Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

DBH conducted a needs assessment in FY25, with the goal of completing a corresponding strategic plan in FY26. The team sought to identify strengths, weaknesses, opportunities, and threats (SWOTs) that could influence the strategic plan. When reviewing data, we looked for: (a) significant changes year-to-year; (b) differences in prevalence, outcomes, or services provided between the District and nationally; and (c) variances between targets and measured outcomes.?

The team conducted four (4) focus groups with youth, families, school-based providers, community and consumer experiences, adult behavioral health and system providers, and substance use disorder [SUD] providers). The team also prepared "customer journey maps," which are representations of group members' interactions with behavioral health services and systems. These maps identify user experiences, pain points, and opportunities.???

To compile the information in a useable format, the team sought to identify strengths, weaknesses, opportunities, and threats (SWOTs) that could influence the strategic plan. When reviewing data, we looked for the following: (a) significant changes year-to-year; (b) differences in prevalence, outcomes, or services provided between the District and nationally; and (c) variances between targets and measured outcomes. When reviewing other sources of information, including outside reports, hearing testimony, and information from informal discussions with DBH staff, we attempted to identify issues that are important to either DBH or other interested parties.????

There were four (4) areas of focus that came out of the needs assessment findings:??

The DC behavioral health system of care is experiencing a fragmentation within its service delivery model (e.g., care transitions, siloed MH/SUD) that is not consistent with whole person care.

The DC behavioral health system of care is experiencing quality of care concerns.??

The DC behavioral health system of care is experiencing barriers to accessing care (wait time, lack of warm handoffs, crisis specific, messaging, lasting linkages, etc.).??

The DC behavioral health system of care is experiencing chronic clinical workforce shortages and skills gaps.??

Quality of services is measured in numerous ways such as claims audits, medical reviews, fidelity reviews, and consumer interviews. These are practices used by the Centers for Medicare and Medicaid Services, National Committee on Quality Assurance, and the Joint Commission.??DBH also publishes Performance Accountability Reports highlighting our accomplishments, objectives, operations, strategic initiatives, key performance indicators and workload measures. ?
FY 24 - https://oca.dc.gov/sites/default/files/dc/sites/oca/FY24%20PAR%20-%20DBH.pdf?

FY 23 - https://oca.dc.gov/sites/default/files/dc/sites/oca/page_content/attachments/DBH_2024-01-12.pdf?

To measure the quality of the children and youth services provider network, DBH utilizes several methods to measure quality of services. DBH contracts with model developers and purveyors to complete annual fidelity reviews to assess each provider's adherence to Evidence- Based Practice models.??

Community-Based Intervention or (CBI), DBH's most intensive outpatient service, utilizes a third-party consultant to assess fidelity by reviewing each agency's compliance with model components including intensity of service, crisis response and availability, safety planning, and team composition.??

DBH also reviews all Evidence-Based Practice (EBP) outcomes for child and youth evidence- based programs on a monthly basis to assess the impact of services on the youth served. The outcome measurement utilized is the number of successful discharges. Each model also utilizes an assessment tool that rates behaviors and symptoms in the beginning of treatment and end of treatment.????

?In addition, DBH utilizes the Child & Adolescent Functional Assessment Scale (CAFAS) and the Pre-school & Early Childhood Functional Assessment Scale (PECFAS) to determine level of care and track functioning throughout treatment. CAFAS was also identified as the Key Performance Indicator (KPI) to measure the performance of cases.???

DBH contracts with the developer to provide system access for completion of the tool for all DBH-Certified child and youth behavioral health providers and School-Based Behavioral Health (SBBH) providers. Providers may access an individualized report to guide treatment planning. DBH analyzes reports to monitor provider performance as well as how children and youth are improving over their course of treatment.??

Results of the fidelity reviews and system performance on the CAFAS/PECFAS outcomes are shared with DBH and the providers. DBH uses the results to inform areas such as policy, training, and technical assistance plans.??

Fidelity reviews of Evidence Based Practices for Supported Employment and Assertive Community Treatment (ACT) are also utilized. Supported Employment providers are evaluated annually for fidelity to the model.? DBH utilizes these practices to ensure quality in our behavioral health provider network in addition to offering training and technical assistance.????

Additionally, DBH also conducts consumer satisfaction surveys of consumers receiving mental health and substance use services from community providers, as well as individuals in care at Saint Elizabeths Hospital.? If there are significant adverse findings of consumer satisfaction that rise to the level of concern, DBH refers these to the DBH Ombudsman, the Accountability Administration, or both depending on the nature of the report.? This information is also used to improve service delivery at the systems level.??
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We also utilize data produced by the annual claims audit to plan and hold specific training and clinical technical assistance to address identified challenges.? DBH provides quality and compliance trainings and provided technical assistance to providers (particularly to new providers) based on review of provider service documentation. DBH also provides ongoing technical assistance to new and existing providers to address clinical practice.???

The DBH Training Institute examines trends to find areas where providers are not performing well and develops training to address these areas.? In addition, the DBH Training Institute supports quality service through classroom training and eLearning in a wide range of best-practice mental health and substance use areas targeting direct service practitioners, clinical supervisors/managers, consumers, and leaders of the provider network.????????

Service adequacy is evaluated by comparing system capacity and utilization against identified population needs. This includes

monitoring wait times for services, geographic distribution of providers, availability of specialized programs, and alignment with evidence-based practices. Performance measures, client satisfaction surveys, and provider reporting are used to assess service quality, accessibility, and responsiveness. Utilization trends are examined to determine whether existing programs meet demand across prevention, treatment, and recovery. Outcomes data, such as treatment completion rates, reduced hospitalizations, and improved functional status, are reviewed to assess program effectiveness.??

The needs assessment incorporates information from a variety of sources, including data supplied internally; external data; external reports; publications about behavioral health best practices; key informant interviews with DBH leadership and behavioral health advocates; and focus groups assembled from the provider and consumer communities.???

