Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it**. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral health needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections**. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings**. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. **States should develop systems that vary the intensity of care coordination support based on the severity and complexity of individual need**. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve **access to care for mental disorders, substance use disorders, and co-occurring disorders**, including details on efforts to increase access to services for:

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

f) Persons with substance use disorders who have, or are at risk for, HIV or TB

g) Persons with substance use disorders in the justice system

h) Persons using substances who are at risk for overdose or suicide

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

l) Individuals with co-occurring mental and substance use disorders

The following examples demonstrate how the District integrates mental health and primary care, including services for individuals with co-occurring mental health and substance use disorders:

1) The District delivers engagement and support to people with SMI, SUD, cooccurring disorders, and complex medical needs through the Intensive Care Coordination Team. This team of two community behavioral health support specialists, two peers, and a nurse work with people identified in the community as needing connection to care but appear to not have a mental health or substance use provider. The team acts "in lieu of" a certified behavioral health provider until such time as the consumer/client picks a provider with which to enroll. This team is trained to administer Narcan in the community and they carry Narcan and fentanyl test strips for community distribution. The goal is to enroll people within 30-90 days of initial engagement with either a mental or a SUD provider, or both. Approximately 1300 people a year are connected to care by this team
2) The District delivers Assertive Community Treatment (ACT), an evidence-based practice for adults who have serious and persistent mental illness, to approximately 2,000 consumers annually. ACT providers are evaluated against the Tool for the Measurement of ACT (TMACT) which is the Nationally recognized evaluation tool to ensure fidelity to ACT outcomes for people who need a hospital without walls in the community. ACT teams deliver mental health care, substance use disorder treatment, coordinated care for complex medical conditions, and support around the social determinants of health (SDOH) that impair access to care and achievement of positive care outcomes.
3) As part of the Districts effort to integrate behavioral health care (both mental health and substance use) and physical care, the planning for CCBHC began in 2025 with award of a SMHSA planning grant. CCBHC is seen as a transformative system opportunity to rebuild the behavioral healthcare system in DC to truly integrated substance uses disorder treatment and mental health treatment while ensuring intensive care coordination with primary care.
4) The D.C. Healthy Communities Collaborative (DCHCC) Community Health Needs Assessment: The DCHCC includes: 1) a coalition of four hospitals: Children's National Health System, Howard University Hospital, Providence Health System, and Sibley Memorial Hospital); 2) four Federally Qualified Health Centers: Bread for the City, Community of Hope, Mary's Center, and Unity Health Care; and 3) two associations: D.C. Hospital Association and D.C. Primary Care Association.
The DCHCC authored the June 2019 Community Health Needs Assessment Report to serve as an evidence-based, community-driven foundation for community health improvement efforts. Four priority community needs emerged: 1) mental health (prevention and treatment of psychological, emotional, and relational issues that lead to higher quality of life); 2) place-based care/bringing care to the community (care options that are convenient and culturally sensitive); 3) care coordination (deliberate organization of patient care activities and information-sharing protocols among all of the participants concerned with a patient's care to achieve safer and more effective care); and 4) health literacy (ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions). The feedback from this integrated, collaborative assessment is used to inform DBH initiatives and outcome evaluations.
5) Federally Qualified Health Centers (FQHCs), more commonly known as Community Health Centers (CHCs) are community-based and patient-directed primary care centers. They serve those who have 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. The following providers are FQHCs: Community of Hope - creates opportunities for low-income families in the District, including those experiencing homelessness to achieve good health, a stable home, family-sustaining income, and hope. There are three locations in the District. Family and Medical Counseling Services – employs community-based, culturally competent approaches to provide comprehensive services that promote the emotional and physical health of families and individuals, regardless of income or socioeconomic status, to maximize the quality of life. La Clinica Del Pueblo - Serves the Latino and immigrant populations of the Washington DC metropolitan area. The goal is to provide culturally appropriate health services, focusing on those most in need. Mary's Center for Maternal and Child Care, Inc. - Provides health care, family literacy, and social services to individuals whose needs often go unmet by the public and private systems. It uses a holistic, multipronged approach to help each participant access individualized services that set them on the path toward good health, stable families, and economic independence. Mary's Center is a DBH-certified Mental Health Rehabilitation Services (MHRS) core services agency and has three District health locations. Unity Health Care Inc.- Promotes healthier communities through compassion and comprehensive health and human services, regardless of ability to pay. Unity Health Care has ten clinic sites, eleven homeless sites, three school-based health centers, and two specialty sites. Whitman Walker Clinic- The mission is to provide high quality, culturally competent community health center services to the District's diverse urban community, including individuals who face barriers to accessing care, and with special expertise in Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) and HIV care. There are two centers in the District. Bread for the City- This FQHC look-a-like provides District residents with comprehensive services, including food, clothing, medical care, and legal and social services. There are two centers in the District.
6) The Integration of Behavioral Health and Primary Care Health Homes/MY DC Health Home: - The District of Columbia Health Homes (HH) initiative named My DC Health Homes/(Health Homes 1) was launched in January 2016 as a joint effort by DBH and the Department of Health Care Finance (DHCF) as a state plan benefit. 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 Health Homes 1 program is for adults with Medicaid who have a serious and persistent mental illness. Services may be delivered in a Core Service Agency or a Free-Standing Mental Health Clinic. Health home

services include: 1) comprehensive care management; 2) care coordination; 3) health promotion; 4) comprehensive transitional care/follow-up; 5) patient and family support; and 6) referral to community and social support services. The District of Columbia Health Homes (HH) initiative named MyHealth GPS/Health Homes 2 program was launched in July 2017 and is overseen by the Department of Health Care Finance. It operates primarily in Federally Qualified Health Centers and other primary care settings. It provides the same six services described under the Health Homes 1 program. The goals include: 1) improve the integration of physical and behavioral health care; 2) reduce healthcare costs (lower rates of avoidable Emergency Department use and reduce preventable hospital admissions and re-admissions); 3) improve the experience of care and quality of services delivered, and 4) improve health outcomes. To be eligible for the MyHealth GPS program the beneficiary must have three or more listed chronic health conditions, and a SMI or SUD diagnosis is included among the seventeen listed conditions).

7) The DC Mental Health Access in Pediatrics (DC MAP) 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 DC-MAP, 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. 5) 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, Hepatitis C testing services, HIV pre and post counseling, linkage, and referral 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 Assessment and Referral Center (MARC) van that provides for same-day substance use disorder assessments and referrals in the community. The MARC visit multiple locations around the District, targeting areas of high need. The MARC staff consists of a registered nurse and a social worker who provide same day assessments and referrals to substance use treatment. Testing for TB, HIV/HEP-C and pregnancy are offered as part of the overall assessment process. In an effort to provide greater access to care, the MARC van has also begun assessing for and prescribing buprenorphine. In 2019, DBH utilized its regulatory authority to expand intake and assessment services by requiring all certified behavioral health providers to provide these services.

8) Seriously Emotionally Disturbed (SED) Youth with Aggressive Behavior in community and inpatient care settings: In FY 18, DBH received technical assistance from the National Association of State Mental Health Program Directors to address an increase in acts of physical aggression among youth with SED in inpatient settings. The consultant report reviewed findings from the literature on local and national efforts to prevent and manage physical aggression in youth, including information on effective screening, evidence-based approaches to intervention/treatment, outcomes, and limitations. The consultant conducted initial planning calls with representatives of the two impacted acute inpatient care hospitals, followed by on-site visits, presentations of materials, discussed options and provided guidance to meet the District's needs. Follow-up consultations will be provided remotely as needed to help ensure successful the implementation of recommendations.

9) The Department of Behavioral Health (DBH) continues to provide comprehensive training on substance use disorder (SUD) and opioid use disorder (OUD) to long-term care facilities, including skilled nursing facilities, community residential settings, senior centers, and senior housing buildings. The training is facilitated by a contracted vendor, Ms. Malina Afzal, a licensed social worker with expertise in substance use disorders and aging populations. This initiative is designed to enhance staff knowledge and clinical practices in serving older adults affected by SUD and OUD. The training provides a foundational understanding of substance use disorders and addresses the unique challenges faced by the older adult population. It also identifies co-occurring mental health concerns, examines the psychosocial implications and stigma associated with substance use, and provides an overview of community-based resources available in the District of Columbia. The training is available to all employees who provide services to older adults, including both facility staff and community-based providers. In addition to the initial training, DBH offers post-training technical assistance to reinforce learning and support implementation. In 2024, DBH provided this training to 525 healthcare workers across various care settings. As of 2025, an additional 211 healthcare workers have participated in the training.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance **parity enforcement and increase awareness of parity protections** among the public and across the behavioral and general health care fields.

A workgroup comprised of the Department of Behavioral Health and the D.C. Department of Health Care Finance (DHCF), the single state agency for Medicaid, are currently utilizing the Centers for Medicare and Medicaid Services requirements to analyze parity compliance. DBH and DHCF continue to revise regulations to ensure parity compliance.

3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

The District requires the use of the DLA-20 as part of each consumers assessment upon entry into care. The DLA-20 Is a clinician administered functional assessment proven to reliably estimate an individual’s functioning across multiple domains of daily living.

It is a reliable measure for the purposes of justifying medical necessity, determining level of care, identifying co-occurring substance use conditions that require treatment, and for assessing improved functioning over time. When a person screens positive for substance use, the provider network requires to complete an additional screening like the GAIN-SS or another tool of their choosing. Based on the results of those further assessment screenings, a referral is made for substance use treatment if the provider is only certified as a mental health provider.

There are currently 12 certified providers of both mental health services and substance use disorder (SUD) treatment services in the District. This includes a provider of stabilization services that is open 24/7 and addresses the needs of people who have cooccurring conditions who need immediate care for what is perceived to be a substance related community crisis. Individuals can receive care at the stabilization center for up to 72 hours and referrals to ongoing SUD and mental health treatment are made upon discharge.

The District began implementation of a Promoting the Integration of Primary and Behavioral Health (PIPBHC) grant titled Promoting Integrated Whole Person Care in DC (PIWC-DC) in 2025. This SAMHSA grant is designed to serve 2,000 unduplicated consumers a year in both traditional integrated care design of behavioral health (both mental health and SUD) into primary care and in reverse design of primary care into full service behavioral health in a CCBHC. The target population is adults with SMI, a co-occurring substance use condition, and/or a co-occurring medical condition. There is a special focus on adults age 55 or older. This project pilots a no wrong door approach to care delivery that also expects that whole-person needs will be addressed in a single care delivery location. It uses the collaborative care model (CoC) to guide integration and participating primary care providers are able to bill CoC as a service in DC to support this integration work.

a. Please describe how this system differs for youth and adults.

The District requires the use of the Child & Adolescent Functional Assessment Scale ("CAFAS") and the Pre-school & Early Childhood Functional Assessment Scale ("PECFAS") which are rating scales that assess functional impairment attributed to behavioral, emotional, psychological, or substance use disorders in children and youth ages 3-20. The CAFAS/PECFAS is used as a treatment planning and review tool for clinicians. PECFAS measures the functioning for youth ages 3-5. CAFAS measures the functioning for youth ages 6-20. The CAFAS/PECFAS is used as a treatment planning and review tool for clinicians and is implemented within 30 days of the intake, every 90 days, when a significant event occurs, and at and at discharge.

DBH has two certified youth SUD providers that are also mental health providers for youth with co occurring disorders. Both agencies utilize required assessment tools to assess for youth mental health and substance use disorders. Based on the results of the assessment, a referral is made for substance use treatment. In addition, DBH offers Motivational-Enhancement Therapy and Cognitive Behavioral Therapy (MET-CBT) which is a short-term intervention designed for children/youth with cannabis use disorders to increase their motivation to change a substance use behavior and the underlying thoughts or feelings that may trigger maladaptive substance use behaviors.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

No

c. How many IT-COD teams do you have? Please explain.

N/A

d. Do you monitor fidelity for IT-COD? Please explain.

N/A

e. Do you have a statewide COD coordinator? ○ Yes ◉ No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

d) How the state provides integrated treatment for individuals with co-occurring disorders

a. The District supports access to behavioral health care facilitated through primary care providers via a Promoting the Integration of Primary and Behavioral Health (PIPBHC) grant titled Promoting Integrated Whole Person Care in DC (PIWC-DC) in 2025. This SAMHSA grant is designed to serve 2,000 unduplicated consumers a year in both traditional integrated care design of behavioral health (both mental health and SUD) into primary care and in reverse design of primary care into full service behavioral health in a CCBHC. The target population is adults with SMI, a co-occurring substance use condition, and/or a co-occurring medical condition. There is a special focus on adults age 55 or older. This project pilots a no wrong door approach to care delivery that also expects that whole-person needs will be addressed in a single care delivery location. It uses the collaborative care model (CoC) to guide integration and participating primary care providers are able to bill CoC as a service in DC to support this integration work.

The primary care provider in this project hired psychiatric nurse practitioners, social workers, and direct line staff trained in mental health first aid and the collaborative care model who have extensive experience delivering care in both the mental health and substance use treatment systems.

b. As part of this initiative there are also efforts under way to begin to train primary care clinics in mental health first aid and to facilitate their functional use of PHQ-9 assessments so that they move completion and filling in charts to referrals for care.

c. Efforts to integrate primary care into behavioral health settings includes a current Certified Community Behavioral Clinic (CCBHC) planning initiative to stand up CCBHC in 2026. CCBHCs require care coordination with primary care as part of its structure and the District hopes to leverage this to better integrate care for people with complex needs. The Promoting the Integration of Primary and Behavioral Health (PIPBHC) grant titled Promoting Integrated Whole Person Care in DC (PIWC-DC) has a CCBHC sub-grantee that is integrating primary care into its practice with the addition of nurse practitioners trained in both primary care and Behavioral health. These nurses deliver care, and coordinate care for people who have PCPs outside their CCBHC.

d. The District provides integrated treatment for individuals with co-occurring mental health and substance use needs through twelve (12) dually certified providers. As of July 1, 2025, a total of 14,470 people has been served by these twelve providers. The District also provides integrated treatment in two crisis facilities: the comprehensive psychiatric emergency program (CPEP) and the stabilization center. CPEP's primary focus is on addressing the needs of adults who are experiencing a psychiatric crisis, but many people who seek service there also present with a co-occurring substance use condition and may be referred to an inpatient setting to stabilize either or both conditions. The Stabilization Center's primary focus is on addressing the needs of adults who are experiencing a substance use episode in the community needing stabilization. Many of the people who seek service there also present with a co-occurring mental health concern. Referrals to inpatient and outpatient care for mental health are made as needed upon disposition.

Additionally, DBH maintains a close relationship with its sister agency, the Department of Disability Services (DDS). In this partnership people who have intellectual and developmental disabilities and need high touch behavioral health support for mental health and/or substance use conditions receive braided care through both systems to meet their needs in the community. Consumers may receive housing and one to one support for activities of daily living from DDS, and ACT or outpatient substance use treatment from DBH providers. Services and support are selected based on consumer need and choice and braided to meet their needs through person centered plans.

