for this work is LLDC.

As noted above, we are in the process of revising the LLDC plan and within the plan, we have **outlined 38 strategies and their related activities that we need to implement to continue to fight the opioid crisis**. Some of those strategies are **increasing access to harm reduction tools** and **low-barrier recovery housing**, **facilitating collaboration amongst stakeholders**, and **training the workforce to be better equipped to meet the needs** of this vulnerable population.

We continue to experience workforce shortages. In general, behavioral health providers need additional training on ASAM, trauma-informed care, and addressing co-occurring issues.

The District **provides low barrier recovery housing to residents with OUD and STUD**. This housing operates in **compliance with Level III/IV National Alliance for Recovery Residences (NARR) standards**. In these recovery residences, intensive case management is provided to residents along with **access to treatment and other recovery support services**. Residents are also supported through restorative policies that allow for residents who have returned to using substances to be held accountable for their actions while not only responding by enforcing punitive actions such as eviction or discharge.