Gaps and challenges in delivering quality SUD care and prevention services are identified by analyzing needs assessment data alongside service adequacy findings. These may include shortages in specialized providers, insufficient integration of SUD care with physical health services, and limited capacity for high-acuity or residential levels of care. Prevention service gaps are identified through mapping high-need areas with low program coverage. Barriers such as transportation, childcare, insurance limitations, and stigma are also assessed. Input from community partners, providers, and consumers validates findings and helps prioritize solutions. This continuous assessment process informs DBH's strategic planning, funding allocation, and quality improvement initiatives.??

Sequential Intercept Model (SIM) mapping is a process that results in the development of map that illustrates how people with mental and substance use disorders enter and move through the criminal justice system. Through the process, systems are able identify opportunities for linkage to treatment and other support services, and for prevention of further penetration into the criminal justice system.??

Beginning with the adult service system, in 2020 DBH convened a group of behavioral health and criminal justice system stakeholders across the District. The participants systematically identified existing resources for responding to the needs of adults with mental and substance use disorders who are involved in the criminal justice system, gaps in services for the target populations, opportunities for diverting individuals out of the criminal justice system, and opportunities for cross-system collaboration and partnerships. The recommendations spurred by this SIM mapping exercise continue to influence service system design and implementation.?

Recently, in 2025, another group of District partners convened to engage in a similar type of exercise that involved two distinct target populations: youth under the age of 18 and transitional-aged youth between ages 18 and 25. DBH and District partners expect the recommendations to be published in the near future and this will generate collaboration on program design and interventions for these targeted youth populations for years to come.?

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

Mental Health Services

Children with Serious Emotional Disturbance, Partial Hospitalization/Intensive Day Treatment
There's an identified gap between when youth are discharged from inpatient hospitalization and admission into intensive community-based services.? DBH has recognized a need to increase the array of services offered to include partial hospitalization, day treatment, therapeutic respite, crisis beds, and a DC-specific Psychiatric Residential Treatment Facility (PRTF) to enhance the continuum of care for children with SED.
Adults with Serious Mental Illness (Adults in justice system), Jail-Based Enhanced Services and Treatment (J-BEST)?
The national competency crisis refers to the unprecedented escalation in demand for competency restoration and related forensic services in recent years in the United States. A 2017 National Association of State Mental Health Program Directors report showed a 25% increase in IST defendants receiving services between 1999 and 2005 and a 37% increase between 2005 and 2015. (Jennings et al., 2000).???

DC's only public psychiatric facility, Saint Elizabeths Hospital, is a 292-bed facility serving civil and forensic patients.??Since 2009, admissions have shifted from predominantly civil in (59%) to overwhelmingly pre-trial in FY 2024 (88%).??The average wait time for an inpatient pretrial bed for competency evaluation and/or treatment is 12 days.??

Consistent with nationwide trends, there is a need for the District to address the needs of untreated or under-treated mentally ill consumers who are currently detained awaiting adjudication of their legal proceedings.??

These individuals experience significant delays due to their competency being questioned, thus necessitating examination and in some cases, treatment to restore competency.???

These individuals are in a required population [i.e., diagnosed with or serious mental illness (SMI) or are showing signs of early mental illness (EMI)]. These consumers are often also dually diagnosed with substance abuse issues.??

Individuals who have an Early Serious Mental Illness?
Though the District is breaking barriers down barriers and making it easier to access care, there continues to be inadequate resources to address the challenges faced by Early Serious Mental Illness (ESMI) TAY. ESMI TAY must still scale hurdles as they attempt to secure stable housing and meaningful employment. Additionally, biomedical and psychosocial treatment are not widely accepted by TAY; and services and treatments may not be adequately tailored to the specific needs of populations. The District's challenge in serving this vulnerable population is ensuring that staff is adequately trained and that funding supports flexible approaches to provide Individual and/or group psychotherapy, family education and support, case management, medication management and supported employment and education services.

Children with Serious Emotional Disturbance, Transitional Living Program ?
The Wayne Place Transitional Living Program will support the healthy and successful transitions of TAY with SMI. Wayne Place will provide housing opportunities and supportive services.

The intersection of homelessness and ESMI represents a uniquely vulnerable population undergoing the compounding effects of two highly stigmatizing burdensome experiences that negatively impact health outcomes, treatment engagement, and life expectancy.??

There are limited independent housing opportunities for young adults/ transition aged youth (TAY) who may be diagnosed with severe mental illness, such as Schizophrenia, and lack traditional support for their transitions to adulthood.???

The availability of the right amount of support and supervision can make all the difference in an individual's success or failure in a community.??

TAY with schizophrenia need varying degrees of support and supervision at various times as well as mental-health support services flexible enough to respond based on a young adult's needs.??

The Wayne Place program can serve as a springboard for TAY with SMI, like schizophrenia, by assisting them with transitioning to independent living and adulthood successfully.?

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Children with Serious Emotional Disturbance, Individuals with Serious Mental Illness experiencing Homelessness, Youth Mental Health Mobile Unit?
There is a lack of accessible, youth-friendly, and competent mental health services throughout the District for youth 18-24 experiencing homelessness.??

The relationship between mental health and youth homelessness is complex and bidirectional, meaning that each can contribute to the other.??

In the District, 52% of youth experiencing impaired mental health. The TAY Mental Health Traveling Unit is designed to deliver targeted behavioral health support to youth experiencing homelessness.??

Operating as a traveling mental health unit, the program will provide essential mental health services at a local youth homelessness drop-in center, reaching 800 youth ages 18-24 in the pilot year.??

By bringing trauma-informed mental health care directly to youth in need, the project aims to bridge the gap in access to behavioral health resources for one of the most vulnerable populations.?

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Individuals with SMI experiencing Homelessness, Expansion of Homeless Outreach Program?
In DC's current mental health service system, a critical gap exists in the lack of dedicated resources and programs specifically tailored to older adults experiencing homelessness, according to the National Institutes of Health (NIH).??

The limited capacity of the DBH Homeless Outreach Program (HOP) team, a three-person team serving 450 people annually through PATH funding, restricts comprehensive outreach and support for this vulnerable population, particularly those with serious mental illness and co-occurring substance use disorders who are difficult to locate and engage.??

Delays in housing access after voucher receipt exacerbate mental health issues, alongside inconsistent case management quality and challenges with the adequacy and coordination of DBH housing and services.??