5. Describe how the state **provides care coordination**, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

a. All DBH certified mental health rehabilitation services (MHRS) providers are required by regulation to establish and adhere to policies and procedures for adults governing the coordination of the treatment planning and service delivery process including the coordination of mental health and primary care services. These policies and procedures required in regulation also require the coordination of care across behavioral health treatment for either mental health or substance use and primary care.

DBH also directly provides care coordination services through an authority level division designed to remove barriers to care for District residents. The Integrated Care Division coordinates care for the approximately 2700 consumers who are admitted to a community psychiatric hospital in an involuntary legal status. The care managers coordinate with both the hospital and the community providers related to discharge planning and post discharge care to try to reduce readmissions. This team also works with community hospitals on behalf of people who have behavioral health conditions but are in patient related to significant medical co-morbidities. This team works with an interdisciplinary team comprised of multiple government agencies and several community hospitals to coordinate care and care transitions for people with the highest needs.

Through the office of the Chief Clinical Officer, DBH also hosts community integration team meetings designed to support community provider teams that are struggling to get good client outcomes for specific individuals. These team meetings pull together the clinical expertise of DBH to develop coordinated care plans for consumers with the most complex needs.

b. All DBH certified substance use rehabilitation services (ASURS) providers are required by regulation to establish and adhere to policies and procedures for adults that require screening for co-occurring mental health conditions. Providers may not refuse to treat a person based on their mental health diagnosis. ASURS requires a Clinical Care Coordinator as part of the regulator framework to ensure people receiving SUD treatment have care coordinated with other behavioral health providers and primary care.

c. DBH maintains a close relationship with its sister agency, the Department of Disability Services (DDS). In this partnership people who have intellectual and developmental disabilities and need high touch behavioral health support for mental health and/or substance use conditions receive braided care through both systems to meet their needs in the community. Consumers may receive housing and one to one support for activities of daily living from DDS, and ACT or outpatient substance use treatment from DBH providers. Services and support are selected based on consumer need and choice and braided to meet their needs through person centered plans.

6. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

The District provides integrated treatment for individuals with co-occurring mental health and substance use needs through twelve (12) dually certified providers. As of July 1, 2025, a total of 14,470 people have been served by these twelve providers. The District also provides integrated treatment in two crisis facilities: the comprehensive psychiatric emergency program (CPEP) and the stabilization center. CPEP's primary focus is on addressing the needs of adults who are experiencing a psychiatric crisis, but many people who seek service there also present with a co-occurring substance use condition and may be referred to an inpatient setting to stabilize either or both conditions. The Stabilization Center's primary focus is on addressing the needs of adults who are experiencing a substance use episode in the community needing stabilization. Many of the people who seek service there also present with a co-occurring mental health concern. Referrals to inpatient and outpatient care for mental health are made as needed upon disposition.

The District requires the use of the DLA-20 as part of each consumers assessment upon entry into care. The DLA-20 Is a clinician administered functional assessment proven to reliably estimate an individual's functioning across multiple domains of daily living. It is a reliable measure for the purposes of justifying medical necessity, determining level of care, identifying co-occurring substance use conditions that require treatment, and for assessing improved functioning over time. When a person screens positive for substance use, the provider network requires to complete an additional screening like the GAIN-SS or another tool of their choosing. Based on the results of those further assessment screenings, a referral is made for substance use treatment if the provider is only certified as a mental health provider.

This system differs for children and uses in content and not process. Child and youth use the CFAS/PECFAS evaluation instead of the DLA-20 as they are child and youth specific assessments.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

DBH maintains a close relationship with its sister agency, the Department of Disability Services (DDS). In this partnership people who have intellectual and developmental disabilities and need high touch behavioral health support for mental health and/or substance use conditions receive braided care through both systems to meet their needs in the community. Consumers may receive housing and one to one support for activities of daily living from DDS, and ACT or outpatient substance use treatment from DBH providers. Services and support are selected based on consumer need and choice and braided to meet their needs through person centered plans.

Children and Youth are served in the school system until they age out at age 22. People who still need service as adults are transitioned into the adult system before their 22nd birthday and this includes transitioning to adult serving providers, ensuring benefits and entitlements are in place, and securing appropriate housing.

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

Technical assistance around the best clinical and fiscal models to support integrated care for people with the most complex needs. Some of this assistance is currently being provided though the PIBHC-states grant currently. Determining and implementing incentivized/alternative payment methodologies.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by the Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative.Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

States shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals experiencing early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount, the state receives under this section for a fiscal year as required, a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
The District, utilizes a Navigate - informed treatment model to serve young adults identified as experiencing their first episode of psychosis. The Navigate treatment model is a comprehensive team approach treatment program designed to provide early and effective treatment to individuals who have experienced a first	1.00

episode of psychosis.	
	0.00
	0.00
	0.00
	0.00
	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
87,527.35	87,527.35

3. Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.

Medicaid billing is available to the young adults in receipt of services offered by the First Episode Psychosis (FEP) team.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.

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 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 the following staff:

Case Manager – provides individual and team case management, community education, and recruitment of individuals who have begun to experience psychosis.

Medication Manager - monitors the medication of FEP clients and encourages the use of low doses of medications as well as addresses the special issues of clients with first-episode psychosis.

Individual Resiliency Trainer (IRT) – promotes individual resiliency by enhancing illness management and building strengths.

Family Education (FE) Clinician – encourages how to work together as a family to support the individual's recovery.

Supported Employment and Education (SEE) Specialist – pursues employment and educational goals.

Peer Specialist - provides peer support to the family and the individual.

Specific to FEP, the District implements:

1) NAVIGATE-like 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. The NAVIGATE program includes four different treatments: NAVIGATE Psychopharmacological Treatment Manual, Supported Employment and Education, Individual Resiliency Training (IRT), and Family Education.

2) Individual Placement and Support (IPS)/Supported Employment/Education (SEE): 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.

3) 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.

4) 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.

5) 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:

6) 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. A-CRA is a necessary intervention for the targeted population as TAY with mental illness have higher rates of substance abuse than other age groups with mental illness and this behavioral approach has proven to be effective in reducing substance and alcohol use. No modifications will be necessary.

7) 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.

8) 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. TAY TREM consists of three major parts. The first section, on empowerment, helps group members learn strategies for self-comfort and accurate self-monitoring as well as ways to establish safe physical and emotional boundaries. The second component of TAY TREM focuses more directly on trauma experience and its consequences. In the third section, focus shifts explicitly to skills building. These sessions include emphasis on communication style, decision-making, regulating overwhelming feelings, and establishing safer, more reciprocal relationships.

9) 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. It is an extremely safe model as it directly addresses both trauma and addiction, but without requiring clients to delve into the trauma narrative (the detailed account of disturbing trauma memories), thus making it relevant to a very broad range of clients and easy to implement from the very start of treatment (no prior treatment is needed).

10) Child-Parent Psychotherapy for Family Violence- A relationship-based treatment intervention for young children 0-6 with a history of trauma exposure or maltreatment, and their parents or caregivers.

11) 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.

12) Parent-Child Interaction Therapy- A supported treatment for young children ages 2-6 who are experiencing extreme behavioral difficulties.

13) 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.

14) 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.

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

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

5. Does the state monitor fidelity of the chosen EBP(s)? (●) Yes ( ) No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

Outreach activities and essential EBP services are designed and employed to change the long-term prognosis for young adults

coping with schizophrenia. Our outreach efforts widen knowledge about ESMI and AMHI, as well as teaches community providers and others how to screen for concerns and make the appropriate service and treatment referrals. The education and knowledge afforded to the community- at -large encourages early and effective treatment interventions.

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

In FY 26 and FY27, the Department of Behavioral Health (DBH) will continue to use a team approach to address the needs of young adults who are diagnosed with ESMI. Specifically, for young adults identified as experiencing their first episode of psychosis, they will be treated by a coordinated specialty care (CSC) team trained in EBPs that support the needs of the young adult Treatments will be of differing intensity and will aid them in their management of stress, anxiety, and uncertainty associated with psychosis.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

The diagnostic categories include but may not be limited to the following:

1. Major Depressive Disorder

2. Schizoaffective Disorder Bipolar Type

3. Schizoaffective Disorder

4. Bipolar Disorder with Psychotic Features

5. Schizophrenia with Co-Occurring Substance Use Disorder

6. Schizophrenia

7. Substance Induced Psychotic Disorder

8. Post-Traumatic Stress Disorder

9. Acute Stress Disorder

10. What is the estimated incidence of individuals experiencing first episode psychosis in the state?

For an area with the size and population of the District, it is estimated that no less than 70 young adults will be identified as individuals with an incidence of the first episode of psychosis. Despite our outreach and other efforts, the District's FEP program screens approximately nine (9) TAY per quarter which yields about 24 TAY that qualify for FEP services annually.

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

The District will continue outreach efforts to schools, hospitals, churches and other institution that encounter the young adult population. DBH will continue to educate the community on the symptoms of ESMIs and how to access help. In addition, DBH will launch a new web page that is linked to the Department of Behavioral Health home page and the pages of our providers that engages young adults in information and self referral access to FEP and other ESMI services.

12. Please indicate area of technical assistance needs related to this section.

There are no areas of technical assistance needed related to this section at this time.

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Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances communication.

DBH's Plan Of Care Development process includes at a minimum the completion of a comprehensive diagnostic assessment, development of the plan of care, consideration of the consumer's beliefs, values, cultural norms in how, what and by whom services are provided, and consideration, screening, and assessment of the consumer for treatment using an appropriate evidence -based practice (EBP) offered through a certified provider. Court-appointed guardians for adults, children, and youth, and the parents/guardians or family members of children and youth shall be involved in the Plan of Care development process. The plan of care shall be person centered including long term goals, strengths, barriers, objectives, intervention statements, and provide for the delivery of services in the least restrictive environment that is appropriate for the consumer.

Since the beginning of the pandemic, the District has increased telehealth options for providers and consumers. This has allowed consumers the flexibility of options to stay connected to mental health services while social distancing. In FY24, 35,707 behavioral health consumers received at least one telehealth service. Also, in FY25 YTD, 31,812 behavioral health consumers received at least one telehealth service. DC is actively working to enhance tools and capabilities in the Health Information Exchange (HIE), improve HIE access across all provider types, and implement an e-consent platform for consumers to authorize the secure exchange of data protected by 42CFR through the HIE.

4. Describe the person-centered planning process in your state.

The person-centered planning process consists of the following:

1) Conducting a comprehensive, strengths-based assessment

2) Developing an interpretive assessment-based summary

3) Reviewing and considered cultural concerns and preferences in planning and goal development

4) Orienting individuals and their natural supporters regarding the purpose and process of person-centered planning

5) Empowering the individual to identify their hopes and dreams (goals), strengths and barriers to goal accomplishment and then partnering in the development of short-term objectives and interventions that overcome barriers and support individual recovery and resilience.

In FY23, DBH updated person-centered courses offered to comply with national standards. In FY25, DBH will review the current person-centered courses offered and update as needed to comply with national standards.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as **A Practical Guide to Psychiatric Advance Directives**)?

DBH strongly supports a consumer's right to create, or choose not to create, advance directives. DBH has developed a policy that highlights the procedures governing the use of advance directives during admission/enrollment intake process, development of a consumer's treatment plan and during treatment.

6. Please indicate areas of technical assistance needs related to this section.

Funds and technical assistance are needed to provide additional training to our provider network to support Person-Centered Planning and Assessments.

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Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's 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, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 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 U.S.C. § 300x-55(g)**, there are periodic site visits to MHBG and SUPTRS BG 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 made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary prevention, treatment and recovery 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 MHBG and SUPTRS BG. 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 SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have 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 respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

For MH and SUPTRS Block Grant Funding Award Process: The Notice of Funding Availability (NOFA) and Request for Applications (RFA) have traditionally addressed the statutory restrictions on the use of the Block Grant funds. This information is also included in the Pre-Application Conference along with program, performance, and fiscal expectations. Block Grant (BG) Sub-Grant Agreement: The Sub-Grant Agreement provides detailed information about what is required and includes: 1) terms of the agreement, 2) background and purpose, 3) award period, 4) grant administrator, 5) scope and use of funds, 6) grant amount, 7) administrative requirements, 8) reporting requirements, and 9) fund disbursement plan and requirements.

The Data, Quality, and Compliance (DQC) Administration provides pathways to licensure and certification, manage incidents and investigations, training DBH's network of care and to assist leadership and programmatic staff with identifying and improving performance through oversight of the public behavioral health system using data analysis and visualization. The DQC Administration consists of Certification, Licensure, Investigations, Data and Performance Management, Policy, the Training

Institute. The Certification Division certifies providers delivering behavioral health services under the purview of DBH regulatory authority, and the Licensure Division licenses group homes for adults with a severe and persistent mental illness. Both the Certification and Licensure Divisions monitor providers' compliance with governing regulations. The Investigations Division is charged to investigate incidents that violate DBH policy or regulation involving DBH staff, providers or consumers/clients. The Policy Division works within DBH to develop regulations, policies, and bulletins to support DBH's mission. The DBH Training Institute strengthens the knowledge and skills of the behavioral health workforce and consumers by providing quality and consistent trainings.

Provider Relations Division: provides technical support to providers to support their compliance with Chapter 34 regulations and quality indicators identified by the Department. This includes but is not limited to technical support on Person Centered Planning, Locus/ Child and Adolescent Functional Assessment Scale (CAFAS) / Child and Adolescent Functional Assessment Scale (CAFAS)/Preschool and Early Childhood Functional Assessment Scale (PECFAS), and basic administrative operations. In addition, the Division regularly monitors provider treatment plans & encounter note documentation, audit results, and complaints. Technical assistance is provided based on assessment of identified needs. This may require coordination of support from DC government sister agencies (i.e., Department of Health Care Finance, MCOs, Courts and other clinical divisions within DBH).

4. Please indicate areas of technical assistance needs related to this section.

None at this time

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Footnotes:

Environmental Factors and Plan

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)? ○ Yes ◉ No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☑ Other (please list)

The first step in achieving DC Department of Behavioral Health's prevention goals and objectives is to assess prevention needs based on both qualitative and quantitative data to plan prevention interventions.

Community Conversations are a qualitative data collection tool, utilized by our staff and the DC Prevention Center grantees, that fill quantitative data gaps by helping to identify the local conditions contributing to substance use in particular communities and neighborhoods, along with the community readiness and resources needed to address substance use issues. Community Conversations engage an audience by asking guiding questions allowing individuals to speak freely on their personal experiences. Additionally, Community Conversations act as one piece of DBH's early warning system, providing information on new or emerging drugs, substance use patterns, and factors that influence substance use based on responses.

Effective community conversations support the creation of realistic logic models, the development of sustainable action

plans, and the implementation of prevention initiatives that meet the communities' needs.

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** ☑ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☐ Rural communities
- **i)** ☐ Other (please list)

4. Does your state use data from the following sources in its primary prevention needs assesment? (check all that apply):

- **a)** ☑ Archival indicators (Please list)

The DC Community Prevention Surveys (2017 – 2019) were epidemiological surveys focused on alcohol, tobacco, marijuana, and other illicit drug use; consequences; and related risk and protective factors in the District of Columbia. It offered a picture of the extent and impact of substance use in the District, along with information on potential risk and protective factors to target at the District and Ward levels.