These issues, compounded by hesitancy towards site-based Permanent Supportive Housing (PSH) due to concerns about chaos or rules, contribute to the unmet needs of older adults experiencing homelessness in the District.?

Individuals in need of behavioral health crisis services?
One of the gaps in service is the need for a crisis center, such as one based upon the Empath Model, that addresses the needs of

individuals with co-occurring disorders.

Additional licensed staff are needed to support the Crisis Response Team. Currently, there is a workforce shortage of LICSWs and other licensed clinicians to support these efforts.

Subacute care services for individuals experiencing a crisis are needed within the District of Columbia.

Expansion of the existing co-response team currently being implemented in partnership with Metropolitan Police Department.

?SUBSTANCE USE SERVICES?

Pregnant women and women with dependent children? ?
Lack of Family-Centered Treatment Options

Providers and clients report a persistent shortage of treatment programs that accommodate both mothers and their children. This barrier often results in delayed treatment entry or forced separation between mothers and their children during critical periods of recovery.??

Childcare and Transportation Remain Major Barriers
Women often miss appointments or disengage from care due to the lack of on-site childcare and limited transportation options. Services not covered by Medicaid, such as peer support groups or parenting workshops, are especially difficult to access.??

Lack of Trauma-Informed and Responsive Care
Staff and providers note a need for more training in delivering gender-responsive, trauma-informed services tailored to the unique experiences of pregnant and parenting women, particularly women of color.??

Inconsistent Cross-System Coordination
Clients navigating multiple systems, such as child welfare, TANF, and behavioral health, frequently experience fragmented care. Providers report challenges in coordinating services and sharing information across agencies to support holistic recovery and family reunification.??

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Persons who inject drugs
Expanded Low-Threshold, Same-Day Access to MSUD
There is a shortage of programs offering immediate, same-day initiation of medication for substance use disorder for Person Who Inject Drugs (PWID), with existing services often requiring multiple intake steps or wait times that delay entry into care.??

Integrated Health Services
Many overdose prevention and support programs do not currently provide co-located infectious disease testing and treatment, resulting in missed opportunities to address HIV, hepatitis C, and tuberculosis alongside naloxone and fentanyl test strip distribution.??

Improved Transition Through?Levels of Care
Connections to more intensive treatment options, such as detoxification, residential programs, and recovery housing, are inconsistent, leading to service drop-off and interruptions in the care continuum.??

Enhanced Mobile and Geographic Outreach
Mobile outreach coverage is limited in certain areas of the District, leaving high-need neighborhoods without consistent access to prevention, treatment, and recovery services.??

Persons in need of recovery support services for substance use disorder? ?
Limited availability of recovery housing
Safe, supportive housing for individuals exiting treatment is in short supply, increasing the risk of relapse and homelessness during early recovery.??

Use block grant funds to contract with and expand certified recovery residences, including those that accommodate families, to provide stable, substance-free living environments post-treatment.?

Insufficient access to peer support
Few programs offer peer mentorship grounded in lived experience, which can be critical for maintaining engagement after

treatment discharge.??

Train, certify, and place peer recovery coaches in treatment and recovery settings to provide mentorship, care navigation, and ongoing engagement support.

Transportation barriers
Although DBH is providing resources , many individuals lack reliable transportation to attend recovery meetings, employment, and follow-up care, limiting their ability to sustain recovery.??

Fund transportation vouchers, rideshare partnerships, and shuttle services to remove travel barriers to recovery meetings, employment, and follow-up care.

Lack of consistent funding for non-clinical supports
Job readiness programs, sober social activities, and other recovery supports are often not covered by Medicaid, making them financially inaccessible.??

Provide grants to community-based organizations to offer job readiness programs, life skills classes, and sober community events that are not reimbursable by Medicaid.

Individuals with Co-Occurring Mental Health and SUD?
Shortage of integrated treatment programs
Many providers treat only one condition, forcing clients to navigate multiple systems and reducing treatment continuity.??

Fund program development and workforce training to deliver coordinated SUD and mental health care within the same setting.

Fragmentation between service systems
Limited coordination between mental health and SUD programs results in gaps, conflicting treatment plans, and missed follow-ups.??

Limited workforce training on dual-diagnosis care
Staff may lack the skills to implement evidence-based approaches for clients with both SUD and mental health needs.??

Insufficient high-intensity/residential dual-diagnosis programs
Clients with severe, co-occurring needs have limited access to structured, integrated residential care.??

Services for Persons with SUD Who Have or Are at Risk of HIV/AIDS? ?
Limited co-location of HIV services within SUD programs
Few treatment settings offer onsite HIV testing and care, reducing accessibility for high-risk clients.??

Inconsistent HIV risk screening and prevention education
Risk assessments are not always completed at intake, leading to missed opportunities for early intervention.??

Gaps in referral pathways to HIV care providers
Inadequate coordination delays linkage to treatment and prevention services for clients who test positive or are at high risk.??

Services for Persons with SUD Who Have or Are at Risk of Tuberculosis? ?
Lack of routine TB screening in SUD settings
Many treatment programs do not consistently screen clients for TB, leading to delayed diagnosis and treatment.?

Limited integration of TB treatment and SUD care
Clients diagnosed with TB often receive care in separate systems, creating challenges for care coordination.??

Insufficient coordination with public health agencies
Communication gaps hinders timely reporting, follow-up, and management of TB cases among individuals in treatment.??

Inadequate provider training on TB protocols
Without proper training, staff may not recognize TB symptoms or know how to initiate referrals.??

Services for Individuals in Need of Substance Use Primary Prevention? ?
Current and future DC Prevention Centers (DCPCs) grantees need further support from DBH to make significant community changes that will shift community norms and policies around substance use prevention.?Exposure to such evidence-based

interventions coupled with a comprehensive strategic planning process, can aid in mitigating the risk factors for substance use.?