This data:
1. Described the prevalence of substance use in DC, with a special emphasis on age group differences (youth, young adults, and older adults), changes over time, and Ward-level concerns;
2. Examined the consequences of substance use, including related arrests, driving under the influence (DUI), alcohol/drug dependence and treatment needs, alcohol/drug use during pregnancy, substance use-related mortality, and sexual intercourse while under the influence
3. Assessed where residents in Wards within the District faced greater exposure to particular community, family, individual, and school risk factors for substance use consumption and consequences; and
4. Examined the relationship between risk and protective factors and particular outcomes within the District.

We use past data to compare and observe ward-level changes over time.

- **b)** ☑ National survey on Drug Use and Health (NSDUH)
- **c)** ☑ Behavioral Risk Factor Surveillance System (BRFSS)
- **d)** ☑ Youth Risk Behavioral Surveillance System (YRBS)
- **e)** ☐ Monitoring the Future
- **f)** ☐ Communities that Care
- **g)** ☑ State-developed survey instrument
- **h)** ☑ Other (please list)

Community Conversations are a qualitative data collection tool that fill quantitative data gaps by helping to identify the local conditions contributing to substance use in particular communities and neighborhoods, along with the community readiness and resources needed to address substance use issues. Community Conversations act as one piece of DBH's early warning system, providing information on new or emerging drugs, substance use patterns, and factors that influence substance use.

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds? ◉ Yes ○ No

- **a)** If yes, (please explain in the box below)

Using both quantitative and qualitative data, funds are directed throughout the six core strategies based on community needs and evidence-based interventions available. Community Conversations are implemented by the DC Prevention Centers to pull emerging trend and other substance use indicators from our target population. This aids DBH in identifying the necessary interventions to respond directly to community needs.

- **b)** If no, please explain how SUPTRS BG funds are allocated:

N/A

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
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5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? ○ Yes ◉ No

a) If yes, please describe.

N/A

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? ◉ Yes ○ No

a) If yes, please describe mechanism used.

The DC Department of Behavioral Health has a mechanism in place to provide technical assistance and training to various stakeholders at different levels of engagement.

For the general community and public inquiries, the DC Department of Behavioral Health (DBH) has set up an email account (suds.prevention@dc.gov) that functions as a repository for training and technical assistance requests. When a general request is received, a prevention team member begins preparing a response based on the identified need(s). Available resources include ATOD campaign materials, ATOD-related presentations and trainings, community outreach, and other engagement events. Some requests may require connecting with community partners and our sub-grantees for community or ward-specific needs.

Sub-grantees formally request training and technical assistance through monthly grant monitoring and program improvement meetings. These meetings include discussions about the program's progress toward grant deliverables. Additionally, sub-grantees can request training and technical assistance for their staff and key community leaders during programmatic site visits held in the third quarter. DBH also offers technical assistance as needed based on reviews of monthly reports.

Internally, DBH has the framework to provide capacity building and training opportunities to prevention partners and community members. The DBH Training Institute provides a professional mechanism to present a variety of educational

topics in the realm of Substance Use Prevention Treatment and Recovery Services.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

a) If yes, please describe mechanism used.

Based on the five-step strategic prevention framework (assessment, capacity building, planning, implementation, evaluation), DBH Substance Use Disorder Prevention services facilitate a cumulative and multi-level approach that leads to changes in policies, programs, practices, and behaviors.

Community Conversations are part of the first step (Assessment) in the Strategic Prevention Framework (SPF). These conversations fill quantitative data gaps by helping to identify the local conditions contributing to substance use within particular neighborhoods and communities, along with the community readiness and resources needed to address substance use issues.

Once a problem has been identified, our prevention sub-grantees, the DC Prevention Centers (DCPCs), work to identify and develop new community networks while supporting their capacity to reduce the root causes and change local conditions in their communities that lead to substance use. The DCPCs are dedicated to helping their respective communities find the resources they need to keep them drug-free. Through three core functions: community education, community leadership, and community change, the DCPCs provide workshops, trainings, and educational resources for youth, parents, caregivers, and other community stakeholders. A key component of this strategy includes community training on the Strategic Prevention Framework, as it guides prevention networks on planning and implementing action plans that result in meaningful change in their communities.

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in WebBGAS

N/A

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

- ☐ Yes
- ☐ No
- ☑ Not applicable (no prevention strategic plan)

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** ☐ Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** ☐ Timelines
- **c)** ☐ Roles and responsibilities
- **d)** ☐ Process indicators
- **e)** ☐ Outcome indicators
- **f)** ☑ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ◉ Yes ○ No

- **a)** Does the composition of the Advisory Council represent the demographics of the State? ◉ Yes ○ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ○ Yes ◉ No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

N/A

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☑ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☐ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

The information dissemination strategy of the DC Department of Behavioral Health's (DBH) substance use disorders (SUD) branch is to disseminate targeted prevention messages and resources to DC youth and adults at various levels of engagement. Throughout the community the Drug Free Youth DC website, our DBH Community Engagement Team, the four DC Prevention Centers (DCPCs), social media engagement, other communication channels all work in tandem to meet the needs of district residents.

The DC Department of Behavioral Health continues to use its Drug Free Youth DC (www.drugfreeyouthdc.com) website as the primary method for disseminating information throughout the District of Columbia. Included within the site is information on the District's laws as it pertains to substances (e.g., 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 the District's SUD Prevention 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.

The Community Engagement team, including the community prevention specialist, responds to requests via the SUDS.prevention@dc.gov email address to disseminate information and educational opportunities within the community.

DC Prevention Centers (DCPC) are sub-grantees under the substance use prevention division funded primarily through the SUPTRS BG. These four (4) DCPCs provide information dissemination to communities within their designated wards within Washington DC. DCPCs share SUD Prevention developed campaign and community education materials created through SUPTRS BG funding at various events within their designated wards within the District. Some examples of activities that have occurred in the past have been, dissemination of substance use prevention literature and outreach materials, as well as presentations and webinars presented at local community events, health fairs and townhalls.

The DC Department of Behavioral Health raises awareness around tobacco use and other substances through the launching of its Tobacco 21 Campaign. DBH used this social marketing campaign to educate the community and merchants on the law through printed materials such as counter mats, window clings and folders displaying the legislation as well as social media messaging.

Other examples of activities conducted, and methods used for this strategy include (but are not limited to) the following:
- Clearinghouse/Information Resource Centers;
- Resource directories;
- Media campaigns;
- Brochures;
- Radio/TV public service announcements;
- Speaking engagements;
- Health fairs/health promotion; and
- Information line (DBH Access Helpline)

b) Education:

Prevention Education represents a two-way interaction between the educator/facilitator and the participants in a learning atmosphere.

As the community hub of the DC Department of Behavioral Health, the DCPCs provide education through community presentations and discussions at health events and local events. DCPCs may also conduct educational sessions after a Community Conversation is completed. This allows for an engaged audience to share open-ended dialogue at the end of each conversation and provides participants with education around substance use, which includes correcting misinformation and myths within their community. DCPCs are required to collaborate with at least two schools in their communities and provide education and interactive training within those schools.

The Community Prevention Specialist, funded through the SUPTRS BG, educates and trains groups from partner agencies as well as those in the workforce in need of substance use education and its impacts on the individuals being served by other programs. Generally, trainings consist of signs and symptoms of substance use, how to identify resources, and emerging issues within the community.

Other examples of activities and methods used for this strategy include (but are not limited to) the following:
- Classroom and/or small group sessions (all ages);
- Interagency SUD Prevention training
- Parent and caregiver substance use prevention sessions;
- Community leaderships programs and training; and,
- Prevention education programs for youth groups

c) Alternatives:

DBH's Substance Use Disorders (SUD) Prevention Branch is committed to preventing and delaying the onset of alcohol, tobacco, and other drug (ATOD) use among the district's youth and young adults by providing constructive and healthy activities that offset the attraction to, or otherwise meet the needs usually filled by alcohol, tobacco and other drugs.

Alternative activities allow the SUD Prevention Community Engagement Team to facilitate activities directed at providing healthy distraction for substance use outside of traditional prevention education. Through feedback from our DCPC youth leaders, youth wanted more coping strategies and mental wellness solutions within our substance use prevention

strategies. One of the major initiatives that resulted from these conversations was the Pause and Play campaign and our youth focused summer event series. Our DCPCs have also organized alternative events for youths within their designated communities.

Examples of activities conducted include (but are not limited to) the following:
• Drug free parties;
• Community Wellness Events focusing on coping with stress, anxiety, and depression (include community members of all ages)
• Community Service Activities
• Artistic Expression Activities
• Mindfulness Activities
• Physical Fitness and Movement Activities

d) Problem Identification and Referral:

The problem identification and referral prevention strategy work to identify those who have indulged in illegal or age-inappropriate use of alcohol, tobacco, and/or other drugs to assess if their behavior can be reversed through education. Our community engagement team and DC Prevention Centers perform activities under this strategy.

After conducting a community conversation, DCPC staff can identify community prevention networks (CPNs) to address substance use issues within their respective wards. Through a logic model and action planning process, DCPCs identify problems related to substance use within the community and develop an action plan to tackle this issue locally. Additionally, if a SUD concern is identified in an area school, our prevention centers mobilize to conduct a series of interventions within the school environment. Similarly to starting the CPN process, the prevention center will initiate community conversations to explore usage trends and evaluate the knowledge of the school administration, students, and, if possible, parents and caregivers. From there, the prevention centers can assess community readiness for behavioral or policy change, strengthen school-wide capacity around SUD prevention, and/or plan and implement programs to address primary prevention needs of the school community.

Within the community engagement team, the Community Prevention Specialist maintains a community presence, assessing primary prevention needs in areas with increased usage trends. If there is evidence of illegal or age-inappropriate usage, the community engagement team will focus primary prevention activities in those areas. If needed, coordinated efforts with prevention partners (i.e., DC Prevention Centers, DBH Community Response Team) will also occur.

e) Community-Based Processes:

DBH collaborates with sub-grantees, community partners, and other DC government agencies to enhance the ability of the community to more effectively provide prevention, treatment, and recovery services for alcohol, tobacco and drug abuse disorders.

Our DC Prevention Centers collect exploratory data and emerging trends through community conversation with stakeholders that can inform and fill data gaps. The conversation participants are selected based on identified data needs while considering individuals that are best equipped to provide relevant insights. These participants usually include community leaders, faith-based organizations, area universities, local business organizations, law enforcement, mental health organizations, youth serving organizations, and district residents (both youth and adult). Community conversations are held regularly throughout the year to ensure that trends over time are accurately recorded.

In addition to collecting data and leading community education activities, DCPCs identify community prevention networks (CPNs) and re-engage non-active CPNs to address substance use issues within the community. CPNs are community-led coalitions that engage in planning efforts and take meaningful action around ward-specific risk and protective factors to create measurable community changes. CPNs are flexible in structure and can be comprised of members of a particular geographic boundary, family and/or parent groups, or individuals with a shared interest in substance use prevention. By going through an action planning process with these community prevention networks, DCPCs can address and discourage substance use within the community.

Workgroups and interagency collaboration are a major component of DBH's community-based process. Prevention subgrantees and members of the community engagement team are active participants of numerous workgroups and communities including but not limited to the Office of the State Superintendent of Education Data Workgroup, DC Health/DBH Tobacco Prevention Task Force, and the Live.Long.DC Prevention Opioid Strategy Group.

f) Environmental:

DBH focuses on three subcategories of environmental strategies; those that focus on legal or regulatory initiatives (policies), those that relate to service delivery (programs) and action-oriented initiatives (practices).

The DC Prevention Centers conduct various community level programs to change local policies and practices within their communities under the SUPTRS BG. Once a community network has been identified, action planning helps to address problems within the community resulting in a change in local practice to prevent and discourage substance use within the

community. CPNs use descriptive (qualitative) and measurable (quantitative) information to identify priority problems in their communities, CPNs identify and discuss underlying risk factors and local conditions that are driving substance use problems in their specific communities, as well as related protective factors that may mitigate the risks.

SUD Prevention Social Marketing efforts prioritize behavior change while also increasing awareness or knowledge. It aims to motivate individuals to take specific actions that benefit themselves and the environment

Other Activities conducted under this prevention strategy include the following:
• Promoting the establishment or review of alcohol, tobacco and drug use policies in schools;
• Technical assistance to communities to minimize availability and distribution of alcohol, tobacco and other drug use;
• Modifying alcohol and tobacco advertising practices; and
• Youth participation in photography-based projects highlighting community strengths and local conditions that effect underage drinking, youth marijuana abuse and opioid use.

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) Yes (if so, please describe)

The DC Department of Behavioral Health (DBH) allocates the budget per the terms and conditions of the SABG award (e.g., the set-aside requirement for Primary Prevention). In addition, the Primary Prevention set-aside requirement of SABG funds support a four (4) DC Prevention Centers at approximately $250,000 each ($1,000,000 total) who serve as prevention hubs within the community and provides coverage for the District's eight (8) wards. Lastly, the Primary Prevention set-aside goes towards supporting five (5) DBH Prevention Services staff.

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in WebBGAS

N/A

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☑ Establishes methods for monitoring progress towards outcomes, such as prioritized benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☑ Includes National Outcome Measurement (NOMs) requirements
- **d)** ☑ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☑ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☑ Other (please describe):

DBH monitors subgrantees directly to provide oversight of all program implementation for activities under the six core strategies. Subgrantee reporting has been structured to document progress using Strategic Prevention Framework as a guide for narrative sections (Assessment, Capacity Building, Planning, Implementation, and Evaluation).

Sub-grantee programmatic and fiscal reporting follow the structure presented below:
A. Reporting Frequency: Monthly basis on a form/format prescribed by DBH.
B. Annual Reporting: Summary data on service delivery, accomplishments and challenges.
C. Evaluation: A detailed evaluation plan which includes an annual site visit that will occur towards the mid-point of each award year.

DBH holds monthly Grant Monitoring and Program Improvement Meetings with sub-grantees. During these meetings, discussions on program progress related to the SUPTRS BG occur and DBH will provides technical assistance as needed. Sub-grantees must be able to internally track service delivery, numbers served (including demographic information),

number of programs/activities implemented, accomplishments and challenges.

g) ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

a) ☑ Numbers served

b) ☐ Implementation fidelity

c) ☑ Participant satisfaction

d) ☑ Number of evidence based programs/practices/policies implemented

e) ☑ Attendance

f) ☑ Demographic information

g) ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

a) ☑ 30-day use of alcohol, tobacco, prescription drugs, etc

b) ☑ Heavy alcohol use

c) ☐ Binge alcohol use

d) ☑ Perception of harm

e) ☑ Disapproval of use

f) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

g) ☑ Other (please describe):

Community Conversations identify the local conditions contributing to substance use in particular communities and neighborhoods, along with the community readiness and resources needed to address substance use issues. Community Conversations act as one piece of DBH's early warning system; providing information on new or emerging drugs, substance use patterns, and factors that influence substance use.

The DC Community Prevention Surveys (2017 – 2019) were epidemiological surveys focused on alcohol, tobacco, marijuana, and other illicit drug use; consequences; and related risk and protective factors in the District of Columbia. It offered a picture of the extent and impact of substance use in the District, along with information on potential risk and protective factors to target at the District and Ward levels. The report informed District-wide and ward-level needs assessment processes. While we haven't completed this survey since 2019, we are in the planning stages of implementing this survey again in the future.

The Youth Risk Behavior Survey (YRBS) is a survey of health-risk behaviors conducted in middle and high schools every two years in Washington, DC and around the United States. The YRBS covers topic areas including alcohol, tobacco, and other drug use.

Footnotes:

Environmental Factors and Plan

6. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Department of Behavioral Health provides prevention, intervention and treatment services and supports for children, youth, and adults with mental and/or substance use disorders including emergency psychiatric care and community-based outpatient and residential services.

DBH serves eligible adults, children and youth and their families through a network of community based providers and unique government delivered services. It operates Saint Elizabeths Hospital—the District's inpatient psychiatric facility.

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.

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 Help Line serves as an access point for individuals to get connected to services provided by the Department of Behavioral Health and its certified behavioral health care providers. DBH provides same day urgent care with services including assessments, counseling, medication management, and psychiatric evaluations. DBH also develops, implements, and 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 deliver a range of treatment services including crisis services, residential, outpatient treatment, counseling, and community supports.

The Consumer and Family Affairs Division 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 Division also promotes consumer and client leadership, manages the peer certification training, and provides expertise on the consumer and client perspective. This Division is made up of the following teams: Peer Support, Consumer Engagement, Consumer Rights, Quality Improvement, and Saint Elizabeths Hospital. It also contracts with a Peer Operated Drop-In Center and launched the D.C. Certified Peer Academy.

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, adults.

DBH partners include: 1) D.C. Public Schools, 2) D.C. Public Charter Schools, 3) Office of the State Superintendent of Education, 4) Child and Family Services Agency, 5) Department of Youth Rehabilitation Services, 6) Department on Disability Services, 7) Department on Human Services, 8) D.C. Office on Aging, 9) Department of Health, 10) Department of Health Care Finance, 11) Office of Disability Rights, 12) Rehabilitation Services Administration, 13) D.C. Housing, 14) Department of Housing and Community Development, 15) Department of General Services, 16)D.C. Metropolitan Police Department, 17) Department of Corrections, 18) Superior Court of the District of Columbia, and 19) D.C. Superior Court Juvenile Division.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	● Yes	○ No
b)	Mental Health	● Yes	○ No
c)	Rehabilitation services	● Yes	○ No
d)	Employment services	● Yes	○ No
e)	Housing services	● Yes	○ No
f)	Educational services	● Yes	○ No
g)	Substance use prevention and SUD treatment services	● Yes	○ No
h)	Medical and dental services	● Yes	○ No
i)	Recovery Support services	● Yes	○ No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	● Yes	○ No
k)	Services for persons with co-occuring M/SUDs	● Yes	○ No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Evidence-Based Practices (EBPs) are described in #1 of this section.

3. Describe your state's case management services

Chapter 34 of the DC Code prescribes mental health rehabilitation services (MHRS) standards. Case management is not one of the nine (9) listed services, but the District offers Community Support in lieu of case management as well as Recovery Support Services, which has a case management component. Community Support services are rehabilitation and environmental supports, which are essential to assist the consumer in achieving rehabilitation and recovery goals that focus on building and maintaining a therapeutic relationship with the consumer. These services include but not limited to: 1) participation in the development and implementation of a consumer's Plan of Care; 2) assistance and support for the consumer in stressor situations; 3) mental health education, support, and consultation to consumers' families and support systems directed exclusively to the well-being and benefit of the consumer. Qualified practitioners include psychiatrists, psychologists, licensed social workers, advanced practice nurses, registered nurses, licensed practical nurses, licensed professional counselors, social workers with supervision designation, and addiction counselors.

Recovery Support Services (RSS) are strength-based supports for those with addictions and those in recovery from SUD. These services are provided to assist clients with implementation of their recovery plan through direct contact interventions provided to an individual or a group of individuals. RSS are determined by a Recovery Support Evaluation, that is a part of the overall treatment plan of care. Each recovery program must have a recovery program manager who is responsible for overseeing services within the recovery program.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Saint Elizabeths Hospital (SEH), the District of Columbia's inpatient psychiatric facility, is operated by the Department of Behavioral Health. The Hospital's goal is to maintain an active treatment program that supports the individuals in their mental health recovery. SEH provides inpatient psychiatric, medical, and psycho-social person-centered treatment to adults to support their recovery and return to the community.

SEH Social Workers and Clinical Administrators focus on building and strengthening linkages with community-based treatment and support services during hospitalization and leading to discharge. Social Workers coordinate with Community Support providers and ACT teams as well as legal guardians, family, and other natural supports to maintain key relationships to support reintegration into the community at the time of discharge. Community Support/ACT workers, other formal supports, guardians and natural supports are invited to Individual Recovery Plan (IRP) meetings and are kept abreast of treatment progress and involved in discharge planning throughout hospitalization. The inpatient treatment team works with formal and natural supports to tailor plans for return to the community to individual consumers' needs and support their maintenance in the community rather than return to the hospital. SEH Social Work staff formally coordinate with DBH clinical and housing leadership when discharge is approaching to assess and implement the most important supports for an individual and assess any barriers to accessing the resources necessary for stability in the community.

The DBH Division of Integrated Care is dedicated to managing the involuntary hospital admission process. To date, the Integrated Care Division manages approximately 2,700 involuntary hospital admissions a year. Two Independently licensed social workers process the FD-12s presented for involuntary admissions notifying the Core Service Agency (CSA) or the Assertive Community

Treatment (ACT) provider of the admission and requesting a continuity of care visit to the consumer and the hospital treatment team within 48 hours of the admission. These social workers monitor the admission progression with utilization reviews twice a week making calls to the CSA/ACT team if their participation is lacking.

In July of FY24, a nurse care manager was added to the team who contacts the CSA/ACT to confirm that the consumer has been seen within seven days and again within 30 days of discharge. DBH's Continuity of Care Guidelines for Adult (policy number 200.2B TL-178) and for Children and Youth (policy number 200.5A TL-160) outline the expectations of DBH certified providers to ensure consumers are seen both during hospital admissions and post discharge. Known violations are reported to the Data Quality and Compliance Administration for investigation and consequence.

The full range of MHRS services are available to adults enrolled with a CSA, and consumers identified as needing a higher level of support can be referred to receive Rehabilitation Day or Assertive Community Treatment (ACT) specifically to help prevent readmissions and improve overall mental health.

DBH was awarded a $1 million grant from SAMHSA in December 2024 to develop the infrastructure to support Certified Community Behavioral Health Clinics in the District of Columbia. This promising service delivery and payment model has shown to help reduce recurrent hospital admissions.

5. Please indicate areas of technical assistance needs related to this section.

No technical assistance needed at this time

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

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	38,992	37,659
2.Children with SED	7,492	4,801

2. Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

The Department of Behavioral Health (DBH) does not generate data on prevalence and incidence. DBH reports information provided by SAMHSA from the Center for Behavioral Health Statistics and Quality (CBHSQ). SAMSHA fills-in the prevalence data on the relevant Uniform Reporting System (URS) tables. Incidence data comes from paid Medicaid and local mental health claims.

For planning purposes, DBH has used prevalence and incidence data to make adjustments to service capacity. As incidence for the public system approached citywide prevalence numbers, DBH implemented a moratorium on new providers and an authorization process to target waste, fraud, and abuse. DBH continues to monitor the impact of current protocols and procedures. Lastly, DBH continues to implement collaborative efforts to engage consumers, community, and system of care stakeholders throughout this process.

The most recent data that the Department of Behavioral Health (DBH) has is 2023 data provided by Hendall for adults with SMI and children/youth with SED.

Number of Adults with Serious Mental Illness (SMI), age 18 and older, by State, 2023

Civilian Population Adults Age 18+ 549,187

Civilian Population Age 18+ with SMI (5.4%) 29,656

Lower Limit of Estimate (3.7%) 20,320

Upper Limit of Estimate (7.1%) 38,992

3. Please indicate areas of technical assistance needs related to this section.

Not noted at this time.

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

a)	Social Services	(●) Yes	( ) No
b)	Educational services, including services provided under IDEA	(●) Yes	( ) No
c)	Juvenile justice services	(●) Yes	( ) No
d)	Substance use prevention and SUD treatment services	(●) Yes	( ) No
e)	Health and mental health services	(●) Yes	( ) No
f)	Establishes defined geographic area for the provision of services of such systems	(●) Yes	( ) No

2. Please indicate areas of technical assistance needs related to this section.

Technical assistance is needed to strengthen the system of care for youth SUD services (Youth Outpatient, Residential, and SUD Withdrawal Management for adolescents)

In addition, Technical Assistance is needed around the implementation partial hospitalization, intensive outpatient, day treatment, therapeutic respite, crisis beds, and a District of Columbia- specific Psychiatric Residential Treatment Facility (PRTF) within the District's children's behavioral health system.

[1] *A system of care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults
Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

The District of Columbia has no rural jurisdictions. The District of Columbia is an urban setting with a population of 689,545 residents living within 68.34 square miles between the states of Virginia and Maryland. The District does not have any rural populations.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

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 who 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.

Strategic Plan: The ICH Homeward DC 2.0 Strategic Plan (2021-2025) envisions ending long-term homelessness in the District by through a Strategic Plan built on three (3) major goals: 1) ending homelessness among veterans; 2) ending chronic homelessness among individuals and families; and 3) any household experiencing housing loss will be rehoused within an average of 60 days or less.

The Plan identifies a series of action items across five (5) key strategies that include: 1) develop a more effective crisis response system; 2) increase the supply of affordable and supportive housing; 3) remove barriers to affordable and supportive housing; 4) increase the economic security of households in the system; and 5) increase prevention efforts to stabilize households before housing loss occurs.

This plan builds on the work of Homeward DC with the vision that homelessness in the District of Columbia will be rare, brief, and nonrecurring, and that we will eliminate racial inequities in the homeless services system and create systemic fair treatment for all people.

FY 2025 Winter Plan: The Homeless Services Reform Act (HSRA) of 2005 mandates that by September 1 of each year, a plan be in place describing how those who are homeless will be protected from cold weather injury. 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.

This plan builds on past efforts, incorporates new strategies and responds to lessons learned from previous winters. The Plan addresses: 1) how the District will manage communications among stakeholders; 2) process for calling a hypothermia alert and the considerations involved; 3) process used to develop estimates for shelter capacity needs during the FY 2017 winter as well as the plan for delivering the number of beds/units needed; 4) transportation services that will be provided to ensure that clients have access to shelter and services; 5) services provided to help clients access shelter and while in shelter; 6) protocol and available resources for serving unaccompanied minors and transition aged youth (TAY); and 7) resources in place to monitor shelter operations as well as protocol for raising concerns and/or filing complaints.

District of Columbia 2025 Point-in-Time Count of People Experiencing Homelessness

The Community Partnership for the Prevention of Homelessness (TCP) has conducted the Point-in-Time (PIT) count, a requirement for all jurisdictions receiving federal homeless assistance funding, on behalf of the District since 2001. On January 29, 2025 TCP conducted the annual PIT count. It provides a snapshot of the number and demographic characteristics of adults and children who were experiencing homelessness in the District on that day. This single day enumeration of the homeless services CoC gives TCP and District government partners an opportunity to identify gaps in the current portfolio of services and informs future program planning with special consideration to Homeward DC, the local strategic plan to end homelessness.

In 2025 PIT showed an overall 9% decrease in homelessness from 2024 including an 18.1% decrease among families and a 4.5% decrease among unaccompanied individuals. Since last year's PIT count, the District has worked hard to deepen investment and focus on programs that work while launching new, innovative initiatives that continue to meet the needs of neighbors experiencing homelessness. These efforts have been key drivers of this year's positive trend, and they include:?? ? ?

Project Reconnect:?The District deploys staff to shelters, day centers, and with outreach teams to assist individuals newly

experiencing homelessness or who are currently facing housing crises by providing housing counseling and flexible funding to either divert individuals from the homeless services system or facilitate a rapid exit to stable housing. In FY 2024, Project Reconnect successfully diverted nearly 400 individuals from entering homelessness. ?

Front Door Navigation?Tool: DHS launched a new data-powered tool in coordination with the Homeless Services Hotline to increase opportunities for connection to diversion assistance and resources in a timelier fashion. Since its launch, Front Door Navigation has connected more than 150 referrals to Project Reconnect.?

Transforming Our Shelter System: The District continued its work to improve and expand its shelter system, including the opening of The Aston non-congregate bridge housing program to provide 100 new shelter beds for unsheltered, adult-only families (without minors) and those who cannot be served effectively in low barrier shelters. The District will open a second non-congregate bridge housing program in 2025.?

Targeting Youth Homelessness:?The District has been a national leader in building a comprehensive system to address and prevent youth homelessness. Through programs focused on homelessness prevention, intervention, and transitional and permanent housing, the District provided vital, targeted services to hundreds of Transition Age Youth (ages 18 to 24) over the last year – including the addition of daily transportation services through the District's shelter hotline and increasing the geographic footprint of youth-focused street outreach services.?

Permanent Housing: The District supported more than 900 individuals and families to lease up with permanent housing vouchers in FY 2024 and leveraged Medicaid funding to provide supportive services to nearly 9,000 households. So far, in FY 2025, over 550 individuals and families have leased up with permanent housing vouchers.?

Peer Case Management Institute?(Winner of the Cafritz Team Award): DHS graduated its first cohort from the Peer Case Management Institute, a partnership with Howard University that trains District residents with lived experience of homelessness to become qualified case managers in the Homeless Services System. More than half of the first cohort has been employed as case managers in the Homeless Services System; the second cohort is set to graduate in June 2025.?

The District's results were among the strongest in the region. Four of the eight continuums of care that participate in the Metropolitan Washington Council of Governments (COG) saw an increase in their numbers this year, with four others (including the District) seeing varying degrees of decrease. While this points to the positive impact of the District's targeted investments in strategic and innovative services, it also underscores the growing need of residents in the local region and the importance of regional collaboration.?

Overview of District Services: The District's CoC provides persons experiencing 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.

Families facing housing crises in the District can visit the Department of Human Services (DHS) Virginia Williams Family Resource Center and receive homelessness prevention services, emergency rental or utility assistance, housing services, or other community resources such as Temporary Assistance for Needy Families (TANF), childcare assistance, access to the food stamp program, or Medicaid.

Unaccompanied individuals in need of homeless services may access the District's low barrier, severe weather, or temporary emergency shelters for overnight accommodation and meals. To access the CoC supportive housing resources, unaccompanied persons may visit one of numerous sites throughout the District associated with the Coordinated Assessment and Housing Placement (CAHP) system (including the District's low barrier, severe weather, and temporary shelters). Through CAHP, individuals experiencing homelessness are matched to the appropriate assistance that meets their immediate and long-term housing and service needs. Unaccompanied veterans or youth experiencing homelessness can receive population specific resources through CAHP as well.