DBH has instituted requirements within its school-based behavioral health program for all Community Based Organizations (CBOs) to provide evidence-based prevention curricula to all students in its assigned schools. Through this effort, although much more must be done, the limited integration of substance use prevention education in is not consistently embedded in school curricula, youth programs, and primary care practices.? Risk factors for substance use among adolescents include a history of adverse childhood experiences (ACEs), peer and familial influences, and poverty, among others. (SAMHSA, 2019).? According to an overview fact sheet published by the US Department of Health and Human Services in 2020, there are significant social and economic differences between wards in DC (USDHHS, 2020). These differences have also been found to be directly correlated with access to preventive health services (Fusco, 2020). Current 30-day usage trends for substances are as follows: marijuana (20.5%), alcohol (15.2%), and tobacco/vaping (9.6%) (YRBS, 2023). Although substance use trends among DC youth overall have been either unchanged or declining over the past five years, risk factors for substance use are prevalent within the district. Thus, there is a strong need for DBH to increase its capacity to ensure youth and transitional-aged youth have positive alternatives to engaging in substance use.?

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Need to expand the capacity of the local prevention workforce through training and hiring – There is a significant need to continue existing efforts to build the capacity of existing local Community Prevention Networks (CPNs) and/or organizations that are either in the development phase and not yet eligible/ready to apply for funding. Due to rapidly changing trends within substance use in DC, there is a continuous need to scale up existing training and capacity building programs for staff within the organization as well as with community partners.?

Priority Population – Youth, Residential Youth Treatment
The District of Columbia has a gap in youth substance use treatment. As a result, youth are not receiving the full array of substance use treatment services. Currently, DBH only provides substance use treatment in an outpatient setting.

Community Services Reviews & Independent Peer Review

Last conducted in 2016, DBH is planning to re-institute Community Service Reviews (CSR) for all certified MHRS and SUD providers to increase oversight. The CSR is a qualitative review process used to evaluate the quality of services. To fill the gap of conducting independent peer review, DBH seeks to adapt the CSR tool to meet the requirement to assess the quality, appropriateness, and efficacy of treatment services.

Mental Health & Substance Use
Certified Peer Specialists

Co-Occurring Disorders
Many individuals face both mental health and substance use issues, yet services are often siloed. Peer Specialists can navigate both systems and offer integrated, real-world guidance.

Addiction and Behavioral Health Integration
Too often, addiction recovery is separated from behavioral health treatment. Peer support helps bridge this gap through ongoing engagement, overdose prevention and support, and relapse prevention.

Justice-Involved Populations
Individuals reentering society from incarceration face stigma, trauma, and limited access to care. Peer Specialists with shared experiences play a crucial role in reentry support, reducing recidivism and promoting long-term recovery.

Family and Youth Needs
Families affected by behavioral health conditions often lack education, resources, and support. Peer-led family and youth programs foster connection, reduce intergenerational trauma, and promote early intervention and prevention.

Provider understanding Peer Role and Providing Supervision
Materials and increased staffing supports to further development of peer programming and training

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

Children w/Serious Emotional Disturbance, Partial Hospitalization/Intensive Day Treatment
Partial Hospitalization is a covered service within the Managed Care Organization (MCO) network and DBH is actively collaborating

with partners to explore the possibility of providing partial hospitalization services for youth in the District.
(The implementation should be broken into three phases, planning, implementation, revisions for sustainability. The first planning phase would happen over six months to establish memorandum of understanding, policy, and training to implement the service to fidelity. The second phase over the next nine months will implement the service through agency and non-governmental partners. In the third phase, we will evaluate and analyze the program to ensure sustainability)
DBH has been collaborating with Department of Youth Rehabilitation Services and Children and Family Services Agency to explore additional options for youth needing more intensive behavioral health supports.
(DBH has ongoing partnerships with DYRS and CFSA. To improve outcomes and expand access to the service, we will establish new programs including an intensive outpatient program for youth and young adults who require more support than traditional outpatient services. The first two quarters of FY26 will focus on designing the program. This will include defining the clinical framework, establishing levels of care and admissions criteria, and exploring the staffing structure. The next 6 months DBH will move toward direct service provision and refining operations. Clinicians will begin implementing services, staff will receive on-going training and supervision, and programs will collect data to assess effectiveness of the services. The following year DBH will continue to evaluate the program and refine practices and services)

While increasing access to Intensive Outpatient Programs and Partial Hospitalization Programs and High Fidelity Wraparound services over the next year will provide youth with more access to higher levels of care, some youth may continue to need to receive services at a Psychiatric Residential Treatment Facility. While DC does not currently have a PRTF in the city, there are several programs in the surrounding states.
(During FY26, DBH will reach out to PRTFs in neighboring states to explore the possibility of securing increased access to resources for District youth. Over the next year DBH will work with DHCF to create a plan with specific steps outlining the process including identifying appropriate PRTFs, outreaching to the facilities, gathering information and exploring their interest and linking the facility with appropriate staff at DBH and DHCF to complete the process)

Adults w/SMI (Adults in justice system), Jail-Based Enhanced Services and Treatment (J-BEST)
Jail-based treatment programs focusing on restoring individual's competency have been increasing in recent years. Jail-based treatment programs have several benefits, including decreased costs of psychiatric hospitalization, reduced wait times for hospital bed space, elimination of incentives to malinger, and ability to manage more behaviorally disruptive individuals who require court -related education to attain competence, or to maintain competence without the need for re-hospitalization.
Through a collaboration with the Department of Corrections (DOC), the Department of Behavioral Health (DC's agency charged with providing mental health and substance abuse services for District residents) will implement a jail-based enhanced services and treatment (J-BEST) program to address the local competency crisis in the District.
(In months 1-2, DBH will map existing coordination gaps, create MOAs outlining partner responsibilities and commitments, create treatment plans templates for targeted interventions, and develop data-sharing protocols)
Anticipated program benefits for identified populations (Adults with Serious Mental Illness and Individuals with Early Severe Mental Illness including psychotic disorders) include improved and earlier access to behavioral health care, reduced incarceration stay, expedited adjudication of the criminal matter, triage for those who need higher level of care, offers legal literacy prior to inpatient/outpatient restoration, permits competency maintenance outside of the inpatient hospital setting, reinforces psychiatric stability and offers care coordination with providers outside the Department of Corrections.
J-BEST will identify individuals who have been screened as incompetent to proceed or the evaluator was unable to determine their competency status. These individuals will receive enhanced jail-based treatment services whereby they will receive mental health programming and legal literacy education provided by the identified J-BEST vendor. There will also be an emphasis on addressing mental health treatment needs by collaborating with the DOC psychiatric treatment vendor, Unity Health Care.
(In months 2-4, DBH will facilitate cross-agency learning sessions to build mutual understanding of each system's policies and constraints. We will also establish regular multidisciplinary team meetings for case coordination. In months 3-4, DBH will monitor early outcomes such as timeliness of referral, partner engagement, and intervention completion rates. In months 4-6, DBH will conduct a program evaluation to ascertain the efficacy of the treatment interventions and whether there are any barriers to coordination and delivering the services. Based on the results of the program evaluation, DBH will adjust partner agreements and protocols, as well as the treatment interventions provided to the participants)