The District continues progress towards the goals outlined in Solid Foundations DC, the CoC's strategic plan to prevent and end youth homelessness and has made significant investments over the past year to serve the unique needs of youth experiencing homelessness. Efforts include further refining the CAHP system for young people and expanding shelter, transitional housing, and permanent housing options available to youth experiencing, or at risk of experiencing, homelessness. The District's Youth Action Board, which was created in 2018 to ensure youth who have experienced homelessness have a role in planning services for this population, has served in a leadership role on several efforts over the past year.

Finally, DBH partners with sister agency Department of Humans Services to provide engagement and outreach services to people experiencing homelessness that have the expertise to work with people who experience serious and persistent mental illness and co-occurring substance use disorders. These teams act "in lieu of" a behavioral health provider until such time as the person chooses a provider.

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

Older Adults with SMI enrolled in the public mental health system includes 4043 adults aged 55-64 and 9470 adults aged 65 and above. Of the 13,513 enrolled older adults, 172 had a PASSR level II determination completed in FY21 for placement in a skilled nursing facility. The majority of older adults receiving services in the Districts public mental health system live in the community. Significant resources and supports are identified to support the care needs for this population as many consumers have complex medical needs as well as a SMI diagnosis.

The Department of Behavioral Health has an authority level registered nurse who supports the management of the PASRR requests, and who provides technical support and care coordination guidance to providers, DBH partners including the Department of Health Care Finance (DHCF), the Office on Aging, Freeman's Health, and the Long-Term Care Ombudsman. These cross-agency teams coordinate Home and Community Based Services, Mental Health Rehabilitation Services/Adult Substance Abuse Rehabilitation services needs, and supports treatment teams to determine and then secure the appropriate levels of care to include identifying and securing housing supports.

DBH offers a range of targeted services to support the behavioral health needs and well-being of older adults across various settings. These services include:

Discharge and Transition Support: DBH facilitates discharge planning and transitional care for older adults moving from hospitals to nursing facilities and other appropriate levels of care within the community.

Pre-Admission Screening and Resident Review (PASRR): DBH collaborates with the Medicaid authority which oversees the contracted vendor responsible for conducting PASRR evaluations. The vendor is responsible for conducting PASRR evaluations to assess the appropriateness of nursing facility placement and provide behavioral health services recommendations.

Substance Use Disorder Education and Training: DBH provides substance use disorder prevention education and training to older adults residing in senior apartment communities, nursing facilities and community residential facilities.

Naloxone Training: DBH offers education and training on the use of Naloxone for opioid overdose reversal, specifically tailored for older adults and their caregivers.

Behavioral Health Workshops: DBH facilitates trainings that address key mental health topics affecting older adults, including depression, opioid overdose awareness, grief support, social isolation, and other behavioral health conditions.

d. Please indicate areas of technical assistance needs related to this section.

There is no requested technical assistance at this time.

[1] **https://www.samhsa.gov/homelessness-programs-resources**

[2] **https://www.samhsa.gov/resources-serving-older-adults**

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

1. Describe your state's management systems.

Previously, DBH intended to implement a Telehealth pilot to distribute smart phones and devices to 300 highly vulnerable and clinically at-risk consumers in order to enhance their access to care and connectivity to their providers. We could not execute this initiative due to legal constraints related to Federal anti-kick back laws (relative to providers), as well as budget constraints. Consequently, DBH increased our community engagement / care coordination staff to better support these consumers in following up with their treatment plan and to help them navigate the care delivery system based on their individual clinical needs.

Additionally, in the Child and Youth System of Care, most services to youth with SED are provided in person. However, when barriers occur, many services can also be offered through telehealth, which helps to expand access to care. Due to a shortage of licensed behavioral health providers, DBH has faced challenges in placing a clinician in each of the 254 DC public and public charter schools. To address this and to increase assess to behavioral health services, DBH is exploring the use of telehealth behavioral health services in high schools and schools with adult learners.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic 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. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access the federal resource guide **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.**

2. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

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 launch last year, was delayed as we explored and resolved legal concerns to ensure compliance with Federal anti-kick back 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.

3. Please indicate areas of technical assistance needs related to this section.

No TA is being requested at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

7. Substance Use Disorder Treatment – Required for SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services (with medications for addiction treatment included in v-x):

i)	Screening	(●) Yes ( ) No
ii)	Education	(●) Yes ( ) No
iii)	Brief intervention	(●) Yes ( ) No
iv)	Assessment	(●) Yes ( ) No
v)	Withdrawal Management (inpatient/residential)	(●) Yes ( ) No
vi)	Outpatient	(●) Yes ( ) No
vii)	Intensive outpatient	(●) Yes ( ) No
viii)	Inpatient/residential	(●) Yes ( ) No
ix)	Aftercare/Continuing Care	(●) Yes ( ) No
x)	Recovery support	(●) Yes ( ) No

b) Services for special populations:

i)	Prioritized services for veterans?	(●) Yes ( ) No
ii)	Adolescents?	(●) Yes ( ) No
iii)	Older Adults?	(●) Yes ( ) No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Does your state have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling? (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots? (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare? (●) Yes ( ) No

d) Inclusion of recovery support services? (●) Yes ( ) No

e) Health navigators to assist clients with community linkages? (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance? ( ) Yes (●) No

h) Providing transportation to and from services? (●) Yes ( ) No

i) Educational assistance? (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The District of Columbia Department of Behavioral Health (DBH) employs a comprehensive, multi-tiered strategy to monitor program compliance related to services and activities for Pregnant and Parenting Women with Dependent Children (PWWDC). These strategies are rooted in federal and local regulatory requirements and are designed to ensure the provision of accessible, evidence-based, and gender-responsive behavioral health services.

DBH's Program's Department conducts regular oversight through both scheduled and unannounced site visits and performance data analysis. These monitoring activities include the review of clinical records, verification of service delivery against contractual obligations, and compliance with service standards specific to the needs of the PWWDC population. Additionally, DBH monitors the use of funds and program outcomes through monthly expenditure reports and quarterly performance reports submitted by providers.

Compliance issues are identified through audits, provider self-reports, consumer complaints, and ongoing data review in the Department's electronic health records and claims systems. Indicators such as service timeliness, retention in care, and access to care are reviewed to ensure alignment with federal block grant requirements and best practices in maternal and child behavioral health.

When deficiencies are identified, DBH implements a structured corrective action process. This includes issuing a formal Notice of Findings to the provider, followed by a required Corrective Action Plan (CAP) that outlines measurable steps and timelines for resolution. DBH staff provide technical assistance to support providers in meeting compliance requirements, and follow-up monitoring ensures sustained improvement. Continued non-compliance may result in financial sanctions, suspension of referrals, or contract termination, in accordance with DBH policy.

Furthermore, DBH collaborates with stakeholders, including community-based organizations and the Department of Health Care Finance, to align service delivery with Medicaid standards and promote integrated care. These partnerships help identify system-level gaps and guide corrective system-wide strategies that enhance outcomes for pregnant and parenting women and their children.

Through ongoing monitoring, corrective action, and system-level quality improvement, DBH ensures the effective delivery of behavioral health services to the PWWDC population in the District of Columbia

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

- **a)** 90 percent capacity reporting requirement? ◉ Yes ○ No
- **b)** 14-120 day performance requirement with provision of interim services? ◉ Yes ○ No
- **c)** Outreach activities? ◉ Yes ○ No
- **d)** Monitoring requirements as outlined in the authorizing **statute** and implementing **regulation**? ◉ Yes ○ No

2. Has your state identified a need for any of the following:

- **a)** Electronic system with alert when 90 percent capacity is reached? ○ Yes ◉ No
- **b)** Automatic reminder system associated with 14-120 day performance requirement? ○ Yes ◉ No
- **c)** Use of peer recovery supports to maintain contact and support? ◉ Yes ○ No
- **d)** Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? ◉ Yes ○ No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The DBH Accountability Administration oversees provider certification, incident management, major investigations, claims audits, and compliance monitoring and corrective actions. They investigate major unusual incidents reported by providers, staff or community stakeholders. Under this administration, the Office of Certification monitors compliance with agency regulations and issues corrective actions as appropriate.

The DBH Substance Use Program Division provides clinical and programmatic oversight and technical assistance to providers based on identified areas of need focusing on program development and infrastructure as well as upon provider request. Program staff conduct yearly pre-scheduled site visits as well as quarterly virtual check-ins that help to identify areas of need, programmatic changes and assess overall program stability.

DBH Provider Relations Division works with providers to provide technical assistance and support around billing and fiscal needs, training, and performance feedback to the system of care. The District's CQI process monitors data for key performance indicators that measure clinical quality or client outcomes and provide analysis on system performance and individual provider performance. The CQI staff facilitate planning programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families, and then project manage the implementation of those plans and their impact on performance. Policies and procedures include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? ◉ Yes ○ No

2. Has your state identified a need for any of the following:

- **a)** Business agreement/MOU with primary healthcare providers? ○ Yes ◉ No
- **b)** Cooperative agreement/MOU with public health entity for testing and treatment? ◉ Yes ○ No
- **c)** Established co-located SUD professionals within FQHCs? ○ Yes ◉ No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

DBH continues to work with DC Health to support SUD providers with screening and testing for tuberculosis and linking individuals to care if testing is positive. DBH and DC Department of Healthcare Finance also provide technical assistance to new and existing SUD around for billing Medicaid for screening and testing. The Certification Division within DBH's Office of Accountability is responsible for evaluating certified providers, and those pursuing certification, at prescribed intervals to ensure provider internal policies and practices align with DBH regulations, policies, and practices. The Certification Division issues corrective action plans and notices of infractions (where applicable), when certified providers are found to be non-compliant with expectations. DBH also maintains a 24-hour compliance line which clients, staff, etc. can report instance of potential regulatory or policy violations.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery?

(●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas?

( ) Yes (●) No

b) Establishment or expansion of tele-health and social media support services?

( ) Yes (●) No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS?

(●) Yes ( ) No

Hypodermic Needle Prohibition

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances **(42 U.S.C.§ 300x-31(a)(1)(F))**?

( ) Yes (●) No

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Workforce development efforts to expand service access? (●) Yes ( ) No

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services? (●) Yes ( ) No

c) Establish a peer recovery support network to assist in filling the gaps? (●) Yes ( ) No

d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, persons experiencing homelessness)? (●) Yes ( ) No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered care? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services (●) Yes ( ) No

b) Establish a program to provide trauma-informed care (●) Yes ( ) No

c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education. (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (**42 U.S.C.§ 300x-65**, 42 CF Part 54 (**§54.8(b) and §54.8(c)(4)**) and **68 FR 56430-56449**)? (●) Yes ( ) No

2. Does your state provide any of the following:

a) Notice to Program Beneficiaries? (●) Yes ( ) No

b) An organized referral system to identify alternative providers? (●) Yes ( ) No

c) A system to maintain a list of referrals made by religious organizations? (●) Yes ( ) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Review and update of screening and assessment instruments? (●) Yes ( ) No

b) Review of current levels of care to determine changes or additions? (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities? (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements? ◉ Yes ○ No

b) Training on responding to requests asking for acknowledgement of the presence of clients? ◉ Yes ○ No

c) Updating written procedures which regulate and control access to records? ◉ Yes ○ No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure? ◉ Yes ○ No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? ◉ Yes ○ No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (**42 U.S.C.§300x-52(a)**) and **45 §CFR 96.136** require states to conduct independent peer review of not fewer than 5 percent of the Block Grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of Block Grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

DBH provides SABG funding to 15 providers annually.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan? ◉ Yes ○ No

b) Establishment of policies and procedures related to independent peer review? ◉ Yes ○ No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations? ◉ Yes ○ No

4. Does your state require a Block Grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for Block Grant funds? ◉ Yes ○ No

If Yes, please identify the accreditation organization(s)

i) ☑ Commission on the Accreditation of Rehabilitation Facilities

ii) ☑ The Joint Commission

iii) ☑ Other (please specify)

Council on Accreditation (COA)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ● No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service? ○ Yes ● No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing? ○ Yes ● No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state? ● Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services? ● Yes ○ No

c) Performance-based accountability? ○ Yes ● No

d) Data collection and reporting requirements? ● Yes ○ No

If the answer is No to any of the above, please explain the reason.

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs? ● Yes ○ No

b) Addition of training sessions designed to increase employee understanding of recovery support services? ● Yes ○ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services? ● Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort? ● Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers[1] (TTCs)?

a) Prevention TTC? ● Yes ○ No

b) SMI Adviser ○ Yes ● No

c) Addiction TTC? ● Yes ○ No

d) State Opioid Response Network? ● Yes ○ No

e) Strategic Prevention Technical Assistance Center (SPTAC) ○ Yes ● No

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C.§ 300x-22(b)**,**300x-23**,**300x-24**, and **300x-28** (**42 U.S.C.§ 300x-32(e)**).*

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women (300x-22(b)) ○ Yes ● No

2. Is your state considering requesting a waiver of any requirements related to:

a) Intravenous substance use (300x-23) ○ Yes ◉ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (**42 U.S.C. § 300x-28**)

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

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[1] **https://www.samhsa.gov/technology-transfer-centers-ttc-program**

Footnotes:

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use 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. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

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

We report client-level data currently for MH-TEDS from our electronic health records. Each of DBH's contracted providers has an EHR that provides us monthly Behavioral Health Supplemental Data on admissions and discharges.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is 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.).

We report client-level data for MH-TEDS as part of the larger system that collects data from both mental health and substance-abuse consumers/clients. The data warehouse also contains information from other government agencies, including the

Department of Corrections, Child and Family Services, the Office of the Chief Medical Examiner, and Fire and Emergency Medical Services.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

DBH receives behavioral health community-based services claims and hospital admission and discharge data from the State Medicaid Authority. We do not receive data from juvenile justice, public health, hospitals, employment, or the school system.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

DBH is able to report evidence-based services that are paid via fee-for-service claims (e.g. ACT, CBI, supported employment). The ESMI program is paid via contract, so DBH receives aggregate data from the provider. Mobile crisis and psychiatric emergency crisis services can be reported at the client level, but many crisis calls do not include the name of the caller in their documentation, so outcomes cannot be measured.

5. Briefly describe the limitations of the SMHA 's existing data system.

DC continues to work to improve data quality using the new portal for MH-TEDS data submissions. Providers have submitted incorrect treatment settings, and there has been a high level of use of “not collected” for a number of data elements, which we are working to reduce. Some providers are incorrectly using this code instead of unknown. Providers are also reporting high numbers of unknown values.

6. What strategies are being employed by the SMHA to enhance data quality?

DBH has created a dashboard that mirrors the TEDS feedback reports we receive, and the data can be broken down by provider, allowing us to give targeted feedback to the providers with the highest proportion of unknown/not collected responses. We can track their monthly data submissions to see if they are improving.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

No barriers.

8. Please indicate areas of technical assistance needs related to this section.

DC made a significant change in our TEDS data collection in FY24, from a shared system where all providers directly entered their data, to a portal in which they submit data from their own (new) electronic health records. Compliance with submission is not yet at 100%, and we are working with providers that are submitting to reduce the number of not reported and unknown values.

We have created a data quality dashboard that mirrors the reports we receive from Hendall, but at the provider level so we can follow up with those submitting the least complete data. We are working with the Hendall staff to improve data quality and update our records.