By providing enhanced mental health treatment services to this population (including medication management, psychosocial intervention, and legal literacy education), there is an increased likelihood of reducing the need for inpatient evaluation and treatment at Saint Elizabeths Hospital. Moreover, this will allow DBH to appropriately triage individuals into a higher level of care as well as ensuring individuals get earlier access to behavioral health care that may ultimately reduce their length of incarceration and/or hospitalization.
As mental health treatment needs for these consumers are met earlier, they can proceed with adjudication of their legal proceedings quicker, have a greater chance for mental health recovery, and will be provided the resources for continued mental health stability.

Individuals who have an Early Serious Mental Illness (ESMI)
The District has erected a FEP and CHR-P program that uses a CSC model. To address gaps identified, there needs to be funding to ensure that the team is able to support continued and on-going staff training. Staff supporting this population must obtain training beyond the initial multidisciplinary team training. Additionally, the integrated care team model approach could be enhanced with more flexible funding. The ability to use flexible funds to address social and emotional concerns that negatively impact the TAYs mental health and well-being, could make the difference between exacerbation or extinction of symptoms. Lastly,

because TAY are an "out of the box" population, neither children nor adults, they must be afforded out of the box treatments and services until such time as treatments are normed for this population. Having funding to work with treatment purveyors and training entities to adjust evidence-based treatments to meet the unique needs of TAY would be beneficial.
For implementation DBH proposes training for staff and community who work with TAY who are diagnosed with or at risk for an ESMI we plan to implement continued EBPs and other non-conventional treatment training for staff who work with ESMI TAY population.
Continued EBPs and other non-conventional treatment training for staff who work with ESMI TAY population
Invite all staff who work with TAY aged 16-25 years old.
(Provide training opportunities for staff within three months of funding received)
Expand Access Across Communities
Prioritize education and training for communities working with TAY who are diagnosed with or at risk for an ESMI. Offer non-conventional training opportunities for ESMI diagnosed TAY so that they can better manage their symptoms.
(Conduct a minimum of 1 training per fiscal year for the community specifically focused on addressing the needs TAY who are diagnosed with or at risk for an ESMI)
Provide Continuing Education and Career Pathways
Support TAY peer workforce development through training, certifications, supervision, and career ladders to retain young adult talent and maintain service quality.
(Offer at least 2 training slots per bi-annual training course offered for TAY peers)

Children with Serious Emotional Disturbance, Transitional Living Program
To address the gaps identified, supportive services will be offered and will aid in enhancing a young adults independent living skills and acquiring academic, vocational and/or career opportunities.
From the first day within their 18 months stay, a TAY will be assigned a TAY Specialist who will provide case management services and facilitate the coordination of other needed services, to include educational, vocational, and health services.

With 30 days, all TAY will work with their support staff to develop an individual service plan (ISP), which will create a blueprint for each resident to achieve their goals. The established goals will incorporate concepts that promote self-sufficiency and include civic engagement, education enhancement, personal self-care, financial literacy and budget planning.
Ensure that housing is available for unhoused ESMI District TAY
Develop supportive housing programs to address the needs TAY who are diagnosed with an SED/SMI to ensure successful transitions to independent living.
(Within three to six months provide annual training to Wayne Place Staff on EBPs and other techniques that support ESMI TAY living independently)

Expand opportunities and supportive services for TAY with SED/ SMI.
Prioritize supportive housing for TAY populations with SED /SMI who have no other housing options.
(Within three to nine months set aside a minimum of five (5) ESMI slots for SED/SMI TAY in need of housing per funding year)

Children with Serious Emotional Disturbance, Individuals with Serious Mental Illness experiencing Homelessness, Youth Mental Health Mobile Unit
To address the stated gaps in services for youth experiencing homelessness DBH is proposing the creation of a traveling behavioral health unit to bring competent and trauma-responsive mental health supports to TAY where they physically congregate.
The primary goal of Mobile Behavioral Health Unit is to improve mental health outcomes for youth experiencing homelessness, empowering them to address their behavioral health needs and work toward long-term stability.

Key objectives include immediate access to mental health support, reducing barriers to care and data-driven impact assessment. To achieve this the specific services will be: Mental Health Counseling and Support: Clinicians will provide individual and group counseling, covering topics like grief, trauma reaction and response, anxiety, depression, and adaptive coping skills; Peer Support: Peer specialists, with lived experience and understanding, will provide service and resource navigation by building trust and establishing goals with the youth; and Crisis Intervention: Immediate support for youth in crisis, aiming to stabilize youth, reduce further crisis, and guide them toward ongoing care.
Developing a Mobile Behavioral Health Unit
Launch a Mobile Behavioral Health Unit that will increase access to mental health services for 80 TAY experiencing homelessness.
(Within one to three months of funding establish and codify the Mobile Behavioral Health Unit structure/ identify specific mental health needs, target populations, and existing resources to determine what and how services will be offer)

Construct a Team that will offer mobile services
Hire qualified staff to deliver services via the Mobile Behavioral Health Unit.
(Within two to four months of funding recruit licensed and experienced mental health professionals such as counselors, social workers, and psychiatric nurse practitioners to compose the team)
Establish Partnerships
Collaborate with community organizations, leaders, and other stakeholders to build support and improve access to services.
(Within three to five months of receiving funding begin outreach activities to establish partnerships – connect with three partners

per quarter)
Promote Your Services
Market mobile clinic to reach your target population and inform the community about the services you offer.
(Participate in a minimum of one outreach activity to promote the clinic per quarter)

Individuals with Serious Mental Illness experiencing Homelessness, Expansion of Homeless Outreach Program
A recent Point in Time (PIT) count revealed 6,521 individuals experiencing homelessness in DC, including 3,875 single adults, 608 of whom were unsheltered. 44% of single adults were chronically homeless, and a significant portion had mental health (38%) or substance use (22%) issues.

A key approach to addressing this need is to expand the DBH HOP team by three additional staff aiming to nearly double the number of unhoused individuals (900-1000) with serious mental illnesses they serve, which could facilitate more targeted efforts to identify and engage with older adults. (Implementation Timeline)
The DBH HOP team conducts 24/7 outreach, particularly in high-need areas like downtown and NOMA. They partner with various entities, including MPD and Park Police, to support individuals with behavioral health issues experiencing homelessness. The city also has an encampment team, led by the Deputy Mayor for Health and Human Services (DMHHS), according to The Community Partnership. HOP assists with encampment protocols, providing warnings, outreach, on-site behavioral support during cleanups, and post-cleanup services. This depends on the needs of the person. Engagements can last one day for support on clean up days and can extend to several months when people need time to connect with HOP staff and support to choose a behavioral health provider.

Improve coordination and collaboration among agencies within the Continuum of Care, including those focused on aging services, to ensure smoother transitions between services and a more holistic approach to meeting the needs of older adults, potentially including Housing Supportive Services (HSS) benefits.
(At least 12 months to establish the need for relationships and workflows, and to pilot them making adjustments that lead to final approaches)
Address the reported delays in housing placement after receiving vouchers and the varying quality of case management within the Permanent Supportive Housing program to ensure individuals receive the timely support necessary for stable housing and improved mental well-being.
(Dependent on how long an individual person needs support. Most people need 30 days to 6 months – some people need longer. From a project perspective it will take 6 months with work with DHS to work through the delay issues to develop workflows and protocols to test)

Individuals in need of behavioral health crisis services, Crisis Project?
DBH will train staff in the Access Helpline (AHL), Community Response Team (CRT) and Comprehensive Psychiatric Emergency Program (CPEP) who deliver crisis services to adults with SMI and children and youth who experience an SED in topics related to suicidality and the prevention of suicide. These trainings include all staff participation in the American Society Association of Suicidology (AAS) annual summit offered virtually for all levels of staff including non-clinicians and peers. This training is usually offered in August, and staff can participate in real time and watch video recordings for sessions they miss. Completion of the training will be expected by September 30, 2026.
Additionally, licensed clinicians in the AHL, CRT and CPEP will also complete training like the Recognizing and Responding to Suicide Risk: Essential for Clinicians offered by the AAS that supports counselors, psychologists, psychiatrists and social workers who serve adults with SMI and children and youth with SED. This training typically offered in November provides licensed clinicians with advanced clinical training in the 24 core competencies related to assessing suicidality and effectively treating people expressing it.
Offering clinicians training that includes 12.5 hours of continuing education units is a strategy to improve retention addressing the workforce challenges in crisis services. Continuing education that includes significant CEUs supports staff who are required to be licensed to perform their core functions.
DBH will begin to explore how to transform the CPEP into a crisis response program that is foundationally grounded in the EmPATH crisis model. EmPATH stands for emergency psychiatry assessment, treatment and healing and it is an evidence-based practice for crisis mental healthcare. It focuses on creating a treatment environment that is calming and therapeutic for adults age 18+ with an SMI who need observation-level care to resolve their crisis. DBH will conduct site visits to similar programs to learn about implementation, attend training to support re-design, and explore the ways the CPEP environment can be modified to begin to create a more soothing and therapeutic offering to people using this service. Planning will start in 2026 and anticipate implementation in 2027.
DBH will purchase 250 Mental Health First Aid certification slots to train 250 staff and community providers who work with adults who have an SMI and children and youth who have an SED. Mental Health First Aid is an evidence-based practice designed to teach the skills needed to recognize and respond to the symptoms of a mental health and/or a substance use crisis. Trainings are offered throughout the year through the DBH Training Institute for new staff at DBH and for community providers to create a baseline of system knowledge and skill in addressing the crisis needs of the community. Creating a baseline of skill and expertise addresses the need to improve the quality of mental health crisis response throughout the District. The purchase of manuals and training will commence in Q2, 2026 and anticipate completing by Q3, 2027.

SUBSTANCE USE

Pregnant Women and Women with Dependent Children?

Expand family-centered treatment capacity

Fund the development of outpatient programs that allow mothers to engage with treatment while remaining with their children while receiving services. These programs will integrate parenting education, family counseling, and child wellness supports to prevent family separation and promote recovery within a safe, supportive environment.

(Within one year, expand family-centered treatment capacity by funding outpatient programs that integrate parenting education, family counseling, and child wellness supports, launching services, and evaluating outcomes)

Provide childcare and transportation assistance

Allocate resources for on-site childcare at treatment and recovery centers, transportation vouchers, and partnerships with rideshare providers. These supports will improve appointment attendance, program completion rates, and access to non-Medicaid -covered services such as parenting workshops and peer support groups. (Within one year, provide childcare and transportation assistance by funding on-site childcare, vouchers, and rideshare partnerships, piloting services, expanding access, and evaluating outcomes)

Increase trauma-informed and responsive care

Offer targeted workforce training and technical assistance to ensure all providers are equipped to deliver gender-responsive, trauma-informed services tailored to the unique needs of pregnant and parenting women, with particular attention to serving women of color and those with histories of trauma.

(Within one year, increase trauma-informed and responsive care by developing and delivering targeted workforce training, rolling out sessions, and evaluating impact for sustainability)

Strengthen cross-system coordination

Establish formal agreements, shared care plans, and data-sharing protocols between behavioral health providers, child welfare agencies, TANF, and other relevant systems to ensure seamless, holistic support for mothers and children. This will reduce fragmentation, improve family reunification outcomes, and ensure that recovery plans address the full spectrum of family needs.

(Within one year, strengthen cross-system coordination by establishing agreements, shared care plans, integrated outreach and support services and data-sharing protocols across agencies, piloting systems, training staff, expanding collaboration, and evaluating outcomes)

Persons Who Inject Drugs

Expand low-threshold, same-day access to MSUD

Fund additional service sites and mobile units offering same-day initiation of for substance use disorder to reduce overdose risk and improve engagement.