Continued data quality improvement is a high priority, and we hope to make steady progress over this year.

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Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system has 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.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

District of Columbia Department of Behavioral Health (DBH) is working to expand, strengthen, and integrate the District's behavioral health crisis services with the goal of realigning the crisis system to a health-first, community-based, and clinically appropriate system of care – in line with SAMHSA's National Guidelines for Behavioral Health Crisis Care, as well as statutory requirements associated with implementation of the 988 Suicide and Crisis Lifeline (NSDL) established in the National Suicide Hotline Designation Act (P.L. 116-172).

Prompted by the launch of 988 last July, the District has been purposefully making changes to modernize and realign the crisis system to provide

the most effective, health-first and clinically appropriate response to persons in behavioral health crisis while limiting law enforcement involvement and ensuring equitable access and care.

Vision, Guiding Principles, and Governance

The District's approach to crisis system redesign and ongoing system development is guided by the following principles:

* Prevent crises before they occur, through early intervention and system coordination
* Respond rapidly and appropriately, with clinical, peer and mobile services
* Recover from crisis and reduce recidivism, through seamless follow-up care
* Optimize care, using real-time data and analytics, technology, and person-centered, person-directed care

Leading these efforts, DBH has created new leadership roles in crisis services, including a new Chief of Crisis Services and Deputy Chief, and moved program areas that were previously spread across multiple divisions into one centralized organizational structure for greater cohesion and accountability.

988 Implementation: Access HelpLine and 911 Diversion
DBH is the designated 988 Suicide & Crisis Lifeline affiliate for District residents. The Access HelpLine (AHL) is the single point of entry to DBH's behavioral health services and operates 24/7, providing triage, crisis intervention, and care coordination.

AHL staff are now co-located in 911 at the Office of Unified Communications (OUC) to support the District's 911 Behavioral Health Call Diversion Program and provide on-the-spot consultation and education to 911 staff, in order to increase diversion of appropriate calls to behavioral health responders and decrease police response to non-violent behavioral health calls.

Thanks to federal funding and local investments, DBH has added 41 positions to support the expansion of AHL and the Community Response Team (CRT). We are also upgrading our technology to implement elements of the "air traffic control" model (used by many cities nationwide) that is recommended in SAMHSA's Crisis Now framework. This work will include real-time tracking of field teams, bi-directional referral tools, and data dashboards to monitor system performance and outcomes.

Mobile Crisis Services: Community Response Team (CRT)

DBH's primary mobile behavioral health response unit is the Community Response Team (CRT). The CRT is a 24/7 response team available to respond to crises in homes and the community, including public spaces. Staffed by clinicians and peer specialists, the CRT coordinates with the MPD, FEMS, and OUC to provide an appropriate response, and to reduce unnecessary emergency room visits or law enforcement involvement.

The CRT has integrated the after-hours responsibilities for DBH's Children and Adolescent Mobile Psychiatric Services (ChAMPS) program, ensuring that there is crisis response coverage for youth all hours of the day.

Crisis Receiving: Comprehensive Psychiatric Emergency Program (CPEP)
The Comprehensive Psychiatric Emergency Program (CPEP) is the District's single 24/7 site for receiving persons in behavioral health crisis, with staffed beds and on-site psychiatric care available 365 days per year for persons age 18 and older.

The goal of CPEP is to provide crisis assessment, stabilization, and short-term observation (up to 72 hours), with warm handoffs to inpatient or outpatient services when needed. CPEP staff provide crisis stabilization for individuals with high rates of co-occurring substance use disorders (~50% of CPEP admissions) and can initiate Suboxone treatment and dispense Narcan. CPEP is planning to expand onsite somatic care and telehealth capacity for provider consultation and plans to develop a set of designated Extended Observation Beds (EOB) for specialized stabilization needs.

Children and Youth Crisis Services

The Children and Adolescent Mobile Psychiatric Services (ChAMPS) program provides mobile crisis intervention and stabilization services to youth ages 6–21 with the goal of diverting youth from unnecessary inpatient care or foster placement disruption. The ChAMPS program, operated by Catholic Charities, provides service coverage Monday through Friday, with after-hours coverage and response integrated into CRT, as noted above.

DBH also provides crisis supports through the School Behavioral Health Program, which can provide training and in-school interventions, as well as post-crisis support to teachers, administrators, and students in local schools. The District also partners with the Juvenile Behavioral Diversion Court, which links court-involved youth to up to one year of behavioral health care.

Cross-System Collaboration and Technical Assistance
DC's progress in advancing the crisis system has been due to robust inter-agency collaboration, as well as federal TA:

Learning Site Visits: In 2022, staff from DBH, MPD, FEMS, and DHCF participated in site visits to Houston and Harris County, TX, visiting and

learning from other model crisis systems nationwide that were also SAMHSA Learning Sites. These included nationally recognized models of the co-responder model and the use of telehealth to augment crisis response.

SAMHSA Region 3 TA: DC also participated in a Crisis Response workshop featuring national subject matter experts, including the Crisis Now model from Arizona. This workshop featured presentations from CHS Tucson, the Crisis Now partner that is also featured in Case Study #1 in SAMHSA's National Guidelines.

Harvard Government Performance Lab (GPL): The District was selected by Harvard's GPL to participate in a year-long, intensive TA initiative focused on scaling up the 911 call diversion work. This collaboration has resulted in a reduced exclusion criteria and an expanded menu of divertible behavioral health call types.

Planned Use of Grant Funds
If awarded, we plan to use this funding to support the following efforts and priorities:

* Expanded 988 crisis call infrastructure, staffing, training, and technology infrastructure
* Expanded mobile crisis response capacity, particularly in the areas of after-hours coverage and youth
* Expanded crisis receiving and stabilization capacity, including facility planning and design for
* additional stabilization beds
* Telehealth consultation capacity across crisis programs
* Procurement of real-time tracking/referral platform for cross-program coordination and data sharing

Integrated Care Division

Integrated Care is a division with the Department of Behavioral Health responsible for providing continuity of care and complex care management. While this program has historically focused on care coordination through interventions with systems and DBH's provider network, moving forward in 2023, the division has begun to provide direct care through intensive care coordination. Though there is not a direct-line reporting relationship within Crisis Services, ICD is a key partner and has important roles to play in interrupting recurrent crises and modifying and strengthening the overall care plan for individuals following a crisis episode.

Community Response Team (CRT)

During the summer of 2019, three legacy programs were braided together to form the Community Response Team. Specifically, the Department of Behavioral Health employs a 24-7 multi-disciplinary approach that includes certified peers to deliver mobile crisis, pre-arrest diversion and homeless outreach supports adults who are vulnerable due to complex psychiatric and substance abuse challenges. Through CRT's ongoing engagement efforts, consumers receive assessments and are linked to ongoing services.

Together with the Office of Unified Communications, MPD, and DBH's Access HelpLine, CRT provides mobile response as needed for 911 calls diverted to DBH from OUC. Locally and throughout the nation, systems of care are working to develop alternative response models and to move toward a "health-first" approach rather than an automatic law enforcement approach to individual experiencing behavioral health crisis. The Metropolitan Police Department still has a significant role to play in ensuring the safety of the individual in crisis, affected community members, and the behavioral health responders for some calls where a risk of violence is present.

As noted elsewhere, CRT receives direct calls AND can be enlisted and dispatched via AHL regardless of whether the call originated through 988, 911 or the local helpline number. DBH is actively exploring a recommendation to integrate all crisis calls into a single call center in the future. CRT performs other functions including participating in scheduled events, providing emotional support to communities in distress following homicide deaths or other traumatic events, and those calls would continue to go directly to CRT. However, we envision a much more robust call center capable of managing all calls, working to resolve calls telephonically with the ability to link to needed resources in real time (e.g., scheduling next day prescriber appointments when needed) as well as deploying mobile crisis teams when needed. More work remains to integrate these existing components, including the nascent co-response initiative, and to explore expansion and privatization more fully.

Stabilization and Sobering Center

DBH, in close collaboration with FEMS, MPD, DC Health, and the Department of Health Care Finance, is preparing to open the District's first ever Stabilization and Sobering Center because of more than two years of planning, procurement, and implementation. Through a contract with an experienced national provider, the DCSSC will open in a government-owned building by Fall, 2023. While DBH leads this planning effort, a great deal of input has been incorporated from multiple government partners, including Fire and Emergency Management (FEMS), the Metropolitan Police Department (DBH), the Department of Health Care Finance (DHCF), and DC Health. While not yet operational the plan is to locate the Stabilization and Sobering Center at a government-controlled site where it will serve individuals 24 hours/7 days a week. While FEMS and MPD are expected to be the primary referral sources, individuals in need will also be able to walk in. The plan is for the center to have a capacity to serve sixteen individuals concurrently for up to 24 hours and to serve another four individuals for up to 72 hours.

Individuals seen at the Stabilization and Sobering Center will be active users and have a positive toxic screen for drugs, alcohol, or both. Staff will conduct medical screening and be able to serve as an internal Assessment & Referral Center by assessing the needs of the individual and linking them to ongoing services. The goal of the program is to regularly employ peers who have gone through DBH's State Opioid Response (SOR) funded peer education programs.

The site will have resources for laundry, meals, showers, and lockers, will offer clean clothes, and will check for weapons, preferably by security. A process will need to be implemented for individuals refusing admission who potentially possess weapons and will need to surrender them and/or not have them returned. Based on FEMS' experience it is expected that 85% of those seen will be Medicaid recipients, and up to 90% of the individuals seen will be served and discharged within 8 hours.

Future Crisis Receiving Centers:

A capital plan has been funded to renovate a century old firehouse to house a second sobering stabilization program. Because of strong community advocacy for more equitable geographic access for underserved communities, the concept for DCSSC #2 mimics that for the first site. However, through various SAMHSA TA opportunities and our participation in a range of learning collaborative as well as the Harvard GPL cohort, we have begun to socialize the notion of a comprehensive crisis receiving center. Rather than relying on individuals and first responders to determine whether someone's crisis is primarily psychiatric or the result of use or misuse of substances, a comprehensive receiving center would have the capability of assessing and managing the full range of individuals and presentations and NOT require others to pick between a CPEP or a sobering center. A comprehensive crisis receiving center will also allow us to reinvigorate the pre-arrest diversion function that was an essential part of CRT's formation and further leverage the strengths of the co-responder as it matures. DBH is actively scheduling additional visits and consultations with nationally recognized programs who have fully implemented best-practices—including Connections Health Solutions and RI International—to inform future solicitations and our FY25 budget formulation.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☑	☐
Safe place to be	☐	☐	☐	☐	☑	☐

3. Briefly explain your stages of implementation selections here.

As described in detail above, DBH directly operates the District's behavioral health crisis call center (AHL), mobile crisis (CRT), and the District's only psychiatric crisis receiving center (CPEP). The District also provides child and adolescent mobile crisis via a contract. We are seeking to expand and optimize but these are not new programs. First with ARPA funding and with local appropriations going forward, the District's budget has invested funding to expand mobile crisis (from 38 to 65 positions) and the call center (from 16 to 30 positions). The District has committed capital funding for two sobering and stabilization centers and awarded a contract for the first to begin operating before the end of FY23.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

In addition to the planned expansions identified above, DBH is actively working to strengthen activities in the 4th (information technology) and 5th (training/consultation) "lanes." We are evaluating options for procuring and implementing technologies and software to enable us to more fully achieve the vision of the "air traffic control" model with the capacity to geo-track mobile teams, schedule clinic appointments, and connect people in crisis to resources in real time to avoid unnecessary emergency department encounters and inpatient stays. We are also exploring enhanced pre-service and in-service training for all crisis services staff including certifications where available.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state

i. In the 988 Suicide and Crisis lifeline network: 1

ii. Not in the suicide lifeline network: 0

b. Number of Crisis Call Centers with follow up protocols in place

i. In the 988 Suicide and Crisis lifeline network: 1

ii. Not in the suicide lifeline network: 0

c. Estimated percent of 911 calls that are coded out as BH related: 0

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 1

b. Integrated with public safety first responder structures (police, paramedic, fire): 1

c. Number that utilizes peer recovery services as a core component of the model: 1

Safe place to be

a. Number of Emergency Departments: 6

b. Number of Emergency Departments that operate a specialized behavioral health component: 6

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 1

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

DBH plans to utilize the 5% crisis set aside to enhance the technology tools needed to enable us to fully achieve the vision of the "air traffic control" model with the capacity to geo-track mobile teams, schedule clinic appointments, and connect people in crisis to resources in real time to avoid unnecessary emergency department encounters and inpatient stays. Through recent consultation with SAMHSA and the Vibrant team, we have decided to engage a consulting group to optimize the telephone and to add functionality and data analytic capability. We recently experienced a drop in our in-state answer rate for 988 calls and need in-house expertise under our direct control to assist in diagnosing and remediating technical problems more quickly. While DBH has a Chief Information Officer, the telephone platform was dictated to us by the District's Office of the Chief Technology Officer and it is their vendor, not DBH's, that is responsible for the implementation and troubleshooting. Expertise related specifically to crisis call center is critical to achieving and sustaining our center performance at the highest level to meet the needs of District residents in crisis.

7. Please indicate areas of technical assistance needs related to this section.

As noted above, we are seeking to procure ongoing assistance with the technology and data sophistication required to stay on the forefront of behavioral health crisis response. We also anticipate needing technical assistance as we build out the 988 chat and text functions and work to better reach specific populations such as the LGBTQ population which may be reluctant to use mainstreams crisis services because of historically being poorly served.

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Footnotes:

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of 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 health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

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, there are 10 identified 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 **Working Definition of Recovery.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing, and monitoring the state behavioral health treatment system.

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Use Block Grant funds for recovery support services? ( ) Yes (●) No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Recovery and recovery support services for adults with SMI includes:

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.

Recovery and recovery support services for children with SED includes:

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. CBI services may be provided at the time a child or youth is identified for a service, particularly to meet an urgent or emergent need during their course of treatment.

There are three (3) levels of CBI services available to children and youth.

CBI Level I is delivered using the Multisystemic Therapy ("MST") treatment model adopted by the Department of Behavioral Health which is 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 has a long-term relationship and who is willing to participate in treatment.

CBI Level II is delivered using the Intensive Home and Community-Based Services ("IHCBS") model adopted by the Department of Behavioral Health which is an intensive, time-limited mental health service for youth up to age 21 with serious emotional disabilities and their families, provided in the home, school and community where the youth lives, with the goal of stabilizing mental health concerns, and safely maintaining the youth in the least restrictive, most normative environment.

CBI Level III is delivered using the Intensive Home and Community-Based Services ("IHCBS") model adopted by the Department of Behavioral Health which is an intensive, time-limited mental health service for youth up to age 21 with serious emotional disabilities and their families, provided in the home, school and community where the youth lives, with the goal of stabilizing mental health concerns, and safely maintaining the youth in the least restrictive, most normative environment. This is a short-term service that is offered for up to 90 days.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

Recovery Support Services (RSS) covers the provision of non-clinical services for individuals in treatment or in need of supportive services to maintain their recovery. DBH has incorporated recovery support services as a core required service for all certified treatment providers. Additionally, DBH certifies two stand-alone RSS providers that work with individuals in need of recovery support services outside of the treatment domain. Consumers seeking SUD Recovery must be assessed and admitted to SUD certified treatment or RSS provider.

RSS services are Medicaid billable and can include: 1. Recovery Support Evaluation; 2. Recovery Support Individual; 3. Recovery Support Group. Many of these supports can also be provided by certified peer specialists.

DBH's Peer Specialist Certification Training Program provides the core curriculum, training, and instruction required to obtain DBH's Peer Specialist Certification. The training builds upon the experience of the participant with training in foundational competencies consistent with the national standards outlined by The Substance Abuse and Mental Health Services Administration (SAMHSA). The Peer Specialist Training reinforces participants' knowledge of recovery based on their individual experiences with their behavioral health recovery process, which bring a unique consumer perspective to person centered care and enrich the practice of peer recovery support services in the District of Columbia.

RFA for RSS non-Medicaid billables services- alternative therapies- support people in recovery.

5. Does the state have any activities that it would like to highlight?

In FY22/FY23, as part of system redesign efforts and transition to managed care, Department of Healthcare Finance (DHCF), the

District's Medicaid Authority contracted with PCG to complete comprehensive rate studies including the review of 53 behavioral health services that included the establishment of new rates and enhanced rates that matched the intensity and scope of services. Based on the recommendations provided, DBH and DHCF established new rates, updated regulations, and implemented State Plan Amendment (SPA) changes.

Currently, DBH is looking to expand recovery support to include child, youth, and adult mental health support services. In the District of Columbia, adults with SMI and youth with SED will be eligible for the same non-clinical recovery support as individuals in substance use treatment. Our system of care encourages integrated and coordinated care between substance use and mental health providers.

6. Please indicate areas of technical assistance needs related to this section.

Not at this time

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Footnotes:

Environmental Factors and Plan

11. Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health disorder and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1] Most mental 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.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

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 using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

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 use, 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, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to financing, workforce development, and implementing evidence-based treatments.

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 SUD and co-occurring M/SUD 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 functioning of children, youth and young adults in home, school, and community settings. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult, and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. 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:

1. non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[2]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.

[3]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.

[4]The National Center on Addiction and Substance use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

[5]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 **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? (●) Yes ( ) No

b) The resilience of children and youth with SED? (●) Yes ( ) No

c) The recovery of children and youth with SUD? (●) Yes ( ) No

d) The resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Health care? (●) Yes ( ) No

c) Juvenile justice? (●) Yes ( ) No

d) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? (●) Yes ( ) No

d) Is the state providing trauma informed care? (●) Yes ( ) No

6. Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The substance use disorder services offered to children and youth within the District of Columbia include prevention services,

early intervention, treatment, and recovery support services. Prevention services are delivered primarily through four DBH-funded DC Prevention Centers (DCPCs) that cover all eight wards, the school-based behavioral health program, and DBH prevention campaigns and activities. Treatment and recovery support services are available through two DBH-certified Adolescent Substance use Treatment Expansion Program (ASTEP) providers, and school-based services. The two ASTEP providers are Latin American Youth Center located in Northwest, and Hillcrest Children and Family Center with locations in both Northwest and Southeast.

The DC Prevention Centers include workshops and trainings on SAMHSA's Strategic Prevention Framework – an approach for developing strategies aimed at addressing and preventing substance use among District youth, engaging and conducting outreach to residents through community events such as health fairs, and fostering the leadership skills of youth via the respective Youth Prevention Leadership Corps. The Prevention Centers have created partnerships with local middle and high schools within their wards and work directly with the school-based behavioral health program to include a focus of substance use prevention. This includes conducting presentations in classrooms and school assemblies on the harms and dangers of substance use, the adoption of curricula aimed at preventing drug use "Too Good for Drugs," and establishing school specific Youth Prevention Leadership Corps.

The ASTEP providers deliver both mental health and substance use services to youth within the community and schools. The ASTEP providers receive self-referrals as well as referrals from school staff, child serving agencies including the DC Department of Youth Rehabilitation Services (DYRS), the Child and Family Services Agency (CFSA). When referrals are made, the ASTEP providers reach out to the referred youth, conduct an assessment, and enroll youth into services that best address their substance use needs.

In FY 24, DBH continued to partner and collaborate with Child and Family Services Agency (CFSA) to better serve the behavioral health needs of children and families in the District. DBH continued to have a staff member co-located at CFSA to support the linkage, enrollment, and follow up of behavioral health services to children, youth, and families needing services. Services are provided to parents, guardians, and resource parents of children and youth involved in the child welfare system, but this data is not aggregated in our database system. The adults have access to services available in the DBH network to address their own needs in addition to psychoeducation and behavior management strategies that will support parenting and family dynamics. Parents, guardians, and resources parents are also instrumental in supporting the behavioral health needs of children and youth impacted by trauma. DBH continues to provide trauma informed and evidence-based programs (EBPs) services which include the following: Parent-Child Interactive Therapy (PCIT), Trauma Focused –Cognitive Based Therapy (TF-CBT), Trauma Systems Therapy (TST), Child-Parent Psychotherapy (CPP), Functional Family Therapy (FFT), Multi-Systemic Therapy (MST), Transition to Independence Process (TIP), and Attachment Biobehavioral Catch-Up (ABC). The EBPs provide youth and families with the skills and knowledge necessary to overcome traumatic events and experiences.

In FY 24 DBH expanded treatment, recovery, support services, and reinforced evidence-based practices aimed at addressing all life domains for District transition age youth (TAY). Training for three (3) new evidenced based practice (EBP) treatments that are dedicated to support the needs of TAY with SMI/SED concerns were offered. Expanded treatment services included:

Enhanced Illness Management and Recovery (E-IMR): E-IRM is an approach used to support the recovery of individuals with mental illness. It incorporates integrated dual disorder treatment (IDDT) principles into the IMR intervention to better serve individuals diagnosed with serious mental illness and a co-occurring substance use disorder (COD).

Recovery-Oriented Cognitive Therapy (CT-R): CT-R is a treatment approach designed to promote empowerment, recovery, and resiliency in individuals with serious mental health conditions. It is a strength-based approach that focuses on activating adaptive modes of living, developing meaningful aspirations, and engaging in personally meaningful activities to bring about one's desired life.

Seeking Safety: Seeking Safety is an evidence-based treatment model that treats the co-occurring diagnoses of PTSD and Substance Abuse. Specifically, the model aims to help young adults obtain coping skills, that will allow them to feel safer in their relationships, thinking, and actions.

In FY 24, DBH trained over 100 individuals in TAY focused evidenced based treatments. Some TAY services are Medicaid billable. The newer services, like Seeking Safety, Enhanced Illness Management and Recovery, and Recovery – Oriented Cogitative Therapy do not yet have billable codes, thus making it difficult to ascertain how many TAY are participating in programming or services. DBH will collaborate with DC Healthcare Finance (DHCF) to explore the possibility of adding modifiers to better identify TAY usage of services.

In an effort to decrease recidivism and penetration to the adult criminal justice system amongst children and youth involved in the juvenile justice system by engaging them in services and supports in an expedited manner, the Department has continued it's partnership with the Superior Court of the District of Columbia, Court Social Services Division, and the Office of Attorney General, offering two voluntary diversion programs- The Juvenile Behavioral Diversion Program (JBDP) link court-involved youth under the age of 18 with appropriate community-based mental health services and supports and Here Opportunities Prepare you for Excellence (HOPE) Court, support children and youth at risk or involved in sexual exploitation. Both diversion programs, offer a team-based approach, connect youth to specialized mental health and social support services and have the possibility to dismiss charges or shorten probation, if the program is successfully completed.

Additionally, the Department of Youth Rehabilitation Services (DYRS) and DBH entered into a MOU to ensure that young adult returning citizens who lack housing connections and resources, have appropriate housing and behavioral health support. Through this partnership, these young adults are placed in a shared apartment within the Wayne Place Independent Living Program. The Wayne Place program not only addresses the young adults housing needs but provides opportunities for on- and off-site behavioral health support.

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.

DBH and the Department of Health Care Finance (DHCF), DC's state Medicaid agency, began partnering in 2020 to plan for the full integration of behavioral health services in the Managed Care Organizations (MCO) service delivery. The Behavioral Health Integration is a District-wide effort to provide a full continuum of whole-person care to youth. While the full integration was paused due to fiscal impacts, DBH and DHCF continue to collaborate to strengthen the full continuum of psychiatric care for children and youth in the District.

7. Does the state have any activities related to this section that you would like to highlight?

DBH continues its partnership with the Child and Family Services Agency with various initiatives to support the overall wellbeing of children, youth, and families. The most recent partnership includes CFSA's 211 Warmline whereas DBH partners with CFSA to ensure behavioral health resources, specifically mental health and addiction recovery services are available and streamlined to those district residents needing services. The goal of the CFSA's 211 Warmline is specifically designed as a referral and service navigation hub for individuals, seniors, children, and families connecting across the District of Columbia residents to vetted community and government supports. The 211 Warmline is housed in the headquarters of DBH, where behavioral health resources are readily available.

As a part of the School-Based Behavioral Health expansion, the School Year 2024-2025 landscape of DC Public and DC Public Charter schools was 254.

In FY24, DBH published Bulletin 140 that approves the initiation of CBI services in carceral settings and reauthorization of services when medically necessary. The bulletin was published as a response to the Department Of Youth Rehabilitative Services (DYRS) and a need for services for youth prior to discharge from New Beginning.

In FY22/FY23, as part of system redesign efforts and transition to managed care, DHCF contracted with PCG to complete comprehensive rate studies including the review of 53 behavioral health services to include child and youth services. Based on the recommendations provided, DBH and DHCF established new reimbursement rates to cover two additional evidence-based models: Attachment Biobehavioral Catchup for toddlers 6-24 months and their caregivers and Motivational Enhancement Therapy for adolescent with substance use challenges. DBH and DHCF also included one promising practice Intensive Care Coordination (ICC). ICC is a comprehensive, holistic, child/youth and family driven approach to case management for children and youth experiencing behavioral health challenges. These services help to strengthen the system of care of care for youth in the District.

The establishment of the Medicaid rate for Intensive Care Coordination (ICC) contributes to DBH's vision of whole person care by integrating a high level of clinical care coordination to ensure there is collaboration among partnering agencies and organizations and the correct services and supports are offered to children and families.

DBH launched the chat and text functionality for the 988 Lifeline on September 17, 2024, which expands access to services and support consumers who wish to remain anonymous but need psychiatric support as well as transition aged youth and young adults who prefer this method of communication when reaching out for help.

8. Please indicate areas of technical assistance needs related to this section.

The Substance Use Disorders (SUD) Prevention team needs technical assistance particularly as it pertains to developing a strategic plan. This need is critical especially with the scope of prevention expanding to include harm reduction, and with the desire to increase outreach to and engagement of adult populations.

In addition, technical assistance is needed for conducting risk assessments from early childhood through Transition Age Youth. The transitional aged youth could benefit from being supported in adapting existing EBPs or identifying EBPs that have been adapted to meet the needs of young adults. It would also be beneficial to receive technical assistance and funding to support activities that help young adults explore and mange their behavioral health utilizing non-traditional therapies. Opportunities that

expose young adults to non-traditional therapies include therapeutic arts which include a range of creative activities used to promote well-being, self-discovery, and healing; equine therapy which includes utilizing interactions with horses to help individuals explore emotions and improve social skills; expressive arts therapy includes employing various art forms like painting, music, or dance to facilitate emotional expression and processing; activity therapy includes engaging in recreational activities like sports, games, or arts and crafts to promote relaxation and social connection; music therapy which includes using music to address emotional, cognitive, and social needs, such as playing, composing, or analyzing music; and nutrition therapy which focuses on the impact of diet on mental health, often alongside other therapies.

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Footnotes:

Environmental Factors and Plan

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan since the FY2024-2025 Plan was submitted? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

We would have hoped to have leveraged funds from our 988 States and Cooperative Agreement grants to update the District's current suicide prevention plan. Current restrictions within the District regarding spending and accessing federal funds have prevented DBH from moving forward with this initiative.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments? (●) Yes ( ) No

If yes, please describe how barriers are eliminated.

We do not currently have any barriers regarding this. We have implemented a follow-up protocol within the Access Helpline for both call takers who encounters consumers who have engaged in active suicide attempts or threats to do are contacted (per their choice) to ensure they are connected to services to mitigate risks of said behavior occurring in the future. Additionally, our internal team that manages the FD-12 process resulting in hospitalizations also follow up with consumers to ensure linkage to services post-discharge.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

We continue to prioritize populations of focus included in Mayor Bowser's Health and Racial Equity plan designed to ensure that people of color and other marginalized populations have access to services needed.

6. Please indicate areas of technical assistance needs related to this section.

None

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Footnotes:

Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority 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 M/SUD 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 prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, 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 emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

The Department of Behavioral Health (DBH) has developed new partners as well as participated in new projects with existing partners. The new initiatives include:

Early Childhood Innovative Network (ECIN) is part of the Children's National Health System to develop new strategies to support and improve services in child development centers and schools. During FY23, the Healthy Futures program, which is a prevention and early intervention program for children birth to five, partnered with ECIN to support their teacher wellness research program CPR2 (Compassion, Practice, Relationships, and Restoration). Healthy Futures clinicians partnered with ECIN to deliver CPR2 to teachers in a select number of child development centers.

The Healthy Futures program partners with the Office of the State Superintendent of Education (OSSE) to support their Quality Improvement Network (QIN). The QIN focuses on building high quality, comprehensive early childhood development and family engagement services for infants and toddlers. The Healthy Futures early childhood clinical specialists work with QIN coaches in 14 early childhood development centers and 17 home providers.

The Healthy Futures program partners with OSSE to support the Pre-K Enhancement and Expansion Amendment (PKEEP) program, PKEEP supports Community-Based Organizations (CBOs) to enhance high- quality pre-K education services in existing pre-K programs. Healthy Futures supports PKEEP in the 27 child development centers that are currently participating in the program.

Children's National Hospital established the DC Autism Collaborative (DC-AC), a multidisciplinary, public-private coalition of professionals and community leaders to increase early and equitable access to high-quality Autism Spectrum Disorder (ASD) diagnosis, treatment, and coordinated care. The Healthy Futures program has partnered with Children's National Hospital in creating and delivering community workshops and disseminating educational materials to the early childhood community.

With the goal to expand knowledge and education around ESMIs and first episode psychosis (FEP), the TAY (Transition Age Youth) Division, which is develops a continuum of care for youth ages 16-25, identified a need to partner with local hospitals and universities (i.e., Sibley, Howard, American, George Washington) to ensure that better support and more focused treatments are offered to young adults with behavioral health concerns. Our efforts included educating the school and hospital communities on behavioral health screeners and assessments which are used to improve early identification, intervention effectiveness, and recovery outcomes for young adults.