(Within one year, expand low-threshold, same-day MSUD access by funding new sites and mobile units, updating protocols, retraining staff, deploying services, and evaluating outcomes)

Integrate overdose prevention, support and health services

Fentanyl test strips and naloxone distribution, HIV/HCV/TB testing, and linkage to care within existing overdose prevention, support and treatment programs.

(Within one year, integrate overdose prevention, support and health services by co-locating fentanyl test strips and naloxone distribution, HIV/HCV/TB testing, and care linkages through agreements, staff training, rollout, scaling, and evaluation)

Improve linkage to higher levels of care

Strengthen referral systems and employ linkage coordinators to connect individuals to overdose prevention and support programs to detox, residential treatment, and recovery housing.

(Within one year, improve linkage to higher levels of care by organizing coordinators, standardizing referral protocols, expanding support, and evaluating outcomes)

Enhance mobile and geographic outreach

Expand mobile outreach teams to underserved wards, offering overdose prevention and support supplies, health screenings, and connections to treatment and recovery supports.

(Within one year, enhance mobile and geographic outreach by expanding teams, equipping and training staff, deploying services in underserved wards, and evaluating impact)

Persons in Need of Recovery Support Services for Substance Use Disorder?

Expand recovery housing capacity

Use block grant funds to contract with and expand certified recovery residences, including those that accommodate families, to provide stable, substance-free living environments post-treatment.

(Within one year, use block grant funds to expand certified recovery residences, including family options, through contracting, capacity upgrades, openings, referrals, and evaluation)

Increase peer recovery coaching availability

Train, certify, and place peer recovery coaches in treatment and recovery settings to provide mentorship, care navigation, and ongoing engagement support.

(Within one year, increase peer recovery coaching by recruiting, training, certifying, and placing coaches in treatment and recovery settings, then evaluating and expanding placements)

Enhance transportation assistance – Fund transportation vouchers, rideshare partnerships, and shuttle services to remove travel barriers to recovery meetings, employment, and follow-up care.
(Within one year, enhance transportation assistance by funding vouchers, rideshare partnerships, and shuttles, expanding access, and evaluating effectiveness for sustainability)
Support non-clinical recovery activities
Provide grants to community-based organizations to offer job readiness programs, life skills classes, and sober community events that are not reimbursable by Medicaid.
(Within one year, support non-clinical recovery activities by funding community organizations to provide job readiness, life skills, and sober events, then expanding and evaluating impact)

Individuals with Co-Occurring Mental Health and SUD?
Expand integrated dual-diagnosis treatment programs
Fund program development and workforce training to deliver coordinated SUD and mental health care within the same setting.
(Within one year, expand integrated co-occurring treatment by funding programs, training staff, developing protocols, launching services, and evaluating outcomes)

Improve cross-system care coordination
(Within one year, improve cross-system care coordination by developing agreements, training staff, expanding the intensive care coordination team to address the needs of children and youth, implementing referral pathways, and evaluating continuity of care)
Enhance workforce training
(Within one year, enhance workforce training by developing and delivering IDDT-focused professional development, expanding participation, and evaluating impact for sustainability)
Increase high-intensity/residential capacity
(Within one year, increase high-intensity residential capacity by funding facilities, upgrading infrastructure, recruiting specialized staff, launching integrated services, and evaluating outcomes)

Services for Persons with SUD Who Have or Are at Risk of HIV/AIDS?
Co-locate HIV services within SUD programs
Fund integration of HIV education, testing, and linkage and referral to treatment in substance use treatment settings.
(By December 2025 we will fund at least one provider (dependent on qualified applications))
Standardize HIV risk screening
Require and support routine HIV risk assessments and prevention education during intake and throughout treatment.?
(By January 2026 subgrantees will have HIV risk assessments and identified linkage coordinators)
Strengthen referral pathways
Establish direct referral agreements with HIV care providers and fund linkage coordinators to ensure immediate follow-up.
(By January subgrantees will have referral agreements)

Services for Persons with SUD Who Have or Are at Risk of Tuberculosis?
Integrate TB screening in SUD settings
Fund the implementation of routine TB testing in outpatient, residential, and detox programs.
(Within one year, fund and implement routine TB testing in outpatient, residential, and detox programs through planning, training, piloting, expansion, and evaluation)
Coordinate TB treatment with SUD care
Partner with public health agencies to provide onsite TB treatment in SUD programs for clients with active or latent TB.
(Within one year, coordinate TB treatment with SUD care through partnerships, protocols, staff training, integration, and evaluation)
Improve public health coordination
Create formal communication protocols between SUD providers and DC Health for TB case reporting and management.
(Within one year, improve public health coordination by establishing formal TB reporting protocols between SUD providers and DC Health through planning, protocol development, training, piloting, expansion, and evaluation)

Provide provider training
Develop training modules for SUD staff on TB symptom recognition, prevention, and referral procedures.
(Within one year, provide provider training by developing and delivering TB modules for SUD staff on symptom recognition, prevention, and referral through planning, curriculum design, piloting, rollout, and evaluation)

Services for Individuals in Need of Substance Use Primary Prevention
Current DC Prevention Centers (DCPCs) and future grantees will be funded by DBH to implement group-level evidence-based interventions and community level environmental strategies in each of the eight wards in Washington DC. This will allow grantees to address to increase protective factors for residents in the District of Columbia and provide them with positive alternatives to engaging in substance use. By working together to address risky behaviors, the District and the funded communities can more

effectively begin to overcome the public health challenges such as substance use among target populations.
(The current DC Prevention Center grantees will continue to be funded through FY2026. A Request for Applications will be available in quarter 4 of FY2026 to be applied for and awarded for FY2027)

Currently, all four DCPCs are encouraged to build a partnership with a high school and a middle school in their designated wards. DBH plans to scale up the proposed partnerships to four schools per each DCPCs and increase outreach and educational efforts around substance use prevention within these schools, Since, prevention education is not consistently embedded in school curricula, DCPCs funded by DBH will provide the educational interventions within classroom settings.
(In the first year of the new award, the DC Prevention Centers school partnership requirements will increase from 2 to 4)
DBH plans to build the capacity of its existing internal workforce as well as current and future grantees through training and hiring. These capacity building efforts will provide the resources needed for local Community Prevention Networks (CPNs) and/or organizations to become eligible and technically equipped to apply for future funding.
(DBH will develop at least 2 training opportunities for community organizations and/or new grantees. Additionally, DC Prevention Centers will increase their training efforts within the community to increase from identifying 15 new CPNs to 30 by FY2027)

Priority Population – Youth, Youth Residential Treatment
To account for the complexities in delivering Level 3.5 services to youth, DBH will develop certification regulations for youth Level 3.5 services upon the publication of updated youth ASAM criteria in 2026.
(Upon release of ASAM: 4th Edition: Adolescent & Transition Age Youth Volume, DBH will develop a workgroup in partnership with the Department of Health Care Finance to develop a State Plan Amendment (SPA) specifically for youth substance use treatment services.
Community Service Reviews & Independent Peer Reviews
Update the review tool to reflect the current services and practices and will leverage the updated CSR tool to facilitate provider peer reviews.
(Publish solicitation for vendor to update CSR tool, Q1, FY26. Award contract and begin CSR work, Q2, FY26. Finalize CSR tool, Q3, FY26. Begin CSR reviews, Q4, FY26.)
DBH will utilize its Training Institute to deliver professional development to individuals on the CSR review process and tool.
(Beginning in Q3, FY26)
Adapt the CSR tool for SUPTRS Independent Peer Review requirement also utilizing the Training Institute for training to treatment providers on usage of the tool and understanding results.
(Q3, FY26)
Identify at least 5% of SUD treatment program sample. Conduct Independent Peer Reviews. Analyze and report results.
(Q4, FY26 and Q3, FY 27)

Mental Health & Substance Use
Certified Peer Specialists
Continue Developing the Peer Specialist Program
Including specialized peer roles focused on youth, families, justice-involved individuals, and those with co-occurring disorders.
(Update training material for facilitators and participants within one year)
Expand Access Across Communities
Prioritize underserved populations and ensure services are relevant, trauma-informed, and recovery-oriented.
(Conduct annual survey to peers/consumers regarding access to peer support across communities and quarterly strategy sessions to expand access, collaborate and implement).
Provide Continuing Education and Career Pathways
Support peer workforce development through advanced training, certifications, supervision, and career ladders to retain talent and maintain service quality.
(Offer at least 3 elective training courses for peers quarterly)
Provider Education on Supervising Peers and Understanding the Peer Role
(Offer bi-annual training)
Pilot New Initiatives
Launch peer-led crisis response teams, peer-run drop-in centers, and support groups tailored to addiction recovery, co-occurring disorders, and transitional support. Increasing/incorporating peer supports in those settings.
(TBD Monthly strategic planning and quarterly reporting on progress/next steps)
Update Facilitator and Participant training materials and programming of Peer Support in our Behavioral Health System.
(Complete updates in one year)

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

Footnotes:

DC Department of Behavioral Health

SUPTRS Block Grant, FY26-27 Combined Plan

EIS/HIV Work Plan – Services for Persons with SUD Who Have or Are at Risk of HIV/AIDS

Goal: Co-locate HIV services within SUD treatment programs

Objective: Utilize SUPTRS block grant funding on the integration of HIV education, testing, and linkage and referral to treatment in substance use treatment settings to ensure compliance with § 96.128 and § 300x-24.

Activity	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sept.	Oct.	Nov.	Dec.
Draft RFA	x															
Leadership Review of RFA	x															
RFA Released		x														
Applicants Due			x													
Applications Reviewed			x													
Funding Awarded				x												
Program Orientation/Training					x											
Program Implementation					x											
Monthly Data Report						x	x	x	x	x	x	x	x	x	x	x
Monthly Progress Report						x	x	x	x	x	x	x	x	x	x	x
Program Monitoring						x	x	x	x	x	x	x	x	x	x	x
Technical Assistance (As requested or required)						x	x	X	x	x	x	x	x	x	x	x
Site Visits										x	x	x				

Activity Descriptions:

1. **Draft RFA** – Collaborating with the Grants Management Office, program staff will draft the request for application (solicitation) to provide funding to DBH certified SUD treatment providers to support HIV education, testing, linkage and referral for consumers in treatment. The RFA will require subgrantees to provide HIV education and risk assessment and prevention services for all consumers enrolled in their treatment program. Additionally, it will provide funding for the purchase of HIV testing supplies which shall be used to provide onsite rapid HIV testing. Lastly, subgrantees will be required to identify linkage coordinators in their program that will develop a referral network that aligns with the DC Health HIV Red Carpet Entry Sites to ensure unfettered access to HIV post-testing care. Linkage coordinators will be responsible for ensuring consumers have knowledge of, and access to HIV treatment.
2. **Leadership Review of RFA** – RFA is routed for review and approval by executive leadership.
3. **RFA Released** – RFA competition is open for 30 days.
4. **Applications Due** – Upon receipt of applications, documents are reviewed for compliance and prepared for evaluation.
5. **Applications Reviewed** – Independent reviewers receive applications and rubrics to score and participate in consensus conference. Reviewers provide award recommendations.
6. **Funding Awarded** – Funding recommendation is reviewed and executed by agency director.
7. **Program Orientation/Training** - DBH will meet with subgrantees to orient them to detailed requirements of the grant and ensure training around HIV education, testing, linkage and referral services.
8. **Program Implementation** – Subgrantees will begin HIV education, testing, linkage and referral services with consumers enrolled in their treatment program.
9. **Monthly Data Report** – Subgrantees will submit monthly data reports that include the number of consumers that received education and testing, test results and linkage and referral
10. **Monthly Progress Report** – Subgrantees will provide a written report that outlines program progress and challenges.
11. **Program Monitoring** – DBH program monitor will conduct monthly meetings with subgrantees to review data, and progress reports.
12. **Technical Assistance** – DBH program monitor will provide technical assistance for identified challenges.
13. **Site Visits** – DBH program monitor will conduct at least one site visit to each subgrantee to review program goals, progress and overall implementation.