DBH has formed a strong relationship with the Department of Human Services (DHS). The two agencies have embarked on a referral process that encourages the elimination of barriers that hinder a young adult's access to services. In addition to making the ease into treatment services easier, the two agencies work together to make sure that young adults not only receiving behavioral health treatment, but they are also receiving housing and housing resources. This existing partnership identifies new strategies that support housing, early psychosis care, improve the quality of services, and benchmark needs and gaps needed to support young adults.

DBH SUD (Substance Use Disorder) prevention services, are funded by the twenty percent primary prevention set-aside Single State Authority for Prevention in the District. SUD Prevention uses these funds to implement the six core strategies throughout the District. Additionally, SUD Prevention funds four DC Prevention Centers (DCPCs) to deliver primary prevention services to all eight wards, supports the school-based behavioral health program as well as DBH prevention campaigns and activities. The DC Prevention Centers, which are the primary implementers of community-based processes, provide workshops and trainings on SAMHSA's Strategic Prevention Framework – an approach for developing strategies aimed at addressing and preventing substance use among District youth, engaging and conducting outreach to residents through community events such as health fairs, and fostering the leadership skills of youth via the respective Youth Prevention Leadership Corps. The Prevention Centers have created partnerships with local middle and high schools within their wards and work directly with the school-based behavioral health program to include a focus of substance use prevention. This includes conducting presentations in classrooms and school assemblies on the harms and dangers of substance use, the adoption of curricula aimed at preventing drug use "Too Good for Drugs," and establishing school specific Youth Prevention Leadership Corps.

Synar Tobacco Enforcement and Education are longstanding SUPTRS block grant mandates. DBH SUD Prevention partners with

sister agencies such as the Department of Health (DCHEALTH) and the Department of Licensing and Consumer Protection (DLCP) to ensure the effort is done efficiently and effectively. DLCP currently aids DBH in the enforcement of underage tobacco sales to minors while DCHEALTH is part of a Synar workgroup with DBH aimed at identifying opportunities to improve education to the community and improve laws and policies focused on tobacco prevention within the District.

DBH SUD Prevention has recently put forth efforts to develop a series of alternative activities in the form of community wellness events. These events identify fun, healthy, and engaging activities to deter youth from participating in risky behaviors. The DC Department of Parks and Recreation were a partner in this effort, leveraging resources such as recreation centers, equipment, summer camps and pools to help us reach a targeted audience throughout the District.

Treatment and recovery support services are available through two DBH-certified Adolescent Substance Use Treatment Expansion Program (ASTEP) providers and school-based services. The two ASTEP providers are Latin American Youth Center (LAYC) located in Northwest, and Hillcrest Children and Family Center with locations in both Northwest and Southeast.

During FY2024 and FY2025, DBH Opioid Abatement Division continued the partnership with Dr. Sivabalaji Kaliamurthy and his team at Children's National Hospital. The goal of this partnership is to improve services for children and adolescents with substance use disorders and to bolster engagement in treatment. This clinic expanded hours to five days a week and incorporates peers into the service delivery model. Peers support completing referrals to treatment services, engage youth, and ensure successful connections to treatment.

DBH and Federal City, a DBH-certified SUD provider, have partnered to ensure services are comprehensive and appropriate for youth and their families who need a higher level of care. Federal City will open a community-based level 3.5 SUD treatment facility for youth in the Summer of 2025. This is the only 3.5 level facility in the District of Columbia for youth.

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. Additionally, the District has a Coordinating Council on School Behavioral Health which is co-chaired by the DBH Director and a Non-Government leader. The members of the Coordinating Council on School Behavioral Health are from various partner organizations and agencies which also include Child and Family Services Administration, Children's Law Center, Children's National Health System, and Department of Health. The current role and status of the Coordinating Council on School Behavioral Health has shifted to the mission of recommending policies to enhance service delivery, coordinate services across systems and make recommendation for funding the School Behavioral Health Program. And, the Comprehensive School Based Behavioral Health System continues to be a strategic collaboration between school personnel, community behavioral health providers, students and families to create a positive school culture that provides timely access to high-quality, reliable supports for children, youth, and their families. School Behavioral Health teams offer a full array of trauma-informed, culturally-responsive, evidence-based tiered interventions to promote wellness, identify challenges early, and offer treatment services when necessary, so that all children and youth succeed and thrive.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

DBH continues to certify providers who serve as core service agencies that offer a full continuum of services to include therapy, medication management, and community support. As a part of the rate study, new services were added to include Intensive Care Coordination, Dialectical Behavioral Therapy, Motivational Enhancement Therapy – Cognitive Behavioral Therapy, and Attachment-Biobehavioral Catch-up. In Q3, one of DBH's partners, Medstar Georgetown University Hospital opened a new adolescent Intensive Outpatient Program (IOP) which accepts DC Medicaid. During FY25, DBH will continue to collaborate with partners and explore opportunities for additional IOPs.

DBH, Office of the State Superintendent of Special Education (OSSE), and DC Public Schools (DCPS) have a strong and long-standing partnership regarding School Behavioral Health. The agencies collaborate to support overall program alignment, joint communication and resource creation, school leader engagement, and plan for work plan analysis. The DBH Clinical Support Manager, the OSSE School Behavioral Health Outreach Specialist, DCPS Expansion Outreach Director, and additional OSSE Health and Wellness Leaders have bi-weekly meetings. The DBH School Behavioral Health Branch Chief meets monthly with the DCPS Expansion Outreach Director in support of the active Memorandum of Agreement which formalizes the partnership that places DBH-hired clinicians in assigned school placements within DCPS. Additionally, the DBH School Behavioral Health Branch Chief serves as an Executive level advisor and attends quarterly meetings of the OSSE managed Community Schools Advisory Committee. The DBH Program Coordinator for the School Behavioral Health Internship Program collaborates quarterly with the OSSE Mental Health Coordinator in the Workforce Development committee in the context of recruitment, retention, and capacity building. Additionally, the School Behavioral Health Internship Coordinator attends monthly Advancing the Recruitment and Retention of Our Workforce (ARROW) grant meetings with OSSE and DCPS.

DBH is actively collaborating with the Office of Unified Communications (OUC) and other public safety cluster agencies to implement the 9-8-8 program effectively. This partnership involves training OUC personnel on mental health crisis response protocols to ensure seamless communication during emergencies. Regular meetings facilitate coordination of resources,

establishing a framework for rapid response and follow-up care. Additionally, DBH and OUC are developing shared protocols to enhance data collection and analysis, helping to refine service delivery. This collaborative approach aims to create a comprehensive support system for individuals in crisis, improving outcomes across the community.

The Healthy Futures leadership team participates in ongoing community of practice and coordination meetings with OSSE and Children's National Hospital. These meetings bring together participants from each program to maintain the effectiveness and efficiency of the programs and partnerships.

DBH TAY is working to place more TAY-focused teams (transition facilitators (TF) and youth development leads (YDL) in educational and other spaces utilized by young adults. Despite the support provided by DBH's Children's Services Division to schools, TAY has recognized a greater need to create programs that leverage the adult and children services from a young adult perspective. We have been working to ensure that programs are designed to match the experiences and needs of young adults.

Each school leader identifies a school-hired staff person to serve in the role of the School Behavioral Health Coordinator (SBHC). The SBHC provides leadership and coordination of each school's behavioral health team. The Department of Behavioral Health's (DBH) School Behavioral Health Program is comprised of DBH-hired and Community Based Organization-hired (CBO-hired) providers who implement multi-tiered prevention, early intervention and treatment services within DC public and public charter schools. The DBH-hired and CBO-hired providers are integrated into the school's behavioral health team and work to implement a Comprehensive School Behavioral Health Model. The school's behavioral health team annually completes a school-centric assessment that informs the annual development of a School Strengthening Work Plan that serves as the operational mechanism for implementing integration and coordination of the school behavioral health services provided by each school behavioral health provider across the levels of prevention, early intervention, and treatment services. The School Strengthening Work Plan is to be revisited at mid-year and revised throughout the school year, as appropriate.

DBH, Office of the State Superintendent of Education (OSSE), and DC Public Schools (DCPS) have a strong and long-standing partnership regarding School Behavioral Health. The agencies collaborate to support overall program alignment, joint communication tools development, and school leader engagement. During FY24, DBH Clinical Support Manager, the OSSE School Behavioral Health Outreach Specialist, DCPS Expansion Outreach Director, and additional OSSE Health and Wellness Leaders had bi-weekly meetings. The DBH School Behavioral Health Branch Chief met monthly with the DCPS Expansion Outreach Director in support of the active Memorandum of Agreement, which formalizes the partnership that places DBH-hired clinicians in assigned school placements within DCPS. Additionally, the DBH School Behavioral Health Branch Chief served as an Executive level advisor and attended quarterly meetings of the OSSE managed Community Schools Advisory Committee. The DBH Program Coordinator for the School Behavioral Health Internship Program collaborated quarterly with the OSSE Mental Health Coordinator in the Workforce Development committee within the context of recruitment, retention, and capacity building. Additionally, the School Behavioral Health Internship Coordinator attended monthly Advancing the Recruitment and Retention of Our Workforce (ARROW) grant meetings with OSSE and DCPS.

4. Please indicate areas of technical assistance needs related to this section.

None

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Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in **42 U.S.C. §300x-3** for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)

Due to the council's summer recess we will not be able to present the State Plan until Sept. 26th. Meeting minutes and letter of support will be provided thereafter.

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan ○ Yes ◉ No

b. State Report ○ Yes ◉ No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

The District of Columbia Department of Behavioral Health (DBH) serves as the State Mental Health Authority (SMHA) and the District of Columbia Single State Agency (SSA) for substance use disorders. As the SMHA, DBH certifies community based providers to provide mental health services and supports to children, youth, and adults across the District of Columbia. Services include prevention, early intervention, and treatment services to ensure comprehensive services across the entire continuum.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? ◉ Yes ○ No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) ◉ Yes ○ No

6. 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.

The purpose of the Behavioral Health Planning Council (BHPC) is to serve as an advisory body to the Department of Behavioral Health (DBH), guiding it on policies and programs. The council focuses on ensuring access to services, promoting recovery and resilience, and advocating for District residents with behavioral health needs.

Core functions
The BHPC's main responsibilities are:
-Advising the DBH: The council advises the DBH on planning and implementing consumer-directed behavioral health services that are accessible, integrated, and coordinated with physical healthcare.
-Advocating for residents: It advocates for District residents with serious emotional disturbances, mental health issues, and substance use disorders.
-Integrating services: The BHPC supports combining mental health and substance use prevention, treatment, and recovery services with overall health services.
-Reducing disparities: The council works to decrease disparities in the prevention and treatment of mental health and substance

use disorders.
-Improving coordination: It strives to strengthen coordination and collaboration with community organizations and relevant agencies to improve the system of care.
-Managing federal grants: The BHPC provides input for the development of the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health and Substance Use Block Grants.
-Evaluating services: The council monitors, reviews, and evaluates the adequacy of behavioral health services within the District at least once a year.
Operational approach
To accomplish these goals, the BHPC has historically:
-Shared information with stakeholders.
-Invited presentations from relevant agencies.
-Participated in departmental initiatives when requested.

7. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Gail Avent	Parents of children with SED			totalfamilycarecoalition@gmail.com
Lorenzo Baylor	Advocates/representatives who are not state employees or providers			lbaylor0409@gmail.com
Tia Brumstead	State Employees			tia.brumstead@dc.gov
Ramona Carmona	Advocates/representatives who are not state employees or providers			ramon.carmona@dc.gov
Dante Daniel	State Employees			dante.daniels@dc.gov
Nicole Denny	Youth/adolescent representative (or member from an organization serving young people)			nicole.denny@dc.gov
Theresa Early	State Employees			theresa.early@dc.gov
Donna Flenory	Parents of children with SED			dlflenory34th@gmail.com
Esther Ford	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			estherford777@gmail.com
Hammere Gebreyes	State Employees			hgebreye@dchousing.org
Charles Gervin	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			charles.gervin@dc.gov
Nicole Gilbert	State Employees			nicole.gilbert@dc.gov
Larry Gourdine	Advocates/representatives who are not state employees or providers			larry.gourdine@uhsinc.com
Jean Harris	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			jeanjmharris@aol.com
Jerome Hinkle	Individuals in recovery (including adults with SMI who are receiving or have			jeromehinkley95@gmail.com

	received mental health services)			
Alvin Hinkle	State Employees			alvin.hinkle@dc.gov
Jennifer Joyce	State Employees			jennifer.joyce@dc.gov
Hilary Kacser	Advocates/representatives who are not state employees or providers			hilarydc@yahoo.com
Mark LeVota	Advocates/representatives who are not state employees or providers			mark.levota@dcbehavioralhealth.org
Diane Lewis	Advocates/representatives who are not state employees or providers			dlewis@acg-cos.com
Elizabeth Maldonado	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			jpjnewpost@gmail.com
David Moody	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			davidjosephmoody@gmail.com
Jennifer Moore	Advocates/representatives who are not state employees or providers			jmoore@picn.health.com
Ifeoma Muoka	State Employees			ifeoma.muoka@dc.gov
Nadine Parker	Advocates/representatives who are not state employees or providers			nparker@nccpud.net
Rosalind (Roz) Parker	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			rozaka@aol.com
Jo Patterson	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			pwwithjopatterson@gmail.com
Debby Shore	Advocates/representatives who are not state employees or providers			dshore@sashabruce.org
Rachel Shpak	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			shpak.rachel@gmail.com
Jaclyn Verner	Advocates/representatives who are not state employees or providers			jverner@uls-dc.org
Audrey Whetsall	Advocates/representatives who are not state employees or providers			awhetsell@consultrp.net

*Council members should be listed only once by type of membership and Agency/organization represented.

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Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	4	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	5	
3. Parents of children with SED	2	
4. Vacancies (individuals and family members)	0	
5. Total individuals in recovery, family members, and parents of children with SED	**11**	**35.48%**
6. State Employees	8	
7. Providers	0	
8. Vacancies (state employees and providers)	0	
9. Total State Employees & Providers	**8**	**25.81%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	0	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	1	
13. Advocates/representatives who are not state employees or providers	11	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	**12**	**38.71%**
16. Total membership (all members of the council)	**31**	

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Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. §300x-51) requires, as a condition of the funding agreement for the grant, that 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 the federal government.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ◉ No

b) Posting of the plan on the web for public comment? ◉ Yes ○ No

If yes, provide URL:

https://dbh.dc.gov/page/behavioral-health-services-block-grants

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://dbh.dc.gov/page/behavioral-health-services-block-grants

c) Other (e.g. public service announcements, print media) ○ Yes ◉ No

d) Please indicate areas of technical assistance needs related to this section.

None

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Footnotes:

Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:
Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (PWID), SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the **HIV.gov website.**

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (**42 U.S.C.§ 300x-31(a)(1)(F)**) and **45 CFR § 96.135(a)(6)** explicitly prohibits the use of SUPTRS BG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

2. Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(a)**) and **45 CFR § 96.127** requires entities that receives SUPTRS BG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

3. Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(b)**) and **45 CFR 96.128** requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SUPTRS BG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (**42 U.S.C. 300x-28(c)**) and **45 CFR 96.132(c)** requires states to ensure that substance use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
No Data Available					
Totals:		$0.00		0	

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Footnotes:

Washington DC does not use Block Grant funds for Syringe Services Program